DOMESTIC HOMICIDE OVERVIEW REPORT

REPORT INTO THE DEATH OF VICTIM Susan

Report produced by Peter Stride – Foundry Risk Management Consultancy

On behalf of Safer Somerset Partnership

May 2019

FOREWORD

The Safer Somerset Partnership would like to express their condolences to all those affected by the sad loss of Susan. We sincerely hope the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future. As the Independent Chair of the DHR Panel, I would like to thank all agencies who, contributed to the process in an open and transparent manner. This review has demonstrated that more needs to be done to raise awareness and change attitudes towards domestic abuse. Also that it is crucial to offer appropriate and timely help and advice to victims, their families and friends, and to professionals. I am confident the learning points and recommendations will provide a platform to help national, regional and local agencies to implement measures designed to prevent what happened to Susan from happening to others.

Following Susan's death, there is emerging evidence of positive change at a local level. We all must do our utmost to take immediate action both to protect the victim and to deal effectively with the perpetrator and I would urge everyone to take note and act on the findings of this Review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline and community level to help bring domestic abuse to an end.

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INTRODUCTION

The key purpose for undertaking a Domestic Homicide Review is to enable lessons to be learned, about the way in which local professionals and organisations work individually and together to safeguard and support victims of Domestic Abuse including their families. Also, clearly identify lessons to be learned including policy changes and improved inter-agency working.

This Domestic Homicide Review was commissioned by the Safer Somerset Partnership, following the death of a female at an address in Somerset. A 36-year-old female died from injuries following an assault by her former partner.

This Domestic Homicide Review examines agency responses and support given to Susan and Daniel prior to her death.

ANONYMITY

In order to maintain anonymity, the various parties referred to in this review have been provided with alternative identities.

Deceased	-	Susan
Assailant	-	Daniel
Deceased Mother	-	Catherine
Deceased Father	-	Tom
Deceased ex-husband	-	John
Assailants ex Wife	-	Debra
Susan and Daniels Child	-	Baby A

Susan and John had 3 children who will be referred to as B, C & D. Daniel and Debra had 2 children who will be referred to as E & F.

In April 2017 Susan became friendly with another male, subsequently they were arrested on several occasions for theft. He will be referred to as Sam.

TIMESCALES

The Chair of the Safer Somerset Partnership decided to commission a DHR on 29th December 2017. Subsequently the initial Review Panel took place on the 5th March 2018 and agreed Terms of Reference. Matters of Confidentiality were set out within a Confidentiality Agreement signed by all stakeholders. This review considers agencies contact with the victim from November 2010 until her

death i.e. 7 years prior to Susan's death. This timeframe was agreed as being appropriate to capture all the relevant circumstances which reflected:

- The relationship between Susan and Daniel
- Significant milestones affecting the emotional state
- Their engagement with Somerset agencies.

There were three subsequent panel meetings on the 11th July, 3rd and 22nd October 2018. These meetings allowed for the panel to discuss the analysis of the Individual Management Reviews by the chair.

CONFIDENTIALITY

Details of confidentiality, disclosure and dissemination were discussed and agreed, between panel member agencies during the first panel meeting and all information discussed was treated as confidential and not to be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

All agency representatives were personally responsible for the safe keeping of all documentation that they possessed in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

It was recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or gcsx. Confidential information must not be sent through any other email system. Documents may be password protected. The Overview and Executive Reports will not be published until passed by the HO QA panel'.

DISSEMINATION

The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed below

Peter Stride	-	Independent Chair and Overview Report Author
Mark Wolski	-	Vice chair
Peter Brandt	-	BGSW Community Rehabilitation Company
Kristy Blackwell	-	Sedgemoor District Council
Lucy-Antoinette Duncombe	-	Taunton & Somerset NHS Foundation Trust (Musgrove)
Saj Rizvi	-	Avon and Somerset Police
Punita Bassi	-	Avon and Somerset Police
Julia Burrows	-	Somerset Partnership NHS Foundation Trust
Michael Hammond	-	Barnardo's (SIDAS)

Mel Thomson	-	LiveWest (SIDAS)
Dr Andrew Tresidder	-	Somerset Clinical Commissioning Group
Christian Sweeney	-	Somerset County Council Children Social Care
Suzanne Harris	-	Somerset County Council Public Health.

Plus it will be circulated to:

- Safer Somerset Partnership
- Somerset Safeguarding Adults Board
- Somerset Domestic Abuse Board
- Avon and Somerset Police Crime Commissioner

The reports will also be published online at www.somersetsurvivors.org.uk (the local Somerset domestic abuse website).

REVIEW PROCESS

The review has been conducted in accordance with statutory guidance under s.9 (3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

There were no other reviews conducted contemporaneously that impacted upon this review.

EQUALITY AND DIVERSITY

The chair of the review and review panel considered whether the protected characteristics of:

- Age
- Disability,
- Gender reassignment,
- Marriage and Civil Partnership,
- Pregnancy and maternity,
- Race
- Religion and belief,
- Sex
- Sexual orientation,

were relevant in this review. The panel noted that Susan was 36 years old at the time of her death. She was a white heterosexual female. Daniel was 42 years old at the time of Susan's death and was a white heterosexual male. There was no information available to indicate that either person had a disability. There was no reason to believe that either party had any particular religious beliefs and while they remained a couple for a significant period of this review it is not believed they were ever married. Between late 2015 and June 2016 Susan was pregnant with Baby A, and the removal of the baby appears to have had a significant impact on the emotional state of Susan and Daniel, both as individuals and as a couple and ultimately their relationship ended.

As pregnancy is part of characteristic 5 the panel considered whether her access to services (Particularly mental health and substances misuse) was negatively impacted due to her condition. In fact, the chair and panel felt that Susan's pregnancy raised the engagement of services in supporting her.

TERMS OF REFERENCE

At the initial panel meeting the chair presented a draft copy of the Terms of Reference (ToR). They were agreed and circulated along with an IMR template, which was to be completed by agencies that were reporting contact with Susan and family. Following a subsequent panel meeting the ToR was amended to include subject i). This amendment was shared with Catherine, the victim's mother.

The terms of reference are summarised below.

a) Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.
b) To review the involvement of each individual agency, statutory and non-statutory, with Susan and Daniel during the relevant period of time: 1st January 2010 and the date of the homicide.
c) To summarise agency involvement between 1st January 2010 and 23rd of November 2017.
d) To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
e) To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
f) To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
g) To commission a suitably experienced and independent person to:
    - chair the Domestic Homicide Review Panel;
    - co-ordinate the review process;
    - quality assure the approach and challenge agencies where necessary; and
    - Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) The review considered a variety of themes which developed throughout the process including Mental Health, Substance Misuse and Susan's pregnancy with couple's child (Baby A). Panel members and IMR authors were asked to consider these issues within the context

of the reported domestic abuse, their engagement with partner agencies and decisions made during and following those engagements.

j) On completion present the full report to the local Community Safety Partnership.

The review process identified the follows themes upon which to focus its areas of learning and development:

- Dash Risk Assessment
- Multi Agency engagement
- Mental Health Assessments

CONTRIBUTORS

These Overview and Executive Reports are anthologies of the information and facts provided by the organisations represented on the panel. These are the agencies drawn together by Safer Somerset CSP as being those responsible for providing support for Susan, Daniel and relevant family members. Each agency provided a chronology of events and Individual Management Review (IMR) containing their record of contact, analysis of performance, identification of good practice, and lessons to be learned with recommendations for improvement. IMR's are carried out by senior management not connected with the events and the chair has been reassured regarding the independence of the panel members.

- Bristol Gloucestershire Somerset and Wiltshire Community Rehabilitation Company
- Somerset County Council Children Social Care
- Taunton & Somerset NHS Foundation Trust (Musgrove Hospital)
- Avon and Somerset Police
- Somerset Partnership NHS Foundation Trust
- Barnardo's (SIDAS – the local Specialist Domestic Abuse Service)
- Somerset Clinical Commissioning Group
- LiveWest (SIDAS – the local Specialist Domestic Abuse Service)
- Somerset County Council Adult Social Care

REVIEW PANEL

The review panel consisted of:

Name	Job Title	Agency
Peter Stride	Independent chair and Overview Report Author	Foundry Risk Management

Mark Wolski	Vice chair	Foundry Risk Management
Peter Brandt	Assistant Chief Probation Officer	BGSW Community Rehabilitation Company
Kristy Blackwell	Community Safety Manager	Sedgemoor District Council
Lucy-Antoinette Duncombe	Governance and Quality Improvement Matron	Taunton & Somerset NHS Foundation Trust (Musgrove)
Saj Rizvi	Detective Inspector	Avon and Somerset Police
Punita Bassi	Safeguarding Review Author	Avon and Somerset Police
Julia Burrows	Associate Director	Somerset Partnership (SOMPAR) NHS Foundation Trust
Michael Hammond	Children's Service Manager	Barnardo's (SIDAS)
Mel Thomson	Strategic Business Manager	LiveWest (SIDAS)
Louise White	Adult Safeguarding Manager	Adult Social Care
Dr Andrew Tresidder	Patient Safety Lead	Somerset Clinical Commissioning Group
Christian Sweeney	Operations Manager	Somerset County Council Children Social Care
Suzanne Harris	Senior Commissioning Officer	Somerset County Council Public Health

Where required, panel members organised completion of an individual management review (IMR) for their agency. An IMR is a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation. The IMR process is not designed for identifying gaps in the actions/activities of other organisations. Its purpose is to look openly and critically at individual and organisational practice and at the context within which people were working.

All panel members reviewed all agency's IMRs as part of the review process.

AUTHOR AND INDEPENDENT CHAIR

Peter Stride was appointed by the Safer Somerset Partnership as Independent Chair and Author of this Domestic Homicide Review panel. Peter is a retired Metropolitan Police Officer and has over 30 years of detective experience in the field of Domestic Abuse, Public Protection and Safeguarding in London. His experience includes specialist and generic investigative roles at New Scotland Yard and the boroughs of Westminster, Brent and Harrow.

As Detective Chief Inspector he has been the vice chair of two Local Adult and Children's Safeguarding Boards and was responsible for the creation and implementation of various MASH and MACE panels as well as chairing MAPPA and MARAC meetings.

Since retirement Peter has established his own business consultancy, coaching and training in a range of risk management environments focusing upon child and adult safeguarding within the public sector.

Vice Chair
Mark Wolski was appointed by Safer Somerset Partnership as Independent Deputy Chair of the DHR Panel and is the co-author of the report. He is a former Metropolitan police officer with 30 years operational service, retiring in February 2016. He served mainly as a uniformed officer, holding the role as Deputy Borough Commander across a number of London boroughs.

During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding. Mark has subsequently acted as a consultant in the field of Community Safety, Independent Chair of a MARAC Steering Group and as a DHR chair/co-chair.

Peter and Mark have both completed Home Office approved training and received subsequent training by Advocacy After Fatal Domestic Abuse.

Neither Peter nor Mark have any connection with Safer Somerset Partnership or any of the agencies involved in this review.

BACKGROUND INFORMATION (THE FACTS)

THE HOMICIDE OF SUSAN

In November 2017 police received a call from Daniel who reported that Susan had stabbed herself several times and was dead. Officers attended the scene and discovered Susan in the first-floor bedroom.

A post mortem examination was carried out and the pathologist concluded that the cause of death was: "Multiple stab wounds to the neck and chest".

Daniel was arrested on suspicion of murder and at a subsequent trial was found guilty and sentenced to life imprisonment.

RELATIONSHIP HISTORY

Details of the incidents leading up to the death of Susan in November 2017 have been difficult to confirm and the chair has been reliant upon anecdotal evidence and agency reporting.

Prior to meeting, Susan and Daniel had both been in long term relationships. Susan had been married to John and they had 3 children. Daniel had been married to Debra and had 2 children. The IMR's suggested that Daniel had made of number of violent threats towards Debra including using knives and bottles from as early as 2001. In 2011 Daniel was involved in a serious car crash which seems to have significantly negatively impacted on his mental health. By 2013 Daniel had been admitted to an inpatient ward for treatment by the Mental Health Services team and it was during this time that his relationship with Debra ended.

In 2014 Daniel remained in contact with Debra and demonstrated acts of coercive control towards her with various physical acts and texting behaviours. E.g. Despite correspondence from Debra's solicitor, Daniel continued texting and messaging Debra and their daughter telling them that he couldn't live without them, and how they will "all join each other in heaven". This led to police involvement. However Debra was reluctant to support any police actions and no prosecution was ever pursued, although a DASH risk assessment graded this as a 'High Risk' case.

In 2015 Daniel met Susan at a social club in Somerset and they moved in together quite shortly afterwards. The details of the relationship and involvement with a variety of Community Safety partners is detailed below and their problems appear to revolve around the issues of Mental Health, Drugs and Alcohol. Their relationship was highly volatile with many calls to police to settle domestic disputes.

Later in 2015 Susan fell pregnant with Daniel's child, and further issues were raised due to the couple's inconsistent engagement with Children's Social Care. The ongoing and deteriorating situation led to a child protection plan being put in place, when the couple's child (A) was born in June 2016. Shortly afterwards Baby A was removed into foster care, before returning to Daniel and Susan in November 2016. Within a few weeks Baby A was again removed into foster care and Daniel and Susan subsequently separated.

In December 2016 Susan had moved in with Sam who lived locally, however she and Daniel appeared to remain in regular contact often making threats of harassment and reports of going missing. Records show irregular but frequent calls to the police including a call in June 2017 when Susan attended Daniel's home, shortly after the final adoption hearing regarding Baby A. In July 2017 Sam and Susan were arrested on two separate occasions for theft related crimes.

The chair has considered whether Susan was the victim of any kind of coercive control or economic abuse during her relationship with Sam particularly as a result of evidence of thefts. Details of Susan's relationship with Sam were never fully confirmed and appeared to be quite brief. It is believed that Sam paid a month's rent on a property which the couple shared. The couple were arrested for theft and Susan told officers that Sam had a hold over her as he had paid the rent. This allegation was never pursued as an allegation of domestic abuse however, it seems to have been an opportunity to investigate the relationship between the two. It's unclear if they were in an intimate relationship. There were reported domestic incidents regarding Sam and Susan's relationship, although both parties were interviewed about other matters on several occasions.

FAMILY INVOLVEMENT

The chair and co-chair assumed responsibility for contacting Susan's parents and the details of their interviews is detailed in sections 35 -38 and 39 – 45. It was agreed that Catherine would act as the families point of contact, the chair confirmed that her relationship with Tom was friendly and they got on well. It was agreed that she would keep family members, including Susan's ex-husband (John), up to date on the progress of the review and also feedback, questions and commentary as the process moved forward. Tom and Catherine were provided with details of both statutory and voluntary agencies who were able to support them in understanding the purpose and process of a Domestic Homicide Review.

The chair discussed and agreed the terms of reference (ToR) with Catherine and ensured that she had plenty of time consider what was being proposed. Once agreed with the family, the 'confirmed' ToR document was shared with the panel members.

The chair recognised the benefit of having family engagement with the Review Panel and therefore invited both Catherine and Tom to meet the panel and provide a family perspective. Due to ill health and problems with travelling neither party were willing to take up the offer so instead the chair maintained a strong line of communication with Catherine, including letters and telephone conversations.

Once draft copies of the Overview Report had been prepared, they were shared with Catherine and the victim's sisters and their feedback invited. Catherine and her family wished to pass on their gratitude at the energy and hard work which had been put into the whole review process and this was passed on, to the panel, by the chair.

HISTORY AND BACKGROUND

Susan's Mother - Catherine – Summary of interview with the chair

Catherine was interviewed by the chair and the following is a detailed summary of that conversation.

Catherine and Tom married when she was very young. He was older than Catherine and she found him to be very controlling, probably due to his army background. Susan was born not long after they were married, and Catherine found the situation overwhelming and as a result left the family in Somerset and returned to London. Catherine's opinion was that Susan was better off living with her father.

Catherine and Susan were separated for 17 years and in recent times Catherine had started to make efforts to find Susan. She was aware that Susan had been into foster care for a period, during her childhood. Eventually (several years ago) Catherine received a phone call from Susan and their relationship was re-established. They became very close and Catherine met Susan's husband (John) and their 3 children (C, D and E). Catherine's opinion of Susan was that of her being the model mother and wife, very house proud and wanting the best for her family. Susan was very strong willed and often pushed John for money. Eventually Susan and John's marriage broke down; Catherine's recollection of this is vague although, when questioned, she confirms that domestic abuse was never mentioned, and that John remained very co-operative. John was awarded custody of the children and this appears to have affected Susan very badly. Catherine described Susan as someone who needed to be loved and consequently, she began to bring several boyfriends to visit. Most of them were not to Catherine's taste, including one older man who had to be asked to leave as he became very aggressive.

Catherine never met Daniel or knew anything about him. Catherine paints a picture of great regret at having been absent from her daughter's life for so long and believes that this may have had a significant impact of Susan. She describes herself as a parent who allowed her children to get on with their lives and be there for them when they needed her. She was unaware of any Mental Health, Drink or Drug issues.

Susan's Father - Tom - Summary of interview with the Co-Chair

Tom was interviewed by the review's co-chair and the following is a detailed summary of that conversation.

Tom brought Susan up as a single parent, following his separation from Catherine and described her as a happy child and that they had a 'brilliant' relationship. Tom confirmed that Susan had very little contact with her mother growing up and didn't demonstrate any medical issues. Susan was a peaceful child who grew up to be a brilliant and caring mother.

Susan left home at the age of about 17 or 18 to marry John. Tom felt she was too young and knew that John had previously been in a relationship and had children, and that Susan was a natural 'step-mother'. Tom describes issues of domestic violence within their relationship and eventually they split up.

Tom met Daniel in 2014 and knew that he had been married before and that the relationship had broken down due to his abusive and threatening behaviour towards the children. He asked Susan about Daniel and she described him as having 'strange ways' (during a separate conversation, with

Tom, Daniel described Susan in the same way but that "he loved her to bits", and "she was very special").

Tom knew that Daniel didn't work and so he would help, from time to time, sending £40 or £50 whenever Susan asked. He thought it was possible that Susan may have taken drugs. He describes their lifestyle as being very unusual, they would spend £10 - £12 on a sandwich and coffee and drove an expensive Audi car, but couldn't afford the 'basics'.

Tom knew that Susan and Daniel had a child and thinks the child may have been adopted.

Tom appears to feel that more should have been done to support Susan and she had enough of a support network around her to get the help she needed. He assumes that she was too embarrassed to seek help and that when he felt there were problems, he had called his own GP to find out more. The GP had reassured him that everything was fine.

