EAST SUSSEX SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the homicide of 'Julie'

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Abbreviations

CSP: Community Safety Partnership
CCG: Clinical Commissioning Group
CRC: Community Rehabilitation Company
DASH: Domestic Abuse, Stalking and Harassment and Honour-based violence risk identification, assessment and management model
DHR: Domestic Homicide Review
DVPO/DVPN: Domestic Violence Protection Order/Domestic Violence Protection Notice
GAD: general anxiety disorder
GDPR: General Data Protection Regulations
GP: General Practitioner
HMPPS: Her Majesty's Prison and Probation Services
IDVA: Independent Domestic Violence Advisor
IMR: Individual Management Review – reports submitted to the review by agencies
IDVA: Independent Domestic Violence Advisor
MAPPA: Multi-Agency Public Protection Arrangement
MARAC: Multi-Agency Risk Assessment Conference
PCLDS: Police and Court Liaison and Diversion Service
RAR: rehabilitation activity requirement
SCARF: Single Combined Assessment of Risk
ONS: Office for National Statistics
VAAR: Vulnerable Adult at Risk Assessment

Glossary

Evidence-based prosecution: where a prosecution can proceed without the victim giving evidence if there is sufficient evidence surrounding the events to provide a realistic prospect of conviction
Section 117 of Care Act 2014 places an enforceable duty on health and social care to provide aftercare services to a patient on discharge from hospital with the aim of preventing a deterioration in their mental disorder.
Single Combined Assessment of Risk Form (SCARF) Within East Sussex, this assessment amalgamates risk assessments for vulnerable people, including Domestic Abuse, Stalking and Harassment and Honour Base Abuse (DASH) and Vulnerable Adult at Risk (VAAR). SCARFs are triaged by the MASH and shared with partner agencies as appropriate, helping partners build a complete picture and identify any concerns or emerging problems which may require intervention.

- If the SCARF risk is standard and there have not been two previous incidents in the past 12 months, the SCARF is filed within police records and accessible to all staff.
- If there have been two or more incidents in the past 12 months, the SCARF is referred for consideration to be taken to MARAC.
- If the SCARF risk is medium or high, it is sent to Health and Social Care Connect and the Portal's Independent Domestic Advisor Service
- If the SCARF risk is high, the case is sent to MARAC

Preface

Members of the review panel offer their deepest sympathy to the family and to all who have been affected by the victim's death.

The Chair would like to thank the panel and contributors for their commitment to the review and to improving services for victims of domestic abuse.

Contents

1. Introduction

1.1 Background

1.1.1. This review concerns the circumstances leading to the homicide of a 47-year-old woman by her partner who had a history of serious violence and domestic abuse.

1.2 Aim and Purpose of a domestic homicide review

1.2.1 Domestic Homicide Reviews (DHR) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom they were related or with whom they were or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

1.2.2 The purpose of a DHR is to:

" a. establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b. 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;
c. apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e. contribute to a better understanding of the nature of domestic violence and abuse; and
f. highlight good practice" (Multi-Agency Statutory Guidance 2016, para 7)

1.2.3 As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should

"articulate the life through the eyes of the victim…The key is situating the review in the home, family and community of the victim and exploring everything with an open mind" (Multi-Agency Statutory Guidance 2016, paras 8 and 9).

1.2.4 Hence, the key purpose for undertaking a domestic homicide review is to enable lessons to be learned where a person is killed as a result of domestic violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.3. Timescales

1.3.1. The homicide occurred in July 2018 and the decision to undertake a review was made by the Chair of East Sussex Safer Communities Partnership in consultation with affected agencies in October 2018. The Home Office was notified of the decision on 29th October 2018.

1.3.2. The review commenced after criminal proceedings had completed in February 2019. The review was delayed in its conclusion as a result of national arrangements to contain the spread of the Covid-19 pandemic. Nonetheless, the panel met three times. All panel meetings were minuted and all actions agreed for the panel have been tracked and completed.

1.3.3. The panel considered and agreed the draft Overview Report in May 2020 and the final Overview Report was endorsed by the Community Safety Partnership in November 2020, after consultation with the victim's family, prior to submission to the Home Office.

1.4. Confidentiality

1.4.1 This Overview Report has been anonymised in accordance with statutory guidance. In order to protect the identity of the homicide victim, her family and significant others, hereinafter, the victim will be referred to using the pseudonym 'Julie'[1].

1.4.2 Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the family's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

2. Terms of Reference

2.1. Methodology

2.1.1. The review followed the methodology required by the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (HM Government, 2016a).

2.1.2. Twenty-seven local agencies were notified of the death and were asked to examine their records to establish if they had provided any services to Julie or the perpetrator and to secure records if there had been any involvement. Fifteen agencies were found to have relevant contact with Julie or the perpetrator. Twelve local agencies had had no relevant contact.

2.1.3. Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author and agree the make-up of the multi-agency review panel.

2.1.4. Sussex Police provided the findings from the criminal investigation and provided details of the family who were to be invited to engage with the review.

2.1.5. The terms of reference for the review were drawn up by the Independent Chair, together with the panel, incorporating key lines of enquiry and specific questions for

[1] This pseudonym was provided by the victim's family

individual agencies where necessary. It was identified that ten agencies were to provide Individual Management Reviews (IMRs) and chronologies analysing their involvement, and a further five agencies were to provide information reports due to the brevity of their involvement. Briefings were made available for IMR authors by the Independent Chair in order to support the report authors in their task and maintain the focus of the key lines of enquiry.

2.1.6. All reports were written by authors who were independent of the delivery of services provided. Wherever possible, report authors presented their findings to the review panel in person and, where necessary, were asked to respond to further questions. The individual agency reports concluded with recommendations for improving their own agency policy and practice responses in the future and informed the multi-agency and thematic recommendations which followed.

2.1.7. The Independent Chair authored the Overview Report after consultation with Julie's family, and each draft was discussed and endorsed by the review panel before submission to the Community Safety Partnership.

2.2. Involvement of Family and Friends

2.2.1. Julie's family[2] were notified about the review in writing by the Independent Chair of the review. They were also provided with Home Office explanatory leaflets and leaflets from the support agencies Advocacy After Fatal Domestic Abuse and Victim Support Homicide Service. As a result, they took the opportunity to meet with the chair and comment on the draft terms of reference and were updated as the review progressed. The findings of the review were discussed with the family and the draft report shared prior to submission to the Home Office. The family were satisfied that the review had been thorough and incorporated their concerns.

2.2.2. Following consultation with his psychiatrist, the perpetrator was invited to engage with the review, but he did not return contact and was therefore deemed to have declined

[2] Details of family member(s) involved have been redacted for the purpose of confidentiality

engagement. Given that the perpetrator had a history of high-risk domestic abuse towards his previous partner, consideration was given to enabling her involvement in the review, but due to reasons of sensitivity and risk, this was not considered proportionate. Details of the perpetrator's previous domestic abuse and offending history nonetheless feature within the review.

2.2.3. As Julie lived in a small close, her neighbours were also written to, with accompanying Home Office explanatory leaflets, but they did not respond. Consideration was given to contact with the Julie's former work colleagues, but several years had elapsed since she last worked, and she had not worked within the time period considered within this review.

2.3. Independent Chair and Author

2.3.1 The Independent Chair and Author is Paula Harding, an Associate Chair with the charity, Standing Together Against Domestic Abuse. She has over twenty-five years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years she was a local authority strategic and commissioning lead for domestic abuse and violence against women and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office, *Conducting a Homicide Review,*[3] as well as undertaken accredited training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

2.3.2 The review was managed and administered by Standing Together Against Domestic Abuse, hereinafter referred to as Standing Together, which is a UK charity bringing

[3] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

communities together to end domestic abuse. It promotes the adoption of the Coordinated Community Response (CCR) Model across the country. This model is based upon the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the domestic homicide review process since its inception, chairing over seventy reviews to date and bringing expertise and support to the Independent Chair and the review.

2.3.3 Beyond domestic homicide reviews, the Chair has no connection with East Sussex Safer Communities Partnership or any of the agencies involved in this case.

2.4. Members of the Review Panel

2.4.1 Multi-agency membership of this review panel consisted of senior managers and designated professionals from the key statutory agencies and all were independent of the case.

2.4.2 Wider matters of diversity and vulnerability were considered when agreeing panel membership. Change Grow Live (CGL) provides the local domestic abuse service and therefore brought particular expertise on domestic abuse and the 'victim's perspective' to the panel. CGL also provide the local substance misuse services and enabled another panel member to provide expertise on drugs and alcohol which were pertinent to this review.

2.4.3 The review panel members were:

Name	Role/Organisation
Paula Harding	Independent Chair
Alison Cooke	Named Nurse Adult Safeguarding, Sussex Community NHS Foundation Trust

Bryan Lynch	Deputy Director of Social Work, Sussex Partnership NHS Foundation Trust
Debbie King	The Portal (multi-agency domestic and sexual abuse service), Change Grow Live
Domenica Basini	Assistant Director for Safeguarding and Quality, NHS England
Gillian Field	Designated Nurse Safeguarding Adults, Sussex Clinical Commissioning Groups
Julie Wooderson	Detective Sergeant, Safeguarding Reviews, Strategic Safeguarding Team, Sussex Police
Lee Whitmore	Assistant Chief Probation Officer, Kent Surrey and Sussex Community Rehabilitation Company
Rosalind Green	East Sussex Adult Social Care, Professional Lead for Social Work
Lindsay Adams	Strategic Commissioner for Domestic Abuse and Sexual Violence, East Sussex County Council
Micky Richards	Director, East Sussex Change Grow Live
Natasha Gamble	Partnership Officer for Domestic, Sexual Abuse and Violence, Joint Domestic, Sexual Violence & Abuse and Violence Against Women & Girls (VAWG) Unit, Brighton & Hove and East Sussex County Council
Paul Cotton	Southern Housing Group

2.5. Time period and key lines of enquiry

2.5.1. The panel agreed that the review should focus on the contact that agencies had with Julie and the perpetrator during the period from March 2016, when the perpetrator's domestic abuse towards Julie was first reported to the police, until the homicide in July 2018. Information about earlier times was included for contextual information only.

