OLDHAM COMMUNITY SAFETY AND COHESION PARTNERSHIP

DOMESTIC HOMICIDE REVIEW IN THE CASE OF CAROLINE

(died February 2018 aged 24 years)

FINAL REPORT (MARCH 2021)

PERIOD REVIEWED: 1ST JANUARY 2012 – DATE OF DEATH

INDEPENDENT CHAIR/AUTHOR: MAUREEN NOBLE

CONTENTS

1. Introduction Pages 3-8

2. Conduct of the DHR Pages 9-13

3. What Agencies Knew Pages 14-29

4. Learning from the Review Pages 30-38

5. Conclusions and Recommendations Pages 39-45

Introduction

1.0 This Domestic Homicide Review relates to the death of Caroline who was murdered by her partner Paul in February 2018. The review panel offer sincere condolences to Caroline's family on their tragic loss.

1.1 On a day in February 2018, at 07:41 hours police received a 999 call, stating that a male (later identified as Paul) had jumped from a second-floor window of a property (a commercially rented apartment).

1.2 Paul landed on the roof of a car and tried to steal the car. He then proceeded to assault the female driver of the car. He was covered in blood and was shouting that someone had been stabbed.

1.3 Police and North West Ambulance Service (NWAS) attended the scene and Paul was detained.

1.4 At 08:03 hours police gained entry to the property from which Paul had jumped. On entering the property, the attending officers immediately saw blood stains on the walls inside the flat and blood on the door. An officer then located the body of a female (later identified as Caroline) lying on the floor. The body was covered in blood and a blood-stained knife lay next to the body.

1.5 The attending paramedics confirmed that Caroline was deceased at the scene.
Paul was arrested, questioned, and charged with Caroline's murder. Paul initially entered a plea of 'not guilty' to murder on the grounds of diminished responsibility. Following assessment of Paul's mental health, it was deemed that he was of sound mind and fit to stand trial.

1.6 In July 2018 Paul was tried and found guilty of Caroline's murder. In August 2018 he was sentenced to life imprisonment to serve a minimum of 21 years.

1.7 The DHR panel decided that the period to be reviewed should be 1st January 2012 to the date of Caroline's death.

1.8 Key People

Name/Pseudonym	Relationship
Caroline	Victim (deceased)
Paul	Perpetrator
Jack	Caroline's Previous Partner
Tricia	Paul's Previous Partner (and Caroline's Cousin)

NB: Jack and Paul have the same forename. This led to some difficulty in establishing which of them was being referred to in some notes and records, however the panel is satisfied that specific events that relate to either Jack or Paul are correctly identified.

1.9 At the time of writing no Coroner's Inquest has taken place. The Coroner was informed at the commencement of the DHR and asked to be kept informed of the estimated date for completion of the review.

1.10 Greater Manchester Police referred the case to the IOPC. The lead investigator for IOPC and the DHR Chair shared terms of reference and met on two occasions to discuss progress of the respective enquiries.

1.11 The IOPC investigation report is published. The IOPC investigation concluded that there were no police conduct issues identified in relation to police involvement with Caroline and Paul. The report identifies learning for Greater Manchester Police emerging from the case.

Background to Caroline and Paul

1.12 Caroline was described by her sister as a loving and bubbly person who adored her children and would do anything for them.

1.13 The review learned from Caroline's sister that Caroline had had what was described as a 'difficult' childhood. Caroline had been subjected to abuse by an adult male, who was ultimately convicted of crimes against her and her sister.

1.14 Caroline had been deeply affected by the abuse she had experienced. Caroline's sister told the review that Caroline found it difficult to cope with the impact of the abuse and could not forget or resolve what had happened to her, and that this affected her relationships both in adolescence and adulthood.

1.15 As a result of the abuse she had suffered as a child, Caroline began to use drugs in her adolescence. Caroline's sister said that this was a coping mechanism for Caroline. In later years Caroline's drug use became chaotic, particularly after she met Paul. Caroline tried hard to stop using drugs and she sustained periods of being drug free, however when things became difficult for her she returned to drugs as a means of coping.

1.16 During the early part of the period under review Caroline was in a long-term relationship with Jack. Although the relationship with Jack was turbulent, Caroline's sister told the review that they had been happy together. Caroline and Jack had three children.

1.17 Caroline's relationship with Jack ended in May 2014, following an assault by Jack upon her. Jack tried to re-establish the relationship with Caroline. She told professionals that she had rejected Jack and did not intend to resume a relationship with him.

1.18 Following the assault on Caroline in May 2014, CSC became involved with the family and Caroline's children were firstly subject to CPP (Child Protection Planning), and an Interim Care Order in 2015, and subsequently became Looked After on a full care order. Caroline's sister told the review that Caroline was devastated by the removal of her children and that Caroline felt she had done everything she could to try to prevent this from happening.

1.19 Caroline's sister told the review that Caroline and Paul met when Caroline was buying cannabis from him *(NB this information came from family sources and was not known to other agencies at the time).*

1.20 Sometime between March and May 2016, Caroline began a relationship with Paul. The relationship appears to have been abusive from the outset. Caroline's family told the review that Paul was said to be unpredictable, manipulative and violent. The review was told that Paul coerced and controlled Caroline by telling her that he loved her and making her feel sorry for him, and that whenever there was an argument or assault by Paul, he would make excuses to Caroline and would not take responsibility for his actions.

1.21 It appears from information provided to the review that Paul spent some time staying with Caroline at her property in the period between March and June 2016. During this period there were a number of reports and complaints made by Caroline's neighbours regarding disturbances at the property. These were reports of verbal arguments and altercations, with one neighbour expressing concern that Caroline may be being abused.

1.22 Caroline appears to have increased her use of drugs at this time and both Caroline and Paul were thought to be using crack cocaine together on a frequent basis.

NB: Although unknown by any professional at the time, the criminal trial heard that Paul had humiliated, and threatened Caroline and that Caroline had been in fear of him. At sentencing the judge in the criminal case told the court that, in 2016 Paul had kept Caroline prisoner in her home for four days. Amongst other acts of violence and control he had continually spat at her, urinated on her clothing and verbally and physically abused her. Paul had stopped Caroline from seeing her friends and had also stopped her from attending the job centre.

1.23 Caroline told family and professionals that she had ended the relationship with Paul in around June/July 2016, however it is apparent that they remained in contact after that, and that Paul continued to abuse Caroline.

1.24 In August 2016, Paul assaulted Caroline causing her several injuries. Caroline presented to A&E and told staff that she had been assaulted by Paul. Caroline later retracted the allegation of assault and no charges were brought **(***NB the review learned that in the weeks prior to Caroline's retraction, Paul had threatened and coerced her into retracting her allegations of assault).*

1.25 Following the assault Caroline separated from Paul, however It appears that Caroline resumed her relationship with Paul sometime in 2017. There are reports from neighbours of them being seen together and reports made to police by Paul's family that they were using drugs together. There were reports from neighbours to the housing officer of disturbances at Caroline's property.

1.26 Late in 2017 Caroline was notified that she would receive a compensation payment of several thousand pounds related to the abuse she had experienced as a child. Caroline received the payment in January 2018. Caroline's family felt that Paul had exploited this as an opportunity to use Caroline's money to buy drugs.

1.27 Prior to the period under review Paul had sustained a head injury that required surgery. During the surgery he experienced trauma which he later reported had an ongoing impact on his mental health. Paul also experienced physical health problems.

1.28 In October 2012 Paul was diagnosed with Post Traumatic Stress Disorder (PTSD) related to surgical trauma and was prescribed medication for low mood and depression.

1.29 During the first part of the period under review (2012 to mid-2014) Paul was in a relationship with Tricia. Tricia is Caroline's cousin.

1.30 Tricia had three children. Paul is the father of one of Tricia's children. All Tricia's children were subject to Child Protection Proceedings at varying points during the period under review. None of Tricia's children are referred to individually in this report.

1.31 Paul had one child to a previous partner who is referred to in this report as 'Paul's child'. At times during the period under review Paul's child lived with Paul and Paul's mother.

1.32 Paul was known by his family and by some professionals to have violent and aggressive outbursts. He was also known as a perpetrator of domestic abuse in previous relationships (both with Tricia and with a previous partner).

1.33 During the period under review there are two recorded incidents of members of Paul's family reporting to police and others that they were frightened of him and expressing their concern that he might harm them or someone else.

1.34 Paul was a frequent user of crack cocaine for much of the period under review. This was said by his family and by Caroline to have exacerbated his changes in mood and violent behaviour. Paul had periods of engagement with substance misuse services, although he did not maintain this contact for any sustained period.

1.35 Paul experienced instability with accommodation during the period under review. He lived with Tricia and, when their relationship broke down, he lived with his mother. He also appears to have spent time staying with friends. It appears that he stayed with Caroline for a period between May to July 2016.

1.36 Following an assault upon Caroline in August 2016 Paul presented himself to hospital reporting that he had mental health difficulties. He was admitted to hospital as an informal/voluntary patient[1] (this means that he was not subject to any enforceable requirement to remain in hospital).

1.37 As he was undergoing a mental health assessment, Paul was not immediately charged but was referred to the Mentally Vulnerable Offenders Panel (MVOP). Further information is provided about the MVOP provision later in this report. During this period, it appears that Paul convinced agencies that he was 'sectioned' under the Mental Health Act, however, the reality is that Paul was at liberty to come and go as he pleased from the Mental Health Ward. It is apparent that during this time he coerced and controlled Caroline and persuaded her not to press charges against him for the assault. As a result of Paul's coercion and control Caroline told police she had 'lied' about the allegation and no further action was taken.

1.38 Paul was discharged from hospital in September 2016. On discharge Paul was not identified as having any current mental illness. He went to stay with his mother and sought his own tenancy.

1.39 He continued the relationship with Caroline and continued to abuse her. He was aware that Caroline would be receiving a settlement of damages for abuse experienced in her childhood and Caroline's family believe he financially abused Caroline, using the money to buy drugs.

1.40 The DHR panel considered the seven protected characteristics set out in the Equality and Diversity Act[2].

[1] https://www.mind.org.uk/media/5077426/voluntary-patients.pdf

[2] https://www.equalityhumanrights.com/en/equality-act

1.41 The panel noted Caroline's gender in relation to domestic abuse and the disproportionate representation of female victims and male perpetrators.

1.42 The panel noted that both Caroline and Paul had been referred to Mental Health Services. Caroline was diagnosed with low mood, anxiety and depression and treated with anti-depressant medication.

1.43 Paul was diagnosed with Post-Traumatic Stress Disorder (PTSD)[3] in October 2012.

1.44 The review found no other factors to take into consideration in relation to the Equality and Diversity Act.

1.45 Caroline's sister and father were contacted at the start of the review and were invited to participate and comment on the terms of reference. The family were provided with information regarding the DHR process which included Home Office Guidance, a leaflet explaining DHR's produced by AAFDA and local support service contact numbers.

1.46 Caroline's sister agreed to meet with the Chair of the panel. The meeting was arranged via a Homicide Case Worker from Victim Support, who also accompanied Caroline's sister to meetings with the DHR Chair.

1.47 Caroline's sister's contributions to the review are greatly appreciated and have added insight to the review. A summary of Caroline's sister's comments is provided below and throughout the report.

- Caroline was a vulnerable young woman who had experienced significant trauma in her childhood, which had affected her throughout her life.
- She was a devoted mother who cared deeply about her children. She did everything she could to prevent her children becoming Looked After and continued to do everything she could to have them returned to her.
- Caroline lacked self-confidence and did not deal well with conflict.
- Caroline's relationship with Jack had started well, however they argued and ultimately the relationship ended following an assault by Jack (it appears that Caroline resumed a friendship with Jack after her children became Looked After).
- Caroline met Paul because of using drugs, she was a regular user of cannabis and bought drugs from him. Caroline's sister believes that this is how their relationship started.
- Caroline spoke about abuse in the relationship with Paul, however she said that this was because he was not well. She blamed herself for his abuse and excused his assaults and manipulation of her, saying that he loved her and that he did not mean to hurt her. Caroline said that she loved Paul.
- Caroline's family were aware of the coercive and controlling nature of her relationship with Paul and were also aware that he had physically assaulted her on occasion. Caroline's family tried to encourage Caroline to leave Paul, however they were also aware that Caroline was vulnerable to Paul's coercion.

1.48 The Chair of the DHR met with Caroline's sister and father in February 2019 to discuss the findings of the review and the contents of the report. Their views are incorporated throughout this report.

1.49 Caroline's father told the review that Caroline had not had the strength to fight back against Paul, and that Paul had abused her throughout their relationship. Caroline had spent some time

[3] https://www.mentalhealth.org.uk/a-to-z/p/post-traumatic-stress-disorder-ptsd

living with her father, who had encouraged her to separate from Paul, but Paul would not go away and pestered Caroline until she returned to a relationship with him.

1.50 Paul's family were sent a letter informing them of the review at the commencement of the DHR. To date no response has been received.

1.51 The review enquired of Caroline's family whether there were any friends that could be contacted who may wish to contribute to the review. Although Caroline had a network of friends, no specific friends were identified to the review.

1.52 The review saw reports from neighbours in the context of IMRs from FCHO and GMP. The review decided not to ask any of these neighbours to take part in the review. This decision was ratified at a panel meeting on 10th March 2021.

2. Conduct of the DHR

2.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004)[4]. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set in the guidance.

2.2 This Domestic Homicide Review was commissioned by Oldham Community Safety and Cohesion Partnership in April 2017. The Review has been completed in accordance with the regulations set out by the Act and with the revised guidance issued by the Home Office to support the implementation of the Act. The Home Office definition of domestic abuse and homicide is employed in this case.

2.3 Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.[5]

2.4 The panel noted the revised definition of domestic abuse (2016) to ensure that all aspects of domestic abuse were addressed in the terms of reference and in the reports provided by agencies.

2.5 The over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children through a co-ordinated multi-agency approach that ensures that domestic abuse is identified and responded to at the earliest opportunity.

2.6 The rationale for the DHR is to ensure that the review process derives learning about the way agencies responded to the needs of the victim. It is the responsibility of the panel to ensure that the daily lived experience of the victim is reflected in its considerations and conclusions and, wherever possible and practicable, family and friends of the victim should participate in reviews to enable the panel to gain a deeper understanding of the victim's life.
The review aims to understand how agencies respond to domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide.

2.7 Learning from the review should help to improve services to victims of domestic abuse and strengthen prevention and earlier intervention. It should also strengthen support to family and friends of victims of domestic abuse.

---

[4]https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004
[5] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

2.8 A multi-agency action plan is appended that clearly sets out the actions that the commissioner and agencies should undertake to improve service delivery.

2.9 The terms of reference were agreed by the panel and set out below:

- To establish what contact agencies had with the victim and with the perpetrator; what services were provided and whether these were appropriate, timely and effective.
- To establish whether agencies knew about domestic abuse (in all its forms) and what actions they took to safeguard the victim and risk assess the perpetrator.
- To establish whether there were other risk factors present in the lives of the victim and perpetrator (e.g., mental health issues, substance misuse, transience and vulnerability in relation to accommodation)
- To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways
- To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
- To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan
- To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.
- To consider specific issues relating to diversity.

2.10 The following key lines of enquiry (detailed questions) were agreed by the panel:

- Did any agency know that Caroline was subject to domestic abuse by Paul or any other party at any time during the period under review? If so, what actions were taken to safeguard Caroline and were these actions robust and effective?
- Was Paul known to any agency as a perpetrator of domestic abuse, and if so, what actions were taken to reduce the risks he presented to Caroline and/or others?
- Did any agency have knowledge that Caroline and/or Paul was experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors?
- Did Caroline disclose domestic abuse to family and/or friends, if so, what action did they take? What information and advice would support families to protect their family member where domestic abuse is suspected, and if the family were aware of abuse, did they know what action to take or where to seek help, and did they think this was effective?”
- Did Paul make any disclosures regarding domestic abuse to family or friends, if so, what action did they take?
- Did any agency identify concerns in relation to safeguarding children?
- What systems and processes did agencies use when working with the Caroline and/or Paul in relation risk assessment, risk management, provision of services and interventions, service pathways (within and across agencies), management supervision and quality assurance of decision making
- Were these systems and processes effective and of a good quality?
- What was the level and type of multi-agency working in the case, was this effective?

2.11 A DHR Review Panel was established by the CSCP and met on seven occasions to oversee the review. The Panel received reports from agencies and dealt with all associated matters such as family engagement, media management and liaison with the Coroner’s Office. In addition, the panel liaised with local police in relation to the criminal investigation. The CSCP appointed Maureen Noble

as Independent Chair and Author to oversee and direct the Review and to write the overview report. The Chair was previously employed by Manchester City Council as Head of Crime and Disorder. She left this role in September 2012 and has worked as an independent consultant since that time. The Chair has more than 15 years' experience in the field of domestic abuse and has worked as a member of the NICE quality standards group and programme development group for intimate partner violence. The Chair has no connection with any of the agencies involved in the review, nor with any of the subjects of the review.

2.12 A panel of senior representatives from relevant agencies was appointed, membership of panel is set out below.

Name/Designation	Agency
Lorraine Kenny, Community Safety Manager, Internal Chair	Oldham Council
Eileen Mills, Designated Safeguarding Lead – Children	Oldham CCG
Janine Campbell, Designated Safeguarding Lead – Adults	Oldham CCG
Jayne Ratcliffe, Head of Adult Social Care	Oldham Council
Debbie Holland, Early Help Service Manager	Oldham Council
Tanya Farrugia, Early Help and IDVA Team Manager	Oldham Council
DC Suzanne Fawcett	Greater Manchester Police
Julian Guerriero, Reducing Reoffending and Complex Dependency Coordinator	Oldham Council
DCI James Faulkner, Divisional Inspector	Greater Manchester Police
Joanne Wadsworth	Reviewed the final report in her capacity as Domestic Abuse Manager, Jigsaw (a local agency providing services to victims of domestic abuse).
Julie Jones, Neighbourhood Manager	First Choice Homes
Jenny Archer-Power	Community Rehabilitation Company
Janice France, Senior Probation Officer	National Probation Service
Helen McGawley, Criminal Justice/Health Team Manager	Pennine Care NHS Foundation Trust
Amanda Smith, Named Nurse Safeguarding	Pennine Care NHS Foundation Trust
Julie Wan Sai Cheong, Named Nurse Safeguarding Adults	Northern Care Alliance
Leanne Cooper, Service Manager, Children's Social Care	Oldham Council
Gary Oulds, Senior Operations Manager	Turning Point (An agency that replaced ADS/One Recovery as local provider of substance misuse services post-homicide/DHR)
Chris Judge, Director of Strategic Development and Innovation	Addiction Dependency Solutions (ADS)
Vanessa Woodhall, Named Nurse Safeguarding Children	Bridgewater Community Healthcare NHS Foundation Trust

2.13 The following agencies provided IMRs (Individual Management Reviews) or short reports to the review:

- Children's Social Care – Lincolnshire – Short Report and Chronology (re Tricia's children)
- Children's Social Care (CSC) – Oldham – IMR and Chronology
- General Practitioners for Caroline and Paul (GP) – IMR and Chronology
- ADS Drug Service (ADS) – IMR and Chronology
- Pennine Care Acute Services (Mental Health) – IMR and Chronology
- Pennine Care Community Services – IMR and Chronology
- Greater Manchester Police (GMP) – IMR and Chronology
- Adult Social Care – Oldham – IMR and Chronology
- IDVA Services (IDVA) – Oldham –IMR and Chronology
- First Choice Housing (FCHO) – Oldham – IMR and Chronology
- Community Rehabilitation Company (CRC) – Oldham – IMR and Chronology
- North West Ambulance Service (NWAS) – Short Report

2.14 There were no conflicts of interest recorded during the Review. Authors of IMRs and short reports were not directly connected to either Caroline or Paul.

2.15 Authors of reports were invited to attend a panel meeting to provide an overview of their contacts with Caroline and/or Paul. Panel members were able to question authors to gain a deeper insight into agency involvement. This led to identification of key learning for each agency, and single agency action plans were developed from IMRs and engagement with the panel.

2.16 Each agency was asked to make single agency recommendations based on learning from the DHR (key actions from the single agency action plans are highlighted in the analysis section of this report).