With regards to police involvement, Tom's only recollection was during an incident when Susan had reported Daniel missing and the police had called as part of their enquiries.

ATTEMPTS TO CONTACT THE PERPETRATOR

Daniel has been in prison throughout the period of this review. The chair has contacted both his legal representatives and to the prison directly in order request a meeting with Daniel. The chair has written to Daniel and sought support from prison authorities to ensure that letters have been delivered to him. Despite these efforts no contact has ever been granted and access to medical records never been given.

TIMELINE OF RELEVANT EVENTS AND REPORTED CONTACTS WITH AGENCIES

This section summarises information known to each agency who were identified as having contact with Susan and Daniel in the 7 years prior to the Homicide. Each agency was provided with copies of ALL the IMR's and given the opportunity to provide written and verbal feedback regarding the quality and validity of each report. This quality assurance process ensured high quality outcomes for each IMR and the panel was satisfied that the process reached expectations.

2010

During a visit to the GP surgery on **17th August 2010**, along with a 'friend', Susan referred to her husband (John) as being abusive and alcoholic, however it was afterwards that the surgery provided support to Susan's husband in gaining custody of the children, following the couples divorce.

2013

On the **25th June 2013** police were called to an incident, separately by Susan and John. The circumstances involved a verbal argument at John's address during the collection of the children. No criminal offences were disclosed, and the matter was referred to the police's Safeguarding Co-ordination Unit (SCU). Susan's risk was assessed as standard and no further action was taken. The IMR author was satisfied that a suitable risk assessment process was followed, however no formal 'Domestic Abuse, Stalking and Harassment, Honour Based Violence' (DASH) risk assessment was recorded.

July 2013, Daniel was referred to Somerset Partnership (Sompar) by his GP due to concerns about his deteriorating mental health and increased levels of aggression towards Debra, who had left the family home with their children. Debra had moved to her parents due to Daniels behaviour and to protect the children from his bizarre and aggressive actions. On the **17th July** the CRHTT, via a Mental Health Social Worker were in contact with Daniel and a crisis slot was offered. He received daily support from the Sompar home treatment team between the 17th and 23rd and the Crisis team assessed a psychiatric overview, however his condition continued to deteriorate.

21st July 2013, Debra called the police and reported Daniel missing, following a night out. She described his low mood and incidents of self-harming (i.e. cutting his arms). Daniel sent a text to Debra stating, "I'm lost - wish I had someone to help me why aren't you here when I'm being beaten up, hand bleeding, stupid people shit life". Consequently, the risk was categorised as High. An officer visited Daniel's home and found him there, fit and well. No DASH Risk Assessment was completed as the matter was reported as a missing person and not as a Domestic Incident.

23rd July 2013 Daniel was informally admitted to an 'acute mental health inpatient ward' where he remained until **23rd September 2013.** During this admission (on 12th August 2013), Debra disclosed a history of verbal and physical abuse by Daniel as well as controlling and harassing behaviour and threats to kill her. Staff sought advice from Sompar safeguarding team however no DASH risk assessment was completed.

On **30th July 2013** Matters were noted in the Sompar records of safeguarding children's concerns regarding the situation of Daniel having 'home leave' and it is unclear if these were ever brought to the attention of the Children's Social Care (CSC) or Sompar Safeguarding Children's Team[1].No further action appears to have been taken.

On **8th August 2013** it was recorded, by Sompar, that Daniel had become fixated on Islam and rape. He remained in hospital.[2]

On **10th August 2013** it was recorded by Sompar, that Daniel was putting pressure on Debra for him to leave hospital early in order to have sex. No further action appears to have been taken.

[1] The IMR records do not show any such referral by the inpatient ward staff.
[2] The IMR author records that the mental health inpatient ward staff could have gathered and shared this information and considered further action.

13th August 2013. Debra called police to inform them that Daniel had voluntarily admitted himself into the local mental health care. She is concerned that he will come to her home and cause trouble as she considered his mental health to be deteriorating. She also described historic incidents of Daniel self-harming and attempting suicide. She informed police that she does not want any action taken and the details were recorded on the police tasking and resourcing system called 'Storm'[3]. The author's analysis recognised a variety of high-risk indicators including:

- Escalation of behaviour
- Threat of Harm
- Separation between partners
- Child contact issues
- Use of weapons
- Animal Abuse
- Deteriorating mental health

The IMR author also notes the absence of a DASH risk assessment despite the informant's willingness to engage with the Police.

On **22nd August 2013** Daniel was interviewed by a local housing officer, from Sedgemoor District Council, whilst as an in-patient at a local hospital in Somerset. His application was as a single person and appears to be linked to the break-up of his marriage to Debra.

23rd September 2013 Daniel was discharged from the acute mental health inpatient ward and received on-going support in the community from the mental health services until **December 2013** when he was discharged under the 'orange card' scheme. This scheme was a fast track method back into the Mental Health Support services as patients required.

9th December 2013 A report from a mental health worker confirmed concerns for the safety of Debra and their children. Daniel had visited her address the previous evening, apparently drunk, to see their children. Debra had been too frightened to call the police and Daniel had threatened to kill himself if she involved the police or their families. The IMR records that no Mental Health assessment had been deemed necessary as this incident had been alcohol related and was not interpreted as a deterioration of his mental health. There are various safeguarding activities completed by the police including a 'flag' to treat all calls to the address as urgent. However, a DASH risk assessment was not completed, and the police log recorded that no offences had been disclosed.

This incident was considered by the Sompar Safeguarding team and it was advised that a CAADA (DASH) Risk Assessment should be completed if the circumstances deteriorate.

On **11th December 2013** Debra contacted CSC as Daniel had visited her home and threatened to hurt himself. She had called the police who had visited the house, but Daniel had left. No further action was taken by CSC.

[3] http://www.high-availability.com/downloads/STORM_HAC_Clustering.pdf

2014

On **4th February 2014**. Debra reports that her daughter and herself were receiving 'messages' from Daniel despite instructions from her solicitor that he shouldn't be making such contact. The messages stated that Daniel couldn't live without them and that they would 'join each other in heaven'. The purpose of the solicitor's letter was to remind both parties of their responsibilities and accumulate evidence if the advice is not heeded.

Debra became concerned that he may visit her address and harm both the children and her. The police collated information from various internal data bases and completed a DASH risk assessment, which recognised several triggers:

- The ex-partner as a 'HIGH RISK' victim;
- Suitable for a Multi-Agency Risk Assessment Conference (MARAC) referral;
- There had been an absence of DASH reporting previously;
- The ex-partner 'needed' a referral to local Victim Support Services (VSS).

This matter was closed as Debra did not want Daniel contacted as she didn't find the messages harassing and feared police contact with him would make things worse.

On **6th February 2013** a multi-agency meeting was held, not believed to be a MARAC,[4]and the risk of immediate harm to Debra was assessed as low. A plan was proposed to have Daniel's mental health assessed[5]. The DASH assessment was down-graded to medium, partly as Debra did not wish to pursue the complaint. The IMR author expresses concern at the lack of rationale for reducing this risk.

After **March 2014** Daniel was struggling to deal with Debra leaving and began to receive support from the local Community Mental Health team (CMHT), however this ended in **March 2015** as he no-longer required secondary Mental Health support. There was an on-going plan for him to receive further assistance from 'Rethink'[6].

1st April 2014. Contact from child B and C's school to Children's Social Care, with regards to their contact with Daniel. He had made comments relating to not letting the children be with their mother. The children were reported to be scared of Daniel and there is a high level of anxiety.

On **17th April 2014** Susan was interviewed by the Housing Officer as she was seeking a private tenancy deposit. This was awarded on **22nd May 2014** and Susan moved into a property in the Sedgemoor area of Somerset.

[4] Minutes/notes of this meeting no longer exist.

[5] There is no evidence of this assessment taking place

[6] Rethink is a national charity who offer a local outreach and resettlement program for people with long-term enduring mental health needs who require support to maintain a tenancy and increase their skills and confidence whilst working towards independence and recovery. This process was part of Daniel's Care Plan and Review.

On the **4th September 2014** Susan attended Musgrove Hospital and was diagnosed as having renal colic[7].

9th November 2014. There is a 'domestic incident' during a supervised visit to Debra's home by Daniel, to see their children. Daniel became upset when Debra confirmed that she was moving to a new house. Consequently the children became upset and Debra called the police. She told the call handler that she was scared of Daniel's unpredictable behaviour. She was advised to call 999 if anything further happened. The IMR author noted that, by this time, the Avon and Somerset Police's Lighthouse Victim and Witness Care unit[8] had gone live and that due to the domestic history with her ex-partner it would have warranted a referral.

16th December 2014. The school of child E contacted CSC to provide information with regards to disclosures made about Susan's behaviour at home, including sex with various partners and heavy drinking. CSC were also concerned about Susan's mental health, and there were issues over the children missing school because of a lack of sleep. CSC decided to progress matters to a 'Child and Family Assessment' and as documented below the children were taken into the care of John.

24th December 2014. A call was received from the South West Ambulance Service Trust (SWAST) from child E. She was at home and couldn't wake Susan up. Also, in the house were children D and F. John arrived during the phone call. A conversation took place with the allocated social worker and it was agreed that it was best for the children to stay with John.

7th December 2014 Susan contacted the police to tell them she had concerns over John's ability to take care of their children, who are staying with him. A police visit confirmed that all was well, and advice was given regarding civil remedies and consultation with Children and Family Services.

2015

3rd January 2015 Police are called to a sandwich bar by a male who was a friend of Susan's. Officers discovered Susan and the children (B C & D) sitting separately from John who appeared to be shaken at police attendance. This 'meeting' appeared to be part of the access arrangements for Susan to see her children. Susan told officers that she was afraid of John and wanted to take the children home with her. John was spoken to by police officers and informed them that he was looking after the children as CSC had concerns about Susan's ability to look after them. The children were spoken to separately and confirmed that they would rather stay with their father. No offences were disclosed; however, the author notes that no DASH assessment took place as Susan chose to disengage with the officers. Referrals were made to Children's Social Care and the children's schools. Susan's mental health issues and chaotic lifestyle appear to have been the main contributing factors towards the removal of the children into John's care.

[7] https://www.healthline.com/health/renal-colic

[8] Lighthouse was established to ensure that particularly vulnerable victims are provided with an enhanced service, including details of how crimes are investigated and the victim's role with it, this includes enabling access to restorative justice and support.

29th January 2015 John called police and informed them that Susan had contacted him and stated that she wanted to 'end it all'. Police officers spoke, in person, to Susan who confirmed that this wasn't her intention and that she just wanted to see her children, as she hadn't seen them in a month. Susan told officers that John was very controlling. Officers established that John was seeking to take legal action to safeguard the children due to Susan's chaotic lifestyle and mental health problems. The police sent an intelligence report to CSC informing them of this incident. As John was taking care and responsibility for the couple's children and had begun legal action to have full time care, no further action was taken following this incident.

18th February 2015 A family assessment was completed with regards to children B, C and D. The decision is taken to close the assessment, as the most pressing concern was contact with the children and arrangements were being made through the court process.

On 2nd March 2015 Susan went to the GP and alleged that in 2014 she had been admitted to 'hospital' as a culmination of Domestic Abuse which she had suffered at the hands of John. Susan was seeking support in her application for legal aid. The IMR author comments that the GP maintained a supportive attitude including a letter for court. There were no allegations or notes of recent abuse and Susan did not attend a subsequent 3-week case review.

On the **16th March 2015** the GP wrote to Susan regarding a recent visit and a request that Susan had made to support her application to receive legal aid. The application appears to reference previous domestic abuse problems; however, the IMR author confirmed that the medical notes confirm that 'nothing had been written down' about that aspect of Susan's life.

4th April 2015. Susan contacted the police to complain that John had prevented her from seeing the children over the Easter weekend. It appears that Susan had missed previous 'contact' appointments, and this had caused John to take this course of action. The officer provided Susan with advice about civil remedies.

16th April 2015. John requested CSC involvement in his application to have custody of children B, C, & D, following advice from his legal representative. This was declined.

On **9th May 2015** Susan visited the surgery and explained that she no longer required Oramorph.

30th June 2015. CSC received a disclosure request, by way of court order. The requested information is logged, with the court, on **8th July 2015**.

On **24th July 2015** Susan attended the surgery with Daniel and the surgery wrote a letter to the district court confirming that she had stopped taking Oramorph and abusing opiates (as above). She was issued with a sick certificate noting stress, relating to family problems.

On **27th July 2015** the medical centre wrote to the local Family Court Manager. The letter referred to issues raised by a court order. The GP confirms that:

Susan had been prescribed Mirtazapine due to poor sleep patterns but was on no other medication. The doctor explains that at a visit, to the surgery on 9th May 2015 Susan explained that she no longer required Oramorph (as per above). "Current arrangements are adequate to protect the children's welfare".
Susan has struggled with opiates addiction for a long time and that she had a history of anxiety and depression. (This summary was reached in consultation with other doctors who had treated Susan).

Last year her physical health was poor but had recently improved.[9]

On the **16th August 2015**. Susan had her second attendance at Musgrove Hospital where she was admitted due to a diagnosis of renal colic, she was discharged on the same day.

On **9th November 2015** Susan visited her GP confirming that she was pregnant and homeless but staying with her new partner (Daniel). The GP issued her with a sick certificate.

On the **16th November 2015** Daniel made a self-referral to Sompar, due to his decline in mental health and the need to support his new partner (Susan) 'who has mental health problems'. A Mental Health Assessment appointment is offered, to both Daniel and Susan for the **25th November 2015** however neither attend, and Daniel requested a subsequent appointment in the New Year.

12th November 2015. Susan requested support from CSC, as she was seeking access to her children. She alleges mental cruelty, as well as controlling and unreasonable behaviour by John and blackmail regarding her un-born child. The request is declined as matters were being dealt with through the courts. The matter of the pregnancy was not clarified, there was no record of a referral from the GP and no record of early planning to mitigate any potential risk to the unborn child.

9th December 2015. Midwife appointment booking process. Susan's next of kin is now Daniel and records show their employment status as 'Long term sick'. Susan's health problems were recorded as:

- low mood/anxiety issues;
- a history of duodenal ulcer;
- previous addiction to opiates.

It was also recorded that she had smoked cannabis during this pregnancy. There were mental health concerns and Susan was referred for consultant led care as she was deemed to be 'high risk', particularly with regards to social issues and a history of drug misuse. When asked the direct question Susan confirmed she had been the victim of domestic abuse with a previous partner, although not with Daniel and she had been sexually abused as a child, whilst in foster care. She denied suffering any mental health problems but stated she was having housing issues.

[9] *The IMR author stated that the GP contacted social services and discussed the 'issue' obtaining more information however no details appear to be available*.

On **23rd December 2015** the landlord of Susan's address contacted Sedgemoor District Council (SDC) to complain that her rent was in arrears, and that Susan had left the address.

2016

6th January 2016. Ante Natal appointment arranged, but Susan did not receive the appointment letter.

31st January 2016 Susan contacted police to inform them that Daniel had gone missing. Susan stated that they had been drinking together and Daniel had suffered an "episode" due to his significant mental health issues. Susan was 4 months pregnant by this stage. Officers completed a risk assessment and visited Daniel's home address, where they found him asleep. Subsequent referrals to CSC, and ASC were completed, and warning markers placed on the Police National Computer.

In **February 2016** Daniel contacted Sompar community mental health team and requested to have an assessment and see his psychiatrist, this took place on the **2nd March 2016**. He disclosed being physically and verbally assaulted by Susan. He was offered a Somerset Integrated Domestic Abuse Service referral but declined it. Daniel accepted a referral to a self-management group facilitated by *Talking Therapies.*[10]

5th February 2016. The CSC received a report from the police. Susan reported Daniel as being missing and that he has various mental health problems including previously threatening to self-harm.
The IMR author notes that matters needed to "progress to pre-birth assessment, due to:

- Susan being intoxicated whilst pregnant
- The father (Daniel] having complex mental health issues
- The father is violent
- The father carries blades and other items
- The mother's (Susan) mental health issues
- Raising significant concerns for the welfare of the unborn".

A pre-birth assessment was commenced due to reports of Susan's drunkenness whilst 4 months pregnant. Also concerns were raised about Daniel's drink and drug abuse, his state of mental health and displays of aggression. Susan told the assessment team that Daniel became violent, unpredictable and carries weapons. Susan's own mental health issues also caused welfare concerns for the unborn child. No DASH risk assessment was completed.

10 https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwizy-mElNnlAhUOTRUIHZkGCjcQFjAAegQIBBAB&url=https%3A%2F%2Fwww.talkingtherapies.berkshire.nhs.uk%2F&usg=AOvVaw2vpO5ID24PzHZpZCxnqAfO

On the **17th February 2016** (Week 18/40) Susan did not attend (DNA) her antenatal appointment regarding her pregnancy with Baby A.

9th March 2016 Regarding Baby A, (Week 21/40) Susan had not made any further appointments and Musgrove Hospital telephoned Ashcombe Birth Centre at Weston Hospital to see if she'd registered there, as she was talking of moving to Weston Super Mare. But Susan wasn't known on their systems. So a home visit was then planned by the midwife.

16th March 2016 Police officers were called to the couple's address and allegations are made of Daniel assaulting Susan; consequently, Daniel was arrested in accordance with the Avon & Somerset's 'positive arrest policy' and risk management strategy. He told officers that Susan was upset due to her children being taken into care; Susan refused to support the prosecution. A DASH risk assessment is completed and scored at medium. A referral was made to Children's Social Care. Daniel was seen by the Sompar Court Advisory and Support Services (CASS) following his arrest. CASS recognised him as a potential victim of domestic abuse and he was offered a follow-up appointment, however he did not engage.

29th March 2016. A CSC Child and Family Assessment was competed. The IMR author identified that the key risks were:

- Mental health (psychosis, depression, suicidal ideation) and the instability of the parent's relationship and the potential impact on the unborn baby.
- Domestic Abuse
- Substance Misuse

Considerations for a Child Protection Plan were given but not progressed due to the stage of pregnancy.

6th April 2016 the GP surgery was contacted by Susan's health visitor stating that she had been involved in a 'domestic violence' incident and that a Children in Need meeting should be arranged.

12th April 2016 Regarding Baby A, (Week 26/40) Susan did not attend (DNA) her Consultant Obstetrics appointment. The DNA process was followed, and new appointment sent.

20th April 2016 As part of the pregnancy for Baby A, (Week 28/40). Susan and Daniel (and Daniel's parents) attended the antenatal appointment. The consultant appointment is declined as Susan feels that anxiety is no longer a problem. The GROW chart assessment suggests that the baby is small for gestation and Susan is referred for a GROW scan and consultation.