2.6. Individual Management Reports

2.6.1 Chronologies and Individual Management Review (IMRs) were requested from the following organisations:

- Clinical Commissioning Group (in respect of primary care services)
- Change Grown Live (CGL) Domestic Abuse Portal

- East Sussex Healthcare NHS Trust
- East Sussex County Council Adult Social Care Services
- East Sussex County Council Safer Communities Team
- Hyde Housing Group
- Kent and Sussex Community Rehabilitation Company (to incorporate National Probation Service response)
- Sussex Community NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- Sussex Police
- Southern Housing Group

2.7. Agencies without contact

2.7.1 The following agencies were contacted but confirmed that Julie or the perpetrator were either not known to them, or that their involvement was not relevant to this review:

- Eastbourne Borough Council
- East Sussex County Council Children's Services
- Hastings District Council Housing Services
- Home Works (housing support service in East Sussex)
- Lewes District Council Housing Services
- Maidstone and Tunbridge Wells NHS Trust
- Optivo (social housing provider)
- Refuge (domestic abuse services)
- Sussex MAPPA
- STAR (substance misuse services in East Sussex)
- SWIFT Specialist Family Service
- Victim Support

2.8 Definitions

2.8.1 The Government's definition of domestic violence and abuse, which sets the standard for agencies nationally was applied to this review:

> *"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: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*" (HM Government, 2016a).

2.8.2 At the time of writing, the Government has committed to enacting domestic abuse legislation (Home Office, 2020). The Domestic Abuse Bill 2020 seeks to provide a legal definition of domestic abuse and one which incorporates economic abuse, which is relevant to this case. Whist yet to be defined in law, economic abuse is understood to include, "behaviours that interfere with the ability to acquire, use and maintain economic resources" (Sharp-Jeffs, 2017:6).

2.9 Parallel Reviews

2.9.1 As well as criminal proceedings, Sussex Partnership NHS Foundation Trust undertook a Serious Incident Review of their involvement in this case. Kent, Surrey and Sussex Community Rehabilitation Company also undertook a Serious Further Offence Review to cover both the public and private aspects of the probation response. Each of these reviews informed this domestic homicide review.

2.10. Equality and Diversity

2.10.1 The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010[4], as well as to wider matters of vulnerability for both the victim and the perpetrator.

2.10.2 Julie was a forty-seven-year-old, white British woman and mother of two grown-up children. She was reported to suffer from anxiety and sleep disturbance, and at one-point, self-reported paranoid thoughts and self-harm. As time went on, her mental health was reported to have prevented her from working, although it was not subject to any treatment beyond primary care. She also experienced problematic drug and alcohol use.

2.10.3 The perpetrator was fifty years of age when he committed the manslaughter. He is of white British ethnicity and has a long history of mental illness and problematic substance use. He had been diagnosed with schizophrenia and experienced psychotic episodes when unwell.

2.10.4 Mental health and problematic substance use were therefore considered within the review in respect of both the victim and perpetrator. Other matters of faith and sexuality were not perceived to raise any issues for either party. However, the Panel considered that issues of sex and gendered violence required specific consideration. Domestic abuse and domestic homicide are considered to be, most often, gendered crimes (Stark, 2007). In the three years before Julie was killed, the majority (seventy-four per cent) of victims of domestic homicides in England and Wales were female (ONS, 2019). The significance of sex and gendered violence should, therefore, always be considered in a domestic homicide review.

2.10.5 Whilst Julie was not formally recognised as a carer, she undertook a range of caring responsibilities for her partner which included attending mental health appointments

[4] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

with him and alerting professionals when his mental health was deteriorating. Caring responsibilities also have a gendered dimension. Sharma et al (2016) recognised that women are the predominant providers of informal care for family members with chronic medical conditions and adults with mental illnesses. This research recognised there are societal and cultural expectations of women to adopt the role of a caregiver, but these norms and demands do not protect women from the emotional, physical and financial stress that may ensue (Sharma et al, 2016:8).

2.10.6 The Review applied an intersectional framework in order to understand the lived experiences of both victim and perpetrator. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their community.

2.12. Dissemination

2.12.1. The following individuals and organisations will receive copies of this review:

- Julie's family
- East Sussex Community Safety Partnership and its agencies
- Sussex Police and Crime Commissioner
- Standing Together Against Domestic Abuse Domestic Homicide Review Team

3. Background

3.1. Persons involved in this review

Julie's background

3.1.0. Julie was adopted as a baby and became one of four siblings in her adoptive family. Finding out that she was adopted appeared to have impacted upon her badly and unlike her siblings, she left school early. She also started her own family relatively early, beginning a long-term relationship and having two children. However, she was described as struggling to settle, she started drinking and taking drugs and her relationship with the children's father eventually broke down.

3.1.1. Despite her challenges, Julie has been described as bright, intelligent and capable. She was very gregarious, full of life, very much enjoyed social occasions and had a 'wicked' sense of humour. She also worked hard as a care-worker and was well liked at work. Prior to her relationship with the perpetrator, Julie had always been financially independent and self-reliant.

3.1.2. Julie met the perpetrator through an ex-partner in 2013 and, after beginning the relationship, it was noted that there was a marked difference in her life: she became less stable; no longer worked; relied on welfare benefits and generally had no money. Although her relationship with her family had always been episodic, she gradually lost contact with her friends and family and became much more insular and isolated.

3.1.3. She also became alienated from her (grown-up) children after her relationship with the perpetrator began. The police were aware of an incident involving one of her children assaulting both their mother and the perpetrator in 2013, indicating an early breakdown of Julie's relationship with her children. Julie declined support from domestic abuse services at that time.

The perpetrator's background

3.1.4. The perpetrator worked in the building trade and has an extensive history of serious violent offending, mental illness, alcohol and substance misuse. As a young man, he had been involved with an extremist skinhead group and was convicted of grievous bodily harm at the age of 21. Thereafter, he acquired an extensive forensic history and criminal record. His substance misuse began as a teenager and included cannabis, Amphetamines, cocaine and alcohol.

3.1.5. He had been abusive throughout his previous long-term relationship and was reported to have tried to suffocate his ex-partner a number of times. On the last attempt, she was losing consciousness before the perpetrator was stopped by another member of the family. It transpired that he often threatened to suffocate his ex-partner and was arrested for assaulting her in this manner in 2008, but no further action was taken, and his ex-partner took out a non-molestation order herself. In the same year, he had tried to strangle a fellow offender whilst in prison.

3.1.6. The perpetrator breached the order when he was found outside his ex-partner's house with a container of petrol, threatening to set fire to the car unless she went outside. When the police arrived, they found him wearing a stab-proof vest with a Stanley knife in his pocket and a machete around his waist. He claimed these were for his own protection. He was detained and found to have symptoms of paranoid psychosis.

3.1.7. Whilst in prison, his serious violence to staff and fellow prisoners continued and he was placed in segregation and identified as being at high risk of self-harm or suicide. However, the degree of his threat to others meant that 6 prison officers were needed to be present at all times to safely unlock his cell. He was later transferred to a high-security psychiatric hospital where he was diagnosed with an 'acute and transient psychotic episode' and with persecutory beliefs regarding his family.

3.1.8. After two years of treatment and latterly, escorted leave, he was discharged under a Community Treatment Order in 2011, with a non-molestation order protecting his ex-partner and children in place. He continued to have regular treatment from community mental health services in London, until he was discharged back to the care of his GP in

2015. He appeared to have relocated to Sussex in 2016 after having been in a relationship with Julie for approximately three years.

3.2. The homicide

3.2.1. The perpetrator killed Julie by smothering her. He then went on to try to conceal her body by trying to enlist the help of an estranged family member who called the police.

3.2.2. When he was tracked down by the police, he displayed bizarre and violent behaviour and, as a result, a psychiatric assessment was conducted through the hatch door of the cell by a consultant psychiatrist. However, during the assessment, he managed to punch the doctor in the face through the hatch. He was declared fit for interview and detention.

3.2.3. The perpetrator pleaded manslaughter on the grounds of diminished responsibility and was sentenced to life imprisonment with a minimum of 9 years. The court imposed a hospital order under S.45a Mental Health Act 1983, and he was sent to a high-security psychiatric hospital.

4. Chronology

4.0 The following sequence of events represents the Independent Author and Panel's view of significant events concerning Julie and the perpetrator.

4.1 The perpetrator's unprovoked violent assaults in March 2016

4.1.1 At the end of March 2016, the perpetrator was arrested for aggravated vehicle taking and assault, having made unprovoked violent assaults on members of the public. Due to his extremely hostile presentation during arrest, Sussex Police undertook a welfare visit to Julie who stated that he had been behaving very oddly for a few days but that he had never been violent towards her and she was not in fear. A standard risk Single Combined Assessment of Risk From (SCARF) was submitted to Adult Social Care that day. The SCARF incorporates the Domestic Abuse, Stalking and Harassment risk assessment.

4.1.2 The police revisited Julie the next day and she further described the breakdown in the perpetrator's mental health and that she was suffering from depression herself. She said that she was concerned that a mental health nurse was no longer visiting or monitoring him and was worried about his returning home whilst still being ill, although she did not want to separate from him in the long term. The officer advised Julie how to contact the National Centre for Domestic Violence, who provide assistance in gaining non-molestation orders, and advised her to contact her housing association, who had no record of being contacted by her in this regard, as well as the perpetrator's mental health nurse. Her risk level was increased to medium risk and a new SCARF was sent to the Multi-Agency Safeguarding Hub (MASH), Adult Social Care and CGL's Independent Domestic Violence Advisor (IDVA) service, known as The Portal.