2.17 Each agency contributed to the compilation of the multi-agency action plan which is attached as an appendix to the main overview report.

2.18 The final report was peer reviewed by a specialist domestic abuse manager from a third sector agency and relevant amendments were made. This was not an 'independent' commission.

2.19 With regard to disclosure of relevant material, the panel liaised with the Senior Investigating Officer in the case to ensure that any new or additional material was made available that may be relevant in the criminal proceedings.

2.20 The DHR process was subject to local and national guidance in relation to confidentiality. A confidentiality statement was completed at each DHR meeting which included guidance to agencies in line with local and national confidentiality protocols.

2.21 The incident leading to the review took place in February 2018 and notification was made to the Home Office on the 10th March 2018. It was agreed by the local CSCP that a DHR would take place, which commenced in April 2018. Due to the complexity of the review, there were some delays in gathering information which resulted in the final reported being submitted to the Home Office Quality Assurance Panel in July 2019.

2.22 Comments from the Home Office in the form of a 'pre-quality assurance assessment' were received at the end of February 2020 and were immediately responded to by the author. The CSCP was informed by the Home Office that the report would be submitted to the Quality Assurance Panel in March 2020.

2.23 The CSCP submitted the revised report in May 2020 and had further communication with the Home Office in December 2020 in relation to delays to the action plan resulting from Covid 19 pressures.

2.24 In February 2021 the CSCP received a further communication from the Home Office, including a 'resubmission' form. A covering note indicated that the Home Office Quality Assurance Panel were not satisfied that the report was yet suitable for publication, and further analysis and amendments were requested.

2.25 The panel was reconvened on 10th March. At this meeting the panel reviewed decisions made regarding the involvement of friends and neighbours in the review. The panel was content with its initial decisions in this regard, and with the rationale for them i.e., no friends were identified as being able to contribute to the review, and neighbour complaints related to noise nuisance which the panel felt would not add to learning (one neighbour had expressed concern regarding Caroline being abused, however, they had indicated that they did not want this reported to police).

2.26 The panel approved a revised report which was submitted to Home Office for quality assurance in March 2021.

2.27 Following quality assurance by the Home Office and notification to the family this report will be disseminated to Caroline's sister and father. It will also be sent to all agencies who participated in the review and to HM Coroner and IOPC.

2.28 The final report will be published on the website of the Oldham Community Safety and Cohesion Partnership in line with Home Office guidance.

3. What did agencies know about Caroline and Paul? Timeline and key events.

3.1 Caroline and Paul both had many contacts with agencies during the period under review. The timeline set out below includes records of contacts which were considered by the panel to be significant in the overall context of the review. However, not all these events and contacts are analysed in detail.

Events in 2012

3.2 In early February, Paul presented to A&E in relation to ongoing medical issues for which he was awaiting surgery.

3.3 Paul the presented to his GP in April reporting that he was feeling depressed and suicidal (he said he did not have thoughts of harming himself). He reported that Tricia was pregnant and that this was adding to his levels of stress. Paul's GP referred him to mental health services who offered an appointment in May 2012, however Paul did not attend this appointment.

3.4 In May, one of Tricia's children became subject to child protection planning (CPP). It was recorded that Paul had said that he wanted Tricia to have a termination and that he had threatened her with violence if she did not have the pregnancy terminated.

3.5 In June, Paul was seen by mental health services following re-referral by his GP. He was referred to the psychological medicine service and was seen in August 2012 by a practitioner from the Home Treatment Team. He was assessed as not having any form of psychotic illness and not requiring medication. Paul did not attend his next appointment and was discharged.

3.6 In September, Caroline and Jack became tenants of FCHO and moved into a property with their two children (their second child had been born in February).

3.7 On 30th October, Paul was seen by PCFT psychological medicine services. He reported trauma symptoms from past surgery and was diagnosed with PTSD. Paul said his drug use had increased and he was encouraged to seek treatment.

3.8 In November Paul applied to FCHO for rehousing and a medical assessment was completed by them.

3.9 In December, Tricia reported to police that Paul had assaulted her. Paul was arrested and charged with assault; however, Tricia withdrew her complaint and the prosecution was discontinued.

3.10 In December, Caroline's father reported to police that Jack had assaulted Caroline and smashed up her property. Police attended and removed Jack from the property, no other criminal offences were disclosed.

Events in 2013

3.11 On 11th March, Paul was seen by a clinical psychologist where drug use was discussed. A further appointment was made to see Paul; however, which he did not attend and was discharged.

3.12 On 11th April, Paul attended ADS drug service regarding. ADS prescribed a reducing dose of Diazepam and liaised with Paul's GP. Over the following six weeks Paul attended four 'key work' sessions with the service.

3.13 On 27th June, Paul attended his GP asking to be re-referred to the psychology service and was seen by them on 15th July. During the appointment Paul was noted to have engaged with drug services. Paul reported ongoing suicidal thoughts and disclosed that he and his partner (Tricia) had a turbulent relationship and that he continued to experience panic attacks. Anti-depressant medication was indicated. A further appointment was given which Paul did not attend. He was discharged from the service.

3.14 On 23rd July, Paul reported to police that he had had an altercation with Tricia and that she had gouged his face. Police attended but neither party disclosed injuries. Police were concerned regarding the welfare of the children and notified CSC.

3.15 Paul had two further consultations with his GP in July in which he reported low mood. Paul reported that Tricia had moved to another area and that he was losing his benefits and had been told he was fit to work.

3.16 At an appointment with his GP on 8th August Paul said that he was feeling better and that he was trying to get custody of his child.

3.17 In September, Paul reported to his GP that he had been spending time with one of his children and he was feeling better, he also said that he had attended the ADS drug service.

3.18 On 14th October Caroline made a joint application with Jack for a tenancy with FCHO, this was prioritised as Caroline was pregnant.

3.19 On 5th November, Caroline reported to police that Jack had left the house with a knife and was expressing thoughts of suicide. He was reported as suffering from PTSD due to previous active military service. Contact was made with the Army Welfare and Support Helpline, but they stated that they only dealt with serving officers and as Jack was a veteran then he should contact the Samaritans. An urgent response marker was placed on the address by police.

3.20 Following an extensive search Jack was located safe and well. Caroline told police she did not wish to support any criminal prosecution. Police made a vulnerable child referral to CSC and an Initial Assessment was conducted. This resulted in a decision of no further action required by CSC and advice being given to Caroline to access services at the Children's Centre.

Events in 2014

3.21 On 7th January Paul was discharged from the ADS drug service as treatment had been completed.

3.22 On 7th February, Caroline was offered a joint tenancy with Jack with FCHO. The couple moved into the tenancy in March (Caroline's third child was born that same month).

3.23 In February, Paul contacted FCHO requesting a joint tenancy with Tricia, who had recently returned from living in another part of the UK. A provisional offer of a property was made; however, this was withdrawn as Paul had not made contact to pursue it.

3.24 On 25th April Caroline attended A&E with one of the children, who had a laceration to the head. Caroline said that the child had fallen and hit their head on the curb. There is no indication that a safeguarding referral was made to CSC in respect of this presentation.

3.25 On 14th May, police were called to an incident in which Caroline had been physically assaulted by Jack. It was noted that their three children were present and that one of them had a bump to the head. The ambulance crew attending noted concerns regarding the wellbeing of the children.

3.26 Caroline attended A&E following the incident, she had head and neck injuries which were assessed by staff as not requiring treatment. Caroline disclosed that she had been assaulted by Jack and that she had also been assaulted by him approximately a year ago. Two of the children were also seen at A&E, one of whom had injuries. The nurse attending Caroline and the children made a domestic abuse referral to Victim Support, in line with the service protocol. The nurse also made a referral to children's safeguarding and to the duty social worker.

3.27 Jack was arrested and charged with two incidents of assault on Caroline and of cruelty and neglect of the children.

3.28 The incident was assessed as high risk and was referred to MARAC. All the children were made subject to Emergency Protection Orders. The IDVA service contacted Caroline who was very upset and said she had been trying to get hold of the social worker all morning, as she wanted her children back. She said that she was currently staying with her father and that Jack did not know where she was, and that she was safe. Caroline reported that Jack had tried to get into their home and had damaged the locks. The IDVA worker said that someone would contact Caroline to get the locks changed.

3.29 That same day police contacted FCHO requesting a lock change and confirmed that Jack was wanted for assault. An officer from FCHO visited Caroline that day and was told by her that there was a restraining order on Jack. The FCHO officer requested 'sanctuary' work to secure the property. A worker from Victim Support also contacted Caroline following the referral made by A&E.

3.30 The following day Caroline signed a S20[6] agreement for accommodation of the children and a Public Law Outline (PLO)[7] was issued.

3.31 On 19th May, the IDVA spoke to Caroline on the phone. Caroline talked about her relationship with Jack and said that he had PTSD related to military service. She said he blamed her for his PTSD, and that he was controlling and jealous and accused her of cheating on him. She said that the relationship had now ended and that she wanted to put the children first. She informed the IDVA worker that Jack was due to appear in court again on 15th July. The IDVA worker agreed to speak to Caroline again in a few days.

3.32 On 20th May, Caroline reported to the IDVA and FCHO that her children had been returned home. FCHO had fitted safety equipment to the property and Caroline informed them that Jack was subject to bail conditions which prevented him from trying to contact her or the children. She informed them that Jack's bail address was around the corner from their home.

3.33 The IDVA worker spoke to the social worker and they discussed the adverse childhood experiences and abuse that Caroline had experienced. The social worker noted that Caroline needed support, but they also said that the children could be removed in the future if the relationship with Jack resumed.

---

[6] S20 and Public Law Outline are provisions under the Children Act http://childprotectionresource.online/what-does-section-20-mean/

[7] https://www.thefamilylawco.co.uk/blog/2017/03/29/public-law-outline-plo-meeting/

3.34 On 22nd May, a single assessment and strategy discussion took place. At the strategy meeting significant concerns regarding domestic abuse and the safety of the children were discussed and it was agreed that the case should proceed to Section 47. It was noted at the strategy meeting that both Caroline and Jack were abiding by the conditions set in the Public Law Outline.

3.35 That same day Caroline spoke to the IDVA regarding the children who were upset and missing Jack. She also visited her GP and discussed the injuries she had sustained in the assault by Jack. The GP recorded domestic abuse on Caroline's records, however there is no indication of information sharing or multi-agency working in relation to this disclosure.

3.36 On 29th May a MARAC meeting took place. There was an action for FCHO to remove Jack from the tenancy agreement and to transfer the tenancy to the sole name of Caroline, which was completed two weeks later. Other actions from the MARAC meeting were for the IDVA to continue to engage with, and for police to provide support as appropriate.

3.37 Over the next five days the IDVA made several attempts to contact Caroline without success. On 5th June the IDVA briefly spoke to Caroline who said she was unwell, she had seen the social worker and agreed that her friend would help with looking after the children until she was better.

3.38 On 9th June, an initial case conference was held in relation to Caroline's three children. The IDVA attended the meeting. It was agreed that the children would remain on CPP and that support would be offered from the Children's Centre. There were no concerns recorded in relation to Caroline's parenting of the children. It was noted that the tenancy would transfer solely to Caroline and that Jack's bail conditions prevented him from seeing Caroline or the children.

3.39 On 18th June, a core group meeting in relation to the children took place and was attended by the IDVA. It was agreed that the children would remain subject to CPP and that unannounced visits by CSC would continue in order to monitor home conditions.

3.40 On 23rd June, CSC received notification that there had been a breach of Jack's bail conditions, and that he had been seen on more than one occasion entering the property where Caroline was living. That same day the Family Centre worker said she had had difficulty accessing the property as Caroline had been asleep and the children were unsupervised. The IDVA also tried to contact Caroline by phone but was unable to do so. There is no indication of any immediate action by CSC regarding this information.

3.41 On 3rd July, CSC were told that one of Caroline's children had witnessed a fight in a pub whilst in the care of a friend. CSC informed Caroline that the friend was not to have unsupervised contact with the children.

3.42 On 8th July, the IDVA was informed that Caroline's children had been removed due to the incident that took place in the pub on 3rd July. Caroline told the IDVA that she had not been given an opportunity to discuss the removal of the children, and that she had been told that she had to sign forms, which she had done.

3.43 Caroline said she had contacted a solicitor and was going to see them tomorrow. The IDVA attempted to establish with CSC what was happening regarding next stages, as she understood that a planned core group meeting had been cancelled. The IDVA made several attempts to gain further information, however this appears not to have been forthcoming.

3.44 On 15th July, Jack pleaded guilty to assaulting Caroline but not to assaulting the children. He was due for sentence on 8th August.

3.45 That same day Caroline spoke to the IDVA and informed them that she had been told by CSC that they would be taking her to court, and that the children would not be returned to her. Caroline said that she had been told she needed to attend a parenting course and counselling, but nothing in relation to domestic abuse. The IDVA referred Caroline to a local counselling service.

3.46 On 17th July, Caroline attended an appointment with the GP and discussed domestic abuse, separation from her partner and the removal of her children. The GP planned to prescribe a low dose anti-depressant. There is no indication of multi-agency information sharing by the GP or any indication of discussion regarding removal of children.

3.47 On 18th July, the IDVA spoke to the social worker to try to obtain more information regarding the removal of the children. The IDVA was informed that they had been removed due to neglect and safeguarding concerns. The IDVA informed CSC that Caroline would be attending a domestic abuse support course from 4th August. Over the next week the IDVA tried to contact Caroline by phone on two occasions without success.

3.48 On 31st July, Caroline attended the GP, and it was noted that she appeared to be chatty and positive. She said she was preparing the children's rooms and anticipating their return home.

3.49 On 1st August, the IDVA spoke to Caroline regarding the children and Caroline was advised to contact her solicitor, as she was unclear what the next steps were.

3.50 On 4th August, Jack was sentenced to 100 hours community service to be served over 12 months.

3.51 Over the course of the next week the IDVA remained in contact with Caroline and spoke to her about the children. On 13th August Caroline attended the course on domestic abuse, and a second session was arranged for 27th August.

3.52 On 27th August, the CSC records show that the children were made subject to an interim care order pending a full care order. It was noted that there would be separate supervised contact with the children for Caroline and Jack.

3.53 On 27th August, Caroline attended a second session at the domestic abuse course. Caroline told the IDVA that her father had been refused by CSC as an appropriate carer for the children. She said the SW had informed her that the next court date would be December. Caroline said she was starting another course next week.

3.54 On 29th September, the IDVA spoke to Caroline who reported that she had been attending the domestic abuse course. She informed the IDVA that CSC had told her that they did not believe that she had separated from Jack. Over the next two weeks Caroline had several contacts with the IDVA, at which she expressed concern about the outcome of the children not being returned to her. She reported that she had been attending the domestic abuse course which was confirmed by the IDVA.

3.55 On 28th October, the IDVA met with Caroline who told her that the SW had said Caroline needed to move to a new house as she lived too close to Jack. (*NB the review notes that this is not recommended practice and places an inappropriate and unrealistic responsibility with the victim to avoid the perpetrator, rather than offering support to the victim (see reference to trauma-based practice later in this report).*

3.56 That same day the IDVA contacted CSC to enquire about the request that Caroline move to another property, and to point out that this was not straightforward (that Caroline could not easily

move to another property due to the size of property she was now living in because of bedroom tax issues).

3.57 On 7th November, the CSC record notes that the foster placement for the three children had broken down.

3.58 On 2nd December the CSC record notes that there would be a delay in taking the case to court, the court date was now expected to be February 2015.

3.59 On 9th December, the IDVA noted that Caroline had completed the domestic abuse awareness course and that Family Court proceedings would not take place until March 2015.

3.60 On 23rd December, Caroline told the IDVA that all the reports had come back from social care recommending that the children be returned to her. She said she was liaising with the solicitor regarding this.

Events in 2015

3.61 On 25th February the IDVA spoke to Caroline, who said that Jack had visited her at home over Christmas. She said that she was concerned that this would jeopardise the return of the children. She said she had told Jack that she would not be resuming the relationship with him, and that she had told the social worker this. Caroline said that the social worker had then implied that the children would not be returned to her.

3.62 On 20th March the housing officer carried out a standard nine-month tenancy review with Caroline. The issues identified were rent arrears and other debt. The housing officer made a referral to FCHO Tenancy Support team for help with these. Caroline advised the housing officer that she was currently being supported by an IDVA.

3.63 On 2nd April the housing officer submitted a request for a management move for Caroline, following information received that the children were now in permanent care, and that this situation resulted in Caroline's inability to afford the rent on the property. Caroline was offered a one-bedroom property the tenancy for which commenced on 18th May.

3.64 On 16th April, court proceedings regarding Caroline's children requested that independent assessments take place and that decisions regarding their long-term care would be deferred until July.

3.65 On 27th May Caroline told the IDVA that Jack had been contacting her and trying to re-establish the relationship. Caroline said she had told him that this was not going to happen.

3.66 On 2nd June Caroline spoke to the IDVA. She said she was now working and that things seemed to be going well. She informed the IDVA that Jack was still attempting to contact her via a friend, but she had told the friend that if there were any further attempts to contact her, she would ring the police.

3.67 On the 3rd of June Paul was offered accommodation by FCHO. This was subsequently withdrawn as there was no response to the offer.

3.68 On 8th June Caroline informed CSC that someone had tried to get into her property and that she felt that this might be Jack. CSC recorded the information.

3.69 On 18th June Caroline spoke to the IDVA about the children. She said that the social worker had proposed that contact be reduced, as they were trying to establish the relationship with Caroline's Aunt and Uncle, who had been proposed as carers.

3.70 On 26th June Caroline informed FCHO that the restraining order in relation to Jack was due to expire in August. She also said that someone had been banging on her door at night for the last three nights and that she was concerned. FCHO advised Caroline to speak to the IDVA regarding increased safety.

3.71 On 9th July a full care order was granted for Caroline's three children.

3.72 Over the next week the IDVA attempted to contact Caroline twice without any success.

3.73 On 23rd July, Caroline presented to A&E with a head injury. She said she had hit her head on a metal bar at work. Caroline was given information regarding head injuries. Caroline's GP was notified of her attendance at A&E.

3.74 From 4th September 2015 to February 2016 there were several contacts between the FCHO rent team and Caroline regarding rent arrears and payment plans.

Events in 2016

3.75 On 5th January, Paul presented to his GP following an appointment with a neurologist where had had received a diagnosis of migraines resulting in visual disturbances.

3.76 On 17th January, a local support service received a phone-call from Paul's sister saying that he was upsetting his mother and harassing her because he had nowhere to live. Paul said that he was currently staying with a friend. The service suggested a multi-agency meeting involving FCHO to try to resolve the accommodation issues. On 20th January a discussion took place regarding offering Paul accommodation in a shared property. It was noted that his behaviour may cause disturbance to other residents.

3.77 On 9th February, the housing officer carried out 9-month review with Caroline. They discussed rent arrears and that the probationary period would be extended.

3.78 Later that same day the officer visited another tenant, a neighbour of Caroline's, for a tenancy review. The neighbour reported that there were issues of noise at Caroline's property, and that two weeks previously they had heard Caroline shouting 'I'm sick of you battering me get out of my house (NB Caroline used a name however, it is not clear whether this referred to Paul or Jack as they have the same forename).' The neighbour said that they did not want this to be reported to police and they did not want the officer to speak to Caroline about it. The neighbour was advised to ring police anonymously, so that the matter was brought to the attention of an agency with the power to investigate further. There is no indication that the neighbour did this.

3.79 On 17th February, Adult Social Care recorded a domestic disturbance that had been reported to police, it is not clear from the records whether this relates to Paul or Jack. There is no indication whether there was any follow up to this report. GMP do not have any record of an incident being reported.

3.80 On 20th March, police received a phone call from a friend of Caroline's. The friend reported that he had heard arguing going on with 'her partner' whilst on the phone to her. Police rang and spoke to Caroline. She said there was nothing to be concerned about. A DASH risk assessment was

completed; however, all the answers were either declined or answered 'no' by Caroline. The risk was assessed as standard, and no further action was taken.

3.81 On 29th March, CSC received a call from Caroline saying that her new partner had told her that her children's carers had recently been seen in a local pub without her children. Caroline expressed concern about this. She told CSC that Paul's ex-partner (Tricia) was her cousin, which was previously unknown to them. This was noted by CSC, however, there is no indication that it was discussed with Caroline, which would have been good practice.