9th May 2016 Children Social Care convene a Children in Need meeting [Susan did not attend]. As the relationship between Susan and Daniel is volatile and there have been several police calls to the home a foetal file is created (used to share concerns with all maternity and neonatal services).

10th May 2016 Regarding Baby A, Susan DNA her Obstetrics meeting. The DNA process was followed, and it was noted that this is her second DNA. Susan's history leads to the hospital's specialist "Juniper team" and a Community midwife being contacted.

16th May 2016. Regarding Baby A, Susan did not attend her antenatal appointment and a home visit was completed. Susan confirmed that she missed her appointments recently due to her car being off the road.

On **25th May 2016** it comes to the attention of the GP practice that there were significant mental health issues regarding Susan:

- That she had disengaged with local mental health services;
- There were also signs of alcohol abuse;
- The midwife had concerns as Susan was not attending hospital for a check on the size of the foetus;
- Susan was not engaging with Social Services;
- That Susan had limited contact with her children.

There was due to be a strategy meeting, held by Social Services.

Between May 2016 – December 2016 (see below), there are several health visitor records focusing upon Daniel and Susan's ability to take care of their (soon to be born) child. This concern focused upon mental health and domestic abuse problems, as well as drugs and alcohol abuse. Baby A was born and placed under a child protection plan. Baby A was removed briefly from Daniel and Susan in **September 2016** and returned to the parents in early November but removed later in the month following an 'altercation'. At the end of **December 2016** Somerset County Council put Baby A up for adoption.

1st June 2016 Regarding Baby A pregnancy, Susan DNA her antenatal appointment. The Health Visitor was also in attendance and Susan did not respond when a text message was sent.

3rd June 2016. The police arranged a multi-agency Child Protection Conference due to the fact that:

- The parents were not engaging with the Child in Need Programme and had missed several appointments citing financial problems.
- Danial doesn't have any contact with his children, and they are reportedly scared of him.
- Neither parent is engaging with Mental Health Services.
- Parents are showing no insight into CSC concerns and minimising them.

On the **6th June 2016** it was proposed to progress to an Initial Child Protection Plan.

9th June 2016 Regarding Baby A' Pregnancy, (Week 35+3/40) Susan DNA attend her 'Pre-Birth planning meeting as she was an inpatient at hospital at the time. Susan had reported bleeding for several days and was admitted for one night and had a scan to confirm that the baby was showing reduced growth but was clinically well.

16th June 2016 An Initial Child Protection meeting was convened and unanimously agreed that the un-born baby should be subject to a child protection plan. Baby A was registered on a Child Protection Plan.

On the **22nd and 23rd of June 2016.** Musgrove Hospital report that Susan is unwilling to leave despite being medically fit for discharge. Several days later Baby A is born.

6th July 2016 Susan and Baby A enter a "mother and baby" placement, following their discharge from hospital. This was a 4-week placement.

7th July 2016 An interim care order was granted to Somerset County Council for Baby A.

21st July 2016 Baby A's case was brought to the CSC placement panel who decide that Baby A needs to be considered before the legal threshold panel. The placement panel recommended a FAST (Parent/Child Fostering) placement and an external search for a mother and baby placement.

22nd August 2016 Baby A transferred to the 'Child Looked After' team. The decision is taken to allow Daniel to join Baby A and Susan at a parent and child foster placement (FAST). The placement was expected on **7th September 2016**.

27th August 2016 Daniel called the police to tell them that he has been threatened and assaulted by a man who is obsessed with Susan. There appears to be no sign of assault and Daniel doesn't wish to pursue the matter further, no action to be taken.

On **27th September 2016** Susan seeks support from Sedgemoor District Council housing for a larger address as she was in the mother and baby unit with Daniel. She is advised to make a joint application with him. This is submitted, on the same day.

10th October 2016 A 'placement review', chaired by a FAST supervising social worker, was completed and the decision made to deny Daniel and Susan time outside of the placement with Baby A independently. Also, that monitoring would continue constantly, and that Daniel and Susan should not be discharged back into the community. The rationale for this decision was that neither parent was prepared to accept or address the concerns raised by the Local Authority. Also, the nature of their relationship was turbulent. They appeared to sometimes be happy together and other times had serious arguments. There was no evidence that they could contain themselves from negative behaviour when caring for Baby A

19th October 2016 A Child and Family Assessment is completed. CSC agreed that Baby A should remain in the FAST placement with Daniel and Susan, and that the seeking of a permanent placement for Baby A should continue.

27th November 2016 Susan contacted CSC to inform them that she has left Baby A in the flat with Daniel. She alleged that he has assaulted her whilst drunk, and is using Cannabis.

On **18th November 2016** Susan attended the SDC offices with Children's Social Care (CSC) social workers and presents identification for the Homefinder application process.

On **30th November 2016** Susan contacts SDC to complain that her current home is too small and affecting the health of her family and that a letter, supporting this claim would also be forwarded by CSC. This letter is received on **5th December 2016** and SDC housing award Susan and Daniel a 'silver banding'[11].

On **1st December 2016** Susan went to her GP surgery and was diagnosed with being in an 'anxiety state'. The condition appears to relate to a stressful few months of house moves, foster care issues and child access. Susan's partner was present however the IMR author notes that it is not clear who this was. Susan reported recently having a verbal argument with this partner and that he had threatened her but there had been no violence. She was concerned that the relationship would end and that she would need to find her own home. The IMR also notes that the couple seemed to be comfortable in each other company and keen to set up home together. The doctor wrote a letter to support her application to SDC for her to move accommodation. The GP contacted Children's Social Care and discussed the issue and obtained further information and understood that Health Visitors' and Social Workers' were actively involved with Susan. She did not re-visit the surgery again, so they were not able to suggest a self-referral to local Domestic Abuse Services.

7th December 2016 The matter returned to Taunton Family Court, as part of the case management process and on that evening, there was a dispute between Daniel and Susan in the presence of Baby A. It was alleged that he grabbed Susan around the throat and a referral was made, by the police to CSC. Social workers supported Susan into emergency accommodation with a written agreement that she will not have any direct contact with Daniel or return to the family home with Baby A. Susan's social worker arranged for Daniel to have supervised access.

On **8th December 2016** Susan, in the company of two social workers from CSC, was interviewed by the housing officer in relation to a new housing application. Susan made a comment about having mental health and alcohol issues and being in a controlling relationship and that "she is timed when using the bathroom".

The CSC social workers comment that Susan's mental health is deteriorating and there was no expectation of violence from Daniel as he had asked her to leave home. A housing officer arranged an emergency placement and requested a report from the CSC social workers regarding the relationship between Susan and Daniel. This letter is received on **13th December 2016** and then 'placed on file'.

[11] accommodation which is short by one bedroom suitable to your needs. The current accommodation is unsuitable and exacerbates the applicant's or other household members' health condition and more suitable alternative accommodation is required to improve the health condition

On **19th December 2016** SDC received an email from the temporary accommodation warden informing them that Susan has left the property. Contact is made by CSC with Susan, who stated she felt unsafe there, this caused SDC to cancel the accommodation award to her.

20th December 2016 Susan informed CSC that she has moved back in with Daniel. CSC were granted an Emergency Protection Order to safeguard Baby A. Baby A was placed in a confidential foster placement with a plan to seek adoption.

28th December 2016 Susan contacted the police and stated that she has been receiving abusive texts from Daniel, since she left him on Christmas Eve. She also reported being grabbed and assaulted by Daniel on the 7th of December. Subsequently she fails to attend 3 separate appointments with the investigating officer before meeting on the 2nd January. The outcome of this report was that Daniel was convicted of making "Malicious Communications". A DASH Risk Assessment was completed, and the score was 14, however no MARAC referral was made, despite meeting the actuarial threshold. The investigating officer insted identified this as medium risk, without any additional commentary or rationale.

On **29th December 2016** Susan called SDC to confirm that she remains homeless. She is now 'sofa surfing' as she doesn't feel safe at the emergency accommodation and will not return home to Daniel as she fears for the safety of Baby A. Her solicitor confirmed Susan remained homeless and the 'Homeless application' remains open.

On **30th December 2016** SDC contacted CSC who confirm that Baby A is now in full time foster care. Susan is interviewed by the Housing Officer and Susan confirms that she is staying with a friend. The determination was made that Susan is not homeless and a housing application is made.

2017

11th January 2017 Susan referred herself to 'Talking Therapies Service' however she did not respond to various phone calls and letters and was therefore discharged from the service, in April.

January 2017. As part of a court recommendation Daniel self-referred to Talking Therapies where he received one off telephone support. The referral related to Baby A's removal and the anxiety it created. However, after some help and guidance was provided, Daniel didn't engage any further and was discharged after 6 months.

Susan was referred to SIDAS by Children's Social Care, specifically her social worker on **13th January 2017**

On **24th January 2017** Susan attended SDC's offices looking for help with the deposit scheme to secure a private sector housing let, this was followed up with a second visit the next day. The request was declined on the **22nd February 2017** as the property was not a single person occupancy (i.e. 2 bedrooms).

2nd February 2017 SIDAS (Barnardo's) receive a referral from CSC regarding Daniel and for entry onto the Lifeline Domestic Violence Voluntary Perpetrator Programme.

25th February 2017 A call is made by Barnardo's to Daniel to establish contact, discuss the nature of the referral and gather further information. It was unsuccessful.

In **March 2017** An arranged meeting, between SIDAS (Livewest) and Susan didn't take place due to the change of time and unavailability. A second meeting was arranged for **6th April 2017**.

8th March 2017 A second follow up call, from Barnardo's was apparently unsuccessful.

10th March 2017 Daniel called police to complain that Susan is harassing him with calls, text messages and via social media, 'at all hours of the day and night'. He believed that this behaviour was because their child had recently been taken into care. A DASH risk assessment scored Daniel as 2 and the decision is taken that it is 'not in the public interest to pursue the offender' (Susan).

13th March 2017 There was a telephone conversation between the social worker and Barnardo's case worker. Family history and on-going issues were discussed. It is apparent that due to Daniel's mental health issues and his unwillingness to take responsibilities for his actions, it was unlikely he would be offered a place on the Voluntary Perpetrator Programme (VPP)[12]. The Barnardo's worker explained that a decision would be made regarding a referral however there were no assessments or courses currently available.

15th March 2017 An initial Sentence Plan was completed by Daniel's Probation Officer (PO) however no plan was put in place to address the specific risk of further offending, child contact and reconciliation with Susan. Further appointments took place with the PO on the **22nd and 29th March** with no issues raised.

In **April 2017** Daniel is referred by his GP to Sompar for an "Asperger's Assessment", as it was suspected he may have been suffering from Autistic Spectrum Disorder (ASD). The initial assessment took place on **14th July 2017** and it was indicated that Daniel was not suffering from ASD, however further assessment was deemed appropriate due to the stress Daniel was suffering. Daniel told Sompar that he intended to move to another county as his ex-partner was continuing to harass him. It was never made clear who this partner was. This was the last contact that Daniel had with Mental Health services for himself.

2nd April 2017 Daniel had been out with Susan to visit Children's Social Care regarding contact with Baby A. On returning home Daniel was approached by a male friend of Susan's (Sam) who 'strikes' Daniel. Neither Daniel nor Susan wish to support a prosecution but wanted the male spoken to. Sam was spoken to by police officers and words of advice were given.

[12] https://www.saferderbyshire.gov.uk/what-we-do/domestic-abuse/staff-guidance/perpetrator-programme/voluntary-domestic-abuse-perpetrator-programme.aspx

6th April 2017 Susan and the SIDAS caseworker met at her home, after she had been to visit Baby A and she talked about a taxi driver who had been harassing her. She also talked about Sam who she considered a friend despite him making advances which made her uncomfortable. She blamed Sam for messing her about, and that she was trying to get better to get Baby A back. The caseworker commented on how spotlessly clean the flat was. During the appointment there was a visit from Susan's landlord who asked about a disturbance the night before. Susan claimed that she wasn't at home at the time. The caseworker provided details of the National Centre for Domestic Violence (NVDC).

8th April 2017 Susan called the police to complain of harassment from Sam who has 'hacked into her social media accounts'. Susan is not willing to support a prosecution or provide a statement. Officers supported Susan in changing security details and passwords to prevent further harassment and spoke to Sam who stated he simply returned her call and agrees to stop future contact.

5th April 2017 Daniel attends his appointment with the Community Rehabilitation Company (CRC) and reported being assaulted by a man who was stalking Susan. The IMR author noted that the Probation Officer (PO) doesn't follow this up with the police.

19th April 2017 Daniel attended his CRC appointment and raises the issue of the previous assault and the fact that the police weren't willing to charge the suspect. The PO notes that "because of his anxiety/emotional state and tendency to become distressed I am at present not clear how I will work with him".

20th April 2017 Barnardo's held an internal meeting to confirm that Daniel didn't qualify for the Lifeline VPP program, due to his mental health needs and unwillingness to accept responsibility.

25th April 2017 The caseworker called Susan arranging a meeting for **4th May 2017**. This meeting didn't take place due to Susan visiting A in hospital.

26th April 2017 Letter sent by Barnardo's, to Daniel confirming the referral decision for accessing the VPP. A call was also made to Social Worker to confirm the same, a voice mail was left but there was no subsequently follow up.

26th April 2017 Daniel attended his CRC appointment and was upset that a parenting assessment did not go well. Other supportive conversations continue.

28th April 2017 Daniel called the police to tell them Susan has been trying to contact him to sort out their differences – this was "Against professional advice". A DASH Risk Assessment was completed as standard risk, with no immediate risk identified.

12th May 2017 Daniel called police expressing concern that he had seen bruising on Susan's arm and that she had told him that Sam drags her and beats her. Officers called Susan and confirm that this is not a domestic matter as she is not in a relationship with Sam. Officers decided to meet Susan and take a statement; however, she fails to attend the appointment and became non-contactable.

Daniel made further contact expressing concern for Susan's safety in her friendship/relationship with Sam and that he encouraged her to take drugs. Daniel felt she may be High Risk and suicidal as the time is approaching for them to return to court (Daniel assumes that this is regarding their child being put up for adoption). The IMR author notes that the supervision and action plans are very comprehensive. No further contact with Susan and the matter was closed 22nd July.

19th May 2017 An application was made to the court by the Probation Officer, to remove the unpaid work requirement from Daniel's Court Order, this is agreed to due to his unstable health and anxiety.

18th May 2017 The SIDAS caseworker texted Susan to wish her luck for court hearing.

22nd and 23rd May 2017. SIDAS confirm this as the date of the final court hearing regarding Baby A.

23rd May 2017 The Care and Placement orders are granted to Somerset County Council.

24th May 2017 The SIDAS caseworker texted Susan to see how the hearing went. Susan confirms they had lost the case. She asks her to call her next week.

31st May 2017 Daniel and Susan both attend the Probation Office supervision session, this was following the adoption hearing for Baby A. Both were upset at the loss of their child. The Probation Officer encourages the couple to look at positive routes to the future and to access the counselling services available to them.

31st May 2017 The SIDAS caseworker texted Susan to confirm whether she still wanted support. The caseworker also called Susan's social worker and left a message.

1st June 2017 Daniel contacted Crisis Resolution and Home Treatment Team (CRHTT) expressing concern that Susan was not coping well following the loss of Baby A and she was expressing suicidal thoughts and feelings. The Sompar worker commented that Daniel sounded as if he was under the influence of drink. Daniel was keen to emphasise that Susan was staying with him the previous evening and that no further action was required. The clinical team agreed that no further action would be taken.

18th June 2017 A Matching Panel for identified adopters is held by Children Social Care.

20th June 2017 Daniel called police to report Susan as having visited his address at 6am that morning and had been 'screaming and shouting'. She had sat on a chair outside his home and posted rose petals and a love note through the letter box. Daniel had spoken to Susan and informed her that the police and Mental Health Crisis Team had been notified. Daniel told officers that the two had been separated since their child had first been taken in to care in December 2016. Susan was found safe and well at her home address. The police notify CSC of the call. The IMR author notes that Daniel informed the police that they had recently lost their baby and Susan had attempted to take her own life. Daniel called the CRHTT saying that Susan was outside banging on his door

demanding to be taken to the local mental health hospital. Advice given to call the police. No further action[13].

21st June 2017 SIDAS attempted to contact Susan however there is still no answer from her. The caseworker texts Susan again saying that if she didn't hear from her by the end of the month, she will assume she no longer wishes support.

22nd June 2017 At a meeting with his Probation Officer, Daniel reported emotional manipulation by Susan as she makes threats to harm herself, using a knife from the kitchen. He confirms that he had contacted the Police and Mental Health services and stated he wants a non-molestation order. Daniel was encouraged to spend time with his parents, away from the area. There is no evidence of a Spousal Assault Risk Assessment (SARA) report having been completed.

5th July 2017 Susan contacted police to report not having seen Daniel for 2 weeks and expressed concern for his safety due to his on-going mental health issues. Police made visits to Daniel's home address finding him safe and well on the second occasion.

18th July 2017 Susan and Sam were arrested for the theft of jewellery, both admit the allegation. Sam claimed that he was not in a relationship with Susan and that she had got him into drug taking – specifically Cocaine. Susan stated that Sam was obsessed with her and had a 'hold over her' as he had paid her rent.

Daniel and the PO have a further meeting on the **18th July** and **2nd August,** Daniel remained stressed and anxious regarding the loss of Baby A to adoption.

21st July 2017 Sam was assaulted outside Susan's address by two males. He is interviewed by police and confirmed that the two males had sold Susan drugs. He didn't wish to pursue the allegation and the investigation was closed.

21st July 2017 Still no reply from Susan, to SIDAS's efforts to contact her.

10th August 2017 SIDAS caseworker and manager agree to close Susan's case.

16th August 2017 Daniel's Barnardo's case file is closed. And during a meeting with his Probation Officer Daniel reported, as being back in a relationship with Susan, this surprised the Probation Officer particularly due to his previous negativity toward her[14].

22nd August 2017 Baby A is moved to the adoptive placement.

[13] *The IMR author feels that this advice was appropriate as Susan was not known to the team.*

[14] *The IMR author reports no review of the risk management plan*

14th September 2017 – 9th November 2017 Daniel completed all 6 sessions of the CRC's Emotional Resilience programme which he says he enjoyed, particularly connecting with other people. No further appointments were arranged with the PO.

28th September 2017 SIDAS Case file closed.

November 2017 On the day of Susan's murder. Daniel contacted the police to tell them that Susan had stabbed herself many times. Police officers attended his address and attempt CPR; however, this was unsuccessful, and Daniel was arrested for murder.