4.1.3 The Portal received details from the police about the perpetrator's violent background, deteriorating mental health as well as his odd behaviour which included him wanting Julie to have sex with other men in the woods. However, she declined the domestic abuse support that was offered to her at the time.

4.1.4 The perpetrator was remanded in HMP Lewes where he presented as highly aggressive towards court and prison staff. His behaviour initially prevented a comprehensive assessment of his mental health needs from being undertaken. However, based upon his previous history, it was considered by mental health services that he was exhibiting signs of an acute psychotic episode and was treated with depot medication, which is slow-release anti-psychotic medication administered by injection.

4.1.5 In August 2016, the perpetrator pleaded guilty to a number of offences and he was sentenced to a 16-month custodial sentence and a driving ban. At this point, the perpetrator had convictions for 8 offences, all of which were violent including grievous bodily harm (1986); assault of a man with an iron bar (2006); assault of his former partner by grabbing her round the throat and smothering her (2008) and possession of an offensive weapon (2011).

4.2 Home Detention Curfew was not supported

4.2.1 At the end of September 2016, HMP Lewes asked Kent, Surrey and Sussex Community Rehabilitation Company (CRC) to assess the perpetrator's suitability for being released on Home Detention Curfew, which is where an offender is released from prison at an earlier date but curfewed to their home address. The senior probation officer wrote and telephoned Julie, but she did not respond. Nevertheless, the perpetrator's release on Home Detention Curfew was not supported in view of his previous convictions for domestic abuse.

4.3 Julie struggled with paranoid thoughts, self-harm and self-neglect

4.3.1 During the perpetrator's time in prison, Julie attended for an assessment with the Health Assessment Advisory Service, who undertake assessments on behalf of the Department of Work and Pensions. They wrote to Julie's GP, reporting that she was having paranoid thoughts, struggling with her mental health and experiencing self-harm and self-neglect. The GP wrote and telephoned Julie inviting her for a medical review, but she did not respond. Also, whilst the perpetrator was in prison, one of Julie's close friends offered her somewhere to stay but she declined.

4.4 The perpetrator was released from prison: November 2016

4.4.1 The perpetrator settled in mood and behaviour but continued to be monitored by the Integrated Mental Health Team in prison until his conditional release on licence in November 2016 and was referred to the Forensic Liaison Outreach Service, who provide mental health services to low and medium risk offenders in the community. His licence was managed by Kent, Surrey and Sussex CRC and contained specific requirements to address his prolific offending by attending a Thinking Skills Programme for up to 20 sessions; to address his drug and alcohol problems at an approved centre, and to undergo drug testing.

4.4.2 Within the fortnight of the perpetrator's release, Julie attended her GP surgery for a routine blood pressure check. Previous concerns that had been raised with the GP about her mental health, self-harm and self-neglect were not discussed.

4.4.3 The perpetrator registered with the same GP in December 2016 and the GP made enquiries of his previous mental health team to determine and continue his treatment plan and provide monthly anti-psychotic medication by depot injection.

4.5 Disclosure to Julie was considered

4.5.1 The perpetrator met with his probation officer weekly and then fortnightly. One home visit was made by the CRC in January 2017, where Julie was also present. Whilst no concerns of domestic abuse were identified within this relationship at this stage, during the following month, the probation officer advised mental health services that Julie was aware of the perpetrator's previous violent history, whilst recognising that she may only be aware of her partner's version of events. The lead practitioner from Sussex Partnership encouraged the probation officer to consider making a disclosure to her and progressed this request with the probation officer two weeks later. The probation officer indicated that Domestic Violence Disclosure Scheme forms would be completed but there was no evidence that this was done.

4.5.2 The perpetrator was assessed by probation as posing a medium risk of serious unprovoked physical harm to staff, public and partners. Throughout the following months, the perpetrator's attendance at the GP Practice for his depot medication was erratic.

4.6 The perpetrator was discharged from mental health services: April 2017

4.6.1 In April 2017, the perpetrator requested that his depot medication be reduced by half due to the side effects, but this reduction resulted in him being resistant to having any medication and disengaging with the mental health service. A consultant psychiatrist visited in June and assessed that the perpetrator appeared to have a settled mental state despite not having taken any medication for six weeks and discharged him back to the GP with a crisis plan should he relapse. His anti-psychotic medication was stopped but he was to continue with anti-depressants. The GP was duly notified, but the GP later went on to write to Sussex Partnership Trust with concerns about the discharge having been premature[5]. The consultant responded to the GP advising that the perpetrator was mentally well at the time with no signs of relapse but had been clear that he would not engage with mental health services and that the Trust had no means with which to enforce his engagement. It was understood that the perpetrator would be continuing to see his GP to receive anti-depressant medication and thus, the detailed crisis plan would guide the GP should the perpetrator show signs of any relapse in his mental health.

4.6.2 The mental health team also notified the perpetrator's probation officer who, by this time, had changed and had reduced the requirements around the perpetrator's reporting frequency within his licence to monthly, although the rationale for this decision was not recorded.

[5] The GP wrote to Sussex Partnership NHS Foundation Trust after the next incident of an assault outside the GP surgery in October 2017.

4.6.3 One week after the perpetrator had been discharged from mental health services, Julie contacted the police advising them the perpetrator had held a knife to her daughter's[6] throat during an argument and threatened to stab her. By the time the police arrived, the perpetrator had packed a bag and left. Julie went on to describe the assault to the police, saying that she had to flee with her daughter into the garden, locking the doors behind her. Both the victim and her daughter declined to make statements, stating that they were concerned for his mental health. Julie had been trying to get him back onto the medication that she understood had previously been prescribed for him. Although the officer had initially recorded the risk as standard, risk was re-assessed by a supervisor, and a medium risk SCARF was submitted to the MASH that day. From the information that was available to the police, the police review reflected that the risk should have assessed as high and resulted in referral to MARAC. However, the risk was considered only medium at the time on the grounds that the perpetrator was in custody. Thereafter the police did not change the risk level when the perpetrator was released without charge.

4.6.4 Although the perpetrator was on licence and this was flagged on police records, probation services were not contacted by the police to advise about the arrest and potential breach of his licence conditions.

4.6.5 Once the SCARF was received at the MASH, the police administrator recorded the risk as standard, despite this not being within their remit to reassess risk. This had the effect of the assessment not being shared with Adult Social Care or the Portal domestic abuse service's Independent Domestic Violence Advisor (IDVA).

4.6.6 Two weeks later, in mid-July 2017, Julie sought advice from her GP about insomnia and was concerned that her night-sedative medication was being stopped. The GP advised on the risk of addiction and development of tolerance to the medication, and a reduction plan was agreed. However, there was no indication that outstanding

[6] Normal practice would be to redact the sex of children involved. However, domestic abuse towards the daughter should be seen in the context of gendered violence and her sex has therefore been included.

concerns around her mental health that were featured in her notes were discussed with her.

4.6.7 At the end of July 2017, the perpetrator's licence conditions ended, and he commenced a four-month period of Post Sentence Supervision[7]. Whilst the conditions of his supervision were similar to his licence conditions, probation services cannot recall a person to prison if individuals breach the Post Sentence Supervision conditions but have to refer to the Magistrates or Crown Court in much the same way as a breach of a Community Order.

4.7 Attempted strangulation, threats to kill and MARAC: October 2017

4.7.1 In October 2017, Julie contacted the police in the early hours of the morning, reporting that the perpetrator had tried to strangle her and kicked the dog. She said that she was afraid to go back into the house because she thought he would kill her. As well as punching her, she said that twice he had put one of his hands over her mouth and the other pinching her nose so that she could not breathe. She felt that the perpetrator had crossed the line and would support a prosecution as she did not want him to return, particularly as he had threatened to kill her if she called the police. The perpetrator was arrested, and probation were notified, who made an appointment to see him a month later, not responding to the urgency of the matter.

4.7.2 Later, on the day of the assault, Julie went to Uckfield Minor Injuries Unit complaining of having neck pain following an assault by her boyfriend. The Unit, which is staffed by nurse practitioners, made arrangements for her to be transported by ambulance to the Emergency Department to be seen by a doctor that evening. However, she was reluctant to wait for the ambulance and discharged herself against advice. Although

[7] Post Sentence Supervision is an additional period of supervision for the purposes of rehabilitation applied to those who are sentenced to prison and released for a period of under 12 months. The Post Sentence Supervision is an additional period to ensure that each person has a period of supervision in the community adding up to 12 months.

her disclosure of domestic abuse was not discussed, and no signposting information or safety planning provided, the Unit notified the GP.

4.7.3 On the following morning, the police returned to take a witness statement from Julie, as they had not been able to do so at the time of the incident whilst she was intoxicated. Julie then stated that she was certain that the relationship was over, but she declined to make a statement and no longer wanted to support his prosecution. The police assessed her as facing medium risk; completed a SCARF which was sent to Adult Social Care and the IDVA service; referred her to a police domestic abuse caseworker and flagged the case for MARAC as there had been two reports of domestic abuse within the last twelve months.

4.7.4 The perpetrator was charged with assault and criminal damage and bailed with the condition not to contact Julie in any way and to stay away from her home address. Consideration was given to issuing the perpetrator with a Domestic Violence Protection Notice, but as he was charged and served with bail conditions, the notice was not served. The bail conditions required the perpetrator not to contact Julie by any means or to visit the vicinity of her home.

4.7.5 As symptoms of neck pain and headaches persisted, Julie attended Eastbourne Accident and Emergency (A&E) Department the next day and disclosed domestic abuse to both the triage nurse and the attending doctor. She was found not to have a fracture and discharged without any discussion, safety planning or referral to services. However, the GP was notified of the domestic abuse in their discharge letter.