3.82 On 31st March, police were informed by CSC that Caroline was in a relationship with Paul. Checks were made into Paul's history of domestic abuse and consideration was given to making a disclosure to Caroline under the Domestic Violence Disclosure Scheme (DVDS). This was in line with policy in relation to DVDS.

3.83 An officer visited Caroline on 2nd June. Caroline informed them that she was no longer in a relationship with Paul. A decision was then made that a DVDS closure was not appropriate as Caroline said the relationship had ended. The decision was reviewed by a PPIU Sergeant, who closed the PPI document, and no disclosure was made.

3.84 On 2nd April, Paul appeared in court charged with racially aggravated harassment/stalking of his previous partner. On 27th April Paul was sentenced to eight weeks in custody, suspended for a period of eighteen months.

3.85 An OASys assessment completed by the Court Officer identified that Paul posed medium risk to intimate partners and to children. The Court also ordered that during his sentence Paul was to complete a 20-day Rehabilitation Activity Requirement (RAR).

3.86 Between 13th and 20th April a neighbour of Caroline's reported incidents of screaming and shouting between Caroline and a male visitor. The housing officer left a card for Caroline to contact them, and left a message for the local PCSO to discuss the reports. This was good practice. The housing officer followed this up with a letter to Caroline to attend the office to discuss, this was also good practice.

3.87 The Early Help/IDVA Service was also notified. Caroline was offered an appointment to discuss the incidents. On 26th April Caroline rang to explain that she had lost her job and could not attend the appointment (this was later followed up and another appointment being offered).

3.88 Paul's first contact with CRC was his induction to sentence which was completed over two sessions on 29th April and 4th May. During his induction, the nature of the Order to which Paul was subject and the requirements of it were explained to him. Paul was given clear information as to what was expected of him during his time under supervision. At this meeting Paul informed the case manager that he experienced anxiety and depression related to an ongoing medical condition.

3.89 On 5th May, following several missed appointments, the housing officer issued a tenancy warning to Caroline. This was in relation to complaints of noise. The warning was accompanied by details of support available from the IDVA, the STRIVE (STRIVE is a local initiative to support victims of domestic abuse) and police. The housing officer recognised that Caroline may be vulnerable to domestic abuse, and it was good practice for the housing officer to offer support details. However, there may have been an opportunity missed to hold a multi-agency discussion regarding Caroline's vulnerabilities.

3.90 On 9th May, Paul's mother contacted police to report domestic abuse by her son, whom she said was staying with her following the breakdown of his relationship. Police visited Paul's mother regarding the report, however no offences were disclosed. This incident was recorded as standard risk on the PPI system and no information was shared with other agencies which is expected practice.

3.91 On 14th May, a neighbour reported to the housing officer and police that they had heard arguing in the early hours of the morning between Caroline and a male. This had continued outside the property. The neighbour reported that Caroline appeared to be crying. Police attended the property; however, they were unable to gain access. After twenty minutes officers attempted to force entry and Caroline eventually opened the door and let the officers in. The officers spoke with Caroline and attempted to complete a DASH risk assessment. Caroline said that everything was OK and said she did not want to answer any of the DASH questions. No further action was taken. Although Caroline had told police that she had no concerns, the officer could have used their previous knowledge to complete the DASH risk assessment.

3.92 Further reports of noise in relation to shouting and arguing were received from neighbours by FCHO in May. The housing officer remained in contact with Caroline and offered support to her.

3.93 On 19th May, police received a report from a neighbour of a disturbance at Caroline's address, the neighbour said that they had seen Caroline with a black eye. Police rang Caroline and spoke to her. It was noted by the officer that she sounded as if she was 'outside'. Caroline said she was away from home and would be away for about a week.

3.94 On 21st and 22nd May the same neighbour reported that they could hear arguing between Caroline and a male. (NB this was at a time that Caroline had said she would be away from home).

3.95 On 25th May, Caroline's father rang the police to say that Caroline's sister had told him that Paul was 'battering' Caroline. Police went to see Caroline who said that she had not been assaulted and that she had split up with Paul a week earlier.

3.96 That same day information was recorded on the IDVA database that Caroline had said that she was taking paracetamol and threatening suicide. A note on the system says that ACT will follow up and see if any support is needed. There is no indication of any follow up. This was a missed opportunity to hold a multi-agency discussion regarding Caroline's vulnerabilities.

3.97 On 26th May the CRC case manager received a call from Paul's mother saying that he was aggressive to her and she was concerned about his mental health. She reported that Paul was bullying her for money, and that he was using drugs. The case manager advised Paul's mother to contact police if he continued to behave in this way. Paul's child was also known to be living at the property at this time.

3.98 Police saw Caroline on 26th May and spoke to her about the incident on 19th May, which she said had been an argument with Paul and that he was 'just a friend'.

3.99 On 27th May the IDVA contacted Caroline to offer the service. Caroline said she would contact the IDVA if needed.

3.100 On 2nd June the housing officer contacted the IDVA (who had previously known Caroline following the domestic abuse incident with Jack in 2014) to discuss concerns and complaints from neighbours. The IDVA advised the housing officer to complete a DASH risk assessment and make a referral to MARAC, however Caroline did not attend the appointment and therefore the DASH was not completed.

3.101 On 10th June a case review meeting took place with FCHO at which it was agreed that Caroline should be offered another appointment.

3.102 On 17th June Caroline opportunistically spoke to a housing officer whom she saw in the street. She told the officer that she had split up with Paul. The Housing Officer asked Caroline to come into the office on 20th June. This was good practice.

3.103 Caroline attended the appointment on 20th June and the DASH risk assessment was completed, (the score was 7), and a referral made to the IDVA service. Caroline said that there was no violence involved in the disputes with Paul, and that it was just arguing and shouting. She said that the black eye reported by the neighbour was due to her falling downstairs. The officer who completed the assessment contacted the IDVA service and said they felt that Caroline was minimising the problems in the relationship. This was good practice, however, a further referral to MARAC could have been made at this point.

3.104 On 20th June Caroline presented to her GP saying she had fallen downstairs four weeks ago and had bruising to her ribs. The GP examined Caroline and noted a small lump which was painful at times. The GP did not make any enquires regarding domestic abuse or share information. This was a missed opportunity to assess the risk to Caroline and to share information, which would have strengthened a referral to MARAC.

3.105 On 22nd June, the housing officer recorded that the locks had been drilled at Paul's mother's house when he went missing. At this visit the Housing Officer made the link between Paul and his mother, which was previously unknown.

3.106 On 27th June, Caroline attended her GP reporting low mood and saying she had considered 'taking tablets' but would not do so because of her children. She reported to the GP that the children were looked after, and that she did not see them.

3.107 On the 30th June, the Housing Officer contacted the IDVA to inform that Paul had been seen at Caroline's property by a neighbour.

3.108 On 4th July, Paul's sister contacted police to say that she had found Paul and Caroline smoking cannabis and in possession of cocaine at her mother's property, and that she had 'kicked them out'. She said she believed that they had gone back to Caroline's flat. A police officer later spoke to Paul advising him against returning to his mother's address whilst in possession of illicit drugs. That same day the IDVA service advised FCHO that it was their policy not to undertake home visits (as this may not be safe for the victim).

3.109 On 11th July, Caroline attended her GP who noted that she was now taking her medication and appeared to be in more positive mood.

3.110 On the 12th July, Paul's sister contacted the housing officer informing that Paul was staying with his mother and that he had 'smuggled' Caroline into the property. She reported that they were both using cocaine. Police called and spoke to Paul's sister and reported the information to CSC.

3.111 On 13th July, Paul attended an appointment with FCHO regarding accommodation. He reported that he had been living with his mother for four years. He said Probation had offered supported accommodation but that he did not want this. He said that his mother wanted him to leave her property.

3.112 On 13th and 17th July, FCHO received complaints regarding shouting and bad language at Caroline's property.

3.113 On 18th July, the IDVA rang Caroline at home. A male answered on two occasions and the IDVA said they had called the wrong number. On the third occasion the IDVA spoke to Caroline who said she would contact them if needed.

3.114 In August the CRC case manager met with his manager for a risk management review (RMR) meeting (this was in line with policy at that time to provide additional management oversight to domestic abuse cases to be held every three months). Although an initial RMR meeting was held, it was not reviewed as required and there is no indication of dynamic assessment of any additional risks posed by Paul.

3.115 On 4th August, Paul's mother attended her GP and said she was concerned about Paul. She reported that he was living in a tent, that he was not taking his medication and that he was becoming 'angry'. She said that he had been in this position before and that she was very concerned about him.

3.116 The following day Paul's mother rang police to report a violent dispute with Paul at her address. She informed police that he was using illicit drugs and that he was not taking his medication. Police made a vulnerable adult referral on behalf of Paul.

3.117 On 8th August, Paul's mother rang the GP practice to arrange an appointment for Paul. She said this was in response to someone leaving a message on her phone, although it is not clear who this was. She said she would try to get Paul to attend an appointment.

3.118 On 9th August, Paul requested a food parcel from ASC. On the same day he attended his GP and reported that he was sick of his mother nagging and that he had gone camping with friends. He said that he sometimes thought about 'taking tablets' but wouldn't do so as his son is a protective factor. He said he did not want talking therapies but agreed to a referral to psychiatric services.

3.119 On 10th August, Caroline attended her GP. She reported being in low mood which she said was mostly due to the situation with her children. She said she was taking her prescribed medication and was not experiencing thoughts of suicide.

3.120 On 10th August, Paul's referral to ASC was completed, it noted Paul's medical history and current situation, with a note regarding him living with his mother and increasing tensions caused by this situation.

3.121 On 11th August, MASH (multi agency safeguarding hub) checks were conducted prior to case allocation for Paul. Paul said that he had stopped using drugs 3-4 weeks ago. Issues identified were previous medical history, housing support and relationship with mother. The case was allocated for medium term support on key issues.

3.122 On 12TH August, Caroline's neighbours reported a further incident (no detail was given about the nature of the incident).

3.123 On 12th August Paul's GP received a letter requesting help with financial matters. Paul said that he had got into financial difficulty due to his previous illness which had caused memory loss. The GP provided a letter regarding finances but noted that if CSC needed a letter regarding children, they would need to request this separately.

3.124 On 21st August Caroline presented to A&E with friends. She said that she had been assaulted by Paul 3-4 days ago. Her hair had been pulled and she had been punched to the ribs. She told A&E staff that she had informed police of the assault.

3.125 That same day police received an anonymous report stating that Caroline had been beaten up by her boyfriend (this was made by Caroline's friend). An officer attended hospital and spoke to Caroline. She reported that she had been assaulted by Paul a couple of days previously. She said he had punched her several times causing a suspected broken rib and other injuries, including injuries to her face (these injuries were photographed). Caroline disclosed extensive historic domestic abuse and violence throughout her relationship with Paul which she said had gone unreported. An appointment was made for Caroline to provide a video interview.

3.126 A DASH risk assessment was completed during which Caroline said that she was afraid that one day Paul would go too far and may even kill her. She said that she felt depressed and that she had nothing to live for anymore. She said that she has tried to separate from Paul but that she feels sorry for him and goes back to him. She said that the abuse was getting worse and that this week it had been worse than ever. She reported that Paul was verbally abusive and that he had written abusive words about her on a mirror in the house. She was aware of Paul's abuse of a previous partner and said she was financially dependent on Paul.

3.127 Caroline said she was terrified of Paul, but she felt sorry for him as he had a medical issue in the past which she said causes 'funny episodes' and she would feel bad if she left him. She said Paul absolutely flips out when he is on crack cocaine/cocaine, but he cannot stop using it.

3.128 A PPI was created, and the risk was initially set to high. This was downgraded to Medium by a PPIU officer whose rationale for the downgrade included the fact that Caroline was staying at her friend's house and that she was going to stay at her father's address.

3.129 The officer recorded the following "I have asked the victim what she wants to do to which she replied, 'I just need to leave him'. The officer explained the importance of a criminal conviction against the offender, DVPN/O and restraining orders, non-molestation orders. The victim has requested that she provides a statement or Achieving Best Evidence interview and will continue with a prosecution."

3.130 The officer submitted a referral for Caroline and a referral to adult services for Paul in respect of his Mental Health issues and drug abuse. A crime for a S.20 assault was submitted.

3.131 The initial officer attending the report conducted all the primary investigation and updated the crime. Caroline was then contacted by a different officer to produce a statement. The crime has an update on the 22nd August as follows: *"I saw the victim today to get her statement signed. She's been told that Paul has now been sectioned after being persuaded to attend hospital yesterday and that he is at a mental health unit. Caroline is currently staying with her father."*

3.132 On 21st August the Victim Support Case Management system received a referral from police for Caroline via Automatic Data Transfer. The service tried to contact Caroline without success and the case was closed.

3.133 That same day Paul also presented to A&E saying that he was hearing voices and threatening to kill himself. He reported using crack cocaine daily. Due to his mental health history Paul was referred to the 'RAID' team. Paul was admitted to hospital as an informal (voluntary) patient for mental health assessment.

3.134 The respective GPs received notifications of both presentations on 21st August. There is no indication of any action being taken or information shared. (NB Paul remained as an informal patient until 20th September).

3.135 Whilst in hospital Paul behaved in an aggressive and intimidating manner (one staff member cancelled a shift because she was afraid of him). During this time Paul's sister rang the ward to 'plead' with them to 'section' Paul so that he could not leave the ward as they feared that he would do harm. It appears that no action was taken in this regard, nor was any information shared with other professionals (no multi-disciplinary meeting was held).

3.136 On the 24th August 2016 one of Caroline's neighbours informed the housing officer that Paul had been 'sectioned' and that Caroline had black eyes. The Housing officer left a message for Caroline to contact them and spoke to the IDVA who confirmed that Paul was 'sectioned', and that Caroline required a homeless assessment.

3.137 On 26th August, the police crime record was updated with information that, following a conversation with staff at the hospital, Paul would be receiving a full mental health assessment and it was not known when he would be released. The officer noted that, based on this information, a referral would be made to the MVOP (Mentally Vulnerable Offender Panel).[8] The officer's rationale was to ensure that the case was heard, however this is not in line with guidance which states that domestic abuse cases should not be referred to MVOP.

3.138 A Homeless Assessment for Caroline was carried out on the 8th September 2016. Caroline said that she was living with her father and FCHO agreed to a managed move, and that she would be placed in a high banding to give her priority for re-housing. On the same day a neighbour reported that Paul had been sitting outside Caroline's address for several hours. The housing officer contacted Caroline and advised her not to return to the property and also informed the IDVA. An opportunity to share information more widely (particularly with police) was missed.

3.139 On 9th September Paul's sister rang the IDVA and told her that the relationship between Caroline and Paul was 'tearing the families apart'. She reported that Caroline was vulnerable and that she was still spending every day with Paul when he was not in the hospital. She told the IDVA that Caroline had threatened suicide in the past if Paul left her.

3.140 On 10th September Caroline attended the front desk of the local police station. Caroline spoke to an officer and told them that she had lied about the assault by Paul in August. She gave a different account of events, saying that Paul had 'rugby tackled' her because she was trying to self-harm.

3.141 That same week Paul attended FCHO and told them that he was due to be discharged on the 15th September and had nowhere to live. An appointment with housing was made for the following day and a provisional offer was made, however this was withdrawn as a risk assessment was not received from the CRC.

3.142 On 16th September Paul's CRC case manager was notified that Paul was in hospital and that his case had come before MVOP in relation to the alleged assault on Caroline in August. The case manager was provided with details of the alleged offence and advised that the decision of the panel was that Paul should be dealt with within the Criminal Justice System. The case manager was also advised that enquiries to enable this were ongoing and that Paul remained on the ward as a voluntary patient.

---

[8] The MVOP is chaired by GMP and is attended by mental health services and the National Probation Service/CRC. The purpose of the panel is to assess criminal culpability and determine whether an individual who faces potential criminal charges could be more appropriately dealt with by diversion into mental health services.

3.143 On 19th September, Caroline contacted FCHO saying that she had moved in with her mother as Paul's family had turned up at her Dad's and been abusive. (NB Caroline's father confirmed that Caroline had been physically and verbally abused). Caroline said that she had had a 'breakdown' on 17th September and that the mental health team were calling daily (although this is not clear from the records).

3.144 On 20th September the housing officer contacted Caroline to inform her that there were no suitable properties available, and that she should consider refuge accommodation. Caroline said that she would discuss this with her mental health worker. Caroline completed an application for entry into a refuge, however there were no places available in the area, other than one near where Paul lived. Caroline understandably did not want to go to this refuge and declined the offer. Following this there appears to have been no further discussion regarding refuge.

3.145 Paul's CRC Case Manager maintained contact with the hospital, to monitor Paul's discharge. The case manager also contacted police and liaised with them regarding the additional offence (the alleged assault on Caroline) and possible charges. On 28th September the case manager was advised that Caroline had withdrawn her allegations and that Paul would therefore not be charged with any offence, therefore no further action was taken.

3.146 On 24th October, a member of the public contacted police reporting a fight involving a male and female in the street. Officers identified the couple as Caroline and Paul and spoke to both parties separately. Although visibly upset, Caroline denied there had been any assault and displayed no injuries. She explained she had recently 'lost her child to social services,' which caused continuous problems between herself and Paul. The officer noted that both had calmed down and that no further police intervention was required. A DASH risk assessment was attempted, however Caroline said she did not want to answer the questions. Given the very recent history of domestic abuse reports officers could have completed some of the DASH risk assessments questions from their previous knowledge.

Events in 2017

3.147 On 24th January Caroline was offered a tenancy, however this was later withdrawn as the housing officer received information that Caroline was maintaining contact with Paul. An appointment was made for Caroline to discuss this. Caroline said that she had not been in touch with Paul since before Christmas. The housing officer contacted the IDVA who informed them that the case had been closed for some time. There was no consideration given to why Caroline was continuing contact with Paul and that this may have been due to coercion and control.

3.148 On that same day Paul informed the homeless officer that he wanted to take over his mother's tenancy and was informed that he was ineligible to do so. Paul said that his child would be living with him and that he wanted to include his child in the application. Proof of parental responsibility was requested but was never received.

3.149 On the 9th February, a neighbour reported to FCHO that Caroline and Paul were regularly seen at her address and that, on one occasion, he heard Caroline screaming.

3.150 Caroline told the housing officer on the 15th March that Paul had stayed with her for a week and that Jack had turned up and an argument had ensued. Police were informed that Jack had visited Caroline's home address and as he knocked on the door, Paul jumped out of the rear bedroom window. When Jack approached Paul, Paul grabbed a sledgehammer and started swinging it round

in a threatening manner. Caroline informed officers that her ex-partner had arrived and that he didn't like her current partner. As this incident was not a domestic abuse incident no PPI was generated. A crime for Section 4 Public Order was submitted, and Paul and Jack appended to it, however it was not further investigated as Jack said he would not provide evidence for a prosecution.

3.151 On the 22nd June Caroline met with a tenancy support worker and during a detailed assessment said that she felt safe and that there were no issues around domestic abuse.

3.152 There were separate reports from neighbours to the housing officer in August and October, reporting that Caroline and Paul were living together at her address. During this period Caroline continued to have contact with the rent and tenancy support services in relation to finances.

3.153 On 27th October Paul's Community Order terminated and his engagement with CRC ceased.

3.154 In December Caroline was notified that she had been awarded a large sum of money in compensation for abuse she had suffered as a child. Caroline's sister confirmed that Caroline had made Paul aware of this.

Events in 2018

3.155 On 8th January, Paul attended an appointment with the Access (Mental Health) Home Treatment Team and was accompanied by his mother. Paul talked about his frustration regarding ongoing issues with accommodation. He had also recently been informed that he may require surgery in relation to physical health problems. Paul declined referral to talking therapies but agreed to a Care Act referral for social support and support with accommodation. Paul's mother was given details of Healthy Minds to pursue a referral in relation to her needs. On 19th January Paul did not attend an appointment with Psychological Services.

3.156 Caroline had been referred to Healthy Minds and had begun to engage with the service. Due to being unwell she had to cancel an appointment on 7th February. This resulted in a discharge letter being sent by the service to Caroline's GP and to Caroline informing that she would have to be put back onto the waiting list. Discharge in these circumstances is not in line with service protocol. It would have been expected practice to offer Caroline a further appointment.