ANALYSIS

This section focuses upon the analysis of the Individual Management Reviews provided by the agencies represented in this review. The chair has also researched a variety of other Policies and Guidance available from the Safer Somerset Partnership, including:

Multi Agency Safeguarding Adults Policy 2018
Somerset Domestic Abuse Strategy 2017 -2020
Safe Lives DASH Risk Assessment checklist
Somerset Domestic 'Abuse MARAC guide for practitioners.
Somerset Domestic Abuse 'Toolkit for Practitioners'.
The Avon & Somerset Constabulary, Domestic Abuse Procedure.

The themes of the analysis have been recognised as:

THE VALUE AND USE OF DASH RISK ASSESSMENTS AND MARAC REFERRALS

Rationale
The author felt that throughout the analysis, the management of risk has been inconsistent, and this view was supported by the panel. There has been a regular absence of the use of DASH risk assessments and professional curiosity which may have improved the care and support provided to the victim. It also may have enhanced the likelihood of the perpetrator being managed/prosecuted more successfully. Subsequently various recommendations have been made to improve this and ensure a more streamlined approach to this subject.

MULTI AGENCY ENGAGEMENT

Rationale
It was felt that often agencies were working in isolation and that in general terms information sharing could have been better. Frontline staff from across the CSP need to be as well informed as possible

when supporting and managing families like Susan and Daniel. The panel has recognised that there are plans to improve the current situation, however the analysis of this review has generated various recommendations which could support and possibly enhance future plans.

MENTAL HEALTH ASSESSMENTS

Rationale

Mental Health as well as Hidden Harm[15] issues has been a constant theme throughout the lives of both Susan and Daniel, and the analysis process was focused upon identifying areas of learning. This was to help improve the services offered to those who fall outside the definition of Section 42 of the Care Act 2014[16]. The panel agreed that neither Daniel nor Susan qualified under this criterion.

Section 42 Care Act 2014

This section of the Care Act 2014 is clear that where a local authority has reasonable cause to believe that an adult, in its area (whether or not ordinarily resident) has needs for care and support, is experiencing risk of abuse[17] or neglect and as a result of those needs is unable to protect themselves, against the neglect, abuse or risk of it:

THEN

The local authority must make (or cause to be made) whatever enquiries it believes are necessary to enable it to decide whether any action should be taken and by whom.

THE ROLE OF DRUGS AND ALCOHOL AND ITS IMPACT UPON THE REMOVAL OF BABY A

Daniel was a concern to Children's Social Care staff from the initial point of contact. He demonstrated a complete lack of responsibility for his actions and a refusal to acknowledge his mental health issues and dependence on alcohol. He presented as minimising concerns over his relationship with Susan, blaming her or her friends for any physical or emotional abuse. He was unable to comprehend that what he was doing was wrong or abusive.

In his interactions with Baby A Daniel built an attachment, and this was reciprocated by Baby A. However, Daniel often presented in a low mood with poor mental health. Where a child's primary carer is unresponsive or attuned to their needs, this can cause the child to become harmed (emotionally or otherwise). Daniel's history shows a cycle of being withdrawn and depressed, often linked to an unwillingness to take his prescribed medication. His depressive moods resulted in suicidal tendencies or incidences of self-harm.

CSC had significant involvement with Susan and her three children from her previous relationship. There were reported incidents of Susan leaving the children home alone, that they had witnessed

[15] Hidden harm is parental problem drug or alcohol use, that actually or potentially affects their child

[16] http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

[17] *Abuse - encompasses financial matters, including theft, fraud, misuse of monies and being put under pressure in relation to money and property*

domestic incidents involving Susan and John and of the children missing school due to lack of sleep. In 2015 concerns were again raised over Susan's mental health and suicidal feelings, this was during the time of John taking the children into his full-time care.

In February 2016 the CSC received a referral due to Susan being pregnant. A Pre-birth assessment was completed due to Susan having been reportedly drunk at the 4-month period. Further reports (from the police) raised concerns about Daniel and his abuse of drugs and alcohol, that he had displayed aggressive behaviour and complex mental health issues. Susan reported that Daniel's behaviour had become violent and unpredictable, that he often carried weapons. All of these factors raised significant concerns for the welfare of Baby A.

The assessment was completed in March with anxiety being raised about the mental health of both parents, the unstable nature of their relationship and the potential impact upon Baby A. Neither Susan nor Daniel demonstrated sufficient ability to 'parent' either separately or as a couple. Baby A was registered on a Child Protection Plan in June and once born an Interim Care Order was granted to Somerset County Council. Susan and Baby A were moved into a mother and baby placement for 9 weeks and in September they were joined by Daniel and the three of them moved to a FAST family placement.

Despite regular support during the pregnancy of Baby A there was repeated abstention, by the couple, to attend hospital and ante natal appointments and refusal to acknowledge the issues that they faced, both individually and separately. There was a recorded history of Susan's addiction to opiates, and Daniel's use of cannabis. Both had a large amount of contact with Somerset's agencies regarding the mental health challenges and sought to minimise or deflect away their effects whenever the subject was raised.

This lack of acknowledgement must uplift the real and potential risks presented to Baby A and these were constant themes throughout the various multi agency meetings. The review recognised that all reasonable and proportionate efforts were made to support both parents during the pregnancy period, and the developing picture left Somerset County Council Children Social Care with no alternative but to take the legal route that it did.

COERCIVE CONTROL

Coercive control is defined as:

"an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour."[18]

[18]https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

Inextricably linked to Domestic Abuse is the issue of Coercive Control and throughout this review it has been forefront of the panels' thinking and whether Susan was ever the victim of this type of behaviour. This is particularly relevant as Daniel's previous partner (Debra) had referred to this happening to her by Daniel, during discussions with police and hospital staff before the break up of their relationship.

The review can find no evidence that this was the case with Susan. During her many engagements with local agencies there was no disclosure that Daniel was exhibiting these tendencies and practitioners didn't identify coercive incidents or themes. For example, there are number of incidents where one or the other would go missing or make threats to self-harm and the other party would contact the police or other agency to help find them. Despite their issues there was an element of devotion between Susan and Daniel, for a large period of their relationship, particularly during Susan's pregnancy with Baby A and this gives the review panel good cause to believe that Coercive Control was not a factor in this case.

POLICY CONTEXT

MULTI AGENCY SAFEGUARDING ADULTS POLICY 2018

Somerset Safeguarding Adults Board's commitments confirm that: "Safeguarding is the responsibility of everyone including statutory, independent and voluntary agencies as well as every citizen. We will work together to prevent and minimise abuse"

Paragraph 3
"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect".

"Workers across a wide range of organisations need to be vigilant about adult safeguarding concerns in all walks of life including health and social care, welfare, policing…. GPs, in particular, are often well placed to notice changes in an adult that may indicate they are being abused or neglected…"

Paragraph 6
"Findings from serious case reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, then death or serious harm might have been prevented".

Paragraph 8
"When safeguarding concerns arise the mental capacity of the individuals involved – victims as well as those alleged to be responsible - is central to the assessment and decision-making processes. It is essential that in any level of safeguarding enquiry the mental capacity of those involved is clarified at the outset".

SOMERSET DOMESTIC ABUSE STRATEGY 2017 -2020

Effective and resilient system for supporting victims of domestic abuse

Breaking the cycle of victimisation by working with offenders and increasing prevention activity

Working in partnership for best results.

'SAFE LIVES' DASH RISK CHECKLIST

"The purpose of the DASH risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk".

"The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way. The responsibility for identifying your local referral threshold rests with your local MARAC".

SOMERSET DOMESTIC ABUSE 'MARAC GUIDE FOR PRACTITIONERS'

Somerset Domestic Abuse Service (SIDAS) provides a variety of services and support networks to assist those involved on Domestic Abuse and separates the DASH Risk Assessment results into 3 categories:

i. 1-9 Standard Risk
ii. 10-13 Medium Risk
iii. 14+ High Risk

There are clear references to helplines and Independent Domestic Violence Advisors (IDVA's).

SOMERSET DOMESTIC ABUSE 'TOOLKIT FOR PRACTITIONERS'.

This toolkit provides a wide variety of options to provide support to victims of domestic abuse from all backgrounds, cultures, religions and age groups as well as the wider family who can be equally affected. The toolkit is online and requires very basic computer literacy as links to any other websites are provided.

THE AVON & SOMERSET CONSTABULARY, DOMESTIC ABUSE PROCEDURE

The Avon and Somerset police guidance on Domestic Abuse is reflective of the National College of Policing Authorised Professional Practice (APP). A review of this document has highlighted the following areas which are of relevance to this review and support the analysis process.

Introduction

The APP recognises that domestic abuse represents a larger percentage of reports crime, within Avon and Somerset Constabulary (12%) than the national average (8%). "Domestic Abuse is not only high volume, but also high risk. Getting the police response wrong can have severe consequences and result in a failure to protect victims from assault, mental harm of even death. It is too late to recognise police failings in a Serious Case Review, following such a death".

b. Context and definitions

A *Serial Perpetrator* is someone who has been reported to the police as having committed or threatened domestic abuse against two or more victims. This includes current and previous intimate partners and family members. The definition is used as a tool to better support and monitor serial offenders.

c. Risk and Vulnerability

First responders should carry out a primary risk assessment at the first opportunity, usually at the scene or the safety planning process. Responders should complete a DASH Risk Assessment in all cases. They should also consider any history of domestic abuse, in addition to the nature of the specific incident, and be encouraged to use professional curiosity.

RISK MANAGEMENT – DASH ASSESSMENTS AND MARAC REFERRALS

INDIVIDUAL MANAGEMENT AND CHRONOLOGY REVIEW

AVON & SOMERSET CONSTABULARY

On **13th August 2013** Debra informed the police that Daniel was under Section at a local Mental Health Hospital. She was concerned that his mental state was deteriorating and fears that he may return home, as he had previously made threats to harm himself and her. She was advised to take the children and stay elsewhere.

The author of the IMR comments that "DASH risk assessment was erroneously not completed" and "If a DASH had been completed the grading may have been high".

The IMR author notes that despite further reporting, of this same incident to other agencies, no DASH was completed. When the process was completed a variety of concerning factors were recorded including, use of weapons, by Daniel against Debra. Animal Cruelty, Threats to kill, Drug misuse[19] and sexual violence.

[19] https://www.addiction.org.uk/addiction-and-domestic-violence/

The IMR author notes "In matters of Domestic Abuse risk cannot be accurately identified without the use of DASH. Identification and documentation of high-risk indicators, would not only safeguard (Daniel's) partner at the time but if retained, would also highlight the potential risk (Daniel) presents to future partners".

The IMR author rightly makes the link between those that harm animals and violence towards children and the vulnerable[20]*.*

On **9th December 2013** a Mental Health worker informed police that Daniel had visited Debra and the children and threatened to kill all of them, including himself.

The IMR author notes the "lack of DA assessment". No offences were disclosed, and no further investigation took place.

On **3rd February 2014** Debra reported receiving messages from Daniel. This initial investigating officer completes a DASH assessment and is graded High. During the subsequent investigation Debra reassured officers that all was well, and the DASH score was reduced to medium and a further safeguarding meeting reduces the risk further to low.
The IMR author argued that the risk should have remained high.

On **16th March 2016** Daniel was arrested for serious assault against Susan. During her interview she indicated issues of verbal abuse and coercive control. She told officers she was frightened of Daniel and of further injury.

The IMR author suggested that "a MARAC referral was needed but not completed".
The IMR author provided details of the police investigation, including photographs of Susan's injuries and enquiries with neighbours. It was also noted that Susan was not willing to support a prosecution. Daniel's defence included the fact that the reddening to Susan's wrists were not caused by dragging her off a bed, but due to his attempts to remove her from the address. A review was completed by the investigating supervisor and duty Inspector. They considered Crown Prosecution Service guidance, with regards to victimless prosecution and concluded that there is no realistic prospect of a conviction. Consequently, no further action was taken. The review panel considered this to be a missed opportunity to pursue an evidence-based prosecution. However, changes to police policy and methodology provides reassurance that, in the future similar circumstances will result in the robust pursuit of criminal charges being brought, i.e.

- There is now a more dynamic use of Domestic Violence Prevention Notices and Orders, allowing police and those able to support families in similar circumstances to complete risk assessments and implement appropriate safeguarding measures.

[20]https://www.nspcc.org.uk/globalassets/documents/research-reports/understanding-links-child-abuse-animal-abuse-domestic-violence.pdf

- A new, MARAC model is being developed enabling a swifter multi-agency response including daily discussions for cases involving children. With a weekly meeting to deal with adult matters.
- There has been an amalgamation of safeguarding teams across the Partnership due to issues of risk assessing and concerns over managing it according to resource and not to need.
- The Community Safety Partnership has created a 'Joint Working Protocol' involving Sompar, SIDAS and Somerset Drug and Alcohol Service. Members of the panel report that the focus of this protocol is the 'Lower risk, High volume' cases which may not reach the threshold for a MARAC referral.

On **28th of December 2016** Daniel was arrested for harassment and assault. The investigating officer completed a DASH assessment in consultation with Susan and despite scoring over 14, no MARAC referrals are made, and the score is interpreted as medium. Neither the "Safeguarding Coordinating Unit, Lighthouse or line management picked up on this oversight".

The panel considered this as a matter of supervision and compliance. They explored this decision and there does not appear to be any rationale for grading the risk as medium.

a. SOMERSET PARTNERSHIP NHS FOUNDATION TRUST

Whilst Daniel was an inpatient at a local hospital (**23.7.13 – 23.9.13**) Debra "disclosed to staff a history of verbal and physical abuse, controlling and harassing behaviour perpetrated by (Daniel), including making threats to kill Debra and their children. Advice was sought but no DASH risk assessment completed. This maybe the same incident as reported to the police [see 09/12/13].

On **2nd March 2016** Daniel, whilst in police custody, was seen by a mental health worker and he disclosed an assault by Susan. Referrals were offered but no DASH assessment recorded.

In November 2016 following an 'altercation' Susan moved in with a friend leaving their baby (A) with Daniel. No DASH was completed.

The panel considered these incidents and noted that DASH risk assessments had been introduced in 2009. Whilst each incident demonstrates an omission in completing the DASH. The panel was reassured that training and policies had subsequently been introduced and the IMR author was able confirm that this is "not something that would occur today due to significant development in training and safeguarding activity and support, now present in the Trust".

b. SOMERSET INTEGRATED DOMESTIC ABUSE SERVICE

A referral was made by Children Social Care on **13th January 2017** with a DASH score of 11. A meeting took place, on **6th April 2017**, with Susan and the caseworker completed a 'Risk Identification checklist', that related to Daniel and John. Subsequent contact was minimal, and no further risk assessment has been recorded.

c. BGSW CRC

Their management of Daniel was as part of a Community Order. Reference is made to a possible MARAC referral should any further domestic incidents come to notice. The author comments that no further matters arose.

The author comments that Daniel reported being back in a relationship with Susan and "I would have expected a risk management plan review and consideration to be given to police domestic abuse checks as well as a home visit".

This suggests that a DASH risk assessment would have been appropriate, however was not completed.

Having recognised the opportunities to improve services, the author proposes a series of improvements, and these have been highlighted in the recommendations (appendix A). These were discussed by the panel and agreed.

The CRC were asked about the lack of a Spousal Assault Risk Assessment (SARA) during their engagement with Daniel. Their response was that the case was assessed as medium risk to a known adult, this is the highest level of risk the CRC can hold. The index offence would not have justified a higher categorisation, and it was not clear at the time that the Perpetrator and victim had restarted a relationship, if indeed they had. The victims last known movements would indicate that she was homeless and had spent some few days with the perpetrator who had undertaken a structured intervention. As the perpetrator was subject to a Community Order, the CRC had no legal powers to prevent the victim from:

- Forming a relationship with the perpetrator;
- Staying or lodging with the perpetrator;
- Whether he was a victim or witness to family violence as a child or adolescent;
- Mental health;
- Substance misuse;
- Spousal history including, physical/sexual assaults.

Daniel's responses and a level of suitable professional interpretation could then have been shared with other partnership agencies and enhanced the understanding of the dangers presented by Daniel, particularly when considering the vulnerable state of Susan.

There is no evidence from any other agency that the couple had developed a relationship again or that there was any particular concern about a threat to the victim from the perpetrator.

Any additional assessment would not have made a difference to the way the case was supervised. Nor in how the intervention was implemented which was done in compliance with the expectations of Community Orders.

The SARA report contains similar themes to that of a DASH risk assessment and whilst, in this case Daniel appeared to be in constant denial of his issues, there is still value in carrying out the assessment and inviting professionals to use the professional curiosity to assess the answers and comments when completing the process. For example, the assessment includes themes such as, Criminal History and Recent Relationship problems.

In terms of Multi agency working activity this focuses upon the MARAC and MAPPA conferences.

MULTI-AGENCY RISK ASSESSMENT CONFERENCE (MARAC) IN SOMERSET.

The completion of a domestic abuse risk assessment (DASH) helps assess the severity of the presenting risk. This starts the process towards a MARAC where the aim is to ensure effective support to the right people without delay.

MARAC is a partnership approach and its core objective is to share information about domestic abuse victims, perpetrators and families. This involved a number of agencies including Children's Social Care, Adult Social Care, Police, Housing, Education, Specialist Domestic Abuse Services and Mental Health.

There are 4 MARAC meetings regularly held in Somerset, these are Sedgemoor, Taunton/West Somerset, South Somerset and Mendip.

Each agency signed up to MARAC has a MARAC representative who attends meetings and is responsible for the actions of their agency.

MARAC runs alongside other multi-agency assessment processes and so must link appropriately to avoid duplication (i.e. MAPPA and Channel)

MAPPA IN SOMERSET

The Multi-Agency Public Protection Arrangements (MAPPA) is the process that the Police, Probation and Prison Services use to work with other agencies to manage the risks posed by violent and sexual offenders living in the community.

MAPPA allows agencies to assess and manage offenders on a multi-agency basis by working together, sharing information and meeting, as necessary, to make sure that effective plans are put in place. Offenders are managed at one of three levels, based on the level of multi-agency co-operation required and can move up and down the levels as appropriate.

Level 1 – Ordinary agency management is for offenders who can be managed by one or two agencies (for example, police and/or probation). It will involve sharing information about the offender with other agencies, if necessary and appropriate.

Level 2 – Active multi-agency management is for offenders where the ongoing involvement of several agencies is needed to manage the offender. Once at level 2, there will be regular Multi-Agency Public Protection (MAPP) meetings about the offender.