4.7.6 The Portal Domestic Abuse Service received a referral from the police indicating that Julie was facing medium risk. However, the Independent Domestic Violence Advisor asked the police to review their risk rating as they considered that the risk was high as Julie had told the police that she believed that the perpetrator would kill her, or that she would kill him in self-defence. The IDVA went on to try to contact Julie six times over the next three weeks but Julie declined their support and asked them not to contact her again.

4.7.7 A few days after the initial report, Julie contacted the Police to ask if the bail conditions could be dropped because she wanted the perpetrator to come home. She was advised about 'evidence-led' prosecutions that could be taken against violent offenders even without the witness statement and she asked what would happen if she said that nothing had happened. She was warned against lying but thereafter, provided a statement to the Crown Prosecution Service to say that nothing had happened and that she had made up the allegations in order to get him out of the house as she thought he was going to "kick off". The case was discontinued, and the perpetrator returned home.

4.7.8 Following CGL's request, the police reviewed their decision and agreed that Julie should have been considered high risk. This led to Julie's case being heard at MARAC nearly three weeks after the incident. At the MARAC, information was widely shared by agencies, including by the Hospital who reported that Julie had also attended the Emergency Department with a domestic abuse related head injury. Although Sussex Partnership did not attend, they had provided a written submission alerting the meeting to the escalation of risk when the perpetrator's mental health deteriorated. Information was also provided, although the source was not stated in records, indicating that Julie did not work due to her mental health; had rent arrears; felt isolated and had no friends and needed housing support. The actions from the MARAC meeting required that the police domestic abuse officer visited Julie with a letter from the Portal Domestic Abuse Service and that the IDVA was to continue to try to engage her. The Community Rehabilitation Company, as lead officer for the perpetrator, was to inform the Forensic Liaison Outreach Team of this further incident and request a further mental health consultation with the perpetrator. However, this does not appear to have been done.

4.8 Random assaults outside the GP Practice in October 2017

4.8.1 On the same day as the MARAC, the perpetrator attended the GP Practice as his mental health symptoms had returned and he spoke about not feeling safe at home. The GP contacted the mental health services, initially waiting for their Crisis Team to attend.

However, as time elapsed, an ambulance was called in order for him to be assessed at hospital. Whilst waiting for the ambulance, the perpetrator became very agitated and he violently attacked a number of members of the public outside the GP Practice. He went on to kick one of the victims to the head whilst the man was on the ground and broke the man's eye socket. As a result, the GP Practice de-registered him.

4.8.2 The perpetrator was arrested, and a mental health assessment was undertaken at the police station which determined that he needed to be detained, initially under section 2 of the Mental Health Act 1983. Although the clinicians and social worker undertaking the assessment were aware of his history of violent offences from the Police National Computer records that were provided to them, they were not aware of the domestic abuse or that the perpetrator was being considered at MARAC for the high level of threat that he posed.

4.8.3 Once the detention was assessed, a psychiatric bed was not available for him and the police inspector charged the perpetrator under emergency powers with the offence of affray in order to detain him further. Thereafter, the Police submitted his criminal prosecution file to the Crown Prosecution Service, detailing the seriousness of the injuries and advising that the hospital would take up to six weeks to prepare a formal witness statement. Charges of inflicting grievous bodily harm (Section 20 Offences Against the Person Act 1861) and assault by beating were authorised retrospectively by the Crown Prosecution Service. In the meantime, a bed had been located at Hellingly medium-secure psychiatric unit where he was treated with anti-psychotic medication and his detention was converted to section 3 of the Mental Health Act.

4.8.4 After admission, the hospital social worker contacted Julie and discussed the perpetrator's current inpatient admission and provided support around the perpetrator's debts by writing a letter for creditors. The hospital social worker was also not aware of the domestic abuse.

4.8.5 The perpetrator's mental health soon settled on medication and, by the time he was due to appear at court within the month, he articulated clearly that he did not wish to remain in hospital and would rather be sent to prison.

4.8.6 Although the injuries that the perpetrator inflicted on the passer-by were consistent with the charge of inflicting grievous bodily harm, he pleaded guilty to the lesser charges of 'assault occasioning actual bodily harm' and two offences of 'battery'. On the date that the perpetrator appeared before the court, the grievous bodily harm charge was not put. Whilst there was a note on file concerning the seriousness of the injuries, the medical evidence was not yet available.

4.8.7 The Magistrates Court did not require the National Probation Service to submit a pre-sentence report in this case, where a pre-sentence report would normally have provided the court with details of a person's background, current circumstances, offending history, risk of re-offending and risk of serious harm gained from the police, probation and other services.

4.8.8 The Magistrate's Bench considered that whilst the assault had inflicted a high degree of harm, the perpetrator's mental health allowed for some degree of mitigation. He therefore received a sentence of 26 weeks imprisonment which, with his early guilty plea, was consistent with the sentencing guidelines for the lesser charge. He was transferred to HMP Lewes to serve his sentence and the National Probation Service were required to allocate the case to either their service if the perpetrator was high risk, or to a Community Rehabilitation Company if not, within 48 hours of sentencing. In the absence of the information in a pre-sentence report, the National Probation Service assessed his risk of harm using the information provided by the Crown Prosecution Service. His risk was assessed as medium in line with the probation risk assessment that had been assessed earlier in the year and his case allocated to Kent Surrey and Sussex CRC with the stated expectation that their probation officer would review the risk assessment on receipt.

4.8.9 Whilst in prison he was discharged from in-patient mental health care with the plan for the Integrated Mental Health team to follow up and medication to continue, and his mental state remained well. However, his aftercare arrangements had not been stipulated under Section 117 (Care Act 2014) as they should have been. This would have had the effect of requiring assessment and, potentially, requiring services to meet his mental health needs after he was released from prison, assuming his needs continued after that time.

4.8.10 One month into his sentence, Kent, Surrey and Sussex CRC were asked to assess the perpetrator's suitability for early release under Home Detention Curfew. Another probation officer contacted Julie who denied that there were any concerns over domestic abuse and stated that she was happy for the perpetrator to return home. Nevertheless, the probation officer did not support Home Detention Curfew on the basis of the perpetrator's history of domestic abuse.

4.8.11 Prior to the perpetrator's release from HMP Lewes in February 2018, a Care Programme Approach (CPA) multi-agency meeting was held between the prison, health care and mental health staff. The perpetrator was clear that he did not want to engage with mental health services upon his discharge and did not want to accept any depot medication but agreed to take oral, anti-psychotic medication. However, there was not enough time left on his prison sentence to make this change so he would have to do this with his GP after his release.

4.8.12 The Forensic Liaison Outreach Service contacted the perpetrator's former probation officer to advise them of the high risk of his re-offending. Their own risk assessment required that mental health workers were only to meet with the perpetrator in pairs at their offices and not to offer home appointments due to the risks for staff.

4.9 Released from prison: February to July 2018

4.9.1 In February 2018, the perpetrator was released to his home address, with Julie, on licence despite the necessary checks not having been undertaken to assess whether it

was safe and appropriate for him to live there during his licence period. The probation risk assessment was completed prior to the probation officer meeting the perpetrator and was neither updated to include police information nor to include the risk assessment that had been provided by mental health services.

4.9.2 Alongside the standard licence conditions of his sentence, an additional licence condition was included requiring him to attend all mental health appointments and to cooperate fully with the care or treatment that they recommend. However, there was no licence condition added for him to address his substance misuse. Moreover, on the day of his release, the perpetrator had an induction meeting at his local probation office where his licence conditions were explained to him in detail and he signed a copy of his licence. However, on his copy of the licence agreement, the additional licence condition for him to attend appointments with mental health was absent. Whilst it was sent to him later, it is not known whether this important licence condition had been clearly communicated to him and mental health services did not appear to be aware that attendance was a feature of his licence.

4.9.3 Nevertheless, probation and community mental health services worked closely together to try to enable regular health checks. For example, mental health appointments were arranged alongside mandatory probation appointments. In response, the perpetrator frequently re-arranged his probation appointments and continued to be evasive with mental health services. Over the three months of his licence period, which ended in May 2018, the perpetrator only attended one office appointment and two telephone appointments with probation services, and had irregular telephone contact with mental health services, using his employment in the building trade in London as an explanation for not meeting with either service.

4.9.4 During this time, he was being encouraged by mental health services to register with a GP. Until he was registered with primary care, the Community Forensic Outreach Team were keen to ensure that he continued to take his anti-psychotic medication and delivered it through his door if he was not at home. Latterly prescriptions were sent to the pharmacy and the perpetrator picked up his medication from there.

4.9.5 In late March 2018, the perpetrator was invited to meet with his psychiatrist in order for prescribing to continue, but he declined due to work commitments and could not be directly contacted by the psychiatrist through home visit. Concerned by the lack of contact, the mental health lead practitioner contacted the probation manager, requesting a professional's meeting and enquiring whether he may be suitable for Multi-Agency Public Protection Arrangements (MAPPA). The CRC manager advised that the perpetrator did not appear eligible for MAPPA (Category 3) but would discuss with the probation officer whether he would be eligible for Integrated Offender Management (IOM).

4.9.6 Aside from occasional telephone contact, the mental health service were only able to see him in person once during the first four months after his release from prison, in February 2018. On this occasion, they visited him at home and took the opportunity to talk with Julie very briefly on her own and there was nothing in the short interaction that raised concern.

4.9.7 Julie was visited by her new social landlord at the end of April 2018. Southern Housing Group, a registered provider[8] of social housing, they had recently purchased the estate in which Julie lived, and the Home Service Manager was making visits to introduce themselves as the new landlord. The files from the former landlord stated that all residents had mental health issues and that the perpetrator was receiving injections to manage his schizophrenia. Aside from repairs issues, no discussion appears to have been held on other matters or other concerns raised. Julie only had a small amount of rent arrears at this time.