3.157 On 8th February a 999 call was received by police from a distressed female (Caroline), crying and begging to be 'let out' (it was noted by the call taker that the caller appeared to be in a car). The caller said that a male was punching her. The call was terminated and was recorded at 14:25 hours as an abandoned 999 call.

3.158 Caroline re-called 15 minutes later and said that the call had been a hoax carried out by children, who may have got hold of the phone whilst she was getting ready for work. Officers attended Caroline's address at 16:03 hours but there was no reply and attended again the following morning with no reply.

3.159 The FWIN was then updated by the police communications room to state that they had listened to the recording of the original call and that it definitely wasn't a child on the phone and that it sounded like someone in distress. The FWIN was reviewed by a Sergeant and a new FWIN created to check on Caroline's welfare. A PCSO updated the FWIN to state that they had spoken with Caroline and that she had informed them that it must have been a child on the phone.

3.160 Officers attended Caroline's home address at 18:21 hours on 9th February. The FWIN was updated with the fact that all was in order at the address and there were no concerns. The officers recorded that Caroline let them into the flat and that a male was present at the time. The male's identity was not recorded; therefore, it is unknown whether this was Paul.

3.161 Caroline told officers that she had not made a call to the police the previous day. Caroline also told the officers that her children had been removed from her. Police noted no disturbance in the flat, nor did Caroline appear to have any visible injuries. On leaving the flat, and without the male being present, the officers again asked Caroline if there were any problems that they needed to be aware of. Caroline said that she was fine. The officers told Caroline that she should contact them if there were any problems and then left the flat and no further action was taken.

3.162 On the day of Caroline's murder police received a call that a man had jumped from a first-floor window onto the roof of a car and that he was covered in blood. The events described in section 1 of this report took place.

4. Summary of Learning from the Review

4.1 Analysis against the Terms of Reference

TOR 1: Did any agency know that the Caroline was subject to domestic abuse? If so, what actions were taken to safeguard Caroline and were these actions robust and effective?

4.2 Caroline was known as a victim of domestic abuse to most agencies involved in this review, both in her relationship with Jack and with Paul.

4.3 Actions to safeguard Caroline were variable and inconsistent and were often predicated on her responses to risk assessment processes, rather than taking into account Caroline's needs and vulnerabilities, particularly the trauma she had experienced in her childhood and the impact of this.

4.4 Professional understanding of the degree to which Caroline was coerced and controlled by both Jack and Paul, and the impact of this on her decision making, was not apparent in the review. However, there are examples of good practice in this regard in relation to the IDVA service and to FCHO. Both services advocated for Caroline; however, opportunities were missed to bring agencies together in a multi-agency context to assess the risks to Caroline and to implement a safety plan for her.

4.5 When Jack assaulted Caroline in 2014, he was arrested, prosecuted and found guilty of assault and received an appropriate sentence.

4.6 Following the assault, Caroline attended A&E accompanied by one of the children, who also had an injury. An appropriate safeguarding referral was made by A&E in relation to the child, and the attending practitioner referred Caroline to Victim Support in line with the service protocol at that time.

4.7 Caroline disclosed that Jack had been diagnosed with PTSD following discharge from active military service. Police recognised the significance of this and sought support from Army Welfare and Support Helpline, which was good practice.

4.8 The incident was appropriately graded as high risk by police and a referral was made to MARAC. The MARAC meeting took place within a reasonable time period (2 weeks after the event) and identified actions to support Caroline and the children, and the IDVA proactively contacted Caroline to arrange to meet with her.

4.9 Caroline was referred to MARAC as a high-risk victim. Appropriate actions were identified and put in place, however there is no evidence of a MARAC review. This would have been good practice and would have enabled ongoing assessment of the safety of Caroline and her children.

4.10 It is not clear whether CSC were involved in the MARAC and whether information from the MARAC regarding Caroline's vulnerabilities was shared. If it had been this may have resulted in a more supportive approach to Caroline whilst safeguarding her children.

4.11 Between charge and conviction Jack was made subject to a restraining order and bailed to a local address. The review has noted that the bail address was near where Caroline and the children were living. The review considers that it would be good practice not to bail domestic abuse offenders to addresses close to victims.

4.12 Caroline consulted her GP regarding the injuries she had sustained during the assault and disclosed domestic abuse, both recent and historic. There is no indication that the GP initiated any further safeguarding enquiries or offered additional support or referral to specialist services for Caroline. There is no indication that the GP shared information with any other agency regarding Caroline's disclosure.

4.13 When Caroline presented to A&E in July 2015 there is no record of any checks with previous records as to whether Caroline may have been the victim of domestic abuse on this occasion, and no referrals were made.

4.14 In February 2016 when FCHO received a report of disturbance at Caroline's address by a neighbour, it would have been good practice for the housing officer to consider whether they should over-ride the views of the neighbour in relation to safeguarding (i.e., the neighbour did not want this reported to police). The review believes that FCHO could have acted as an intermediary and supported the neighbour in escalating the concerns to police. It would have been good practice for the housing officer to follow up with the neighbour to enquire whether they had spoken to the police.

4.15 Police received third-party reports of possible abuse in March and May 2016. On the first occasion the records indicate that a DASH risk assessment was attempted where Caroline declined to answer any questions. The review noted that this was the third occasion on which Caroline had declined to answer the questions in the DASH risk assessment. This could have triggered further enquiry by officers to understand Caroline's reticence to answer questions. However, Caroline declining to answer questions was accepted and the risk was assessed as standard.

4.16 This was followed by further information from CSC regarding Caroline being in a relationship with Paul which led to consideration of a DVDS. This was not pursued due to Caroline telling police that she was no longer in a relationship with Paul which was accepted without further exploration.

4.17 The decision not to pursue the DVDS lacked professional curiosity regarding the ongoing nature of the relationship. It would have been good practice for the decision not to pursue the DVDS to have been reviewed considering both Caroline and Paul's histories. This may not have resulted in a different decision but would have been a more thorough and robust process on which to base the decision. There is no explicit consideration that Paul may have been coercing and controlling Caroline not to make disclosures and to minimise her experience of domestic abuse by him.

4.19 At this time Caroline's father contacted police saying that Paul was abusing Caroline. Although police went out to see Caroline on this occasion, police believed Caroline when she said that Paul was not abusing her. It would have been good practice to review recent activity and reports and to review the decision regarding DVDS. No consideration of coercion and control by Paul appears to have been applied.

4.20 When Caroline presented to her GP in June 2016 with pain to her ribs, saying she had fallen downstairs, it would have been good practice for the GP to make a targeted enquiry regarding domestic abuse, given Caroline's known history of abuse, the removal of her children, and her

ongoing treatment for low mood and depression. Caroline presented to the GP one week later saying she had thoughts of self-harm. It would have been good practice for the GP to make a targeted enquiry in relation to domestic abuse, and consideration could have been given to referring Caroline to specialist mental health services.

4.21 When Caroline presented in September 2016 seeking support with accommodation it would have been good practice to have continued to try to secure a suitable refuge placement. Refuge placement would have helped Caroline to address long standing issues of domestic abuse and childhood trauma and would have provided respite from contact with Paul.

4.22 It is clear to the review that the risks to Caroline in her relationship with Paul throughout 2016 and 2017 were escalating. Although Caroline was reticent to discuss these risks police, and FCHO and the IDVA, it would have been good practice to convene a multi-agency safeguarding discussion to share information about risk and safety planning for Caroline.

4.23 In February 2018 police received an anonymous call which was terminated by the caller. It was good practice for police to follow up the terminated 999 call on the same day. When they were unable to get a reply from Caroline's address, police appropriately reviewed the call and decided that they should try to contact her again.

4.24 It was good practice for officers to visit Caroline again on 9th February. It was also good practice to speak to Caroline on her own to try to establish whether she had any concerns that needed to be addressed.

4.25 Officers appear to have taken Caroline's assurances at face value, and do not appear to have considered that Caroline may have been subject to coercion when she reported that the call had been a hoax by children, as at the visit on 9th February Caroline told police officers that her children had been removed from her.

4.26 The officer who visited Caroline said that they were not aware of any history of domestic abuse at the address or that Caroline had been a victim of domestic abuse. It would have been good practice to have checked this information before visiting Caroline.

TOR 2: Was the perpetrator known to any agency as a perpetrator of domestic abuse and if so, what actions were taken to reduce the risks presented to Caroline and/or others?

4.27 Paul was known as a perpetrator of domestic abuse and had a history of domestic abuse that pre-dated his relationship with Caroline.

4.28 It is apparent that Caroline minimised or denied the abuse taking place in the relationship (due to coercive and controlling behaviour from Paul). Caroline's minimisation of the abuse appears to have led professional decision making, rather than stimulating professional curiosity and further exploration of known risk factors.

4.29 Of particular relevance in this review are the events that took place in August 2016 when Caroline reported that Paul had assaulted her. At this time Paul was voluntarily admitted to a mental health ward and subject to consideration by the MVOP. The potential risk to Caroline from contact with Paul was not appropriately managed or assessed by any of the agencies involved at that time. It

would have been good practice to hold a multi-agency meeting focused on reducing potential risks to Caroline. However, no multi-agency discussion took place.

TOR 3: Did any agency have knowledge that Caroline and/or Paul was experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors?

4.30 Agencies were aware that both Caroline and Paul used drugs. The impact of drug misuse as a significant risk factor in relationships where there is domestic abuse is well documented. Paul's ongoing use of a range of drugs, including cocaine was known by his family and by Caroline to exacerbate his aggressive and violent behaviour.

4.31 It appears that Caroline's drug use became more chaotic when she began her relationship with Paul. Caroline sought help for her drug use and maintained contact with services. However, it appears that Caroline's drug use intensified when she resumed her relationship with Paul in the six months prior to her murder.

4.32 Both Caroline and Paul sought help from services in relation to drug use and both completed treatment programmes. However, both relapsed into chaotic drug use and did not re-present to services at this time.

4.33 When Caroline received a large sum of money as compensation, Paul financially abused her and coerced her into spending this money on drugs.

4.34 Jack was diagnosed with PTSD in relation to active service in the armed forces. The review acknowledges that the understanding of the relationship between trauma experienced by armed forces veterans and domestic abuse was not well developed at the time that Caroline was in a relationship with Jack) however it was good practice for police to make contact with the relevant support helpline, although ultimately this did not result in Caroline or Jack receiving support.

(NB the review has noted that developments in understanding and practice have taken place and highlights the importance of agencies seeking appropriate support for ex-servicemen and women in this context. Further information is available from the Ministry of Defence at https://www.army.mod.uk/people/live-well/domestic-abuse-and-sexual-violence).

4.35 Caroline experienced periods of anxiety and depression which were linked to her adverse childhood experiences and to the removal of her children. Caroline was treated by her GP for anxiety and depression. She was referred to specialist mental health services in 2017 and engaged with the service, however, she was discharged when she had to cancel an appointment due to illness. This was not in line with the service policy. It would have been good practice to provide Caroline with a further appointment and to seek an understanding of any difficulties she had in accessing services.

4.36 There is no indication that any agency considered seeking information about specific services for survivors of sexual abuse and violence such as the Survivor's Trust or the Local Rape Crisis Service. It is not clear from the review whether awareness of such services and referral to them is embedded in local practice. The review therefore recommends that information about a range of support services is made available through the CSP partnership agencies.

4.37 Paul had a significant history of mental ill health and was diagnosed with PTSD in 2012. He was treated by his GP and specialist services; however, he did not sustain engagement with services.

4.38 Paul's admission to hospital as an informal patient was based on self-report information and was not cross referenced by Mental Health Services with police or any other agency, in relation to the alleged offence of assault on Caroline. There appears to have been no parallel process of assessing the risk that Paul posed to others as an informal patient.

4.39 There is little evidence of ongoing assessment or management of the risks presented by Paul during his hospital assessment period. Caroline visited Paul on the ward and was known by staff to be his partner, however, this did not trigger any further enquiry or professional curiosity in terms of risk assessment. Paul was at liberty to leave the ward as he wished and there is no indication of either a risk management approach or monitoring of his movements at this time.

4.40 The review has seen accounts from Paul's family and from other agency reports that, during this time, Paul maintained frequent contact with Caroline. It is clear from reports given by Caroline's family that, during these contacts Paul subjected Caroline to further abuse, both physical assaults, and coercion and control, and it is highly likely that he persuaded Caroline to retract her allegations of assault. He certainly told Caroline that he had been sectioned under the Mental Health Act, and Caroline's family believed this to be the case (as did other agencies). It appears that police believed that Paul had been sectioned, although there is no information provided to the review to suggest that anyone attempted to verify this assumption.

4.41 A MVOP meeting took place in line with local protocols (see above), however, there is no indication that any challenge regarding Paul's account of his detention in hospital was further explored. Nor was any consideration given to Caroline as a victim of domestic abuse and at potential risk from Paul.

4.42 It is clear that during this time Paul was in contact with Caroline and that this was reported to the IDVA and housing officer by Paul's sister. A neighbour also reported that Paul was waiting outside Caroline's house and the housing officer advised her not to return there. These were missed opportunities to share information regarding Paul's continuing contact with Caroline. It would have been good practice to call a multi-agency meeting at this time to discuss the risks posed by Paul, and for agencies to have a shared understanding of the nature of his detention and to develop a multi-agency risk management plan.

4.43 There is no evidence of multi-agency working to manage the risks that Paul presented to Caroline during this period. No multi-disciplinary team meetings were put in place (in any setting) and there was no indication of consistent information sharing from the hospital to other agencies or vice-versa.

4.44 Paul was admitted to hospital as an informal (voluntary) patient for mental health assessment in August 2016 and remained in hospital until 20th September. There was no specific diagnosis following assessment and it was deemed that Paul did not have a mental illness.

4.45 A referral was made to MVOP on 26th August when police were informed that Paul would remain as an informal patient and that there was no date for a planned discharge. The officer making the referral indicated that they felt this was the most effective way to ensure that Paul was brought to justice, however, this did not comply with the protocol for referral, which excludes

domestic abuse offences. Whilst it is understandable that the officer attempted to highlight the case via referral to the MVOP, this was counter-productive due to the ongoing risks presented to Caroline.

4.46 There is no indication that the MVOP process and the procedures in relation to risk management of informal patients was shared or discussed. This effectively left Paul to his own devices whilst awaiting a decision regarding whether he could be dealt with under the Criminal Justice System. This decision was not finalised until 16th September.

4.47 Although Paul's CRC case manager maintained contact with the hospital during Paul's stay as a voluntary patient, there is no evidence of professional curiosity regarding Paul's actual status (i.e., that he was not in fact sectioned). There is no evidence of consideration that Paul may continue to pose risk to Caroline, and no dynamic assessment of risk.

4.48 In summary this series of events enabled Paul to continue to assault, harass and control Caroline, whilst under the guise of detention under the Mental Health Act. The review believes that there is significant learning regarding multi-agency working and communication in relation to the management of informal patients and multi-agency working to manage risks that they may continue to present. The risk presented to victims of domestic abuse in these circumstances should be of equal importance to the assessment of mental health issues of perpetrators.

4.49 There is scope within these circumstances to explore whether a victimless prosecution may be appropriate using evidence other than that of the complainant. Crown Prosecution Service Guidance (https://www.cps.gov.uk/legal-guidance/domestic-abuse-guidelines-prosecutors) advises that prosecutors should assess as soon as possible whether there is other sufficient evidence (for example, admissions in interview, CCTV, 999 Tapes) to proceed. Where there is evidential sufficiency and a realistic prospect of conviction, prosecutors should consider whether a prosecution is required in the public interest in the usual manner.

TOR 4: Did Caroline disclose domestic abuse to family and/or friends, if so, what action did they take? What information and advice would support families to protect their family member where domestic abuse is suspected, and if the family were aware of abuse, did they know what action to take or where to seek help, and did they think this was effective?"

4.50 Caroline's family were aware that her relationship with Jack was volatile, although they were not aware of any abuse until the incident that took place in May 2014.

4.51 During her relationship with Paul, Caroline made disclosures of abuse to her sister (this was also known to her father), although she tended to minimise these and said that Paul was mentally ill and that this was the reason for his abusive behaviour.

4.52 On one occasion Caroline's father contacted police and told them that Paul was 'battering' Caroline. This contact was followed up by police, however Caroline did not make any further disclosure to them.

4.53 One of Caroline's friends also reported concerns about abuse and telephoned police to say that he thought her partner may be abusing Caroline (NB he did not identify the partner as Paul, therefore it is unknown whether this report related to Jack or Paul). Police followed this call up with Caroline, however she gave assurances that she was not being abused.

4.54 Caroline told her sister that she felt that Paul loved her and that, when he was abusive, he always made up with her and said that he cared about her. Caroline's sister felt that it was Caroline's insecurities and previous trauma that made her stay with Paul. She felt that Caroline needed to need someone and to be needed, and that Paul played on Caroline's vulnerability. To some extent it was this that prevented Caroline's family seeking support from specialist agencies.

4.55 Both Caroline and Paul's family reported to health services and police that they had concerns about Caroline's safety. However, the review notes that Caroline's family did not seek support to from a specialist domestic abuse agencies, national helplines and other support services such as Victim Support.

4.56 The review notes that families may feel they are going against the wishes of the victim if they consult specialist services. Whilst information to families is made available via websites and targeted campaigns, there is a need to ensure that information continues to be updated and freely available in a range of settings and recognises that families are often compromised by their desire to end the abuse but their unwillingness to act against the wishes of the victim. The review has made a recommendation in this regard.

TOR 5: Did the perpetrator make any disclosures regarding domestic abuse to family or friends, if so, what action did they take?

4.57 Paul's abusive behaviour towards Caroline was known by Paul's family. Paul had also been abusive to his mother.

4.58 Records submitted to the review indicate Paul's mother and sister told agencies (Pennine Care and GMP) that they had spoken to Caroline about Paul's violent and aggressive outbursts, and about his controlling behaviour. Paul's mother had said on one occasion that she was afraid that Paul might kill Caroline. Paul's mother became known to ASC in relation to her vulnerabilities and support was offered to her. However, links were not made to the abuse that Paul was committing against Caroline.

4.59 Caroline told her family that she had been subjected to aggression from Paul's family, however the review could not substantiate this information.

4.60 There is no indication that Paul or his family spoke to specialist domestic abuse services or sought support from them.

TOR 6: Did any agency identify concerns in relation to safeguarding children?

4.61 There are two key episodes relating to safeguarding children. One of these episodes relates to the children of Tricia and does not fall within the remit of this DHR.

4.62 The second episode relates to Caroline's children. As a result of the assault on Caroline by Jack in May 2014, CSC conducted a S47 enquiry into the safety of the children, as would be expected in these circumstances. The outcome was that the children were made subject to Child Protection Planning (CPP). The children were initially removed from Caroline's care, and were later returned to her, however they remained subject to CPP.

4.63 Following reports that Jack had been visiting Caroline and an incident involving a report that Caroline's children had been left unsupervised in a public house, proceedings took place to permanently remove Caroline's children. A full care order being granted in July 2015.

4.64 Caroline made efforts to address her vulnerabilities, and the identified risks that her lifestyle and relationships presented to the children. She attended domestic abuse courses and engaged with counselling and therapeutic support, addressing her drug use and attending parenting sessions run by the substance misuse service. Despite her efforts there appeared to have been little hope of Caroline's children being returned to her. The review makes a recommendation regarding safeguarding the children of domestic abuse victims, whilst also ensuring that the victim is not blamed, stigmatised or punished for their situation.

4.65 The impact of a lengthy period of the children being subject to CPP and the ultimate removal of Caroline's children was clearly traumatic for her.

4.66 The review has noted that the removal of Caroline's children had a profound effect upon her, and it is the view of the review that, whilst recognising the primacy of the safeguarding of Caroline's children, Caroline could have been offered greater support during this period, particularly taking into account her vulnerabilities and that she herself had experienced childhood abuse. (NB: The review recognises the importance of safeguarding children and does not challenge the decisions made regarding their safety) The review also recognises that providing further support for Caroline in relation to her vulnerabilities would not have changed decisions in relation to safeguarding children).