Level 3 – Same arrangements as level 2 but cases qualifying for level 3 tend to be more demanding on resources and require the involvement of senior people from the agencies, who can authorise the use of extra resources, for example, surveillance on an offender or emergency accommodation.

SOMERSET SAFEGUARDING CHILDREN'S PARTNERSHIP

- The partnership responsible for safeguarding children in Somerset has been redesigned since September 2019, as part of new arrangements introduced nationally.
- The statutory changes mean that Somerset County Council is no longer the single lead for co-ordinating safeguarding arrangements for children, and there is a tripartite responsibility for safeguarding children in the local area.
- Three organisations – the Somerset County Council, Avon and Somerset Constabulary and Somerset Clinical Commissioning Group – now have joint and equal responsibility to safeguard children and young people, under the name of the Somerset Safeguarding Children Partnership.

The new partnership builds on the strong multi-agency working of the Somerset Safeguarding Children Board and secures future arrangements for safeguarding and improving outcomes for children and young people. The Somerset Children's Trust has merged with the new safeguarding arrangements for children to create efficiencies, and the new multi-agency partnership will to take oversight of the delivery of the Somerset Plan for Children and Young People (2019-2022).

The Somerset Safeguarding Children Partnership will work with 'relevant agencies', who have safeguarding responsibilities under Section 11 of 'The Children Act' (2004), as described in 'Working Together to Safeguard Children' (2018).

The strategic aims of the partnership are to ensure that effective systems are in place to promote the well-being of children and young people and safeguard them from harm. These include:

- Focusing on the impact of all forms of child abuse and neglect;
- Learning, and the dissemination of learning, from local and national research;
- Completion of case reviews;

- Continued identification of indicators of the prevalence of all forms of child abuse and neglect in Somerset and assessing the effectiveness of progress in tackling these;
- Understanding the perspectives of children and young people by asking for their views, listening to them and responding to them so that they know what has happened as a result;
- Supporting and scrutinising the effectiveness of arrangements to reduce risk of abuse and neglect e.g. early help;
- Improving and integrating performance monitoring for safeguarding arrangements and delivering the Somerset Plan for Children, Young People and Families;
- Supporting communication and information sharing across partners.

Significant changes are:

1. Shared and equal responsibility for safeguarding children within the Local Authority boundaries lies with the County Council, Avon & Somerset Constabulary and the Somerset Clinical Commissioning Group.
2. Replacement of the Safeguarding Board with a Somerset Safeguarding Children Partnership comprising:

    - an Executive (the three key partners meeting monthly initially);
    - a wider Somerset Safeguarding Partnership Forum for engagement of wider partners with Section 11 responsibilities (three times per year);
    - delivery subgroups;
    - strengthened professional leadership groups for Education & Health.

a. Maintaining links with other partnership groups, e.g. Safer Somerset Partnership; Somerset Safeguarding Adults Board; Health and Well-being Board; Corporate Parenting Board; Early Help Strategic Commissioning Board
3. Requirement for independent scrutiny arrangements to assure the quality of safeguarding practice across the County.

Under the new partnership, there is no change to key operational processes and procedures, such as the Effective Support for Families guidance (thresholds), the Resolving Professional Differences Protocol (escalation policy), or any of the shared South West Child Protection Procedures (SWCPP). Similarly, there are no changes to the responsibilities that 'relevant agencies' have under Sections 10 and 11 of 'The

Children Act' (2004), such as commitment to systems that are effective in supporting practitioners to identify and act on safeguarding matters; the identification of risks outside the family, and safer recruitment of staff.

The chair offers the upmost support to the structures and frameworks employed by Safer Somerset CSP and recognises the need to ensure that the cases and information available is disseminated into these frameworks to identify all available risks and ensure that safety planning reflects this.

d. SOMERSET COUNTY COUNCIL ADULT SAFEGUARDING

There is one incident prior to Susan's death which related to a 3rd party referral from the South West Ambulance Service Trust (SWAST). They had responded to a 999 call from Susan, who was suffering a panic attack following a disagreement with her partner [no more details known]. The referral was received 24 hours after the incident.

The IMR author comments "There is no suggestion, from information provided from SWAST, that domestic abuse was considered as a factor, in their decision making on responding to this incident".

No concerns were raised with regards to Section 42 of the Care Act 2014 and no other care or support needs were identified.

e. CHILDREN SOCIAL CARE (CSC)

The focus of CSC is on the safety of the children in this matter and the use of the DASH doesn't accurately reflect these concerns. However, the 'Somerset Think Family Strategy 2018 – 2019 places the focus of the problematic behaviour on children as being part of an intergenerational disadvantage amongst the wider family, including within the definition of 'Hidden Harm'.

The panel considered the removal of a child as the potential trigger for a significant escalation in risk and discussed whether such 'trigger' events would merit a referral to specialist services. As risk is fluid in nature, a change in circumstances was considered by the panel as meriting a revised DASH risk assessment, and referral to specialist services.

The risk assessment process carried out by CSC appears to be fundamentally sound and to involve a reasonable amount of interaction, primarily with Avon and Somerset police. However, the question raised is whether there are other agencies who could form part of a wider network to manage and reduce the risks to children in similar circumstances i.e.

In **April 2013** contact was received from the local school about the 'high level of anxiety and fear' felt at home-time, as they fear Daniel's possible appearance.

In **December 2014** the school reports that there have been disclosures about the children:

- Hearing Susan having sex with several partners and describing things to her daughters in graphic detail.
- Drunkenness
- Self-harming.

In **December 2015** Susan made a request for support in accessing her children, following a recent court decision to provide custody to her ex-partner, John. Susan states that she was the victim of domestic abuse over many years and is pregnant with John's child.

In **May 2015** an anonymous report is received regarding a potential risk to Susan's unborn child.

In **June 2016** the local hospital contacted CSC to raise concern that Susan was refusing to leave, despite being medically fit and then having arguments with Daniel.

Each of these incidents represented an opportunity to complete a DASH risk assessment and a potential referral into the MARAC process. This review has identified that the overwhelming majority of referrals were made as a result of the incidents reported by the CSC. And demonstrated that matters reported through children could often contain similar, if not more detailed, information than those provided by victims and perpetrators.

There is no obvious engagement with the Multi Agency Safeguarding Hub (MASH) which would be an avenue for sharing this and other information. Also it would have given an opportunity to raise concerns to encourage the engagement of other agencies within the Partnership.

There is an excellent demonstration of the use of a thorough risk assessment process on **July 2016.** During a conversation with Baby A's guardian a comprehensive risk assessment is completed including domestic abuse, substance misuse, mental health and variety of other influences, for both Daniel and Susan. This was used at the CSC Placement Panel, to manage the needs and process of fostering and adoption going forward.

i. Clinical Commissioning Group

On **17th August 2010** Susan visited the GP surgery with a friend and mentioned a previously abusive relationship (believed to be John). No referrals were documented.

On **1st December 2016** Susan visited the surgery and was diagnosed as being in an 'Anxiety state' and mentioned an argument. This may not have triggered a DASH assessment in isolation, but in light of previous matters and with better information sharing the GP may have triggered one and, led to a swifter response, particularly as Social Services and Health visitors were already engaging with Susan.

f. SEDGEMOOR DISTRICT COUNCIL HOUSING, HEALTH & WELL BEING

Susan had a variety of engagements (13), both as a single and joint applicant. The panel considered the range of engagements and in particular an event on the **8th December 2016**, when she was interviewed with regards to a homeless application and accompanied by two social workers. Susan discussed being in a controlling relationship and that she was 'timed when using the bathroom'. Standard procedure was not followed (i.e. no DASH completed, no onward referral to SIDAS or MARAC if applicable) and it appears that an assumption was made with regards to someone else taking action.

The panel considered this incident and concur that a DASH assessment would have highlighted immediate concerns. The question arose as to who should have completed such an assessment, the accompanying social workers or the Housing Officer. It is believed that assumptions were made as opposed to a conversation between social workers and housing officers, or the housing officer deciding to do the DASH and making a referral to SIDAS if required.

g. TAUNTON AND SOMERSET NHS FOUNDATION TRUST (MUSGROVE HOSPITAL)

There are 3 incidents of note.
3rd June 2015, Susan disclosed a history of domestic abuse during her initial consultation. It appears that all suitable referrals were made. The completion of a DASH risk assessment would have enhanced things along with suitable disclosure of concerns. But DASH risk assessments were not completed.

21st June 2016 concerned what the author describes as an 'awkward disagreement', during an ante-natal visit, however no further details were recorded or recalled.
The IMR author describes this as a "missed opportunity to complete a DASH risk assessment or provide [Susan] with information regarding community domestic abuse services".

22nd June 2016 Susan mentioned Daniel's 'controlling behaviour and history of a volatile relationship'. No DASH risk assessment was completed despite the fact that a police DASH had already been prepared. The IMR author notes "It could have been beneficial for staff to have escalated their concerns by completing a second DASH referral at this stage".

PANEL REVIEW

The DHR panel at its 3rd of October 2018 meeting explored the use of DASH risk assessments and observed, inconsistencies and failures in their completion. The reporting and therefore scoring routinely occurred as a 'Moment in Time' without reflecting previous knowledge, history and other factors. A significant point raised by the panel was the general lack of professional curiosity when carrying out DASH forms and it was felt that front line staff, from all agencies, should be encouraged to explore risks and issues further. Staff should use their own knowledge and experience to reflect an accurate picture (or score) to better inform others during subsequent referral and escalation processes.

Observations by the panel suggested that the process can be used as a simple tick box exercise, and that there are problems with regards to a quality assurance process for suitably disseminating the risks in cases not reaching the MARAC process. The DHR chair is informed that a joint working protocol is being established involving agencies within Mental Health, Domestic Abuse and Substance Misuse, the protocol relates to all levels of domestic abuse risk. It is understood that this will improve lines of communication among agencies linked to 'Hidden Harm'.

SIDAS raised a concern regarding the police downgrading the risk of referrals. They noted that in one month 22 referrals were made, of those 14 were downgraded and SIDAS were concerned at this

level of amendment. The challenge / concern arises from managing risk according to resource as opposed to risk level.

The panel also discussed the use of the current DASH proforma and whether it remained fit for purpose. It was pointed out that the Safer Somerset Partnership is to start using the Association of Chief Police Officers (ACPO) DASH proforma and stop using the Safe Lives DASH. It's believed this will enhance the risks presented by the whole family and children. There was broad support for the changes.

The panel however accept that there were several missed opportunities for completing the DASH risk assessment at various points in time, that collectively may have painted a picture regarding risks presenting to Susan.

i. Opportunities for completing DASH Risk Assessments

Each agencies chronologies identified the following incidents whereby the recording and sharing of a DASH assessment may have influenced subsequent decision making regarding the risks faced by Susan by Daniel:

Partner - Debra
8th August 2013. Mental Health inpatient ward staff reported that Daniel had become fixated upon rape.

12th August 2103 Debra reported to Sompar that Daniel had previously made threats to kill her, he had previously been violent towards her and that she was cared of him.

21th August 2013 Sompar note that Debra reported that Daniel had made threats to kill her and that she did not want Daniel back in the house (once he was discharged from the inpatient ward).

10th September 2013 During a 'Family Therapy' session as an inpatient, Sompar records state that Daniel had made threats to kill his wife (Debra).

9th December 2013 the Sompar Community Psychiatric Nurse reported a domestic incident where Daniel had visited Debra's home whilst he was drunk and frightened the children.

Partner – Susan

31st January 2016 Susan reported Daniel missing to the police, that he had mental health problems, regularly made threats to harm himself and carried weapons routinely. She told officers that he was violent and unpredictable.

16th March 2016 Police were called to the address and investigated a domestic incident involving Susan and Daniel. Susan alleged that Daniel had broken her finger and refused to leave when asked. Daniel was arrested.

22nd June 2016. Susan was visited by her midwife and made comment that Daniel had accused her of having an affair with another man and that she was not aware of his previous mental health problems. She told the midwife Daniel would not let her go out on her own and that he was very controlling.

1st December 2016. Susan told her social worker that she had made an allegation against Daniel and that she was concerned she would need to find her own accommodation.

8th December 2016 Susan was interviewed by the local council Housing Officer. She told the officer that she was in a controlling relationship and that Daniel would time her when she went into the bathroom.

The 14 incidents, identified by this review process, where opportunities for completing a DASH risk assessment was presented could have painted a much more accurate and sinister picture of the threat that Daniel presented not only to Debra and Susan but also to future partners and children. The incidents above demonstrate the following factors which should influence the professional assessment of risk:

- Rape.
- Threats to Kill (twice) – including children.
- Harassment.
- The carrying of weapons.
- Self-Harm
- Coercive Control.

The chair is keen to avoid the obvious issue of hindsight when considering these opportunities however, as part of the function of a Domestic Homicide Review is to learn appropriate lessons then highlighting these missed opportunities in identifying and reacting to the risk presented by this perpetrator seems to be valid and proportionate.

As is pointed out in the 'Domestic Abuse Stalking and Harassment and Honour Based Violence (DASH) Risk Identification and Assessment and Management Model'.[21]

Risk identification is based upon structured professional judgement.

And as a consequence, those using the model (i.e. all front-line practitioners) should be suitably trained and this training should be on-going.

[21] https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009.pdf.

THE USE OF PROFESSIONAL CURIOSITY.

When dealing with matters of domestic abuse it is all too easy to make assumptions and accept information on face value. The DASH risk assessment process encourages front line practitioners to ask a variety of questions in order to generate a simple score and assume a level of risk presented in a particular set of circumstances. However, the weakness of the DASH system is its simplicity. It is too easy to simply tick boxes and add up a score. What is crucial is for those completing the assessment forms to demonstrate a suitable level of professional curiosity.

Professional curiosity is the capacity and communication skills to explore and understand what is happening, within a family rather than making assumptions or accepting things on face value. It requires practitioners to:

- Think outside of the box and consider situations holistically;
- Show a willingness to engage with children, adults, the families and carers;
- Remain open minded;
- See the signs of vulnerability and the potential or risk of harm.

Adults and particularly children are often reluctant to disclose matters of neglect and abuse and it is crucial that those encountering such situations remain open minded and gather as much information as possible, and then share what they have discovered with other agencies.

Professional curiosity is at its best when demonstrated in an open way so that families understand that they are being asked questions in order to keep adults and children safe, not to judge or criticise.

h. THE LINK BETWEEN DOMESTIC ABUSE MENTAL HEALTH AND DRUG ABUSE.

There has been much research onto the links between Domestic Abuse and what is commonly known as the Toxic Trio i.e. issues of Mental Health, Substance Misuse and Alcohol Abuse. This work has demonstrated that these issues have been present in 75% of Serious Case Reviews[22] and whilst research has done little to directly link those demonstrating 'Toxic Trio' characteristics and domestic abuse. They are a clear indicator of increased risk of harm to families and significant factors in Interpersonal Violence and Adult Family Violence.[23]

[22] The term 'toxic trio' (Cleaver et al, 1999) was coined to describe the interrelated issues of domestic violence, mental health and alcohol or substance misuse, factors that are evident in 75% of serious case reviews (Brandon et al, 2009).

[23] http://safelives.org.uk/sites/default/files/resources/Risk%2C%20threat%20and%20toxic%20trio.pdf

REPEAT DOMESTIC ABUSE OFFENDERS

Domestic Abuse takes various forms and is rarely a one-off occurrence. Research completed in 2010 identified that 76% of all reported DA cases involved a repeat offender[24]. The repetitive nature of the domestic abuse tends to manifest itself in one of two ways i.e. acts of violence or actions designed to control and manipulate the behaviour of the victim (coercive control).

CHRONOLOGY AND IMR REVIEW STATISTICS

The chair wishes to acknowledge the time and effort of the Senior Commissioning Officer at Somerset County Council Public Health in the preparation of the chronology, and also all the agencies who prepared and submitted IMR reports. An assessment of these documents, with particular focus on the use of DASH and similar risk assessment methods revealed several missed opportunities, which may have impacted upon the lives of Susan, Daniel and their immediate family. Many of the opportunities could be described as historic. This is because various changes in policies and training programmes have already been actioned or recommended.

In summary there are 11 incidents where IMR authors recognise that no DASH Risk Assessment was completed, and these could be described as missed opportunities, a further 4 were also identified from the chronology. 8 DASH reports were completed including 2 which were initially scored above the MARAC threshold but were either downgraded upon review or missed due to a lack of quality assurance and supervision and so no MARAC referral was made.

COMMENTARY

The panel considered the completion of DASH risk assessments in some detail and concluded that it is not a perfect tool, but a reasonable method to capture risk at a moment in time, according to the account of a victim. It does not reflect many of the factors that ought to be included to understand the level of risk presented. Such factors may include a subject's mental health, addictions, antecedent history that may not be immediately apparent on a DASH. It is suggested that the completion of a DASH ought not substitute 'Professional Curiosity' and indeed panel members articulated examples of where a DASH based on 'ticks' alone would not meet the threshold of medium risk but based upon professional judgement would be high.

The review has highlighted approximately 14 occasions when an opportunity to complete a DASH report was not taken. Those persons involved recorded issues of the following types of domestic abuse: physical, emotional, psychological, sexual and financial. These reports occurred over a 4-year period and had this information and intelligence been gathered through the DASH process, along with the use of Professional Curiosity by practitioners, then a clearer picture of this chaotic lifestyle would been apparent. There are several incidents where MARAC referral opportunities

[24] Smith, K., Flatley, J., & Coleman, K. (2010). Homicides, firearms offenses and intimate violence 2008/ 09 [Home Office Statistical Bulletin 01/10]. London, UK: Home Office.

were missed, either by MARAC threshold scoring (as previously mentioned) or by volume. It is Safe Lives Guidance that a case should be passed to MARAC if there are over 3 incidents over a 12-month period[25]. This review has identified many occasions when criteria was met. Naturally this criterion needs to be considered with regards to proportionality but is something which the MARAC process needs to reflect upon going forward.

In this case, it may be argued that given what is known in respect of the impacts of mental health and substance misuse, there may've been the necessary factors to make the risk level high.

Research supports the idea of the link between mental health and Domestic Abuse is a two-way street i.e. people with mental health issues are more likely to be involved in an abusive relationship, while people already in an abusive relationship are more likely to have mental health problems.[26] The Safe Lives Insights Idva 2017-18 dataset showed that:

"42% of people accessing support from a domestic abuse service had mental health problems in the past 12 months, and 17% had planned or attempted suicide. However, Safe Lives "Cry for Health" report revealed higher levels of mental health needs amongst victim/survivors within hospital settings (57%), compared to those within community-based domestic abuse services (35%) 35. Nearly twice as many hospital-based victim/survivors had self-harmed or planned/attempted suicide than those in community services (43% compared to 23% respectively). This higher disclosure rate of mental health needs in hospitals is likely due to the setting being focused on health and wellbeing, instead of on criminal justice. This could suggest that levels of mental health problems amongst victim/survivors are being underreported within community-based services, or/and that there are differences in the needs of people accessing different services."