4.9.8 Close liaison continued between mental health and probation services and the Forensic Liaison Outreach Service were led to believe, after the perpetrator had failed to attend a meeting with the CRC in early May 2018, that a warning letter would be issued and breach proceedings would be commenced with the possibility of recalling

[8] The Regulator of Social Housing maintains a register of providers of social housing on behalf of HM Government.

him to prison if he failed to attend the next meeting. However, neither action appears to have been taken.

4.9.9 Once the perpetrator's licence period had ended at the end of May, he was made subject to a further post-sentence supervision period, with less enforcement powers, as before. His contact with mental health services remained evasive and he presented as agitated and aggressive with probation. The probation officer had discussed the case with their supervisor during May and before the licence period had ended and had not increased the frequency of meetings as instructed. Discussing again with the supervisor during the period of post-sentence supervision, in mid-June 2018, the probation officer had not undertaken police checks as would have been expected and appeared to minimise concerns over the perpetrator's presentation.

4.9.10 By May 2018, the perpetrator had been able to register with a new GP following and the consultant psychiatrist wrote to them including what was known about his forensic history and enclosing his risk assessment. The consultant also wrote to the perpetrator requiring him to confirm that he was still taking his medication; that he was willing to pick up his prescription from his GP and advising that the mental health team were not able to keep delivering prescriptions through his letterbox.

4.9.11 Attempts were made again to arrange joint meetings with probation and mental health services but by the end of June the perpetrator had become rude and offensive with the probation officer over the phone and thereafter failed to attend his office appointment two days before the homicide.

4.9.12 On the day before the homicide, the Forensic Liaison Outreach Service managed to make telephone contact with the perpetrator who reported that, although he had continued to take his medication, he was experiencing low mood, sleep disturbance and changes to his appetite. As a result, he had not been to work in the past few days and complained that his partner was not being supportive of him.

4.9.13 In view of these changes in his presentation, the perpetrator was invited for a mental health assessment to be held two days later. The assessment was to take place in a clinical setting in view of the risks associated with his mental health and previous offending behaviour. However, Julie advised the mental health team that she was very concerned about him and felt that he could not wait the two days and it was re-arranged for the following day. Julie advised that he was also due an appointment with the new GP on the following day, as a new patient. At some point within the following few hours, the perpetrator killed Julie before either appointment was held.

4.9.14 Whilst in custody, the perpetrator was assessed under the Mental Health Act and found fit to be detained and charged, although his mental health may deteriorate and require hospital treatment at some point.

5. Overview

5.0. This section considers the Individual Management Reviews (IMRs) and Information Reports completed by the individual agencies and the panel's contribution to their analysis.

Criminal Justice Agencies

5.1 Sussex Police

5.1.1 During the period in question, and prior to the murder, Sussex Police were called upon to respond to four reports of the perpetrator's violence to others, two of which were related to domestic abuse.

5.1.2 On the first occasion, although the perpetrator was being charged with assaults against others, Sussex Police made two welfare visits to his partner and it was on the second visit that she disclosed the perpetrator's worsening mental illness and its impact on his aggressive behaviour towards her. Returning for the second visit was therefore seen as good practice and this practice was repeated on the next occasion when domestic abuse had been reported.

5.1.3 Police officers completed SCARFs on the four occasions when it was appropriate to do so, increasing the risk level as more information was revealed by Julie, eventually assessing that Julie was facing medium risk for each incident involving the perpetrator. However, on the second occasion when the perpetrator had held a knife to Julie's daughter's throat, the officer responding initially assessed the risk as standard, failing to take into account the use of weapon, the threat to stab the daughter and the previous assessment. The supervisor only re-assessed the risk to medium, despite the use of a weapon indicating high risk, on the grounds that the perpetrator was in custody. Likewise, the third occasion involved strangulation, which the IMR author and panel considered to be an indicator of high risk, but was assessed again as medium, although the frequency of the reports enabled the case to be referred to MARAC as it should have been.

5.1.4 In order to strengthen the accuracy of risk assessments, Sussex Police have made a recommendation for themselves to conduct a qualitative review of Safeguarding

Templates. This will sit alongside the review of the DASH risk assessment within their wider review of the Force's approach to domestic abuse, including risk and partnership working.

5.1.5 It was noteworthy that there was no indication that the perpetrator's previous history of serious violence, domestic abuse and having been previously a MAPPA nominal, was known or taken into account in these risk assessments. The issue of risk and a lack of disclosure to Julie about her partner's history of violence will be considered further for all agencies in the thematic section which follows.

5.1.6 Having been released from prison under 12 months licence, the perpetrator's arrest on the second report in June 2017 should have been referred to the Probation Service to alert them to a possible breach of the licence conditions. Sussex Police were unable to interview the officer concerned but determined that this was an individual error rather than a common issue of police policy or process and therefore considered that it did not require a recommendation for the Force. As relevant staff were no longer available for interview, Sussex Police have been unable to account for the reasons why their administrator in the MASH downgraded the risk assessment in June 2017. The panel reflected on how this was missed by the Police within the MASH environment. They agreed that this also appeared to be an individual error and heard that there were generally sufficient checks and balances in the supervision and management of safeguarding arrangements in this setting. This view was consistent with those of other agencies represented on the panel.

5.1.7 Sussex Police took positive action, arresting the perpetrator on the two occasions where he had attacked third parties and successfully applying for him to be remanded in prison when he was not subject to detention under the Mental Health Act.

5.1.8 Sussex Police also took positive action for each of the domestic abuse reports involving the perpetrator and Julie and arrested the perpetrator each time. Unlike the first occasion where, without a witness statement there was an absence of evidence, on the second report, police officers had the benefit of wearing body-worn video devices and were able to record visible injuries to Julie and her dog. As a result of this video

evidence, they were able to obtain authority to charge the perpetrator despite the lack of a witness statement which was seen as good practice (HMICFRS,2019).

5.1.9 Other than sharing the SCARF and referring the case to MARAC, Sussex Police reflected that there was little evidence of police working with other agencies in respect of Julie. This was particularly the case in respect of housing and domestic abuse services and will be addressed within the internal review of domestic abuse and risk that is currently being undertaken within the Force.

5.1.10 Sussex Police are introducing a Domestic Abuse Scrutiny Panel with the aims of ensuring and improving the Force's response to domestic abuse. It will include supervisors from local teams across the Force as well as Crown Prosecution Service representation. It is anticipated that the Panel will be able to identify and respond swiftly to improvements needed as well as share good practice in a meaningful way and is therefore seen as good practice. Sussex Police have also recently introduced dedicated police cars which are reserved to respond only to domestic abuse cases and a dedicated pathway for standard risk domestic abuse cases through bespoke teams known as 'Local Resolution Teams'. The Local Resolution Teams reassess the DASH that will have been undertaken with all domestic abuse cases and offer to meet all victims, in person or virtually, normally within 48 hours, improving the identification and assessment of risk at the point of initial call for service and improving the management and oversight of those facing standard risk who might not otherwise have received a follow-up service. The combination of these initiatives has increased the resources available locally to respond to domestic abuse with greater expertise and responsiveness and there have been significantly improved satisfaction rates from those reporting domestic abuse[9].

5.1.11 Notwithstanding these improvements, the Home Office Quality Assurance Panel who assessed this Overview Report considered that there was merit in considering the specific need for recommendations arising from the shortcomings for Sussex Police in this case. Sussex Police is therefore requested to provide assurance to the Community

[9] An initial evaluation revealed that 87% of victims were wholly satisfied and 13% of victims fairly satisfied (July, 2020)

Safety Partnership that the aforementioned internal review of domestic abuse related risk and partnership working together with the improvements in the response to domestic abuse are able to demonstrate outcomes in relation to:

- The accuracy of risk assessments including:
    - That risk is not downgraded solely because a perpetrator of domestic abuse has been taken into custody
    - That a domestic abuse perpetrator's threat of high risk to previous partners influences the risk assessment in relation to their threat to current partners
- The effective use of the Domestic Violence Disclosure Scheme
- Breaches of licence conditions are reported to probation services
- Effective partnership working in the support and protection of victims of domestic abuse and invitation to specialist domestic abuse services to the Domestic Abuse Scrutiny Panel

5.2 Kent Surrey and Sussex Community Rehabilitation Company

5.2.1 The Community Rehabilitation Company (CRC) supervised the perpetrator when he was released on licence from prison in November 2016 and in February 2018. During this time, two probation officers worked directly with him, the second of whom was a temporary appointment. The CRC's response has been subject to a Serious Further Incident Review and the findings have been included here.

5.2.2 On his release from prison in February 2018, the 2nd probation officer failed to complete a sufficient assessment of risk, relying on previously held information without updating the assessment with police and MARAC information about his domestic abuse of Julie or the mental health risk assessment and diagnosis of schizophrenia. In particular, the mental health assessment provided the factors which would increase risk of serious harm quickly which included a deterioration in his mental health, substance misuse and overworking and all of which occurred during his period under supervision. Had the risk assessment being undertaken sufficiently, it would have revealed that the perpetrator was high risk and liaison should have taken place

to re-allocate to the National Probation Service. The 2nd probation officer could not reasonably account for these omissions.

5.2.3 In terms of pre-planning for the perpetrator's release from prison, both probation officers omitted to impose licence conditions. On the first occasion, a licence condition to attend mental health appointments and comply with treatment was omitted, although there was good evidence that the probation officer worked closely with mental health services to achieve the same outcome. On the second occasion, a requirement to engage with substance misuse agencies was omitted on the grounds that it was unrealistic to achieve this alongside the perpetrator maintaining his employment. This decision overlooked the mental health risk indicators regarding his over-working and therefore addressing both mental health and substance misuse should have been a priority. Again, the 2nd probation officer could not reasonably account for these omissions.