4.67 No notification was made by CRC to CSC in relation to risks to Paul's child, although it was known by the CRC case manager that the child was living with Paul's mother and that Paul was living with them. It is expected practice that CRC officers identify and report safeguarding matters. An opportunity was also missed by CRC to identify and refer Paul's mother to ASC as an adult at risk.

4.68 The panel felt that notification of the DHR should be made to the Chair of the Local Safeguarding Children Partnership to make the Partnership aware of practice in the case. In this regard the DHR Chair wrote to the Chair of the Local Safeguarding Children Partnership to inform them on the review.

TOR 7: What systems and processes used in working with Caroline and/or Paul to assess and manage risk, provide services and use service pathways, quality assure decisions effective and of a good quality. What has been learned from the review that could be modified?

4.69 Risk assessment tools were used to assess risks to Caroline; however, Caroline minimised the abuse committed by Paul as highlighted throughout this report. There was a lack of professional curiosity regarding the impact of Paul's coercive and controlling behaviour on Caroline. It would have been good practice to use the 'Severity of Abuse Grid' to assist Caroline in recognising the level and ongoing nature of abuse by Paul. [9]

4.70 The review has noted areas of good practice in relation to support provided to Caroline by the IDVA and by housing staff, in general actions to safeguard Caroline were inconsistent and uncoordinated.

---

[9] http://www.safelives.org.uk/sites/default/files/resources/Severity%20of%20Abuse%20Grid.pdf

4.71 DASH risk assessments were used by the police, FCHO and the IDVA service, which is expected practice. However, in the majority of cases where DASH risk assessments were attempted, Caroline either declined to answer the questions, or answered 'no' to the majority of questions. The review could see no apparent link having been made between risk assessment and Caroline's response to it. It would have good practice to consider incidents as potential indicators of a pattern of perpetrator behaviour, rather than as isolated incidents.

4.72 A DASH risk assessment was undertaken by the Housing Officer on the advice of the IDVA on 20th June 2016 (relating to incidents that had been reported by neighbours involving Paul). The DASH score on this occasion was 7, although it was felt that Caroline was minimising abuse. This was perhaps a missed opportunity to further explore risks with Caroline, given the Housing Officer's uncertainty about whether Caroline was being completely open.

4.73 Opportunities were missed by Caroline's GP to make targeted enquiries into domestic abuse and to share information with other agencies when Caroline made disclosures of domestic abuse.

4.74 Paul was assessed by CRC in April 2016 as being a medium risk of harm to others, following a racially aggravated attack on his previous partner. However, information regarding risk was not shared with other agencies, specifically with CSC, in relation to safeguarding children. CRC could also have notified ASC when they received information regarding possible risk to Paul's mother and to Caroline.

4.75 Paul's admission to hospital as an informal patient is covered in detail in XXX. There appears to have been no assessment of Paul's risk to either himself or to others during the period in which he was an informal patient receiving a mental health assessment.

4.76 The OASys assessment completed by CRC identified that Paul posed medium risk to intimate partners and to children. This did not however result in robust action to identify and safeguard either Caroline or any of the children that Paul had contact with.

TOR 8: What multi-agency working took place and was this effective?

4.77 There is some evidence of joint agency working in the case i.e., between FCHO and the IDVA and between CSC and the IDVA. However, throughout the period under review there is little evidence of a joined-up approach, supported by multi-agency working and information sharing systems which have consistency and momentum.

4.78 There are specific examples where multi-agency working and information sharing would have informed decision making and improved practice. Notably work in relation to Paul's informal/voluntary hospital admission lacked multi-agency input. It would have been good practice for a multi-disciplinary team meeting (MDT) to take place to ensure that all agencies were fully informed regarding the nature of the admission and highlighting that Paul remained at liberty to continue contact with Caroline (and members of his family who had expressed fears about their own safety) and to safeguard Paul's child. This would have improved safety planning and risk management and enabled a multi-agency plan to be formulated.

5. Conclusions and Recommendations

5.1 The review concludes that Caroline was a vulnerable young woman who had experienced significant trauma as a child, having been abused by an adult male in childhood. Agencies were aware of Caroline's history however, the impact that this had upon her during adolescence and adulthood was not fully explored or taken into consideration in responding to her needs.

In the period under review Caroline had two partners, both of whom perpetrated domestic abuse against her. Caroline was made to feel that it was her fault that they were abusive to her. She told her family that she felt sorry for both her partners. Jack because he had issues relating to active service in the armed forces, and Paul because he had mental health problems and wasn't well.

5.2 Caroline's relationship with Jack ended when he assaulted her in May 2014. This began a chain of events that resulted in Caroline's children being permanently removed from her care. Despite Caroline's determination to have her children returned to her by seeking help and support, her three children were permanently removed from her in July 2015. Until that time Caroline had maintained hope that they would be returned to her. This was a devastating outcome for Caroline and contributed to a deterioration in her mental health and wellbeing and contributed to her returning to drug use when she entered a relationship with Paul. Caroline's vulnerability was exacerbated by Paul's propensity for violence and controlling behaviour. The review saw evidence that Paul was controlling, violent, financially abusive and that he coerced Caroline and made her believe that she was 'to blame' for his abuse of her.

5.3 Caroline's vulnerabilities stemmed from traumatic events in her childhood which were deepened by the removal of her children. The review concludes that professional support for Caroline in relation to childhood trauma and to the removal of her children could have been strengthened., whilst also recognising that decisions made in relation to safeguarding children were based on assessment of the risk presented to them.

NB: The panel notes that at the time of these events, practice in relation to the impact of childhood trauma and to the removal of children of vulnerable birth mothers was under-developed both locally and nationally. In this regard the review would commend more recent research and initiatives to support the development of practice in this important area e.g., BASW and Lancaster University research into practice with vulnerable birth mothers.[10]

5.4 Despite the adversity and trauma that she had experienced as a child and later in her relationships with both Jack and Paul, Caroline tried to rebuild her life by engaging in interventions and psychological support services, and she appeared to be making progress. She was inappropriately discharged from psychological support services and returned to a relationship with Paul. Her drug use increased at this time and Paul's abuse of Caroline continued.

5.5 This review highlights a number missed opportunities to safeguard Caroline and to protect her from Paul's violent and abusive behaviour. It also highlights the need for agencies to understand and develop trauma informed practice relating to adverse childhood experiences.

[10] https://www.nuffieldfoundation.org/sites/default/files/files/rc-final-summary-report-v1_6.pdf

5.6 The review has identified learning for agencies in the following areas:

- Professional understanding of and responses to coercive and controlling behaviour by perpetrators[11]
- Multi-agency working and information sharing (particularly in relation to fact checking and corroborating self-report information, shared case management procedures and practice and the designation of lead agencies/lead professionals)
- Strengthening trauma informed practice and professional understanding of the impact of adverse childhood experiences
- Risk management of domestic abuse offenders
- Management and multi-agency understanding of mental health assessment as an informal patient
- MVOP - Systems to divert offenders presenting with mental health issues
- Supporting and engaging victims of domestic abuse
- Focus on families of victims in relation to strengthening information and access to domestic abuse services
- The role of the GP in making targeted enquiries and dealing with disclosures of domestic abuse
- The relationship between safeguarding children and protecting victims of domestic abuse who are themselves adults at risk
- The duty for professionals to share information in relation to safeguarding children

Conclusion 1 - Recognising and responding to coercive and controlling behaviour by perpetrators

5.8 There are several examples throughout the review of professionals across the agencies failing to recognise the degree to which coercion and control impacted Caroline's decision making and ability to safeguard herself (and on occasion her children).

5.9 Similarly, several opportunities were missed by agencies to address Paul's coercive and controlling behaviour of Caroline.

5.10 There appears to have been minimal understanding amongst professionals of the degree to which Paul's coercive and controlling behaviour would influence Caroline's ability to exit the relationship, and therefore that she would be likely to minimise the threat he posed to her, and the abuse that she experienced from him.

5.11 Recommendation 1: The CSCP should review domestic abuse training to ensure that coercive and controlling behaviour is recognised by all agencies as a significant factor in driving the behaviour of victims. The CSCP should also be assured that workforce development and training is put in place to address this apparent gap in professional understanding.

Conclusion 2 - Multi-Agency Working

5.12 There are many examples where more robust multi-agency working could have taken place as set out in the body of the report.

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

5.13 There does not appear to have been either a culture of multi-agency working or sufficiently robust systems to support agencies coming together to manage the risks to Caroline from Paul.

5.14 Single agency action plans address this conclusion

Conclusion 3 – Strengthening Trauma Informed Practice

5.14 Caroline experienced trauma in her early life and was subject to adverse childhood experiences[12] which had a profound impact upon her. Professionals did not demonstrate a full understanding of the impact of Caroline's childhood trauma upon her adult life.

5.15 Caroline's family believe that her vulnerabilities were compounded by the removal of Caroline's children and the review would concur with this (whilst recognising the importance of action taken to safeguard them).

5.16 Recommendation 2: The CSCP, Local Safeguarding Children Partnership and Safeguarding Adults Partnership should collaborate to ensure a strategic focus on strengthening trauma informed practice.

Conclusion 4 - Risk Management of Domestic Abuse Offenders

5.17 Some aspects of risk assessment and management appear to be embedded i.e., DASH risk assessment, MARAC, risk assessment of offenders and mental health assessments. However, the multi-agency systems and practice to share the outcomes of these processes is not apparent in this case.

5.18 The provision of DVDS was not applied in the case because Caroline had said she had separated from Paul. Given the history of abuse and Caroline's vulnerability this decision should have been referred back to the MARAC as this was the forum in which the decision was made regarding disclosure.

5.19 Recommendation 3: The CSCP should receive assurance from GMP that checks, and balances are in place to ensure that appropriate processes regarding decisions related to 'Right to Know' disclosure is in place (in this case referral back to MARAC).

Conclusion 5: Management and multi-agency understanding of informal (voluntary) admission to hospital

5.20 The review saw no evidence of multi-agency awareness and understanding of this provision. It is questionable whether the decision to admit Paul under this provision should have taken place, given that he had, that same day, been accused by Caroline of committing a serious assault upon her.

[12] In the simplest terms, the concept of trauma-informed care is straightforward. If professionals were to pause and consider the role trauma and lingering traumatic stress plays in the lives of the specific client population served by an individual, professional, organization, or an entire system, how would they behave differently? What steps would they take to avoid, or at least minimize, adding new stress or inadvertently reminding their clients of their past traumas? How can they better help their traumatized clients heal? In effect, by looking at how the entire system is organized and services are delivered through a "trauma lens," what should be done differently?

5.21 Paul's account of his admission was that he was in hospital under 'section', and this was taken at face value, by Caroline and by all agencies who had contact with Paul regarding the alleged assault on Caroline. This enabled Paul to continue to have contact with Caroline, and the review is in no doubt that during this time Paul continued to coerce and abuse Caroline to encourage her to retract the allegations of assault, which ultimately, she did.

5.22 The review found that single and/or multi-agency arrangements for supervising and risk managing Paul during this period were inadequate to prevent any further risk to Caroline or to members of Paul's family. There is no evidence that risk management tools (for example SARA) were considered as a means of reducing risk to Caroline.

5.33 The provision of informal (voluntary) admission to hospital for mental health assessment needs to be strengthened, to include appropriate assessment and management of risk for victims.

5.44 Recommendation 4: The CSCP should commission relevant health agencies (via the CCG) that the provision of informal (voluntary) admission of patients with mental health needs is understood, and that this provision is applied in a way which appropriately identifies and manages risk.

Conclusion 6 – MVOP

5.45 Local guidance in relation to domestic abuse offences is that they are not suitable for the MVOP provision. The referral to MVOP in this case should therefore not have been made, although it is understood that the police officer making the referral did so with the best of intent.

5.46 There is no evidence of clear leadership of the MVOP process in relation to Paul, and no consideration given of the risks to Caroline whilst Paul was a voluntary patient who was being processed through the MVOP system. During the period between referral and the decision that Paul should be dealt with in the Criminal Justice System (a period of almost four weeks), Paul was at liberty to further abuse Caroline.

5.47 There is little evidence of multi-agency working and a clear absence of information sharing and communication between agencies at this time.

5.48 This review highlights the need for the MVOP system to be strengthened in relation to its application, particularly in relation to the professional understanding of referral of domestic abuse offences, and its links with other systems. There should also be a clearly identified lead for all MVOP cases, who has responsibility for coordinating multi-agency activity.

5.49 Recommendation 5: The CSCP should examine the current systems for diversion of offenders, including MVOP, and undertake any necessary action to ensure that guidance is being applied and that there are sufficient robust checks and balances in the system to ensure compliance.

Conclusion 7 - Supporting and maintaining engagement with victims of domestic abuse

5.50 Caroline's safety as a known victim of domestic abuse was often not put at the heart of interventions. Service responses were largely reactive, and agencies appear to have been led by Caroline, who minimised the abuse she was experiencing due to Paul's extreme coercive and controlling behaviour, rather than seeking to manage the risk posed to her by Paul. This was compounded by a lack of multi-agency working, inconsistency in information sharing and systemic

issues in relation to diversion of offenders with mental health needs and informal admission of patients.

5.51 Caroline's engagement with services was inconsistent and she found it difficult to sustain contact with services, she sometimes missed appointments and at times services were unable to contact her. Caroline also minimised the abuse perpetrated against her and on other occasions said that the abuse was 'her fault'.

5.52 There is substantive evidence from national research (for example the Citizen's Advice publication 'Domestic Abuse Victims Struggling for Support' (2015)[13] which brings together a range of findings from research, and from other Domestic Homicide Reviews published by the Home Office (Home Office, Key Findings from Domestic Homicide Reviews, 2016), that victims of domestic abuse often have difficulty in maintaining engagement with services. This may be because they are in fear of their abuser(s) or that they have lost resilience and strength to resist the abuse. It may be that they have experienced coercion and control over such a long period of time that they do not recognise the risks and dangers presented to them, or for other reasons. In Caroline's case it is also clear that the role played by her childhood experiences of abuse had a profound impact upon her.

5.53 The review believes that services have a responsibility to understand and try to engage and maintain contact with victims of domestic abuse, and to recognise the insidious nature of coercive and controlling behaviour by perpetrators.

5.54 There are examples of good practice in this review in relation to attempts by services to maintain contact with Caroline, there are also examples of Caroline engaging with support services. However, the review believes that a greater focus on victims of domestic abuse and stronger practice in relation to understanding their decision making and motivation, is required to help victims to sustain engagement and thereby benefit from interventions.

5.55 No specific multi agency recommendation is made in relation to this conclusion; however Recommendation 2 partly addresses the above. In addition, the CSCP is asked to use the findings of this review to support ongoing work – and to monitor progress against action plans overseen by the local domestic abuse steering group.

Conclusion 8: Focus on families in relation to information and access to domestic abuse services

5.56 Caroline's family felt unable to access support from specialist domestic abuse services as they felt they would be going against her wishes, although Caroline's father did report an assault to police.

5.57 Paul's family also reported their concerns about his aggressive and controlling behaviour to police. It is not known whether they sought support from specialist services.

5.58 Recommendation 6: In collaboration with the LSCP and SAB the CSCP should receive assurance that ongoing work to strengthen information and services to the families of victims of domestic continues to be a priority and the action plan for supporting families of victims should be refreshed.

Conclusion 9: The role of the GP in making targeted enquiries and sharing information

[13] https://www.citizensadvice.org.uk/global/migrated_documents/corporate/domestic-abuse-victims---struggling-for-support-final.pdf

5.59 Caroline's disclosures of domestic abuse to her GP were not appropriately acted on or shared with other agencies. The GP did not initiate any safeguarding referrals on Caroline's behalf, nor was it apparent from the records that they spoke to her about support services or safety planning.

5.60 When Caroline presented with low mood, anxiety, concerns about her children and on one occasion an old injury, the GP did not make any enquiries into domestic abuse.

5.61 Guidance from NICE and the Royal College of General Practitioners is clear in relation to GP'S making enquiries about domestic abuse and information sharing, which was not adhered to in this case.

5.62 Work to strengthen GP practice is identified in the CCG single agency action plan.

5.63 Recommendation 7: The CSCP should receive assurance from the CCG the learning from this and other domestic homicide reviews in relation to the GP's role in safeguarding victims, as set out in national guidance, is implemented.

Conclusion 10: The relationship between safeguarding children and protecting victims of domestic abuse who are themselves adults at risk

5.64 The review does not feel it is appropriate to challenge decisions made in relation to the removal of Caroline's children. However, it is important to highlight that the impact of the removal of Caroline's children does not appear to have been fully addressed by professionals (trauma informed practice).

5.65 What is clear to the review is that the degree to which Caroline attempted to address lifestyle factors that posed potential risk to her children, and her willingness to engage with agencies to reduce risks to her children, were not considered to be sufficient to enable her to keep her children with her.

5.66 The review highlights the need for CRC to act on information regarding safeguarding the children of offenders or children with whom they have contact. The CRC case manager should have notified CRC that PC1 was living with Paul and his mother and that he had a history of domestic abuse offending.

5.67 All agencies should be aware of guidance relating to the impact of domestic abuse on children and should be able to act appropriately.[14]

5.68 The role of Adult Services in supporting and safeguarding victims whilst working with Children's Services to safeguard children was not explored in this case. A stronger relationship between Adults and Children's services would have strengthened case management and interventions.

5.69 Recommendation 8 (Part 1): The CSCP should work jointly with the local Safeguarding Children Partnership to ensure that up to date and relevant guidance in relation to safeguarding the children of domestic abuse victims is in place. This should include specific focus on multi-agency working and case management to safeguarding children and victims and the duty for professionals to share information in relation to safeguarding children. A Think Family approach should guide this work.

[14] http://www.safelives.org.uk/sites/default/files/resources/Final%20policy%20report%20In%20plain%20sight%20-%20effective%20help%20for%20children%20exposed%20to%20domestic%20abuse.pdf

It should include the most up to date practice in relation to supporting vulnerable parents in cases where children are removed.

5.70 The Chair of the DHR has written to the Chair of the Children's Safeguarding Partnership to highlight the points raised in this review.

5.71 **Recommendation 8 (Part 2):** The CSCP should work jointly with the local Safeguarding Children Partnership and Safeguarding Adults Board to ensure that guidance relating to the roles of Adults and Children's services in supporting domestic abuse victims with children is in place and that ASC and CSC are implementing this guidance.

Appendices

1. **Multi Agency Action Plan**
2. **Home Office Definition of Domestic Abuse**
3. **Single Agency Action Plans**

Appendix 1

'Caroline' Multi Agency Panel Recommendations Action Plan

Recommendation 1: Lead Agency - Domestic Abuse Partnership						
Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
The Community Safety and Cohesion Partnership should review domestic abuse training to ensure that coercive and controlling behaviour is recognised by all agencies as a significant factor in driving the behaviour of victims. The Community Safety and Cohesion Partnership should also be assured that workforce development and training is put in place to address this apparent gap in professional understanding. (Recommendation 1 – Conclusion 1)	Ensure training on coercive and controlling behaviour is embedded within arrangements for workforce development, with particular emphasis on how being subject to such behaviours may affect a person's decision making or how they may present themselves or act towards professionals.	Training content includes learning on coercive and controlling behaviour	The impact of coercive and controlling behaviour is fully understood by personnel who may come into contact with victims of DVA. Where coercive and controlling behaviour is perceived or apparent, the impact of this upon the victim and children is considered within decision making. Support for victims who have been subject to or are experiencing coercive and controlling behaviour is fit for purpose.	Bruce Penhale	31/07/2019	December 2020 Coercive and controlling behaviour is incorporated within the training delivered by the Partnership, for example as part of the training on use of the Domestic Abuse, Stalking, Harassment - Risk Indicator Checklist. The Safeguarding Adults Board held a specific practice learning event in October 2020 relating to women in coercive and controlling relationships. It was informed by, and included input from, women who were survivors of abusive relationships. Additional training will be undertaken in 2021 when the Domestic Abuse Act comes into force to ensure understanding of the definition of domestic abuse which specifically includes coercive or controlling behaviour within the definition of abuse.