This clearly demonstrates that in circumstances similar to those of this review, victims and perpetrators with mental health issues need to have their risk factors carefully considered when being dealt with by practitioners.

Similarly, the link between substance misuse and domestic abuse has also been clearly linked in the past.

The relationship between domestic abuse and substance misuse is a complex one. While drug and alcohol misuse cannot be said to cause abusive behaviour, they often go alongside it. Home Office statistics show that 48% of convicted domestic abuse perpetrators had a history of alcohol dependence, and 73% had consumed alcohol prior to the event.[27] Research has indicated that there

[25] http://www.safelives.org.uk/sites/default/files/resources/Representatives%20toolkit_0_1.pdf
[26] https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf
[27]https://webarchive.nationalarchives.gov.uk/20110218141158/http:/rds.homeoffice.gov.uk/rds/pdfs2/r217.pdf

are perpetrators of domestic abuse in substance misuse treatment services[28]. Domestic abuse is not restricted to intimate partner relationships; research by Adfam and AVA reveals that parents can also experience abusive behaviour from their substance-using children (under or over 18).[29]

The other side of the coin is that those who have experienced domestic abuse may misuse substances to cope with the trauma, or the perpetrator may use their dependency to exert control over them. Research by "Agenda"[30] indicates that women who have experienced extensive physical and sexual violence are more likely than those who haven't, to then have an alcohol problem or be dependent on drugs, as well as have a range of other complex needs.

It is therefore imperative that substance misuse services recognise that there are likely to be both perpetrators and victims accessing, or in need of, their support, and so should act accordingly.

In this case there appear to be specific examples of downgrading the risk. This raised several questions to the panel, including:

i. Supervision of DASH risk assessments;
ii. Factors considered and recorded in support of downgrading such risk assessments.

The failure to complete risk assessments in accordance with policy and National Practice developed in 2009, also raised the issue of adherence to policy. This again highlighted the necessity for appropriate supervision and quality assurance.

Whilst the issue of completion and grading of risk assessments is a matter of concern, this is on the basis that High-Risk cases do get heard at a MARAC, where partner agencies share information known to them. Had this case ever been heard at MARAC it is reasonable to presume that many of the 348 entries on the chronology would have come to notice, informing subsequent actions. The question however arises as to:

Does a Standard and Medium risk assessment automatically result in an 'on/off switch' approach to the sharing of partnership information. Does this mean an automatic rejection of a partnership approach?

> Throughout this review the chair has noticed that many agencies have identified risk issues involving both Susan and Daniel. Signs of vulnerability and aggression have been recognised in relationships prior to theirs. Domestic abuse was clearly the motivating factor in the break-up of Daniel's relationship with Debra and the same could be argued in Susan's relationship with John. The use of DASH risk assessment was introduced in 2009 and its purpose was "to provide a

[28] Humphreys, Cathy, et al. "Domestic Violence and Substance Use: Tackling Complexity." The British Journal of Social Work, vol. 35, no. 8, 2005, pp. 1303–1320. JSTOR, www.jstor.org/stable/23720558.
[29] https://adfam.org.uk/files/docs/adfam_dvreport.pdf
[30] https://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf

simple and consistent tool for practitioners who work with adult victims of Domestic Abuse" [31]. Questions are themed in areas of abuse including physical, sexual, emotional, child related and coercion. The Safe Lives checklist offers 24 simple questions and the results give clear indications of those suffering domestic abuse and therefore are suitable for referral to the Multi Agency Risk Assessment Conference (MARAC). The 'Safer Somerset Domestic Abuse Toolkit for practitioners' provides some clear guidance with regards to:

- The need for a partnership in which agencies are engaged in the process.
- The process to be completed once an assessment has been graded to whichever risk level (standard, medium or high-risk).

There seems to be an opportunity, in creating and reviewing these assessments. Staff need to be encouraged to take a dynamic approach when carrying out this process and take short/medium/long term ownership of identified risks. As the Somerset Multi-Agency Safeguarding policy[32] states.

"Safeguarding is the responsibility of everyone including statutory, independent and voluntary agencies"

The Somerset Domestic Abuse Strategy 2017-2020 indicates a clear link between the MARAC and MASH process. DASH referrals, from all practitioners engaging with domestic abuse families, need to be submitted and retained by the MASH and used as the corner stone of subsequent risk management processes.

The Safe Lives checklist provides a consistent and simple tool for all practitioners to use in domestic abuse scenarios and forms part of the assessment process when recognising High Risk cases that should be referred into the MARAC process. Parties who are adopted into the MARAC process are provided with a wide variety of support services as highlighted in paragraph 5.3.4. All front-line practitioners would benefit from being provided with a detailed case history when visiting families with a history of domestic violence and abuse. Including if they're serial perpetrators and if they are known to either the MASH or the MARAC processes.

Training should reflect this need and ownership should be encouraged as well as clear pathways of referral.

Reviewing each IMR it appears, to the chair, that many risk assessments have been completed as a 'moment in time' rather than having a reference to previous scores and activity. There is evidence that police line managers have carried out some case reviews however, this not typical across all partner agencies. The development of a centralised risk assessment unit would provide multiple benefits including consistency of performance, expert knowledge and a focal point for practitioners

[31] Safelives DASH risk Checklist, Quick Start Guidance

[32] https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/20190625-FINAL-Joint-Safeguarding-Adults-Policy-Somerset.pdf

to seek advice and guidance. The creation of this quality assurance role would provide support in recognising skills gaps and training needs and ensure that minimum standards of performance are achieved. It is encouraging to note that the changes in the MARAC referral process will allow the Somerset Integrated Domestic Abuse Service (SIDAS) to assume a Quality Assurance role with regards to the MARAC, it should be encouraged in the areas mentioned above.

MARAC REFERRALS

It is recognised that the funding for MARAC is due to end in 2019 and that things must change to reflect this. In Somerset the role of SIDAS will become pivotal as the focus and quality assurance agent for all MARAC referrals. Local research recognises that 30% of cases do not require a face to face MARAC meeting and this needs to be acknowledged going forward. In the case of Susan and Daniel, no MARAC referral was ever made despite the risk sometimes being identified as high. As with all 'non-MARAC' cases the role of the Independent Domestic Violence Advisor (IDVA) is a crucial one. Resources and staff are at a premium and it is unrealistic to expect that every Domestic Abuse referral will result in IDVA engagement. However in cases, such as this, involving the 'Hidden Harm' issues of Domestic Abuse, mental health and substance misuse consideration could be given to engagement with an IDVA to provide appropriate levels of support and assessment. Such an assessment could be fed back to the SIDAS who could make a professional judgement as to whether a MARAC referral is appropriate.

RECOMMENDATIONS

The analysis therefore leads to the following recommendations being presented, by this review.

Recommendation	**Action to be taken**
All panel members to review their own response and activities with regards to the 3 themes. I.e. Risk Assessing, Multi Agency Engagement and Mental Health	Complete formal Assessment. Forward outcomes to the Domestic Abuse Board for subsequent and then onward reporting to the Community Safety Partnership Board
Embed the principles of the ACPO DASH Risk Assessment process throughout all CSP agencies.	Ensure that the Somerset Domestic Abuse Board monitors and supports the uptake of training, by professionals in respect of the ACPO DASH Risk Assessment
Review the systems, policies and procedures that ensure the completion of DASH Risk Assessments and ensure that MARAC referrals are completed when required	Ensure that the Somerset Domestic Abuse Board encourages supports and monitors the completion of DASH reports throughout partnership agencies
Develop a culture of 'Professional Curiosity' of frontline practitioners through on-going training and internal publicity	Ensure that the Somerset Domestic Abuse Board monitors and supports the uptake of training by professionals

Encourage those who work within GP practices to ask Domestic Abuse screening/safety questions	Training for CCG staff including ALL front-line staff GP's and other practice staff. Ensure that Somerset Domestic Abuse Board monitors and supports the uptake of training by professionals.
The development of a robust quality assurance process for managing risk reports within the Lighthouse/Police Safeguarding Unit.	During its creation process quality assurance and governance frameworks must form part of its foundation. Define minimum standards for both Ensure adherence is reported to CSP and safeguarding boards.
The down grading of all DASH Risk assessments must be reviewed and agreed by those supervising frontline practitioners.	The new MARAC process has SIDAS in the role of Quality Assessor. No DASH downgrading should be agreed without their independent review and sign off.
All CSP practitioners and line managers to receive training regarding risk management in domestic abuse cases and subsequent information sharing	The new MARAC Operating protocol sets expectations in this area and therefore reflects the spirit of this recommendation. The promotion of this protocol should be highlighted to all relevant staff. SSP/SCC provide training within this area and staff should attend this training as part of their career development process.
The South West Ambulance Service should enhance their training programme to encourage frontline practitioners to demonstrate more professional curiosity when receiving disclosures of domestic abuse from patients and their families	Training content and policies should be updated so that staff can be encouraged to be proactive in referring information, relating to domestic abuse to the police and relevant agencies

MULTI AGENCY ENGAGEMENT

This section considers the efficiency of information sharing and attempts to understand whether there are opportunities to improve how information is considered across agencies.

The chronology demonstrates there were over 300 contacts involving either Susan or Daniel. Agencies work began in 2013 when Daniel was recognised as having a dependant personality disorder and in July of the same year when Debra reported the first incident of self-harming, domestic abuse and coercive control. There were reports to the police, in the same year, of minor domestic abuse issues between Susan and John. Subsequently many local Somerset agencies have played a significant role in the lives of both parties throughout a variety of traumatic incidents. This

includes the break-up of both their relationships with Debra and John, their own relationship journey, including the birth of Baby A and subsequent removal and adoption, their own separation and Susan's homicide.

Various panel meetings and IMR documents highlight the fact that Susan was routinely reluctant to engage with partner agencies. This made the management of long-term risk and patient care strategies difficult to create and implement. The chronology records that the level of identified risk was identified as reaching MARAC referral level on several occasions as highlighted however, no referral was ever made.

The contact with Daniel has always been sporadic with his behaviour being inconsistent. He had a history of mental health problems. This included a self-referral into a secure hospital ward for assessment and these problems are clearly had a negative impact on his relationships with both Debra and Susan.

IMR AND CHRONOLOGY REVIEW

The chronology records several cases of thorough and professional multi-agency working and this need to be recognised. However, the purpose of this review, detailed in the Terms of Reference, also includes the need to identify and establish lessons to be learned and the application of those lessons. Therefore, the chair has highlighted incidents where the chair and IMR authors have recognised opportunities to improve information sharing and multi-agency working.

AVON & SOMERSET CONSTABULARY

On **13th August 2013** Debra reports Daniel's recent history as being one which demonstrates significant deterioration in his mental health and increasing threats of violence, self-harm and suicide. Debra did not wish to make any formal allegations and consequently the matter was filed away. There is no record of any information sharing with any local agencies.

On **30th January 2015** police were contacted as Susan had made threats to harm herself. She was interviewed by police and all appeared well. No onward referral was made to any health services, although there is no clear route for police to refer people to health services (GP or community mental health).

On **4th April 2015** Susan called the police after she is denied access to her child by her then husband. No formal complaints or offences were alleged. No onward referrals, particularly with reference to Children Social Care.

On **28th December 2016** Daniel is arrested for assault on Susan. Subsequently he is charged with sending Malicious Communications. A DASH risk assessment was completed with Susan and scored 14 i.e. a High-risk case. The score was reassessed as medium and there was no rationale as to why.

The IMR author comments "The systems in place to ensure reviews of this matter failed – neither the Lighthouse nor supervisor review picked up on this oversight".

On **10th March 2017** Daniel called the police to complain of harassing telephone calls from Susan. A DASH risk assessment was completed, but no onward referral.

On **24th April 2017** Daniel called police to complain of attempts by Susan to contact him – against solicitors' advice. This was interpreted as a low-level matter with no crimes alleged. The case is closed with no onward referral.

On **12th May 2017** Daniel called the police as Susan had bruises on her arms and she confirmed that Sam was assaulting her. No subsequent referral and no partnership engagement.

On **5th July 2017** Susan contacted police and reported Daniel as missing. She was concerned that he had recently self-harmed and begun to barricade himself in at home. Police completed enquiries and found him at home, apparently safe and well. No referrals were made to any health services.

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST

On **30th July 2013** there is a similar report to that recorded by the police above (13th August).

The IMR author notes "[The secure ward] could have discussed children's concerns with safeguarding and Children's Social Care".

On **8th August 2013** there is a report on Daniel's notes that he is fixated on Islam and rape.

The IMR author notes that the "The secure ward staff could have gathered further information and considered further action".

On **21st August 2013** Debra disclosed that Daniel threatened to kill her, he has a history of violent behaviour and that she is scared of him.

The IMR author notes "No information sharing with the police."

On **15th June 2016** the Community Mental Health Team decline to attend a Child Protection meeting regarding Baby A. [this particularly pertinent bearing in mind the entries 30.7.13 and 8.8.13].

SEDGEMOOR DISTRICT COUNCIL – HOUSING HEALTH AND WELLBEING

On **8th December 2016** Susan attended an interview with the local council housing officer, in the company of two social workers.

The IMR author notes "she commented that she was in a 'controlling relationship' and raises concerns about potential domestic violence in the home. Standard procedure when domestic abuse is a concern, would be for the housing officer to explore the details and comment further".

There is then the potential to refer to SIDAS and other agencies, "in this case Children's Social Care". This was not done as CSC were present and a presumption was made that these enquiries were already on-going.

BRISTOL GLOUCESTERSHIRE SOMERSET AND WILTSHIRE COMMUNITY REHABILITATION COMPANY

On **12th May 2017** Daniel informed his Probation Officer that he was assaulted by Susan and that she and Baby A are 'high risk'. Daniel believes that his child's welfare is at risk. There appears to have been no sharing of this information.

On **16th August 2017** Daniel reports that he and Susan are moving back in together. This information was not shared.

PANEL REVIEW

The panel discussed this issue and it was apparent that the Somerset Multi Agency Safeguarding Hub (MASH) meet daily to discuss cases specific to children and there is an additional weekly meeting to discuss adult issues. The panel identified that the attrition rate for cases was very high and the volume of information being managed, by the MASH, needed to reduce in order that more cases could be processed.

The issue of consent was raised, and the panel took the view that in cases of significant or high risk then referrals should be made, regardless of consent to make suitable safeguarding decisions.

The panel acknowledged that domestic abuse cases are not currently discussed within MASH, however imminent changes to the MASH process means the incorporation of 'MARAC level' cases.

It is also recognised that Lighthouse and police safeguarding teams have amalgamated to ensure consistency of service and levels of referral, when assessing domestic abuse. A further concern was raised about the levels of 'downgrading' risk and that this hints at a danger of managing to resource levels not victim vulnerability.

COMMENTARY

The challenge presented by cases similar to this, is the risk of the vulnerable falling between the cracks as they do not 'appear' to reach the threshold of high risk for example those whose mental health condition does not require the support provided under Section 42 Care Act 2014 and whose levels of domestic abuse does not translate into referral to the MARAC. The chair has discussed with individual panel members and with the group and it is apparent that there are processes in place to support a wide variety of problems, for example Talking Therapies, IDVA support and Adopt South West.

The chair has researched local agencies that may have been able to support birth families in similar positions to Daniel and Susan. The details of the chronology and IMR presented by the CSC, police and Sompar show that, with all good intentions, contact with the family, around the time of Baby A going forward to adoption, was carried out through a series of unanswered text messages and phone calls. Beginning on the 24th May 2017 and ending with Susan's case being closed on the 28th

September. There were calls to police and CRHTT, made by Daniel, describing Susan's behaviour and apparent reaction to losing Baby A. There appears to have been no subsequent positive contact with the couple which may have identified opportunities to support them. ADOPT SW[33] is a service which supports birth parents going through the adoption process. It provides information about what happens during the adoption process and outlines parents' legal rights. Details of this support includes:

- Advice
- Phone number and email addresses
- A 'letterbox service'[34] for adoptive and birth parents to keep in touch and exchange news once or twice a year.

The chair is very keen to identify opportunities of support to enhance what is already being provided by the CSC and other CSP agencies and therefore feels that raising awareness of support networks similar to ADOPT SW can only be a positive in the future. Therefore, a Recommendation has been raised for guidance and training to be provided through the LSCB.

Somerset commissioners are currently implementing a joint working protocol which focuses upon agencies who work in the areas of mental health, domestic abuse and substance misuse. This represents a significant percentage of those who are vulnerable within, not just in the local area but nationally.

The Somerset Domestic Abuse Needs Assessment draws out various priority areas including "Working in Partnership for Best Results"[35]. The issues raised here clearly echo this need and highlight the crucial impact that collaborative working has. It therefore appears that there is an inference of managing risk according to resource. Whilst this is the reality of working against a background of fiscal restraint, it poses a question of whether this is a reality and misconception and should be raised at more senior levels for further exploration and review.

RECOMMENDATIONS

The analysis therefore leads to the following recommendations being presented, by this review.

Recommendation	**Action to be taken**
LSCB to review their approach to Child Protection Conferences to ensure that the learning, from this review, regarding trigger points for escalated risk of Domestic Abuse	Adult and Children's Safeguarding Boards to have oversight of this review. All CPC chairs are to be made aware of the potential escalation in risk and document

[33] https://www.adoptsouthwest.org.uk/
[34] https://www.adoptsouthwest.org.uk/birth-families/contact-with-a-birth-child/letterbox-service/
[35] Somerset Domestic Abuse Needs Analysis

in the family environment are recognised and acted upon.	considerations and actions to mitigate this possibility. A review of the current Safety Plan processes including policies and procedures. Based on any subsequent policy changes ensure that training is delivered to all frontline practitioners.
The Home Office Quality Assurance panel should direct police forces across the country to confirm that a Mental Health pathway of referral exists, allowing officers to refer those exhibiting symptoms to a framework of support including statutory, volunteer and charities service providers.	Home Office to confirm a national referral route for Police to make referrals direct to community mental health services where required.
All self-harm matters should be considered for vulnerability assessment and followed up with a referral to MASH if appropriate	Ensure partner agencies are reminded of their responsibilities of safeguarding polices, with particular focus self-harm cases
Somerset Local Safeguarding Children Board to improve knowledge amongst Children's Services professionals of the available support for parents whose children have or are going through the process of formal adoption.	CSC staff to be reminded of the Adopt SW pathways for referral and information sharing process

MENTAL HEALTH ASSESSMENTS

The Somerset Health and Wellbeing Board 2014 -2019 self-assessment demonstrates that 50% - 60% of women who have been within Mental Health services suffered domestic abuse and it is anticipated that the new mental health/substance misuse/domestic abuse protocol will recognise the difficulties and challenges faced by these victims[36].