5.2.4 The risk management plans, routinely undertaken by the probation officer, included actions to address his domestic abuse, although he did not appear to have been considered for a domestic abuse programme. The plans lacked actions specifically around mental health and the use of weapons or contingency plans to enable a swift response to any escalation of risk factors. Likewise, the sentence plan, which determines what needs to be done to prevent re-offending, lacked consideration of his mental health and substance misuse and was inconsistent with the rest of the assessment. These matters combined meant that assessments and plans were insufficient to manage the perpetrator's risk of both re-offending and harm.

5.2.5 Moreover, the implementation of risk management actions was not consistent and police intelligence checks were not undertaken. The 2nd probation officer, who was responsible during this time, was unclear about whether they, or the administrators, were responsible for completing agency checks despite having clear procedures to this effect.

5.2.6 In terms of contact, neither probation officer attempted to contact the perpetrator whilst he was in prison, prior to his release. It was identified that doing so may have enabled better future engagement and clarity over expectations of licence conditions.

However, the CRC have recognised that there was no clear guidance to their probation officers regarding the expected level of contact with offenders whilst in prison and Kent Surrey and Sussex CRC have since created guidance for this purpose.

5.2.7 Nonetheless, there was clear guidance in place requiring probation officers to liaise with other agencies prior to an offender's release from prison, yet it was found that the liaison with other services, including the prison-based probation officer (National Probation Service) and forensic mental health service, was minimal. For the latter period, the 2nd probation officer did not follow-up with agencies around the domestic abuse; did not follow adult safeguarding procedures and undergo information checks and did not seek the mental health risk assessment and diagnosis prior to the day of release. Each of these omissions were considered to be based on the individual's lack of knowledge.

5.2.8 In view of the perpetrator's history of violence, probation officers rightly rejected two applications for the perpetrator's early release with Home Detention Curfew, although he was released to his home address with Julie on the two occasions that he was released from prison under licence. Whilst there was no current domestic abuse known on the first release, the home address should have been assessed as unsuitable on the second occasion, given the significant report of domestic abuse that had been made in the meantime. The 2nd probation officer was not aware that they had the ability to direct an individual not to reside at a given address.

5.2.9 Whilst the 2nd probation officer clearly liaised with the mental health service and tried to involve them in three-way meetings with the perpetrator, the officer was unclear over the perpetrator's diagnosis and a professional's meeting should have been called to strengthen the multi-agency approach to managing the threat that the perpetrator posed. The mental health lead practitioner consulted with the probation officer about whether the perpetrator could be managed under Multi-Agency Public Protection Arrangements (MAPPA) but the probation officer advised that he would not be automatically considered. Ways of strengthening the multi-agency response will be considered further in the thematic section which follows.

5.2.10 Despite a management decision being made in May 2018, requiring the perpetrator to meet with probation weekly, the perpetrator was not directed to do so by the 2nd probation officer and a significant number of bi-weekly appointments were thereafter offered over the telephone. Kent, Surrey and Sussex CRC's guidance to probation officers was updated later in October 2018 specifying the minimum reporting frequency for face to face contact, in line with Ministry of Justice guidance. Nonetheless, the 2nd probation officer's management of licence conditions was considered unduly lenient and lacked an enforcement approach to managing re-offending and risk. Again, this was determined to be a lack of knowledge as the officer considered that licence conditions were more of a supportive rather than enforcement measure.

5.2.11 Moreover, there were a number of occasions when the threat that the perpetrator posed meant that the CRC should have escalated the case to the National Probation Service who have responsibility for all high-risk cases.

5.2.12 The serious shortcomings in the knowledge and practice of the 2nd probation officer have been evident. This probation officer had gained their qualification in another country and had been recruited in the context of a national shortage of probation officers which will be considered further. The poor practice generated serious concerns about that officer's ability to undertake their role. As a result, the officer's temporary contract was terminated and a thorough case audit was undertaken of all the probation officer's cases and remedial actions undertaken and audited, bringing the officer's caseload to a required standard. Kent Surrey and Sussex CRC have made a recommendation for themselves to ensure that, in the future, designated managers test the competency of temporary and and/or agency staff through a competency checklist. Recruitment, which now only takes place through one employment agency, also has gone on to require evidence of three years of positive references in addition to evidence of qualifications for all temporary members of staff.

5.2.13 Where having to recruit staff from other jurisdictions, it would be expected that organisations ensure that these staff have enhanced support and supervision to fulfil their role and adapt to the new environment, laws, regulations and cultural expectations. In this case, the supervision and management of the officer was not

robust and lacked in-depth oversight. Whilst the senior probation officer, who was new to the role, undertook regular reviews of the perpetrator's case, these reviews relied upon officers bringing issues to the manager's attention and this approach was found to lack professional curiosity. Kent Surrey and Sussex CRC recognised that there were gaps in the guidance for senior probation officers regarding the level of management oversight required, particularly where staff have been recruited from other jurisdictions. Within their action plan, the CRC has addressed this by distributing Her Majesty's Inspectorate of Probation guidance on expectations for managerial oversight. The requirement and quality of management has been embedded with the support of a new supervisory role located within all teams and Human Resources notified where a person has obtained their qualification in a different country and further support necessary. In this way, the panel heard how significant changes in recruitment practices have already occurred as a result of this case.

5.2.14 In summary, Kent Surrey Sussex CRC revealed significant shortcomings in their supervision of a very violent perpetrator under licence and under post-sentence supervision and that these shortcomings applied to both individual officers and the robustness of the organisation in the recruitment and management of probation officers concerned.

5.3 National Probation Service

5.3.1 Although the National Probation Service's involvement with the perpetrator had been brief during the period considered within this review, it was significant.

5.3.2 We have seen that, following his conviction for assault in November 2017, the National Probation Service allocated the perpetrator's case to the Community Rehabilitation Company because they considered him to pose a medium, rather than a high risk of serious harm. This assessment was consistent with his previous assessment but lacked the information that would normally be available for the risk assessment had a pre-sentence report been undertaken

5.3.3 Had a pre-sentence report been required by the court, the National Probation Service would have expected to have been given full information from the Crown Prosecution Service and a list of previous convictions. In these particular circumstances, the report

author would also have been expected to undertake checks with the police in respect of Julie and domestic abuse and with mental health services.

5.3.4 In the absence of the requirement to undertake a pre-sentence report, the review heard that the National Probation Service does not have the capacity to check all cases that progress through the Court. Nonetheless, cases still have to be allocated within 48 hours of sentencing and so the assessing officer had made it clear in the risk assessment that risk would need to be reviewed upon allocation to the Responsible Officer after allocation, due to the nature of the offence for which he was sentenced, which appeared to the panel to be a proportionate response in the circumstances.

5.3.5 As well as this period of sentencing, the review heard how there were a number of times when the perpetrator's risk of serious harm should have been escalated to the National Probation Service who have both the experience and systems to manage high risk cases of this nature.

Health and Social Care Agencies

5.4 Primary Care

5.4.1 Sussex Clinical Commissioning Groups undertook the IMR on behalf of the GP Practice which had been attended by both Julie and the perpetrator. Julie had been registered at the GP Practice since 2013 and had attended for routine screening as well as general health concerns. The perpetrator was registered between December 2016 and October 2017, when he was de-registered following a violent incident outside the practice[10].

5.4.2 The GP Practice had no record that Julie and perpetrator were in a relationship, and, at the time, did not routinely receive information from MARAC. Had this been in place, they would have received the MARAC agenda involving both Julie and perpetrator a week before the perpetrator's attendance at the Practice in October 2017. The Clinical

[10] Violent patients can be referred to the Special Allocations Scheme which provides a primary care service in a secure setting. However, at the time, this would not have applied to violence taking place away from health premises. The guidance has since changed enabling circumstances such as this to be considered a threat to staff and within the criteria of the Special Allocations Scheme.

Commissioning Group is working with the MARAC team to attempt to establish a primary care pathway with MARAC and this will feature in the thematic section below.

5.4.3 Although the GP Practice tried to contact Julie after concerns about her mental health, paranoia, self-harm and self-neglect had been raised with them by the Health Advisory Support Service, the Practice did not follow-up these concerns again. Neither did the nurse take the opportunity to discuss the concerns raised when Julie next attended the surgery for routine blood pressure check, where she could have been encouraged to book an appointment for a mood review, if the GP felt that was indicated.

5.4.4 Further opportunities appear to have been missed to raise these concerns and make routine enquiry around domestic abuse when she attended her next GP appointment six months later concerning swelling in her neck and when she raised concerns about why her night sedative had been stopped during the following month.

5.4.5 Although the GP Practice had been notified of Julie's attendance at the Emergency Department in October 2017, following a domestic abuse related assault, no flag was put on her records to prompt discussions around domestic abuse during future consultations with GPs and nursing staff. Moreover, when the GP was asked to follow-up an incidental finding on the CT scan of Julie's neck that had been undertaken, to check for injury following the assault, there was no evidence of a discussion about the domestic abuse that led to the attendance at hospital or Julie's current situation. Julie also attended the GP Practice in April 2018 regarding a neurological concern and these were further missed opportunities to offer support.

5.4.6 In respect of the GP Practice's responses to Julie, the Clinical Commissioning Group have recommended that GPs and nurses refer to historical records during consultations to enable any outstanding health issues to be identified and discussed. It was not determined why historical information was not being checked, but the level of demand on primary care in general was noted. They have also recommended that codes on their clinical recording system are used to flag people at risk of domestic abuse and that the GP Practice concerned introduces a domestic abuse policy as it was lacking at the time.