Recommendation 2: Lead Agency - Safeguarding Children Partnership and Safeguarding Adults Board

Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
The Community Safety and Cohesion Partnership, Local Safeguarding Children Partnership and Safeguarding Adults Partnership should collaborate to ensure a strategic focus on strengthening trauma informed practice. (Recommendation 2 – Conclusion 3)	**Local Action** Ensure staff understand the impact of all forms of trauma and recognise the impact upon decision making and behaviours.	Agencies to provide information on trauma informed training and workforce development plans and evidence within practice. A resource pack is being developed for parents whose children are removed from their care.	The impact of trauma is recognised by services and Victims are able to access practical and emotional support both during and after the process of removal of children.	Lisa Morris Julie Farley	31/12/2021	New Action - Ongoing - As part of the Safeguarding Adults Board practice learning event in October 2020 relating to women in coercive and controlling relationships a trauma podcast was commissioned and shared as part of the joint Children's and Adults event. Partners can access the podcast which is hosted on the OSAB website at: https://www.osab.org.uk/professionals/podcasts/ The OSAB Training and WFD Strategy has identified Trauma Informed Practice as one of its lunchtime learning sessions hosted in 2021/22.
	Local Action Ensure staff understand the traumatic impact of the loss of children from the care of a victim of domestic abuse				31/12/2021	
	Local Action Identification of support offer for victims whose children are removed.				31/12/2021	

Recommendation 3: Lead Agency - Greater Manchester Police

Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
The Community Safety and Cohesion Partnership should receive assurance from Greater Manchester Police that checks, and balances are in place to ensure that appropriate	**Local Action:** Ensure domestic abuse policies and procedures include robust dynamic risk management processes for	Production of a 7-minute briefing for GMP Officers on the importance of dynamic ongoing	Officers clearly understand and are able to apply the provisions of the Domestic Violence	DCI James Faulkner / DI Rick Arthern	31/10/2019	Local Update Police Officers within Oldham's Multi-Agency Safeguarding hub manage and deal with all applications. As part of the process, all domestic incidents

processes regarding decisions related to 'Right to Know' disclosures are in place (in this case referral back to MARAC). (Recommendation 3 - Conclusion 4)	perpetrators which assess ongoing risk.	risk management. Briefings delivered to Officers through multi-agency forums and team meetings. Position Statement Report on action to be provided by Greater Manchester Police to the Domestic Abuse Partnership	Disclosure Scheme. Where a 'Right to Know' disclosure has been considered appropriate, but a relationship is no longer perceived to be ongoing at the point the disclosure is to be made, the likelihood of the relationship resuming will be fully considered in all cases and rationale for decision making recorded. Any subsequent decision not to disclose will be authorised by a senior officer.			are reviewed; and a Claire's Law disclosure is made where it is appropriate to do so. There is a requirement for a Detective Inspector to review all applications in order to ensure that any disclosures are appropriate; and that the form of words used in each one, is correct. Greater Manchester Police's Domestic Violence Disclosure Scheme guidance page on the intranet, has been updated to reflect the process. Force Update January 2021 The Domestic Violence Disclosure Scheme policy has recently been submitted to Greater Manchester Police's Policy and Strategy team for rework. The revised policy has made a number of enhancements to ensure that Claire's Law is considered by safeguarding teams on every domestic abuse incident they receive. The revised policy has also re-instated that a Detective Inspector should review and authorise the form of words that is to be disclosed by the victim. iOPS (Greater Manchester Police IT system) has also made

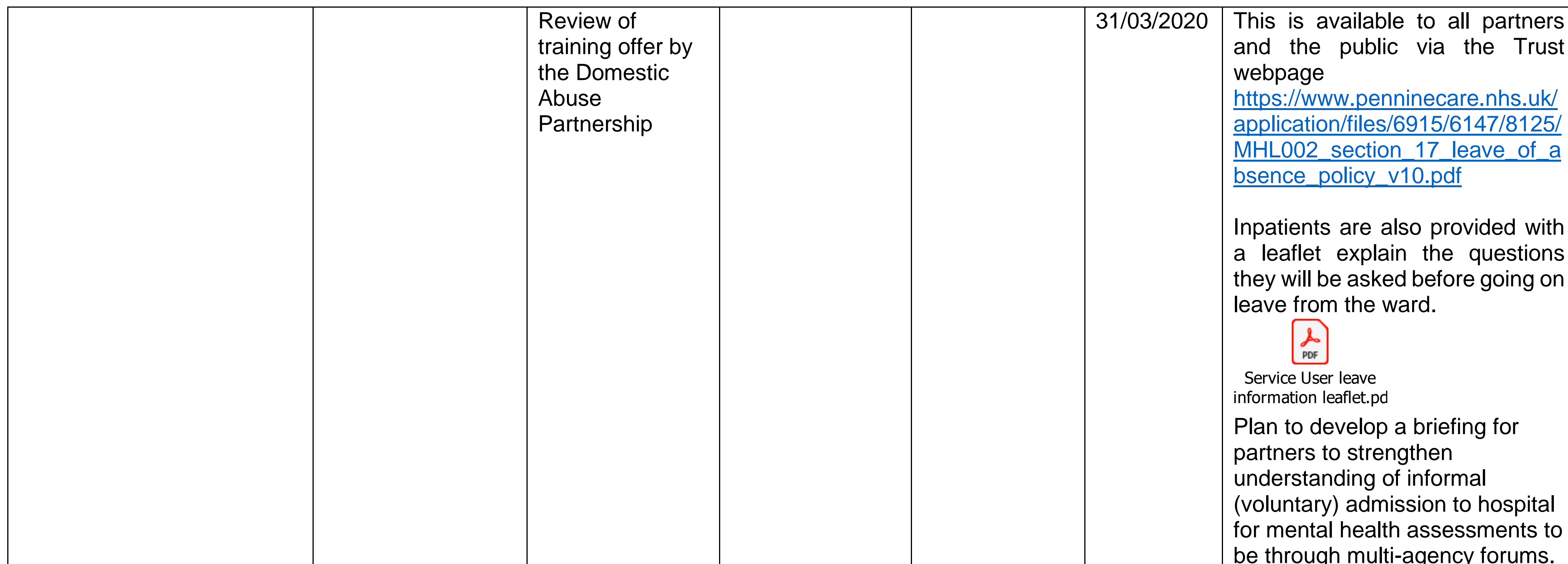
						available a specific Domestic Violence Disclosure Scheme marker which will be applied to a person's record to reflect that they have made an application under Claire's Law. The information marker will denote whether a disclosure was made or not and where further information about the disclosure can be located. This will make it far more visible to all officers that there has either been concerns raised by an individual, a third party, or by Greater Manchester Police themselves. In 2019, the People and Development Branch delivered training to all neighbourhood police officers to raise awareness of the Domestic Violence Disclosure Scheme and their responsibilities to identify when a disclosure may be appropriate, as well as how to share information with the safeguarding team that will ultimately oversee the disclosure process. All new recruits are made aware of the background to the Domestic Violence Disclosure Scheme and the aims and objectives of the scheme. It is intended that when the revised policy is agreed, there will be accompanying training material to raise awareness of the

						key changes and of the process itself.
	Local Action: Ensure that all Domestic Violence Disclosure Scheme and Right to Know decisions and disclosures are managed through the Multi Agency Safeguarding Hub and that the likelihood of a relationship resuming is considered within decision making.	GMP records.			31/10/2019	Where a concern is identified, checks should also be made with partner agencies within the Multi Agency Safeguarding Hub to ensure that any relevant information in relation to the risk is shared with the person at risk that might be held by partners; and agree how this information is to be shared. Under no circumstances should a partner agency be left to share police information independently. A joint disclosure may be appropriate if more than one agency has information to share with a person at risk. See Appendix 2 for further information The policy does not presently exclude that disclosures should not be made when the parties are not in a relationship. I am cautious at this time, of explicitly stating that officers should consider the likelihood of a relationship resuming in decision making, as this is not part of the three-stage disclosure test we must use which is a) It is reasonable to conclude that such disclosure is necessary to protect the person at risk

						from being the victim of a crime; b) There is a pressing need for such disclosure; and c) Interfering with the rights of the subject, including the subject's rights under Article 8 of the European Convention of Human Rights, to have information about his/her previous convictions kept confidential is necessary and proportionate for the prevention of crime. This involves balancing the consequences for the subject if his/her details are disclosed against the nature and extent of the risks that the subject poses to the person at risk.
	National Action: Review of Statutory Guidance relating to the Domestic Violence Disclosure Scheme and Right to Know to ensure that the likelihood of a relationship resuming is considered within decision making.	Amendment to Statutory Guidance			To be determined by Home Office	Please refer to above

Recommendation 4: Lead Agency - Pennine Care NHS Foundation Trust						
Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
The Community Safety and Cohesion Partnership should commission relevant health agencies (via the CCG) that the provision of informal (voluntary) admission of patients with mental health needs is understood, and that this provision is applied in a way which appropriately identifies and manages risk. (Recommendation 4 - Conclusion 5)	**Local Action** Ensure policies and procedures reflect that risk management for victims is a key consideration within mental health assessments and that potential manipulation of services is considered within the assessment framework for informal (voluntary) admissions	Production of a 7-minute briefing to strengthen understanding of informal (voluntary) admission to hospital for mental health assessments	Assessments on voluntary patients fully consider ongoing risks, including the potential for threat, risk and harm behaviours outside of the placement during the admission period. Information is sourced/shared to ensure risk is fully understood and managed. Concerns about the behaviour of patients are escalated immediately and shared with	Sarah Davidson Head of Safeguarding	30/09/2019	07.01.21 – update Pennine Care NHS Foundation Trust can provide assurance to the Community Safety and Cohesion Partnership that the following policies reflect that risk management for victims is a key consideration within mental health assessments. Pennine Care NHS Foundation Trust - Clinical Risk Assessment and Management Policy - sets out good clinical risk assessment and management practices and processes for clinicians delivering services and also includes service users undergoing initial assessment on referral to services. This is available to all partners and the public via the Trust webpage https://www.penninecare.nhs.uk/application/files/1715/9602/8285/CL019_-_Clinical_Risk_Assessment__Management_V9.pdf
		Briefings delivered to partnership colleagues through multi-agency forums and team meetings.			31/12/2019	

		Position Statement Report on action to be provided by Pennine Care NHS Foundation Trust to the Domestic Abuse Partnership	outside organisations where appropriate to reduce risk.		29/02/2020	Pennine Care NHS Foundation Trust - Admission, Entry and Exit Policy of Patients on Mental Health Wards Policy - is to enhance safety and security of all members of staff, patients, carers and members of the public [see page 8 and 9]. This is available to all partners and the public via the Trust webpage https://www.penninecare.nhs.uk/application/files/5815/6328/6355/CL061_-_Admission_Entry_and_Exit_Policy_v5_web.pdf Pennine Care NHS Foundation Trust - Section 17 (Leave of Absence) Policy – provides assurance to the CSCP that all staff are aware of their responsibilities prior to the granting of leave for informal patients who are not covered by section 17 leave [see page 14]
		Production of a 7-minute briefing on coercive and controlling behaviours			30/09/2019	

		Review of training offer by the Domestic Abuse Partnership			31/03/2020	This is available to all partners and the public via the Trust webpage https://www.penninecare.nhs.uk/application/files/6915/6147/8125/MHL002_section_17_leave_of_absence_policy_v10.pdf Inpatients are also provided with a leaflet explain the questions they will be asked before going on leave from the ward.  Service User leave information leaflet.pd Plan to develop a briefing for partners to strengthen understanding of informal (voluntary) admission to hospital for mental health assessments to be through multi-agency forums.
Recommendation 5: Lead Agency - Greater Manchester Police						
Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
The Community Safety and Cohesion Partnership should examine the current systems for diversion of offenders, including the Mentally Vulnerable Offender Panel (MVOP), and undertake any necessary action to ensure that guidance is being applied and that there are sufficient robust checks and balances in the system to ensure compliance.	**Local Action:** Review of procedures relating to diversion of offenders in domestic abuse cases to ensure they are fit for purpose and recognise risk of harm, and that there are arrangements in	Position Statement Report on action to be provided by Greater Manchester Police to the Domestic Abuse Partnership. Audit of cases which have resulted in diversion to be	Circumstances where diversion is an option are clearly defined and understood. Decisions are taken in accordance with defined procedures. Correct decisions are made in relation to the diversion	DCI James Faulkner / DI Rick Arthern	31/10/2019	Local Update Oldham in line with force guidance, have a system where Sergeants and Inspectors will review crimes and assist officers in the case to identify those cases where it is appropriate for diversion as an option. The supervisors will authorise and provide a rationale. The diversionary panel no longer sits with the Public Protection Unit following the removal of a Public

(Recommendation 5 - Conclusion 6)	place for management oversight of decision making.	undertaken to ensure adherence to policy and procedures for diversion.	of offenders, which are reflective of the circumstances of the incident and the individuals involved. There are robust plans in place which are monitored for adherence and compliance for offenders who are diverted through alternative processes and arrangements, including the Mentally Vulnerable Offender Panel. Risk of ongoing harm is mitigated			Protection Unit facility. The Criminal Justice Unit monitor and administer all referrals. Force update The Greater Manchester Police Mental Ill Health, Mental Incapacity and Learning Disabilities Policy and Procedure provides guidance in relation to offenders in domestic abuse cases. Panel Decision Making Responsibility:- The decision maker on whether proceedings will be initiated for the following offences is the PPU Manager or his/her delegated representative: (i) any Summary Only offence (including criminal damage where the value of the loss or damage is less than £5000) irrespective of plea; (ii) any offence of retail theft (shoplifting) or attempted retail theft irrespective of plea provided it is suitable for sentence in the magistrates' court; and (iii) any either way offence anticipated as a guilty plea and suitable for sentence in a magistrates' court, provided it is not:

						• a case requiring the consent to prosecute of the DPP or Law Officer; • a case involving a death; • connected with terrorist activity or official secrets; • classified as Hate Crime or Domestic Violence under CPS Policies; • an offence of Violent Disorder or Affray; • causing Grievous Bodily Harm or Wounding, or Actual Bodily Harm; • a Sexual Offences Act offence committed by or upon a person under 18; • an offence under the Licensing Act 2003. For all other offences Panel recommendations must be referred to CPS for decision. Full guidance may be found in the Director of Public Prosecution (DPP) Charging Guidance 5th Edition May 2013 which accompanies Chief Constable's Order 2013/18. The above Greater Manchester Police Policy and Procedure was updated in July 2019 to reflect system changes brought about by the introduction of iOPS.
Recommendation 6: Lead Agency – Domestic Abuse Partnership						
Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update

<table>
<tr>
<td rowspan="3">In collaboration with the Safeguarding Children Partnership and the Safeguarding Adults Board, the Community Safety and Cohesion Partnership should receive assurance that ongoing work to strengthen information and services to the families of victims of domestic continues to be a priority and the action plan for supporting families of victims should be refreshed.</td>
<td>Local Action
The Domestic Abuse Partnership has commissioned an external independent review (Safe Lives) to look at the whole domestic abuse offer within Oldham for victims, perpetrators and family members. This will include consideration of the support needs for families who are affected by domestic abuse</td>
<td rowspan="3">There will be a full report provided by Safe Lives.

Clear pathways and signposting for support will be developed in accordance with the recommendations from the Safe Lives review.

A resource pack is being developed for parents whose children are removed from their care.

Where a gap is identified the DA Partnership will facilitate multi-agency discussions to consider realigning services and/or commissioning options.</td>
<td rowspan="3">Families feel supported and able to access services for advice and guidance.

Families are aware of referral processes through the Multi Agency Safeguarding Hub where there is a safeguarding concern.</td>
<td rowspan="3">Rebekah Sutcliffe</td>
<td>31/07/2021</td>
<td rowspan="3">New action – to be updated as work progresses.</td>
</tr>
<tr>
<td>Local Action
An action plan will be developed based upon the recommendations from the Safe Lives review.</td>
<td>30/09/2021</td>
</tr>
<tr>
<td>Local Action
The Community Safety and Cohesion Partnership to consider the potential need to commission services to support the families of victims.</td>
<td>30/09/2021</td>
</tr>
</table>

Recommendation 7: Lead Agency - NHS Oldham Clinical Commissioning Group						
Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
The Community Safety and Cohesion Partnership should receive assurance from the CCG the learning from this and other domestic homicide reviews in relation to the GP's role in safeguarding victims, as set out in national guidance, is implemented. (Recommendation 7 - Conclusion 9)	**Local Action** Ensure learning from previous Domestic Homicide Reviews is embedded in practice through multi-agency audit processes.	Position Statement Report provided to the Domestic Abuse Partnership on progress and take up, of training by GPs and other staff within GP Practices. Evidence within audit processes of information sharing and referrals to specialist services where appropriate. Evidence within audit processes of curious enquiry where symptoms /injuries are not reflective of reasons given by patient.	Increased information sharing between GPs and partner organisations. Increased number of referrals to specialist services for victims of domestic abuse. Increased confidence in victims who disclose domestic abuse to GPs. Increase in recorded numbers of GPs and other staff within GP Practices who have attended training.	Janine Campbell	31/10/2019	The Safeguarding Adults Board conducted a multi-agency audit in 2018. This audit has not been repeated at this time.
	Local Action There should be a robust training offer to ensure GP's and other staff within GP practices are aware of their responsibilities to safeguard victims of domestic abuse and have knowledge of / understand local processes and pathways for support and interventions.					NHS Oldham CCG's safeguarding team have delivered bespoke domestic abuse training to primary care in the clusters throughout 2019. The response to this training was positive. Domestic abuse also features as part of the Level 3 Think Family Safeguarding training that is available to all practitioners within primary care services in Oldham.
Recommendation 8 Part 1: Lead Agency - Safeguarding Children Partnership						
Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update

The Community Safety and Cohesion Partnership should work jointly with the local Safeguarding Children Partnership to ensure that up to date and relevant guidance in relation to safeguarding the children of domestic abuse victims is in place. This should include specific focus on multi-agency working and case management to safeguarding children and victims and the duty for professionals to share information in relation to safeguarding children. A Think Family approach should guide this work. It should include the most up to date practice in relation to supporting vulnerable parents in cases where children are removed. (Recommendation 8 Part 1 - Conclusion 10)	**Local Action** Ensure training on safeguarding is embedded within arrangements for workforce development.	Training content includes learning on safeguarding and risk management. Written policies and procedures. Evidence of adherence to policies and procedures within audit processes. Confirmed pathway of support for victims whose children are removed to the care of the local authority.	The impact, potential or actual, of domestic abuse upon children is recognised in a timely manner. Support and protective measures are put in place at the earliest opportunity to safeguard children. There is a reduction in the harm / level of trauma caused to children.	Lisa Morris Julie Farley	31/07/2019	Safeguarding and risk management is included within the domestic abuse training delivered across the partnership through the Safeguarding Children Partnership training offer.
	Local Action Ensure assessments fully consider the risks posed within the wider family environment				31/03/2021	The new Oldham Domestic Abuse Policy has been confirmed and subject to any changes arising out of the new Domestic Abuse Act, it will be formally launched after the commencement of the Act. Domestic abuse is a priority for the Oldham Safeguarding Children Partnership and will be a key focus for 2021 in terms of response for children, young people and families.
	Local Action Ensure learning is embedded in practice through multi-agency audit processes.				31/03/2021	Added to forward plan for safeguarding review and learning group.
	Local Action Review of policies and procedures in relation to domestic abuse with particular attention to the support provided to victims whose children are removed to the				31/10/2020	The Oldham Safeguarding Adults Board held a joint Practice Learning Event in October that centred on interviews with women experiencing domestic abuse, addiction and the removal of children. The session was repeated in Safeguarding Adults Week and as part of a learning event with the Oldham Safeguarding Children

	care of the local authority.					Partnership. All the sessions explored current procedures and identified gaps in the current adult's prevention offer.
					31/03/2021	Feedback from the learning events are being considered as part of the new Adult Support Offer with commissioning proposals being considered at the May Oldham Safeguarding Adults Board. The new Adult Support Offer will connect with the all age early help offer delivered by Positive Steps and mesh with the Children's Early Intervention service. DA case studies are currently being tested out as part of the development of the new Adult Support Offer.
Recommendation 8 Part 2: Lead Agency - Safeguarding Children Partnership and Safeguarding Adults Board						
Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
The Community Safety and Cohesion Partnership should work jointly with the local Safeguarding Children Partnership and Safeguarding Adults Board to ensure that guidance relating to the roles of Adults and Children's Services in supporting domestic abuse victims with children is in place and that ASC and CSC are implementing this guidance.	**Local Action** Develop a multi-agency policy on domestic abuse	Multi-agency policy in place. Evidence within audit processes that support for victims has been offered and/or provided as part of case action plans.	Victims fully understand and are clear on processes and reasons for decision making. The level of trauma for victims is mitigated as much as possible within the process.	Lisa Morris Julie Farley	31/01/2021	Complete. The multi-agency Policy was confirmed at the Domestic Abuse Partnership on the 21st January 2021. Further amendments will be made following the introduction of the new Domestic Abuse Act. The Policy will be launched after the new Act commences. Training on the new Policy and referral procedures will be delivered to partners through the Safeguarding Children Partnership and the

(Recommendation 8 Part 2 - Conclusion 10)			Victims continue to engage with support services after children are removed.			Safeguarding Adults Board training arrangements.
	Local Action Ensure learning is embedded in practice through multi-agency audit processes.				30/09/2021	In light of the learning from Oldham Safeguarding Adults Board reviews the Safeguarding Children Partnership Review and Learning Group will consider the implications for partner agencies which provide services for children; and will review relevant policies via the Policy and Procedure Group and the Greater Manchester Policy Group.
					30/09/2021	The Oldham Safeguarding Adults Board Quality Assurance and Audit Sub-Group will review the impact of the new adult’s pathway once agreed and established for a period of at least 6 months. The review will consider the need for any further changes.