INDIVIDUAL MANAGEMENT AND CHRONOLOGIES REVIEW

AVON AND SOMERSET CONSTABULARY

On **9th December 2013** Daniel went to Debra's house the previous evening to see the children. He refused to leave and stayed the night. Debra was too frightened to call police as he had said he would kill himself if he thought the relationship was over. Mental Health services believed the outburst was alcohol related in desperation to get his family back as opposed to deterioration in his mental health. A mental health assessment was not seen as appropriate.

[36] The Somerset Health and Wellbeing Board report 2014 – 2019.

On **6th February 2014** A multi-agency meeting was held after Daniel sent a number of texts to Debra, in contravention of advice provided by her solicitor, causing unnecessary distress. The risk to Debra is interpreted is low, both IMR and chronology record that "Daniel's mental health would be assessed"

On **30th January 2015** Susan sent a text message to John to say she wanted to end it all. He contacted the police and the issues of Susan's mental health problems and chaotic lifestyle were discussed. A referral is made to Adult Social Care on **2nd February 2015**.

On consecutive days **30th & 31st January 2016** Susan and Daniel reported each other as missing. Both reported concerns over each other's mental state. Both the IMR and chronology report that no action was taken with regards Susan's absence on the 30th although she was spoken to on the 31st when reporting Daniel missing. He was found safe and well, referrals were made to "CSC, Health and Adult Social Care"

On **16th March 2016** Daniel was arrested for assault on Susan, after he called the police and asked for her to be removed from his home. Daniel was offered access to an independent counsellor for support with his drink, drug and mental health issues. It is unknown if this offer was accepted. The following day referrals were made to CSC and Health services.

On **3rd June 2016** police attended an Initial Child Protection Conference where it was recognised that neither Susan nor Daniel were attending mental health services and consequently both had been discharged.

On **12th May 2017** Daniel contacted police to inform them that Susan had been assaulted by Sam and he was also concerned that her mental health may deteriorate as there was an upcoming court hearing regarding Baby A. The police are unable to contact Susan and the case is closed.

On **20th June 2017** Daniel reported Susan sitting outside his house screaming and crying. He informed Susan that he has contacted the police and Mental Health services, at which point Susan left. Eventually police found Susan at her home address and she told them she was fine. Referrals were made to "CSC, Health and Mental Health Services".

On **5th July 2017** Susan contacted the police and reported Daniel missing. She informed officers that he had mental health issues and "drank a lot of Vodka". Susan told officers that she was unhappy as Daniel has recently scratched the words "ha ha ha" on his arm and had taken to barricading himself into his home. Daniel was found safe and well and no subsequent actions were taken.

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST

On **26th February 2013** a GP referral was received, referring Susan for a mental health assessment. An appointment was made but Susan did not attend.

On **9th December 2013** the mental health worker contacted the police with regards to the incident mentioned in the Avon and Somerset Constabulary chronology. The matter was discussed with the

'Trust Safeguarding lead who advised them to complete a Co-Ordinated Action Against Domestic Abuse DASH Risk Assessment if the situation deteriorates'.

On **24th February 2014** Daniel was seen by the Community Mental Health Team (CMHT) after concerns were raised by his mother. The outcome of the meeting was that no mental health concerns were raised, and the issue was that Daniel was distraught over the break up his marriage to Debra.

On **16th November 2015** Daniel referred himself and Susan to Mental Health Services, due to perceived mental decline. Appointments were made for a mental health assessment, on the **25th November 2015**, however neither Daniel nor Susan attended.

On **17th November 2015** Daniel disclosed domestic abuse in Susan's previous marriage and the removal of her 2 children. Also, that Susan was abusing cannabis and alcohol. The IMR author records that an appointment was cancelled on **9th December** and a further one was requested for the new year.

The IMR author records "No consideration of risks with both [Daniel] and [Susan's] declining mental state and her pregnancy. Not seen by Mental Health services during this period of contact.

On **2nd March 2016** Daniel met with the CSC worker as part of an "assessment to parent" process, prior to the birth of Baby A. Daniel was offered a Mental Health Assessment, which he attended. He disclosed an assault by Susan and recognised as a victim, so was consequently offered support, from SIDAS, which he declined. But he accepted referrals into a self-management group and Talking Therapies.

From the 16th **March 2016 – 28th April 2016** following a prosecution where Daniel assaulted Susan, as part of the Court Assessment Advice Service (CAAS) process, a crisis follow-up plan was agreed and shared with the CMHT and GP. Daniel failed to engage with the process.

The IMR author reports "No evidence of Sompar No Response policy or welfare check. Good engagement with GP and external agencies".

On **25th May 2016** There is contact from CSC reporting that the couple are struggling with their mental health.

The IMR author notes "Discussed in local Community Mental Health Team – no services offered, deemed to be more parenting issues (missed opportunity to assess the couple)".

On **1st and 2nd June 2017** Sompar receive telephone calls from Daniel who raises concern about Susan since Baby A was taken into care. He confirms she is having suicidal thoughts and requests help. On the 2nd of June, Daniel calls back to confirm that he and Susan had spoken at length and she had confirmed that her comments about suicide had been a "spur of the moment" thing, and there was no intention behind them.

The IMR author records "No plan for support from this call to contact the police for welfare check if needed. The CRHTT team could have tried to call [Susan] to assess the situation.

TAUNTON AND SOMERSET NHS FOUNDATION TRUST

On **9th December 2015** Susan was asked various questions whilst booking an appointment to see her midwife. She admitted to being the victim of domestic abuse and sexual assault and drug addiction, but denies any mental health problems. This issue is raised again on the **14th of June 2016** and again denied.

On **10th May 2016** it appears that Susan has missed the latest of several ante natal appointments and the patient notes state "Records indicate a history of mental health problems".

On **22nd June 2016**. Susan was interviewed by her midwife, following an incident the day before (awkward disagreement with Daniel during a consultation). Susan denies knowing that Daniel had mental health problems or that his other two children had lost contact with him.

SEDGEMOOR DISTRICT COUNCIL - HOUSING HEALTH AND WELLBEING

On **22nd August 2013**, whilst an in-patient at a secure ward, Daniel was interviewed by the housing officer. He was making a single person's application and was placed on the 'Homefinder' system as seeking housing.

On **8th December 2016**. Susan was interviewed, by the Housing Officer, in the presence of a CSC social worker. She disclosed mental health issues as well as domestic abuse and coercive control. The CSC representative also commented that Susan's mental health was also deteriorating.

CLINICAL COMMISSIONING GROUP

On **25th May 2016** there are notes on the GP records that Susan had significant mental health issues and she disengaged with CMHT in 2014. There are other concerns about alcohol misuse and Susan's lack of engagement with her midwife. The notes also record a Social Services Strategy meeting being planned.

On **13th July 2016** the GP received a Court Order (regarding Baby A parenting issues) to release medical notes. The key issues are mentioned as being domestic abuse, mental health, substance misuse and alcohol abuse.

BARNARDO'S (SIDAS)

On **13th March 2017** during an initial referral from Daniel's social worker there is reference to him suffering with long term mental health issues and had been diagnosed with schizophrenia, bi polar and autism. (The source of this diagnosis has never been confirmed as the review does not have access to Daniel's medical records). At Daniel's trial the prosecution was aware that the defence had a psychiatric report completed on Daniel however it was never disclosed, and its findings never relied upon in court).

BRISTOL GLOUCESTERSHIRE SOMERSET AND WILTSHIRE COMMUNITY REHABILITATION COMPANY

On **22nd June 2017** Daniel had a supervision meeting and provides background and domestic history. This includes details of self-harm and being the victim of domestic abuse. He reported contacting the police and mental health services to seek support.

PANEL REVIEW

During panel meetings, members were satisfied that the threshold was never met to impose 'Section 42 enquiry' and this was rationalised using various examples of the couple 'playing the system' e.g. Daniel trying to support Susan, by contacting CMHT professionals directly and Susan calling for police support whenever Daniel goes missing or makes a cry for help.

The chair is encouraged that the partnership is initiating a 'multiple needs joint protocol' for mental health, substance misuse and domestic abuse. Sompar demonstrate good practice by using an 'Orange Card' system, which allows those patients, who are exiting treatment to self-refer back into the system and quickly access services within 18 months of leaving.

The panel also understands that mental health workers are beginning to locate in GP surgeries to improve patient understanding and access to services. The panel was also made aware that only patients with significant issues are in receipt of secondary mental health services. Clearly this makes a positive early assessment and regular reviews all the more critical, particularly with regards to the Section 42 Care Act 2014 principles.

COMMENTARY

The mental health problems suffered by both Susan and Daniel are constant themes throughout this review. Both could be categorised as being within the 'high risk' bracket due to several concerning issues, including unemployment, low income, stressful life events and domestic abuse (as highlighted by the 'Positive Mental Health - Joint Strategy for Somerset 2014 – 2019). However, the challenge appears to be whether either Susan or Daniel appears to fall within the definition provided by Section 42 of the Care Act 2014.

The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

The Care Act has also introduced the following 3 new categories of abuse, but only if they are affecting an adult with care and support needs:

1. Domestic violence – including psychological, physical, sexual, financial, emotional abuse; so, called 'honour' based violence.

2. Modern slavery – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
3. Self-neglect – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Throughout their relationship they spend many months in apparent contentment, with no need for agency support. However, at moments of particular stress, mental health problems surface and one or the other comes forward looking for help. Throughout the review period the levels of engagement with, for example Sompar and local police, regarding mental health issues appear to be neither of significant volume nor considered to be high risk[37] i.e.

Volume of Calls made by Susan or Daniel, **August 2013 – November 2017**	
Agency	**Volume of Calls**
Avon & Somerset Police	11
SOMPAR	10
Taunton & Somerset Trust	5
Sedgemoor District Council	2
Clinical Commissioning Group	2
Barnardo's	1
BGSW CRC	1

CONCLUSIONS, LESSONS LEARNED AND GOOD PRACTICE IDENTIFIED

This review was generated following the homicide of a female by her ex-partner. Its purpose has been to identify lessons which can be learned to prevent a similar set of circumstances from happening again. The review has taken several forms including panel meetings with Community Safety Partnership agencies and police experts, the preparation and assessment of individual management reviews and research into current local policies and methodology.

This process has generated several questions and challenges along 3 themes i.e. The identification and management of risk, partnership working, information sharing and mental health support. The recommendations have been prepared to address these matters and agreed with the DHR panel members as being both proportionate and practical.

This review does not seek to blame any agency or individual but rather focuses on identifying opportunities to improve services to those in similar circumstances. Recommendations and

[37] Safer Somerset DHR 022/18 Chronology document

proposed actions seek to enhance the service provision to victims and their families as well as raising awareness of the various issues which were subject of the analysis.

Susan and Daniel had been in a long-standing relationship, prior to beginning their own in 2014. Both were parents, their previous relationships were abusive and neither had any ties to their children. They appear to have had very few friends, little or no family involvement and no apparent community engagement.

Despite having a large volume of contacts with many local agencies these engagements were often brief with very little subsequent activity. This made the role of the agencies pivotal in supporting Susan, as she was particularly vulnerable however, due to her regular yet fleeting involvement this support was extremely difficult to provide. With regards to Daniel he appears to have presented a risk to both Susan and his previous partner Debra. However on many occasions there has been very little risk assessing or information sharing to bring Susan and Daniel to the attention of all partner agencies. It is for this reason the first two themes of the analysis, in the review were:

Risk Assessment
Information Sharing.

Consultation with subject experts and panel members has recognised the issue of mental health and problems faced by those who do not fall under the definition of Section 42 of the Care Act 2014. The chair recognises the efforts being made across the partnership to support those suffering with mental health problems but fall outside the Section 42 definition, and feels that this is reflected in the third theme of the analysis:

Mental Health

LESSONS LEARNED.

Children's Social Care have recognised the pre-birth processes during Susan's pregnancy with Baby A as being too reactive and passive. Over the last 18 months this has been identified within the CSC as an area for improvement and a culture of 'joined up' multi-agency' working has become entrenched amongst managers, supervisors and front-line practitioners within the organisation. This culture has been introduced using training sessions and team meetings.

There's also more robust care planning following pre-birth assessments, and more detailed record keeping and line management. The CSC IMR author reports that in this case planning was too timid and record keeping was poor.

More dynamic and honest engagement with parents during the Child Protection planning process, and training should be applied to encourage a pro-active not re-active style.

The opportunity to include referrals to other agencies, regarding behavioural changes during the pre-& post birth planning stages does not appear to have been taken up. However, these referrals

do not offer any guarantees, but they may have provided improvement to the thinking, behavioural and coping skills.

As the result of this review and circumstances surrounding it Sedgemoor District Council's Housing department has reviewed its procedures regarding domestic abuse. New procedures confirm that when dealing with cases of reported or apparent domestic abuse, the victim is the focus of immediate and subsequent activity. Including the need for a sensitive and supportive approach, to ensure that there are suitable and safe lines of communication and specific pathways for information sharing.

Housing Officers are directed to complete ACPO DASH Risk Assessments and to use professional curiosity when completing this assessment. In terms of referrals, Housing Officers are directed to consider the potential escalation of domestic abuse including the volume of calls made by victims.

All cases that are discussed at MARAC will have an alert placed on their Homefinder file. Housing Advisers will provide support to victims, in order that they can remain in the home, however where they feel that they have to leave, victims will be given support with finding other routes for accommodation. Housing Officers are able to discuss individual cases at the weekly 'Together Team Meetings' and cases involving children should are reviewed by Senior Case Officers.

In terms of monitoring the process will be subject to an annual review by the Senior Case Officer.

Housing Officers are also provided with a list of 'Things to Consider' i.e.

- Domestic Violence and Prevention Orders;
- Benefit advice;
- Support for those with no recourse to public funds;
- They are making themselves homeless;
- Home safety improvements;
- Immediate and longer-term accommodation issues;
- Emergency injunctions.

GOOD PRACTICE IDENTIFIED.

The IMR authors have identified examples of good practice:

AVON AND SOMERSET CONSTABULARY (ASC)

The author provides several examples of good use of the DASH Guidelines and Force policy when completing DASH risk assessments, including incidents in June 2013 and December 2013.

In December 2013 the use of information provided by Mental Health workers allows the initial investigating officers to implement safeguarding measures to protect Debra from harassment by Daniel, (warning markers on the police computer to treat all calls to Debra's address as urgent).

The force has recognised the need to provide up to date information and intelligence to officers who attend domestic abuse related incidents, thus allowing them to better identify any safeguarding needs, assess risk and as well as understanding family history. The police recording system now has an enhanced flagging and reporting function to allow this type of information and detail to be recorded and accessed.

The force also recognises the benefit of reviewing lessons learned from other DHR and Serious Case Review reports and seeks to enhance its own performance. The IMR author uses the example of MATAC[38] a "Multi-Agency Tasking and Coordination" meeting focusing upon the perpetrators of domestic abuse and the potential benefits of adopting this process across the Avon and Somerset Constabulary area.

TAUNTON & SOMERSET NHS FOUNDATION TRUST

In November 2015 Susan saw her midwife during an ante natal visit. The midwife identified Susan as being a vulnerable mother and referred her for consultant led care and additional support at Musgrove hospital. Relevant staff including the Safeguarding Midwife and Social worker were given regular updates and utilised for support. Further good practice included:

- Prompt action and record keeping;
- Effective communication between maternity services, social care and health visitor team;
- The arrangement of multi-agency meetings and appointments with Susan;
- Continuity of attendance. The named midwife attended over 80% of the appointments with Susan and Daniel.

SOMERSET CLINICAL COMMISSIONING GROUP

The GP surgery worked hard to support Susan through her various addictions, over an extended period. (2008 – 2015) including the safe prescription of opiates despite her unwillingness to comply. Susan regularly missed appointments which made on-going support and diagnosis challenging, despite this the practice continued to offer support.

The activity of the GP during Susan's admission to hospital in 2015 demonstrated a high level of support during a time of high stress and emotional upheaval. Despite her lack of engagement with hospital staff and Social Services.

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST (SOMPAR)

[38] http://n8prp.org.uk/wp-content/uploads/2017/06/MATAC-N8-presentation-final-11-June-2017.pdf

Susan had 3 opportunities to engage with mental health services during the time frame of this review and chose not to engage each time. Both the CMHT and Talking Therapies teams demonstrated robust attempts to engage with her on numerous occasions evidencing a good level of practice.

In September 2013 Daniel was discharged from the local acute inpatient mental health hospital service. He received on-going support from the CRISIS Resolution and Home Treatment Team (CRHTT) including work with the care coordinator and regular psychiatric reviews. The IMR author has interpreted this as good practice.

In March 2016, following Daniel's arrest for assaulting Susan, lines of communication are opened and continue, between Social Care, GP services and external agencies, in order to support Daniel and the judicial process.

In November 2017, following the adoption of Susan and Daniel's baby, Talking Therapies make extensive efforts to contact Susan, above and beyond what would have been expected.

BRISTOL, GLOUCESTERSHIRE, SOMERSET AND WILTSHIRE COMMUNITY REHABILITATION COMPANY (BGSW CRC)

The Probation Officer completed prompt domestic abuse checks with the police and identified three related pieces of information which they shared with the social services.