5.4.7 The review heard that much has progressed in responding to domestic abuse in primary care since 2018. Sussex Clinical Commissioning Groups have since revamped their training to encourage routine enquiry in domestic abuse and to identify, respond and flag risk. Although the Clinical Commissioning Group had piloted in nearby areas Identification and Referral to Improve Safety (IRIS), which is a well-known evidence-based programme of early identification of domestic abuse in primary care, they found that their own approach to gaining engagement has had greater take-up amongst local practices. Within this approach, they have encouraged the take-up of stand-alone domestic abuse training to compliment the mandatory safeguarding training. However, they have made a specific recommendation concerning routine enquiry and this issue is discussed further in the thematic section which follows.

5.4.8 When the perpetrator registered with the GP Practice, his previous violent offending and schizophrenia were noted, and contact was made with the previous mental health team to determine and continue his current treatment plan. A referral was also made in a timely way by the GP to the local mental health team.

5.4.9 The GP Practice reflected upon their response to the perpetrator's assault of several members of the public in October 2017. It was recognised that, following this incident, the GP wrote to the Forensic Outreach Liaison Team outlining concerns that the perpetrator had been discharged to primary care as soon as his anti-psychotic medication was discontinued. The GP considered his discharge to have been premature, given the perpetrator's past history of violence and paranoid schizophrenia and the GP invited consideration of actions required to prevent this situation happening again, which was seen as a responsible follow-up in the circumstances.

5.4.10 Before the assault, which took place outside the practice, the perpetrator disclosed that he did not feel safe at home. Whilst Practice staff were faced with a very challenging situation at the time, it may have been beneficial afterwards to undertake a review of any outstanding risks facing the perpetrator and to seek to identify the partner he mentions during the consultation. The Clinical Commissioning Group has therefore recommended that, following significant events at the surgery, where risk to individuals has been identified, that a review is undertaken to ensure all relevant information is shared around identified risks.

5.5 Sussex Partnership NHS Foundation Trust

5.5.1 Sussex Partnership NHS Foundation Trust had been providing care to the perpetrator at the time of the manslaughter through the Community Forensic Outreach Service, which has since been renamed the Forensic Outreach Liaison Service in line with national specifications. They had also provided services whilst he was in prison on each occasion through the Integrated Mental Health Service and through periods when he was detained in psychiatric hospital.

5.5.2 Good practice was evident in the lead practitioner recognising the risk to Julie early-on in February 2017 and actively seeking assurance from the probation officer that the perpetrator's violent history would be made known to her through a disclosure under the Domestic Violence Disclosure Scheme, if possible. However, the Trust were not aware of later events concerning his violence to Julie's daughter and assault of Julie later in 2017 which led to Julie being referred to MARAC. As mental health services were not represented at the MARAC on this occasion, having submitted a summary report to the MARAC, they remained unaware of these important incidents concerning the perpetrator's ongoing violence, even though he was not open to their services at the time. Later when he was a patient again, the team did not enquire further, despite knowing that charges had been dropped regarding a domestic incident. The Trust lacked a protocol and guidance around MARAC and identified the need to ensure that a representative from the Forensic Liaison Outreach Service attended MARACs in the future; that MARAC information was included in accessible records for all patients, whether open or closed to services and that MARAC information needed to be checked by all Lead Practitioners and incorporated into risk management plans.

5.5.3 A particular focus was on the period of the perpetrator's release from prison in February 2018 where Sussex Partnership considered the effectiveness of his care in the context of his engagement and compliance with medication. In preparation for his release from prison, the perpetrator had made it clear that he did not believe that making contact and attending appointments with mental health services was necessary and declined having his anti-psychotic medication by depot injection. It was reflected that his Care Plan, whilst very comprehensive, was over-optimistic in so far

as it was reliant upon him making contact with the Forensic Outreach Liaison Team when he was unlikely to do so. There were no contingency plans for his disengagement, despite the perpetrator's history of disengagement and his posing a significant risk to others when he was unwell.

5.5.4 Beyond his disengagement, there was no evidence to suggest a decline in his mental health that would require a Mental Health Act assessment to be undertaken and it is noted that there are no legal restrictions available to manage an informal patient. Nevertheless, Sussex Partnership have made recommendations to strengthen staff's knowledge and understanding of the legal restrictions available where an individual is disengaging with services and declining depot medication and that these restrictions should form part of the risk management plan for those at risk of disengagement. Where a patient misses more than 3 appointments, the Mental Health Act should be discussed and a rationale for decision making documented. The partnership has also strengthened the flagging system to make sure that those at risk of disengagement are automatically considered at weekly team meetings.

5.5.5 Sussex Partnership identified that positive plans for engagement needed to be clearly documented and restrictions and alerts needed to be discussed at multi-disciplinary team prior to being recorded.

5.5.6 The gap in the perpetrator's registration with a GP, following his violent assault and subsequent de-registration, meant that Sussex Partnership were continuing to issue prescriptions and, in order to facilitate his compliance with medication, were initially posting his prescriptions through his door. Sussex Partnership have recognised that patients need to be supported to re-register with a GP, and where there are gaps, that prescriptions are delivered to community pharmacies so that assurance can be sought regarding their collection.

5.5.7 The Trust further recognised shortcomings in respect of their support of the Julie as a carer, and recommended that the 'Triangle of Care', as a therapeutic alliance between patient, professional and carer, should be fully implemented with all patients. The Trust has since put in place a Family and Friends Carers' Liaison Support Worker. They have also committed to identify carer champions within the Forensic Liaison Outreach Service who will attend the Trust's Triangle of Care meetings and to ensure that carer

details are recorded for each patient. The issue of risk to carers in the context of domestic abuse will also be discussed further when considering multi-agency responses.

5.5.8 In respect of the perpetrator's in-patient stays, Sussex Partnership recognised that the specific risk assessment for violent forensic patients (HCR20) had not been completed prior to discharge and before transfer to the community teams. They have made a recommendation to ensure that this happens in the future and to audit compliance.

5.5.9 In respect of the perpetrator's detention under section 3 of the Mental Health Act in November 2017, it was noted that CPA policy was not adhered to, in so far as the Section 117 discharge was not completed. Section 117 of Care Act 2014 places an enforceable duty on health and social care to provide aftercare services to a patient on discharge from hospital with the aim of preventing a deterioration in their mental disorder. The duty continues until the individual's needs had been met and, in this case, would have continued until after his release from prison, in order to prevent any relapse. The duty would also have meant that the perpetrator would have to be subject to regular reviews, enabling further contact with agencies after this time.

5.6 Sussex Community NHS Foundation Trust

5.6.1 Sussex Community NHS Foundation Trust provided services to both Julie and the perpetrator through Uckfield Community Hospital Minor Injuries Unit.

5.6.2 Julie attended the Minor Injuries Unit, complaining about neck pain after being assaulted by the perpetrator in October 2017. Although she discharged herself against advice before she could be transported to the Emergency Department where she would be seen by a doctor, the Trust recognised that they had missed opportunities to contribute to Julie's safety. Julie disclosed the assault and so there was a missed opportunity to discuss the domestic abuse, signpost or refer to domestic abuse and other services and consider potential adult safeguarding concerns. Despite their enquiries, the Trust were unable to establish the reason for the omission on this occasion in view of the time that had elapsed. However, there was no systemic reason, identified to explain why staff had missed this opportunity.

5.6.3 The Trust was able to demonstrate that they had current domestic abuse and adult safeguarding policies and procedures and that they supported staff within their roles through safeguarding training which included domestic abuse at an awareness level. The Trust were able to show 97 per cent attendance compliance with the annual, mandatory safeguarding training which includes basic awareness of domestic abuse. This complies with Level 2 of the Royal Colleges' intercollegiate safeguarding standards (Royal College of Nursing, 2018).[11] However, the more specialist training for clinicians who have a role in assessing, intervening or evaluating the needs of children or adults at risk at Level 3 of the Royal College's intercollegiate safeguarding standards [12], did not feature domestic abuse as a core topic in that year. However, the Trust has since delivered Level 3 training on domestic abuse as a core topic to Minor Injuries Units across the whole of Sussex. The issue of domestic abuse training for health professionals features further in the thematic section which follows.

5.7 East Sussex Healthcare NHS Trust

5.7.1 As well as attending the hospital for unrelated health matters, Julie presented to the Emergency Department of Eastbourne District Hospital complaining of neck pain and headaches following the assault by her boyfriend in October 2017. She attended the hospital alone.

5.7.2 The Trust recognised that there were missed opportunities to respond to Julie's disclosure of domestic abuse both at triage, where a history was taken by a nurse, and when she tearfully disclosed the assault to a doctor.

5.7.3 It was not possible to explore the reasons why the triage nurse did not respond to the domestic abuse disclosure as the signature could not be identified and the matter of identifying clinicians features later as a recommendation for all health agencies. In respect of the doctor's response, it would not have been appropriate to explore the disclosure further before she was sent for X-ray and CT imaging to clarify the extent of her neck injury, although some validation of her disclosure could have reassured her

[11] Mandatory training standards for adult safeguarding are defined within the intercollegiate documents for adults provided by the Royal College of Nursing (2018) where training is defined by levels according to staff roles.
[12] ibid

that she had been heard and her disclosure would be taken seriously. However, the opportunity was missed to revisit the nature of the assault and ensure that she was safe to return home, when reporting back to Julie that there was no evidence of a fracture.

5.7.4 East Sussex Healthcare NHS Trust's Safeguarding Adult's Policy (version 2.0), which was in place at the time, identified that a DASH risk indicator checklist should be completed in such circumstances. However, the doctor was not aware of the DASH and had not received the Trust's domestic abuse training but had received safeguarding training with another Trust.

5.7.5 It was considered that professional curiosity could also have explored why the patient was taking medication for anxiety, recognising that mental health problems are a common consequence of domestic abuse, and determining whether there was a need to refer to mental health services.