Appendix 2

Definition of Domestic Abuse

"any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: a continuing 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."

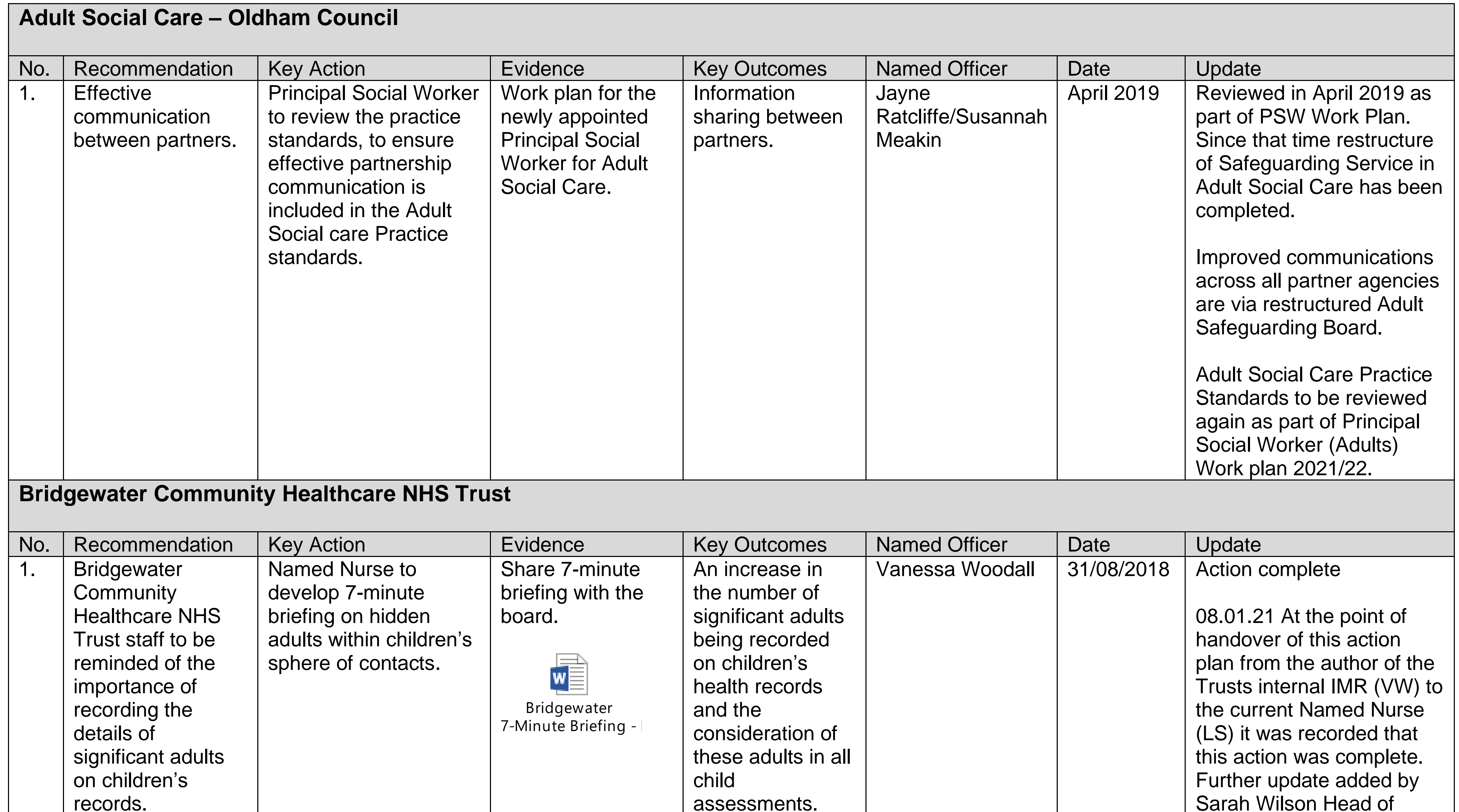
Appendix 3

‘Caroline’ Combined Single Agency Action Plan

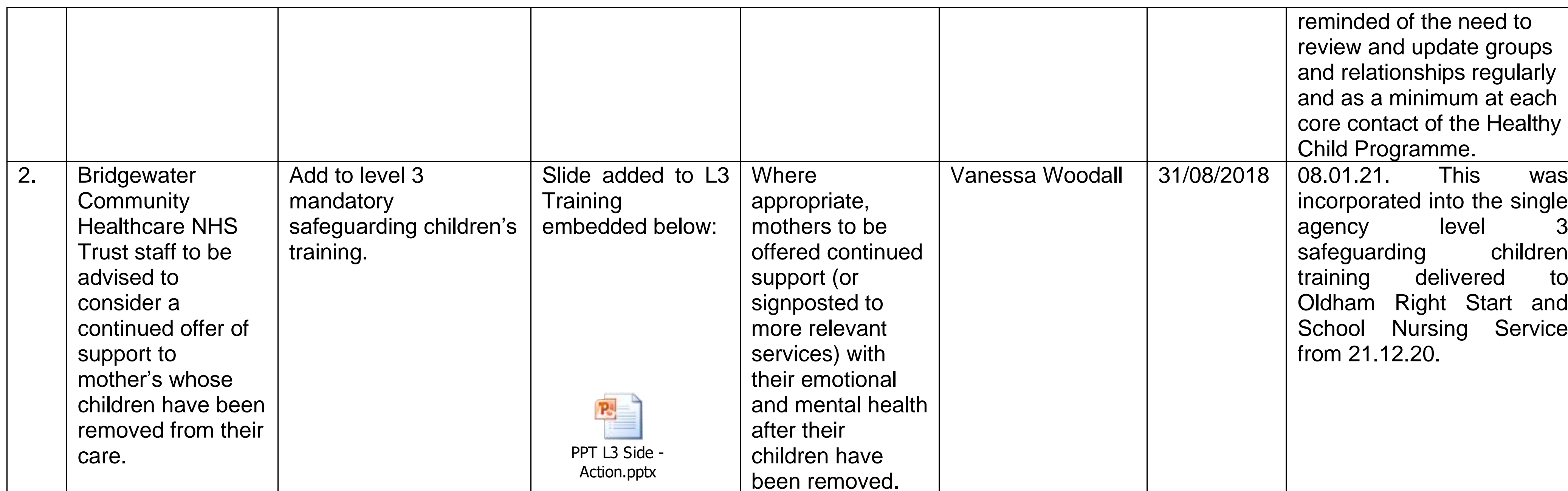
Adult Social Care – Oldham Council

No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	Effective communication between partners.	Principal Social Worker to review the practice standards, to ensure effective partnership communication is included in the Adult Social care Practice standards.	Work plan for the newly appointed Principal Social Worker for Adult Social Care.	Information sharing between partners.	Jayne Ratcliffe/Susannah Meakin	April 2019	Reviewed in April 2019 as part of PSW Work Plan. Since that time restructure of Safeguarding Service in Adult Social Care has been completed. Improved communications across all partner agencies are via restructured Adult Safeguarding Board. Adult Social Care Practice Standards to be reviewed again as part of Principal Social Worker (Adults) Work plan 2021/22.

Bridgewater Community Healthcare NHS Trust

No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	Bridgewater Community Healthcare NHS Trust staff to be reminded of the importance of recording the details of significant adults on children’s records.	Named Nurse to develop 7-minute briefing on hidden adults within children’s sphere of contacts.	Share 7-minute briefing with the board.  Bridgewater 7-Minute Briefing -	An increase in the number of significant adults being recorded on children’s health records and the consideration of these adults in all child assessments.	Vanessa Woodall	31/08/2018	Action complete 08.01.21 At the point of handover of this action plan from the author of the Trusts internal IMR (VW) to the current Named Nurse (LS) it was recorded that this action was complete. Further update added by Sarah Wilson Head of

							Safeguarding. As a Trust we continue to encourage our staff to demonstrate professional curiosity regarding changes to household composition or adults entering into children's lives/sphere of contacts. Practitioners use either genograms or groups and relationships within our Electronic Patient Records (SystmOne) to record this information. This information is recorded as part of the new birth (a mandatory contact which forms part of the Healthy Child Program). On 21.09.20 the Head of Safeguarding completed a dip sample audit of all babies born in Oldham on the 01.08.20. The EPR of 13 children were reviewed. 4 children had a genogram within their EPR whilst all 13 children had details of household and extended family members/significant adults recorded within groups and relationships. As part of an ongoing programme of SystmOne training Practitioners are

							reminded of the need to review and update groups and relationships regularly and as a minimum at each core contact of the Healthy Child Programme.
2.	Bridgewater Community Healthcare NHS Trust staff to be advised to consider a continued offer of support to mother's whose children have been removed from their care.	Add to level 3 mandatory safeguarding children's training.	Slide added to L3 Training embedded below: 	Where appropriate, mothers to be offered continued support (or signposted to more relevant services) with their emotional and mental health after their children have been removed.	Vanessa Woodall	31/08/2018	08.01.21. This was incorporated into the single agency level 3 safeguarding children training delivered to Oldham Right Start and School Nursing Service from 21.12.20.
Cheshire & Greater Manchester Community Rehabilitation Company (CGM CRC)							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	Case Manager's (CM) practice in relation to child safeguarding and the actions required to support this needs to improve. CM needs to demonstrate sufficient child safeguarding activity on all cases.	CM's line manager to assure self of sufficiency of CM's practice in relation to child safeguarding by: • Dip sampling five cases where child safeguarding activity is required by 31.01.2019; • Identifying any further development work linked to CM's child	The following evidence to be produced to demonstrate delivery/ completion of this recommendation: • Dip sample findings; • Action/ development plan, if created;	The key outcomes of this recommendation are: • Evidence of sufficient child safeguarding practice on the part of CM; • Assurances for CM's line manager (and CGM CRC)	CM – CD Line Manager Dave Nixon	31/05/2019	Case Manager is no longer employed by the CRC. A review of practice was being undertaken with the Case manager and his new line manager at the point of him leaving the organisation. This was in the form of a performance improvement plan. In addition, across the CRC, a Quality assurance programme was rolled out

		safeguarding practice which may be required; • If further development activity/ learning is required, an action/development plan addressing the areas of concern to be created by 28.02.2019; If an action/ development plan is required, the actions within it to be completed by 31.05.2019.	Evidence to support the completion of learning contained within any action/ development plan created	that CM's child safeguarding practice is of a sufficient standard; • An evidenced improvement in the understanding & practice of CM in relation to child safeguarding in the event that an action/ development plan is required.			and each team has cases audited on a quarterly basis to provide assurances in relation to risk and safeguarding.
2.	CGM CRC to secure improvements in Adult Safeguarding practice across the organisation and across all operational grades of staff.	This will be achieved through: • The publication and dissemination of Adult Safeguarding Practice Guidance; Staff training/ awareness raising through the completion of E-Learning.	The following evidence to be produced to demonstrate delivery/ completion of this recommendation: • Safeguarding Adults Practice Guidance • Adult Safeguarding Practice Development Session May 2019	The key outcomes of this recommendation are: • Enhanced adult safeguarding practice across CGM CRC Assurances that staff have a clear understanding of the circumstances in which adult safeguarding	Community Director with Risk and Safeguarding lead Community Director with Learning & Development Lead	30/03/2019	This recommendation has been fully completed. Evidence to demonstrate this will be produced as requested.

			• Records showing staff completion of Safeguarding Vulnerable Adults e-Learning.	alerts should be raised			
3.	A review of the delivery of the Effective Management Oversight Meetings within the Oldham office to be undertaken. This should include working with the ISO and consideration of the EMO case tracker to ensure that all appropriate cases are reviewed under the EMO processes and that reviews are held with sufficient frequency. In addition to this, it is recommended that the quality of the management oversight delivered by IM should also be reviewed.	Observation and audit of: • The referral of tracking of cases into the Oldham EMO process; • The frequency of completion of EMO reviews; The quality of the management oversight delivered through the observation/ review of five EMO sessions.	The following evidence to be produced to demonstrate delivery/ completion of this recommendation: • EMO tracker Audit report completed in relation to EMO observation and the quality of management oversight which is delivered.	The key outcomes of this recommendation are: • Effective EMO arrangements within the Oldham office; Improved management oversight.	Community Director responsible for Oldham office	30/03/2019	This has been completed.

Children's Social Care – Oldham Council							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	To ensure that Children's Social Care has a robust Supervision Policy which forms part of Social Workers and Team Managers personal induction and training programme.	The Supervision Policy to be updated and ensure that briefings across the service are undertaken to ensure that all practitioners and managers are aware of the new supervision policy.	Dates of the briefing sessions	This will ensure that all cases have full management oversight through face to face supervision between manager and social worker and that areas of risks are identified early on.	Bernie O'Brien – Principal Social Worker	End of September 2018	The Supervision Policy was updated in May 2019 and refreshed again in November 2019. The Policy has been shared with all staff in Children's Social Care and Early Help. Our Annual Social Work Health Check evaluates the impact of supervision for individuals and our new HR system monitors the frequency of supervision. In May 2020, as part of the continuous drive for service improvement, we have launched Service Practice Standards for Children's Social Care and Early Help. We are now refreshing our Supervision Policy to ensure full alignment to these standards and Social Work England Continuing Professional Development regulations. Finally, we introduced a Children's Social Care and Early Help Induction

							Checklist in October 2019 which provides assurance that all new operational staff and managers are familiar with our Supervision Policy and our expectations of them.
2.	To ensure that Social Workers and Team Managers receive specific domestic abuse training focussing on assessments within this area. Social Work Practitioners have access to an assessment tool which they can use.	Training to be delivered to all Social Workers and Team Managers.	Dates of the training session will be provided.	This tailored training will ensure that assessments capture the impact/risk posed by domestic abuse and increase the level of understanding in this area.	Bernie O'Brien – Principal Social Worker	Sept 2018	The Council's IDVA Service has provided online training courses in respect of assessment and safety planning. All practitioners and managers are able to access training via the Safeguarding Children's Partnership Training Schedule on MARAC, the Domestic Abuse Foundation Course, which included a session specifically for social workers, Oldham's Domestic Abuse Strategy, the Impact of Domestic Abuse for Children and the role of the IDVA. All practitioners and managers have received training on, and understand, the DASH Risk Indicator Checklist.

							The Children's Social Care Single Assessment Tool enables social workers to capture both historic and presenting risks and strengths. Our ICT system, MOSAIC, captures Domestic Abuse as a category of risk.
3.	To widen the focus of the Assessment Skills Coaching Programme which has been commissioned to ensure that the importance of gathering information from all agencies, as well as the importance of sharing information with partners, is emphasised.	The Programme will commence in the next four weeks. The Coach to be spoken with to ensure the Programme includes a focus on information gathering and sharing.	Dates of the Programme will be circulated and all managers to ensure that the relevant Social Workers access the Programme.	Improved quality of assessments will lead to better planning and intervention which in turn will improve outcomes for vulnerable children and young people.	Bernie O' Brien – Principal Social Worker	Ongoing for 6 months.	An external trainer, Martin Calder, was commissioned to deliver the Programme for staff and managers within Children's Social Care. This was successfully completed within timescales.
4.	Briefing sessions to be held within Children Social Care and Early Help on the importance of case recording and ensuring key documents are placed on the individual files of	A Practice Direction to be circulated to all users of MOSAIC reminding all practitioners of the importance of copying key documents to other siblings.	To maintain a record of when the direction was distributed by the MOSAIC Team.	It will assist with accurate information being recorded on each child's record.	Denise Edwards – MOSAIC Change Lead	End of August 2018	This was completed in 2018. The MOSAIC process is currently being refreshed to provide a 'group-based' approach to enable a simplified inputting process without creating multiple case files for siblings.

	all children in the household.						The importance of recording is emphasised with our Practice Standards and monitored through management oversight, supervision, audit and performance monitoring processes.
5.	Social Workers to have a good understanding of where to find the related policies and procedures.	A reminder to be sent to all social workers in respect of the Tri.x procedures. To have a discussion with the Safeguarding board manager to ascertain whether any protocols are being used by agency partners when working with DA.	Date of the email sent will be provided. Date of the conversation and details of any actions from the conversation will be provided.	Practitioners to provide a far more robust service to victims of domestic abuse.	Bernie O'Brien – Principal Social Worker Anisa Patel – Service Manager (Quality and Performance)	End of August 2018	All policies and procedures for Children's Social Care and Early Help, residential homes and Oldham Safeguarding Partnership are now hosted on a Children's Social Care SharePoint site which is accessible to all staff and managers. The site also contains access to the Practice Standards and other Toolkits.
6.	If a re-referral comes in within nine months, then the team manager to have a full oversight and offer scrutiny and record their view on the case management system.	Team manager need to be reassured that a re-referral was not due to incomplete work or case closed prematurely.	Audit to ensure that this is taking place.	Ensure that cases are not closed prematurely.	Leanne Cooper – Service Manager (Front Door)	November 2018	All contacts and referrals into Children's Social Care and Early Help have management oversight from a Team Manager from the point of entry up to exit from the Service. The Team Manager records the analysis and rationale for decisions made on the child's case file. As part of Children's Social Care and Early Help quality assurance processes

							monthly audits are undertaken of children's case files and dip samples of re-referrals are regularly undertaken to ensure that practice is in accordance with standards and practice expectations.
Early Help IDVA Service – Oldham Council							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1	Case recording to be reviewed to make it fit for purpose to include action plans, analysis and clarity between fact and opinion, which include specific responses to vulnerability of both the victim and the perpetrator.	Completed when service moved.	Case notes, management oversight in case notes. New recording template.	Clear understanding of current and historic situation with case. Action plans that demonstrate what is being done and achieved. Management oversight of casework including decision making and analysis of circumstances to inform work.	Tanya Farrugia	June 2018 December 2020	Completed. IDVA case recording moved into Mosaic system in December 2020 which allows more effective recording of decision making and management oversight.
2	Systems for recording Early Help cases, which enable them to be made accessible for cross referencing information and	Process team to have access to the Flare database. Review DV referrals to bring in line with wider Early Help referral process	System access. Early Help cases where DV is present are cross referenced and recorded. Recording	Cases are cross referenced and joint work / information sharing considered.	Debbie Holland/Tanya Farrugia/ Maxine Foster/Positive Steps Managers	August 2018 December 2020	Completed. All Early Help recording including that for domestic abuse moved into Mosaic system so that early help it is far easier to identify where joint working is

	Early Help workers to contact central team if DV is reported during a piece of work for cross referencing.	Information passed to EH teams via team meetings of the requirement to check if DV becomes apparent.	System access.				taking place as it is all in the same system. Workers triaging in MASH have access to all workflows.
3	Clear process to ensure contact with DV victims is face to face where possible particularly at the early stages of work and repeat DV work with victims is considered where time has lapsed and there are vulnerabilities.	Discussion with IDVA team meeting and actioned as appropriate.	Recorded in case records. Case notes. Team meeting. Individual case discussions/ notes.	Help to improve engagement and impact of work. Reinforce learning, helping to ensure that work with victims has the intended impact.	Tanya Farrugia	July 2018 December 2020	Completed. Face to face contact undertaken as far as possible, but this has been more challenging to achieve under Covid-19.
4	A different approach based on a full assessment and therapeutic model once the initial safety plan has been completed and analysis of victims' understanding of the work carried out, to understand if they are able to implement strategies.	Actioned.	Recorded in case records.	Increase impact of work in order to build capacity of victim to safeguard themselves, address the harm caused by abuse and reduce the likelihood of further victimisation. Ability to identify any gaps where further action is required.	Tanya Farrugia	June 2018	Completed.