RECOMMENDATIONS

During the Individual Management Review process authors were encouraged to identify recommendations for improvement within their own environment. These have been recorded together with the recommendations prepared by the chair and is based upon both the IMR's and Chronologies provide by panel members but also drawn from the analysis and research carried out by the chair. For ease of reference, these are consolidated below:

Arising from panel and independent chair

1. All panel members to review their own response and activities with regards to the 3 themes. I.e. Risk Assessing, Multi Agency Engagement and Mental Health (Safer Somerset Partnership's Domestic Abuse Board)
2. Embed the principles of the ACPO DASH Risk Assessment process throughout all CSP agencies. (Safer Somerset Partnership's Domestic Abuse Board)
3. Review the systems, policies and procedures that ensure the completion of DASH Risk Assessments and ensure that MARAC referrals are completed when required (Safer Somerset Partnership's Domestic Abuse Board)
4. Develop a culture of 'Professional Curiosity' of frontline practitioners through on-going training and internal publicity (Safer Somerset Partnership's Domestic Abuse Board)
5. Encourage those who work within GP practices to ask Domestic Abuse screening/safety questions (Safer Somerset Partnership's Domestic Abuse Board)

6. The development of a robust quality assurance process for managing risk reports within the Lighthouse/Police Safeguarding Unit. (Avon and Somerset Police)
7. The down grading of all DASH Risk assessments must be reviewed and agreed by those supervising frontline practitioners. (Safer Somerset Partnership's Domestic Abuse Board)
8. All CSP practitioners and line managers to receive training regarding risk management in domestic abuse cases and subsequent information sharing (Somerset County Council / Safer Somerset Partnership)
9. The South West Ambulance Service should enhance their training programme to encourage frontline practitioners to demonstrate more professional curiosity when receiving disclosures of domestic abuse from patients and their families (Southwest Ambulance Service NHS Foundation Trust)
10. LSCB to review their approach to Child Protection Conferences to ensure that the learning, from this review, regarding trigger points for escalated risk of Domestic Abuse in the family environment are recognised and acted upon. (Somerset Safeguarding Children Partnership)
11. The Home Office Quality Assurance panel should direct police forces across the country to confirm that a Mental Health pathway of referral exists, allowing officers to refer those exhibiting symptoms to a framework of support including statutory, volunteer and charities service providers. (Home Office)
12. All self-harm matters should be considered for vulnerability assessment and followed up with a referral to MASH if appropriate (Safer Somerset Partnership's Domestic Abuse Board)
13. Somerset Local Safeguarding Children Board to improve knowledge amongst Children's Services professionals of the available support for parents whose children have or are going through the process of formal adoption. (Somerset Safeguarding Children Partnership)

Arising from IMRs

14. ASC to improve management of high risk perpetrators to increase the safety of high risk victims (Avon and Somerset Constabulary)
15. ASC to ensure management of DA offenders is in accordance with best practice (Avon and Somerset Constabulary)
16. Compliance by officers of policy to refer domestic abuse cases to Lighthouse Safeguarding Unit (LSU) to be reviewed (Avon and Somerset Constabulary)
17. Probation Officers to ensure they are aware of the definition of a 'significant event' linked to reoffending and harm (BGSW CRC)
18. Probation Officers to ensure that risk management prioritise victim safety (BGSW CRC)
19. Ensure that information provided by service user is checked with partner agencies (BGSW CRC)
20. Encourage those who work within GP practices to ask Domestic Abuse screening/safety questions (Clinical Commissioning Group)
21. Access policy and children's DNA policy to be revised to clearly describe process for maternity users. (Musgrove Hospital)
22. Improve staff awareness of domestic abuse within organisation (Sedgemoor District Council)

23. Publicise help/support available for all forms of domestic violence within organisation (Sedgemoor District Council)
24. Devise a robust approach to risk assessment and management (Sedgemoor District Council)
25. Professionals are confident about sharing information and making informed decisions about actions (Sedgemoor District Council)
26. Ensure that the decision not to accept any referral (for voluntary perpetrator programme) is shared with key partners (SIDAS Barnardo's)
27. Ensure timely closure of client files (SIDAS Barnardo's)
28. Caseworkers to Intensify and record all methods of attempts to engage both client and other professionals during 1st month following allocation (SIDAS Livewest)
29. CW to update other professionals and record in case notes this has happened following significant event during client engagement. (SIDAS Livewest)
30. Effective Information sharing (SCC Adult Social Care)
31. Disseminate learning from DHR across Adult Social Care (SCC Adult Social Care)
32. Improve confidence of professionals in accessing all relevant support for clients (SCC Adult Social Care)
33. SCC Adult Social Care to review, alongside the SSAB Manager, engagement with future DHR and the cross over between other review mechanisms (SCC Adult Social Care)
34. Ensure completion of DASH Risk Assessments when 'in-custody' DA victims disclose abuse, and refer as appropriate(Avon and Somerset Police)
35. CAAS to consult with police officers once a prisoner presents as a domestic abuse victim. Discuss risk management plan and confirm actions required (Somerset Partnership NHS FT)
36. All frontline community mental health service professionals are aware of the 'Hidden Harm' protocol, and use it (Somerset Partnership NHS FT)
37. Ensure compliance with the statutory child protection process obligations (Somerset Partnership NHS Foundation Trust)

The action plan containing all these recommendations can be found at Appendix A.

APPENDIX A

SOMERSET DOMESTIC HOMICIDE REVIEW 022 ACTION PLAN

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
Avon and Somerset Constabulary	ASC to improve management of high risk perpetrators to increase the safety of high risk victims	Local	Review systems and ensure high risk domestic abuse perpetrators are flagged routinely on Niche Annual review to ensure the system is working correctly	• Criteria for review determined • Review completed • Report compiled with actions	30.6.2020	
Avon and Somerset Constabulary	ASC to ensure management of DA offenders is in accordance with best practice	Local	ASC to continue to review the management of DA offenders	• Identification of different methods of DA offender management in use • Review effectiveness and create action plan • Any proposed changes to be implemented	30.6.2020	Complete (September 2018) BRAG process and MARAC used

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
Avon and Somerset Constabulary	Compliance by officers of policy to refer domestic abuse cases to Lighthouse Safeguarding Unit (LSU) to be reviewed	Local	Operational procedures to be reviewed and audit	• Audit use of current procedure • Review current procedure and revise if appropriate • Train officers in use of procedure	30.6.2020	Complete (September 2018). Procedure implemented with training of officers.
Avon and Somerset Constabulary	All self-harm matters should be considered for vulnerability assessment and followed up with a referral to MASH if appropriate	Local	Remind partner agencies of their responsibilities of safeguarding policies, with particular focus self-harm cases	• Promote safeguarding policy	30.6.2020	Complete (August 2019)
Avon and Somerset Constabulary	The development of a robust quality assurance process for managing risk reports within the Lighthouse Safeguarding Unit.	Local	Define minimum standards for both Ensure adherence is reported to CSP and safeguarding boards.	• Oversight / governance of this to be set • Create quality assurance process • Implement process • Review process	30.6.2020	Complete (June 2019) Force-wide procedure reviewed and updated

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
BGSW CRC	Probation Officers to ensure they are aware of the definition of a 'significant event' linked to reoffending and harm	Local	BGSW CRC has delivered 2 workshops in February and March 2018 for all offender managers which covered our risk assessments and significant events. This has been followed up by a quality assurance process.	• Training to be designed and implemented	31.3.2018	Completed March 2018
BGSW CRC	Probation Officers to ensure that risk management prioritise victim safety	Local	BGSW CRC has delivered 2 workshops in February and March 2018 for all offender managers which covered our risk assessments and significant events. This has been followed up by a quality assurance process.	• Training to be designed and implemented	31.3.2018	Completed March 2018
BGSW CRC	Ensure that information provided by service user is checked with partner agencies	Local	Middle Managers to discuss in supervision and review through case audits	• Procedures to be reviewed • Audit of middle managers approach and identification of an gaps. Action plan to be created if	30.6.2018	Completed June 2018 and ongoing

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
				required for management / officer compliance		
Clinical Commissioning Group	Make training available to all Primary Care staff, to embed a higher understanding of Domestic Abuse and an awareness of available resources within the Somerset Trust	Local	Ongoing education in Somerset for Primary Care with Somerset CCG to liaise with education and to use Safeguarding Lead communications to spread learning	• Training to be designed • Training to be delivered	31.06.2020	Complete (December 2019) Training organised and promoted
Clinical Commissioning Group	Encourage those who work within GP practices to ask Domestic Abuse screening/safety questions	Local	Training for CCG staff including ALL front-line staff GP's and other practice staff. Ensure that Somerset Domestic Abuse Board monitors and supports the uptake of training by professionals.	• Training to be designed • Training to be delivered • Reporting to Somerset DA Board	31.6.2020	Complete (December 2019) Training completed
Home Office Quality Assurance Group	The Home Office Quality Assurance panel should direct police forces across the country to confirm that a Mental Health pathway of referral exists, allowing officers to refer those exhibiting symptoms to a	National	Clarify routes for police referrals into community mental health services Work with NHS England and ACPO to issue national guidelines for police, community mental health services and GPs to enable	• Review current routes • Liaison with NHS England and ACPO • Publish new routes and promote this	31.6.2020	

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	framework of support including statutory, volunteer and charities service providers.		people to be referred direct into appropriate mental health service provision.			
Musgrove Hospital	Access policy and children's DNA policy to be revised to clearly describe process for maternity users.	Local	Locate and Cascade the 'Access Policy Refresh and reinforce the 1st Did Not Attend Policy Enhance Mother engagement including their responsibilities should they miss appointments Refer all vulnerable mothers and families to 'Talking Families Complete DASH referrals on all vulnerable mothers	• Review the policy • Revise policy • Promote policy	31.6.2020	Completed (March 2019)
All Panel Agency's	Review their own response and activities with regards to the 3 themes. I.e. Risk Assessing, Multi Agency Engagement and Mental Health	Local	Complete formal Assessment. Forward outcomes to the Domestic Abuse Board for subsequent and then onward reporting to the Community Safety Partnership Board	• Assessment circulated • Responses collated as part of DA Board Self-Assessment 2019	30.05.2020	
All Panel Agency's	Embed the principles of the ACPO DASH Risk Assessment process throughout all CSP agencies.	Local	Ensure that the Somerset Domestic Abuse Board monitors and supports the uptake of training, by	• 2018 DA Board Self-Assessment Action Plan produced and	30.6.2018	Completed (February 2019) Somerset Domestic

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
			professionals in respect of the ACPO DASH Risk Assessment	presented to board • Board members to take the action to their agencies to implement by target date		Abuse Board Self-Assessment Audit
Safer Somerset Partnership	Review the systems, policies and procedures that ensure the completion of DASH Risk Assessments and ensure that MARAC referrals are completed when required	Local	Ensure that the Somerset Domestic Abuse Board encourages supports and monitors the completion of DASH reports throughout partnership agencies	• Domestic Abuse Board members to complete 2018 Self-Assessment • DA Board Self-Assessment to be produced and presented to February 2019 meeting • DA Board members to feed back to their agency to implement	30.6.2020	Completed (February 2019) Evidenced through self-assessment. To be monitored through continued self-assessment
Safer Somerset Partnership	Develop a culture of 'Professional Curiosity' of frontline practitioners		Ensure that the Somerset Domestic Abuse Board monitors and supports the	• Inclusion in Somerset DA newsletters	30.06.2020	In progress Included in July 2019

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	through on-going training and internal publicity		uptake of training by professionals	• SCC organised DA training content reviewed and updated (if required)		newsletter and reminders in subsequent editions
Safer Somerset Partnership	The down grading of all DASH Risk assessments must be reviewed and agreed by those supervising frontline practitioners.	Local	The new MARAC process has SIDAS in the role of Quality Assessor. No DASH down grading should be agreed without their independent review and sign off.	• Audit by Somerset Domestic Abuse Board as part of 2019 Self-Assessment	30.11.2019	Complete Audit in 2019 self assessment
Safer Somerset Partnership	All CSP practitioners and line managers to receive training regarding risk management in domestic abuse cases and subsequent information sharing	Local	The new MARAC Operating protocol sets expectations in this area and therefore reflects the spirit of this recommendation. The promotion of this protocol should be highlighted to all relevant staff. SSP/SCC provide training within this area and staff should attend this training as part of their career development process.	• MARAC Operating Protocol to be finalized and promoted via Somerset DA Board and Somerset DA newsletter • Review SCC organised DA training to	31.05.2020	

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
				ensure includes sufficient focus on risk		
Sedgemoor District Council	Improve staff awareness of domestic abuse within organisation	Local	Safeguarding lead to ensure domestic abuse training is included in generic training to all staff. Frontline service areas to access Somerset training on domestic abuse for key staff	• Training to be organised • Training delivered	30.11.2018 31.12.2018	Complete 21.1.2019 Training completed
Sedgemoor District Council	Publicise help/support available for all forms of domestic violence within organisation	Local	Update staff website and key information platforms with relevant internal communication. Promote awareness of support to the general public through SDC buildings and outreach points.	• Materials sourced • Materials promoted	31.7.2020	Complete (June 2019) Information obtained and promoted
Sedgemoor District Council	Devise a robust approach to risk assessment and management	Local	Review current procedures for undertaking risk assessments and management review of cases.	• Review procedure and amend as required • Implement new procedure so all relevant staff are aware	31.7.2020	Complete (January 2019), new procedure

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
Sedgemoor District Council	Professionals are confident about sharing information and making informed decisions about actions	Local	Review information sharing protocols	• Audit current awareness of information sharing protocols • Review protocols • Promote protocols	31.7.2020	Complete
SIDAS (Barnardo's)	Ensure that the decision not to accept any referral (for voluntary perpetrator programme) is shared with key partners	Local	Although SIDAS Lifeline programme has now closed, ensure learning from this review is shared with any future perpetrator programmes delivered by SIDAS	• Review current process • Revise process and audit its implementation and compliance	30.9.2020	Complete
SIDAS (Barnardo's)	Ensure timely closure of client files	Local	Review processes and revise as required	• Procedures are reviewed • Procedures revised • Compliance is audited by senior managers	30.9.2018	Complete
SIDAS (Livewest)	Caseworkers to Intensify and record all methods of attempts to engage both client and other professionals	Local	Audit by Team Leaders in Case Management Review for all Case Workers to ensure	• Procedures are reviewed	30.6.2020	Complete (case management

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	during 1st month following allocation		intensity and all methods attempted	• Procedures revised • Compliance is audited by senior managers		reviews audited)
SIDAS (Livewest)	CW to update other professionals and record in case notes this has happened following significant event during client engagement.	Local	Refresh standards with Case Workers using this case as example. Refresh expectations of practice with all Case Workers as learning point.	• Procedures are reviewed • Procedures revised • Compliance is audited by senior managers	30.6.2020	Complete (case management guidelines reviewed and updated)
SCC Adult Social Care	Effective Information sharing	Local	SCC Adult Social Care to review all avenues of referrals into the service to ensure that our responses are proportionate.	• Procedures are reviewed • Procedures revised • Compliance is audited by senior managers	30.06.2020	
SCC Adult Social Care	Disseminate learning from DHR across Adult Social Care	Local	To review content of social care "recognising adult abuse" training and ensure DHR learning is evident.	• Current training reviewed • Training revised • Training implemented	30.06.2020	

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
SCC Adult Social Care	Improve confidence of professionals in accessing all relevant support for clients	Local	Ensure appropriate SG leads for other agencies are included in Somerset Regional SG lead forum	• Review existing multi-agency referrers • Invite their safeguarding leads to attend forum	30.06.2020	
SCC Adult Social Care	SCC Adult Social Care to review, alongside the SSAB Manager, engagement with future DHR and the cross over between other review mechanisms	Local	Adult Social Care Safeguarding Service Manager to meet with Somerset Safeguarding Adults Board Manager	• Meeting to be organised and held	30.06.2020	Completed (June 2019)
Avon & Somerset Police	Ensure completion of DASH Risk Assessments when 'in-custody' DA victims disclose abuse, and refer as appropriate	Local	Feedback learning point to CAAS team (now LADS) via Team safeguarding supervision	• Review existing procedures and revise as appropriate • Promote and train staff in new procedure including on completing DASH	30.06.2020	Complete
Somerset Partnership	CAAS to consult with police officers once a prisoner presents as a domestic abuse victim. Discuss risk	Local	Feedback learning point to CAAS team (now LADS) via Team safeguarding supervision	• Review existing procedures and revise as required	30.06.2020	Completed

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	management plan and confirm actions required			• Implement and review compliance by officers		
Somerset NHS Partnership Trust	All frontline community mental health service professionals are aware of the 'Hidden Harm' protocol, and use it	Local	Send out memo to all relevant teams; support ongoing audit programme of shared SDAS / SIDAS and Sompar mental health cases to ascertain adherence to shared protocol	• Location of protocol reviewed and ensure placed where staff can see • Promote the protocol and how to use • Review and audit compliance by frontline professionals in its use	31.03.2020	Completed (May 2019)
Somerset Safeguarding Children Board (LSCB)	LSCB to review their approach to Child Protection Conferences to ensure that the learning, from this review, regarding trigger points for escalated risk of Domestic Abuse in the family environment are recognised and acted upon.	Local	• Adult and Children's Safeguarding Boards to have oversight of this review. • All CPC chairs are to be made aware of the potential escalation in risk and document considerations	• Report (when available to be published) to be shared with local Safeguarding Adults and Children's Boards	30.06.2020	Complete

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
			and actions to mitigate this possibility. • A review of the current Safety Plan processes including policies and procedures. • Based on any subsequent policy changes ensure that training is delivered to all frontline practitioners.	• Review child protection procedures and deliver training if/as required		
Somerset Safeguarding Children Board (LSCB)	Improve knowledge amongst Children's Services professionals of the available support for parents whose children have or are going through the process of formal adoption.	Local	• CSC staff to be reminded of the Adopt SW pathways for referral and information sharing process	• Determine methods of promoting this information • Implement promotion of information • Audit the effectiveness of the promotion		
South West Ambulance Service	Enhance their training programme to encourage frontline practitioners to demonstrate more professional curiosity when receiving disclosures of domestic abuse from patients and their families	Regional	Training content and policies should be updated so that staff can be encouraged to be proactive in referring information, relating to domestic abuse to the police and relevant agencies	• Review current training programme and amend as required • Implement new training	30.6.2020	

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
				• Audit impact		
Somerset Partnership Mental Health Trust	Ensure compliance with the statutory child protection process obligations	Local	Review the performance from the previous reporting year Identify reasons as to why any compliance was missed. Circulate expectations and provide appropriate training, as applicable	• Review and audit compliance • Create action plan for change • Promote this within staff teams	30.06.2020	

APPENDIX B - GLOSSARY

ACPO	- Association of Chief Police Officers
CMHT	- Community Mental Health Team
CPC	- Child Protection Conference
CRC	- Community Rehabilitation Company (probation)
CRHTT	- Crisis Resolution and Home Treatment Team
CSC	- Children Social Care
CSP	- Community Safety Partnership
DASH RIC	- Domestic Abuse Stalking and Honour Based Violence Risk Identification Checklist
GP	– General Practitioner
IDVA	- Independent Domestic Violence Advisor
IMR	- Individual Management Review
LSCB	- Local Safeguarding Children's Board
MARAC	- Multi Agency Risk Assessment Conference
MASH	- Multi Agency Safeguarding Hub
SIDAS	- Somerset Integrated Domestic Abuse Service
Sompar	- Somerset Partnership NHS Foundation Trust