First Choice Homes Oldham (FCHO)							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	Safeguarding referrals are made in all cases where domestic abuse is perceived or reported.	A specific prompt relating to domestic abuse is produced on the ASB case management system in relation to noise cases to ensure that the officer has considered any safeguarding concerns or issues.	Request to ICT for completion of this prompt and confirmation that this has been done.	Identification of domestic abuse. Correct classification of cases.	Paula Field Community Legal Manager	30th September 2018	Completed.
		Where there is concern that there is an element of domestic abuse then the officer must make a Neighbourhood Manager aware and discuss whether a safeguarding referral is appropriate.	Copy of training material. Safeguarding log. ASB Policy & Procedure.	Identification and Safeguarding of vulnerable tenants.	Paula Field Community Legal Manager and all Neighbourhood Managers	September 2018	Completed. Process changed September 2018. Specific training delivered to Community Legal and Neighbourhood Officers 5th September 2018. DA training included in mandatory safeguarding training to all new FCHO staff. It is 3 yearly however this is being reviewed and is to be annual training.
		Mandatory training will be delivered to officers.				5th September 2018	Completed. Ongoing mandatory training for new starters.
2.	Sharing data internally is integral to robust management and decision making.	Develop a coded method of alert on our housing management systems against an individual to highlight	Completion by ICT team. Training materials.	Effective information sharing and safeguarding.	Julie Jones Neighbourhood Manager	30th September 2018	Ongoing - the alert system is under review. Internal teams are informed on a need to know basis of cases at MARAC.

		that they are vulnerable in relation to domestic abuse.					
		Where domestic abuse is identified, ensure that the case officer shares this information with key areas of the business such as Rents and Tenancy Support.	Training materials.	Effective information sharing and safeguarding.	Julie Jones Neighbourhood Manager	30th September 2018	Completed. Ongoing mandatory DV training for all new starters. Internal teams are informed on a need to know basis of cases at MARAC.
3.	Clear and simple definitions and trigger points disseminated throughout the business.	Mandatory domestic abuse training is delivered to all employees.	Training materials.	Increased awareness of domestic abuse and triggers.	Paula Field Community Legal Manager	Rolling programme with effect from July 2018	Completed and ongoing. Clear and simple definitions and trigger points disseminated throughout the business.
		DASH training is delivered to housing and tenancy support officers.	Training materials.	Identification of domestic abuse and process.	Paula Field Community Legal Manager	Rolling programme with effect from July 2018	Completed for all existing housing officers. Managers to ensure that new starters receive this from LSCB.
		Identify and introduce Domestic Abuse champions across the organisation for support, advice and guidance.	List of designated champions.	Support and advice to employees.	Julie Jones Neighbourhood Manager	July 2018	Completed. Designated Safeguarding Officers have been identified.
4.	Where a decision has been made to re-house a person and the reason for this is domestic abuse, the case will remain open and monitored until	Training delivered to Neighbourhood officers and Managers.	Training material.	Effective monitoring of cases where domestic abuse is identified.	Paula Field Community Legal Manager and Neighbourhood Managers	September 2018	Completed. Delivered 5th September 2018. Embedded through case reviews.

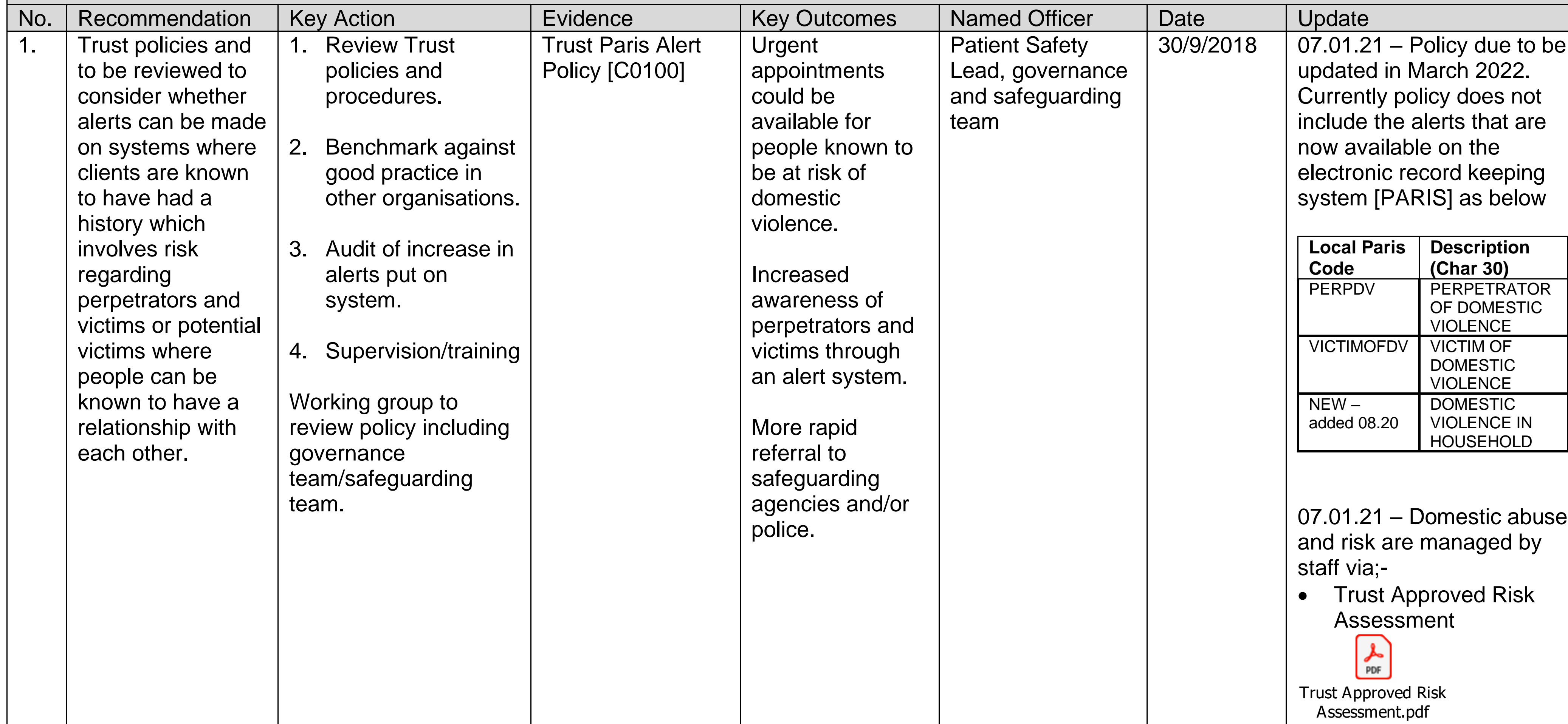
	they are re-housed or terminate their tenancy.						
Greater Manchester Police							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	All officers to be reminded to complete the relevant 'drop down box' when creating a PPI on GMP's computer system to categorise the Investigation Type.	Entry on the Electronic Bulletin System which is seen by all front line GMP staff when beginning their duty.	Information on Electronic Briefing System. Information on Police systems.	This will highlight investigation types, such as DVDS, on an individual's PPI history list and therefore should assist in the assessment of new PPIs and actions required.	Det Insp Cheryl Hughes	July 2018	Completed July 2018. Since then, iOPS has replaced OPUS as GMP's data system. January 2021 The Domestic Violence Disclosure Scheme policy has recently been submitted to GMP's Policy and Strategy team for rework. The revised policy has made a number of enhancements to ensure that Claire's Law is considered by safeguarding teams on every domestic abuse incident they receive. The revised policy has also re-instated that a Detective Inspector should review and authorise the form of words that is to be disclosed by the victim. iOPS has also made available a specific DVDS marker which will be

							applied to a person's record to reflect that they have made an application under Claire's Law. The information marker will denote whether a disclosure was made or not and where further information about the disclosure can be located. This will make it far more visible to all officers that there has either been concerns raised by an individual, a third party, or by GMP themselves. In 2019, the People and Development Branch delivered training to all neighbourhood police officers to raise awareness of the DVDS and their responsibilities to identify when a disclosure may be appropriate, as well as how to share information with the safeguarding team that will ultimately oversee the disclosure process. All new recruits are made aware of the background to the DVDS and the aims and objectives of the scheme.

							It is intended that when the revised policy is agreed, there will be accompanying training material to raise awareness of the key changes and of the process itself.
NHS Oldham CCG							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	Raise awareness of the available tools, guidance and referral options for victims of domestic abuse.	Deliver domestic abuse training for primary care staff. Discuss domestic abuse at the next safeguarding GP lead forum. Visit the 5 clusters and advise on the support services available. Circulate 7-minute briefing, with toolkit and guidance embedded. Provide supervision and support for primary care practitioners.	Training material. Agenda. Correspondence from cluster leads. Completed 7-minute briefing.	Increased awareness of domestic abuse, Oldham processes and Oldham services available to victims and families. Evidence of increasing number of referrals to domestic abuse services.	NHS Oldham CCG Safeguarding Team	Expected December 2018	Domestic abuse training has been delivered to primary care both within the Level 3 training sessions (regular sessions delivered throughout the year) and bespoke sessions within the clusters (delivered throughout 2019). Domestic abuse has been discussed within the safeguarding leads meetings since 2018. Any new information is shared with primary care within this forum. 7-minute briefing hasn't been developed at this time, due to awaiting final report and recommendations.

2.	A review of existing information sharing processes within primary care services where domestic abuse identified by the practice.	Request all GP practices to review their information sharing policies in relation to domestic abuse. Discuss at Safeguarding GP Lead forum, when and how to share information relating to domestic abuse. Reinforce the requirement to share information regarding domestic abuse at Primary Care assurance visits.	Correspondence from practices to confirm this is complete. Agenda. Completed assurance tools	Information will be shared with services in a timely manner.	NHS Oldham CCG Safeguarding Team.	April 2019.	The CCG devised information sharing guidance document for primary care in terms of safeguarding. Information sharing is discussed within the Level 3 training sessions as well as within safeguarding leads sessions. NHS Oldham CCG's safeguarding team reinforce the requirement to share information at Primary Care assurance visits
3.	Pilot domestic abuse screening within primary care.	Liaising with Leeds professionals to review their model. Identify pilot practices within Oldham. Start the pilot programme. Evaluate the pilot programme.	Report for LSCB/LSAB/DVPB with updates as the review progresses.	Increased awareness of domestic abuse. Evidence of increased referrals to specialist services. Increased training figures.	NHS Oldham CCG Safeguarding Team	April 2019.	The pilot has not progressed due to financial restrictions at this time.
Pennine Acute Hospitals Trust (Northern Care Alliance)							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update

1.	Level 3 adult safeguarding training to include domestic abuse.	Review training delivered and enhance domestic abuse information provided.	Training package Staff attendance and compliance.	Competent and skilled workforce.	Domestic abuse lead and safeguarding team	June 2018	Complete – level 3 training includes enhanced domestic abuse.
2.	Domestic abuse training to be provided for identified key areas/staff across all care organisation.	Domestic abuse training sessions to be provided for key areas e.g. A&E.	Training package Attendance figures Increased awareness by staff.	Competent and skilled workforce who recognise and raise concerns.	Domestic abuse lead and safeguarding team	September 2018	Complete – initial training provided and continues.
3.	DASH risk assessment training to be provided to key staff in identified areas	DASH risk assessment training to be provided to identified staff.	Attendance figures Number of DASH referrals received.	Competent and skilled workforce who make appropriate referrals.	Domestic abuse lead and safeguarding team	September 2018	Complete – initial training provided and continues.
4.	Review of domestic abuse policy.	Review of the group domestic abuse policy to provide consistency of approach across the care organisations.	A unified group policy.	A competent and skilled workforce Standards of practice across the care organisations and equity for patients.	Domestic abuse lead and safeguarding team	October 2018	Complete.
5.	Reminder to maternity staff of the necessity to	Domestic abuse highlighted as part of adults and children's	Staff undertake routine enquires of	Competent and skilled workforce who recognise	Named Midwife and safeguarding team	August 2018	Complete.

No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
	ask all patients if they are experiencing or at risk of domestic abuse – routine enquiry.	level 3 safeguarding training. Reminder to be cascaded to maternity staff via Named Midwife.	patients and this is audited.	and raise concerns.			
Pennine Care NHS Foundation Trust							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	Trust policies and to be reviewed to consider whether alerts can be made on systems where clients are known to have had a history which involves risk regarding perpetrators and victims or potential victims where people can be known to have a relationship with each other.	1. Review Trust policies and procedures. 2. Benchmark against good practice in other organisations. 3. Audit of increase in alerts put on system. 4. Supervision/training Working group to review policy including governance team/safeguarding team.	Trust Paris Alert Policy [C0100]	Urgent appointments could be available for people known to be at risk of domestic violence. Increased awareness of perpetrators and victims through an alert system. More rapid referral to safeguarding agencies and/or police.	Patient Safety Lead, governance and safeguarding team	30/9/2018	07.01.21 – Policy due to be updated in March 2022. Currently policy does not include the alerts that are now available on the electronic record keeping system [PARIS] as below **Local Paris Code** – **Description (Char 30)** PERPDV – PERPETRATOR OF DOMESTIC VIOLENCE VICTIMOFDV – VICTIM OF DOMESTIC VIOLENCE NEW – added 08.20 – DOMESTIC VIOLENCE IN HOUSEHOLD 07.01.21 – Domestic abuse and risk are managed by staff via;- • Trust Approved Risk Assessment  Trust Approved Risk Assessment.pdf

							• Individual clinical supervision • Zoning meetings • Use of the DASH risk assessment – available to staff via the Trust intranet • Access to Safeguarding Team for advice support and guidance – 25 consultations where DA primary reason recorded from Oldham services to the Trust Safeguarding Team between Jan-Dec 2020. 07.01.21 – update • March 2020 Domestic Abuse added to Trust incident reporting system as a specific cause code. March – Dec 20 –2 DA incidents have been recorded by Oldham services on the reporting system. [It should be noted that DA can feature in other incident cause codes such as adult safeguarding and physical assaults].
2.	Trust mandatory training requirements are	Trust to review whether specific domestic violence training needs	New training package	More referrals made to safeguarding	Workforce and development team	01/07/2019	• Jan/Feb 2019 – bespoke Toxic Trio

	reviewed with regard to having specific domestic violence training as a mandatory requirement for all clinical staff.	to be mandatory and to identify an appropriate domestic violence training programme which could be used. Via learning and development and how many staff have accessed training. Allow staff capacity to be trained. Staff need to be released to complete the training so future business plans would need to take this into consideration when staff are released.	Meeting minutes	teams/domestic violence agencies/police. More trust incidents would be submitted. Better patient outcomes.			Training delivered to CMHT and EIT. • Dec 2019 – Trust wide Learning Event - Older Adults - Domestic Homicide, Coercion and Control & Implications for Practice. • Trust 2019 Safeguarding Annual Report identified as a priority - Establish support and guidance for staff to be able to routinely enquire about domestic abuse and be confident in how to manage when there is a disclosure to ensure this is able to be evidenced in a robust way. • DA included in mandatory safeguarding children and adults training. • DA Awareness Survey completed with staff November 202 – Results will be available Jan 21.

							• DA awareness training to be rolled out within the Trust in 2021.
Turning Point **NB: Replaced ADS/One Recovery as local provider post-homicide/DHR and have provided information to reflect current offer in consideration of the ADS/One Recovery recommendations which were contained within the IMR.**							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	
1.	ADS will ensure that a briefing session on the details of the Domestic Abuse policy and procedure is delivered to all staff to remind them of its content and to ensure staff fully understand their responsibilities in respect of the policy & Procedure in particular regarding multi-agency communications, referrals and assessment.	Subsequent to Turning Point commencing the contract for drug and alcohol services in April 2018 a number of actions have occurred. The appointment of a dedicated safeguarding lead and point of contact in relation to Domestic Abuse; Learning sets occur regularly; Complex / high risk multi-disciplinary meetings are in place. Regular attendance at multi agency forums. Policy updates are cascaded via regular staff newsletters from the safeguarding lead including domestic abuse. This lists the appropriate organisations to	Safeguarding Lead in post. Policy/ Procedure updates are regularly cascaded via email; team meetings and learning sets. Domestic Abuse issues are captured in risk assessment and care planning procedures. Cascade of the staff newsletter amongst the service. Staff sign to state that they have read TP policies and procedures. Adult safeguarding training was completed on transfer and is regularly reviewed	Clearer policy. Staff are better informed and equipped to deal with issues. More effective multi agency working and communication channels. .	Jacqueline Hall	12/01/2020	

		contact in respect of the specific issues.	and monitored centrally to ensure updates. Appropriate forums exist to discuss challenging cases internally and representatives attend the external complex case panel on a regular basis.					
2.	Staff within ADS will be reminded of their responsibility to follow up all referrals to other agencies and then liaise regularly to monitor attendance, engagement and outcomes via an e-bulletin and this will be an agenda item on all upcoming team meetings.	Follow up and multi-agency liaison is a key aspect of partnership arrangements put in place. We arrange and attend MDT meetings where we would expect cases such as this to be discussed and actions chased. Follow up of external referrals from TP is seen as good/expected practice and is embedded via supervision and team meetings.	Client case notes. Attendance at complex case discussions. Minutes of MDT meetings.	Improved inter agency case management and transfers process. Improved information sharing between agencies. Improved engagement of clients with a range of agencies and support.	Stephen Samuels	12/01/2020		

3.	Lengthy gaps between appointments should not occur in services. Either the care plan is complete and sufficient progress is made to warrant a discharge or further work is necessary and should be planned to closely follow other work completed. This expectation will be communicated to existing services.	An active case management approach is taken with all cases reviewed and the length of time between contacts monitored down to worker level. This is discussed in supervision sessions and team meetings and closely monitored. Additional challenges are being faced in this respect under the pandemic, but we are prioritising maintaining sufficient contact with higher risk individuals.	Turning Point generates a 'No Contact report' detailing where there has been an undue length of time between client contacts (EG 4 weeks +). Turning Point has a Positive Re-Engagement policy detailing steps to be undertaken by workers, and if necessary, clinicians, to promote attendance and engagement in treatment programmes.	A close system of governance and monitoring is in place to maintain regular contact with clients and a prioritisation of higher risk clients. Partner agencies are better informed if there is non-attendance/ engagement and if clients DNA agreed sessions. Systems exist and are utilised to ensure a multi-agency approach when high risk individuals disengage, and concerns remain.	Stephen Samuels	12/01/2020	
4.	Where other agencies are involved in the care or support of a service user attending ADS services, ADS will no longer discharge that person from our	As above – 'unplanned discharges' are subject to scrutiny by managers via supervision and team meetings. In particular where there are clients of concern, we routinely encourage contact with	Client records. Team meeting minutes. Supervision minutes. Re-referrals data, which will highlight the number of clients who re-refer to the service	Better retention of complex clients. Improved re-referral of discharged clients. Ultimately, the actions listed and implemented by Turning Point are	Stephen Samuels	12/01/2020	

	service without first liaising with other organisations outlining any progress made or issues that have not been addressed. Where organisations have significant concerns regarding our plans to discharge, we will not progress with discharge until those organisations have had an opportunity to speak to the service user and encourage continued engagement.	agencies also involved with the client to seek ways of promoting re-engagement with ourselves prior to discharge. It is made clear to partner agencies that should a situation change they can always re-refer an individual for drug/alcohol treatment.	following discharge.	aimed at keeping our clients safe and well.			