5.7.6 Whilst the Emergency Department documented domestic abuse within its discharge letter to the GP, the information shared was limited by virtue of the absence of risk assessment or whether other services had been offered. Neither was there any evidence that an adult safeguarding referral had been considered; that questions were asked whether there were any children in the household or that the hospital safeguarding team had been alerted.

5.7.7 The Trust recorded that there were additional pressures at the time of Julie's admission to the Emergency Department with higher attendance than normal. Nonetheless, neither the Trust's safeguarding policy nor national guidance (NICE, 2014; 2016) had been followed as Julie had not been referred to specialist domestic abuse services. At the time of Julie's attendance, there was no hospital independent domestic violence advisor (IDVA) at either of the Trust's two Emergency Departments, as local funding had recently ceased, but a referral or signposting to domestic abuse services and ensuring the victim left the Department with a safety plan were nonetheless expected practice in this circumstance. As a result, the Trust has already strengthened the domestic abuse training being delivered to all staff and is strengthening the training around safeguarding responsibilities and 'think family'. The Trust has further committed to develop a comprehensive health pathway and embed routine enquiry &

NICE standards into the Emergency Department. This would include: ensuring that staff respond to disclosures and refer to relevant services; completing a DASH where appropriate; identifying when children are in the household; ensuring that a victim is discharged with a safety plan; that information is shared with the relevant agencies; extending the training and actions to monitor and ensure that the pathway, training, policies and procedures are embedded and effectively responding to domestic abuse.

5.8 East Sussex County Council Adult Social Care

5.8.1 East Sussex County Council currently has an arrangement with health commissioners for integrated health and social care provision of mental health services (under Section 75 of the National Health Service Act 2006). This meant that mental health staff from Adult Social Care were seconded to Sussex Partnership NHS Foundation Trust and managed by them. The responses of social workers within the Forensic Liaison Outreach Service and hospital social work are therefore covered above. However, the local authority retained ongoing management oversight of all Approved Mental Health Professionals (AMHP) who were involved in a mental health assessment of the perpetrator under section of Mental Health Act (MHA) 1983.

5.8.2 As part of the mental health assessment, the AMHP completed a risk assessment incorporating the history of violence known to Sussex Partnership and Adult Social Care and the history of violent offences provided to them from the Police National Computer. At this time, the AMHP had not been made aware of the recent bail conditions applied to the perpetrator to keep away from Julie as a result of allegations domestic abuse. Neither was the AMHP aware that the risks had been discussed at MARAC as neither Julie nor the perpetrator had been known to Adult Social Care at that time and there were no actions identified for Adult Social Care from the MARAC.

5.8.3 Due to the number of referrals to AMHPs, Adult Social Care reflected that it would not be possible for them to check MARAC records independently of their own records as they rely upon the information being held in their own and mental health records. They have therefore committed to ensure that all communication and risks discussed at MARAC will be updated onto their own electronic records within 24 hours of the MARAC. It should be noted that Sussex Partnership has also committed to record

MARAC cases, even on closed files and this information will be available to AMHPs in the future. Although the risk assessment did not therefore feature domestic abuse, the range of other available records were accessed. Nevertheless, Adult Social Care has committed to reviewing the shared staffing agreement between the local authority and mental health service to ensure that staff are accessing both sets of records as had been agreed.

Domestic Abuse Services

5.9 Change Grow Live Portal Service

5.9.1 The Change Grow Live (CGL) Portal provides Independent Domestic Violence Advisor (IDVA) support to medium and high-risk victims of domestic abuse across East Sussex and received referrals from the police following two incidents of domestic abuse reported by Julie.

5.9.2 On the first occasion in 2016, Julie declined CGL's offer of support. However, CGL reflected that, on the second occasion in October 2017, once they had identified that Julie should have been high risk, they should have submitted a MARAC referral based on their professional judgement rather than request that the police review their decision that she was facing medium risk. This would have avoided the 10-day delay in the case being heard at MARAC and the delay in multi-agency protective responses being mobilised. CGL have made changes to their operational practice to overcome these types of delays in the future.

5.9.3 The IDVA went on to try to contact Julie six times over the next three weeks. They considered a cold call to Julie's address but determined that this could increase risk to the victim as well as staff. CGL reflected that they could have explored more creative ways of enabling engagement with Julie, including joint visits or shared appointments with other professionals. CGL has made a recommendation to extend their methods of engagement and particularly offer consultation and shared appointments with other professionals where the victim is likely to attend.

5.9.4 CGL also considered their contribution to the MARAC and despite not having had contact with Julie, they had not brought suggestions about protective solutions to the

MARAC, such as Domestic Violence Protection Orders, and this issue will be considered further in the thematic section which follows.

Housing Services

5.10 Hyde Housing Group

5.10.1 Julie had been a social tenant of Hyde Housing Group from 2013 until ownership of the housing estate was transferred in April 2018.

5.10.2 Six weeks after the tenancy began, housing officers visited their new tenants in a planned introductory visit. Only Julie was present, and she advised the housing officer that her partner had schizophrenia for which he received medication, although the original application had listed mental health issues for the whole family. It was planned for her daughter to move in with them, but this did not happen. Aside from this, no matters of vulnerability or concern were noted over the course of the tenancy and no further tenancy visits were therefore conducted. The household had periodic rent arrears but made arrangements by telephone to repay them and the repayments were maintained satisfactorily. There was no indication in the tenancy file that the household were receiving support from any other agency and the agency did not sit on the MARAC.

5.10.3 Whilst Hyde Housing had a domestic abuse policy and procedures at the time, they have since introduced dedicated domestic abuse roles within their housing teams and have signed up to the 'Make a Stand' pledge[13]. The Make a Stand pledge has been developed by the Chartered Institute of Housing in partnership with Women's Aid and the Domestic Abuse Housing Alliance. It was created to encourage housing organisations to make a commitment to support people experiencing domestic abuse.

5.10.4 Hyde Housing is currently working towards accreditation with the Domestic Abuse Housing Alliance (DAHA) which provides the UK benchmark for how housing providers

[13] Further information on the Make a Stand Pledge can be found at http://www.cih.org/resources/PDF/Make%20A%20Stand%20The%20Pledge%20Document.pdf

respond to domestic abuse in the UK and is recognised within the government's Ending Violence against Women and Girls Strategy (HM Government, 2016b).

5.11 Southern Housing Group

5.12 Southern Housing had only recently purchased the small housing estate where Julie lived. They made a brief introductory visit but, despite reference to the perpetrator's schizophrenia and mental health for the whole household featuring in the brief tenancy files that they inherited, this was not discussed during the visit and Julie did not raise any issues herself. These introductory visits appeared informal and the files were not checked in advance and relied upon the tenant themselves raising issues of concern. The tenancy had only small amount of rent arrears and there was no indicator of domestic abuse or anti-social behaviour in the files or in the nature of repairs undertaken.

5.13 Southern Housing were able to confirm that they had current domestic abuse policies and procedures; have attended MARAC when their tenants were involved and provide domestic abuse training for all housing management staff.

6 Thematic Analysis, Learning and Recommendations

6.0 In this section, we will consider the overarching themes arising within the review in respect of domestic abuse, mental health and offender management.

6.1 **Julie's experience of domestic abuse**

6.1.1 A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Multi-Agency Statutory Guidance, 2016). Before considering what agencies knew and understood at the time, the review seeks to consider what is now known about the victim's experience of abuse that may have been underlying the barriers she faced in engaging with agencies.

Physical abuse and threats to kill

6.1.2 We have seen that Julie's reports to the police revealed that she experienced serious physical violence and threats of violence from the perpetrator. By October 2017, it was known by most MARAC partner agencies that the perpetrator had tried to strangle her; had tried to smother her on several occasions; had held a knife to her daughter's throat and had disclosed to the police that either the perpetrator would kill her or she would kill him in self-defence. As a result of the physical abuse, she had sought medical treatment at least twice.

Mental ill-health as a symptom of abuse

6.1.3 Perhaps less at the forefront of agency awareness, there were a number of occasions when concerns over Julie's mental health were revealed. Her original application for social housing, in the year following her relationship with the perpetrator, was prioritised by virtue of her mental ill-health, although no further record could be found about this. Later, whilst the perpetrator was in prison for assaulting her, Julie disclosed to the Health Assessment Support Service that she was experiencing paranoid thoughts, self-harm and self-neglect and she was referred to her GP. She went on to consult the GP over sleep disturbance, and the agencies at MARAC were made aware that mental ill-health prevented her from working. However, agencies did not appear to be considering that the mental health issues that she was disclosing may be

symptomatic of her experiencing abuse and they appear to have missed opportunities to explore this abuse with her.

6.1.4 Women's experience of domestic abuse has been found to be the cause of depression, anxiety, sleep disturbance and broader mental illness (Feder et al, 2006, Rose et al, 2011; Department of Health, 2017; Department of Health and Social Care, 2018). In this way, disclosure of mental health concerns would be expected to generate routine enquiry about domestic abuse (NICE, 2016; RCGP, 2013).

6.1.5 On at least one occasion, the police were unable to interview Julie when she had been seriously assaulted as she was intoxicated. The review heard how Julie had a longstanding problem with alcohol and drug use. However, aside from this one incident with the police, there was no indication that any agency was aware of this. Women who have experienced domestic and sexual abuse have been found to be three times more likely to be substance dependent than those who have not (Rees et.al., 2011). The misuse of alcohol, as a means to cope with violence and abuse and to self-medicate the trauma, is well documented (Department of Health, 2017:73). Substance misuse should therefore always lead to routine, safe enquiry about domestic abuse.

6.1.6 This intersection of mental health, substance misuse and domestic abuse creates significant barriers for agencies' engagement with victims. The fact that CGL is a provider of both substance misuse and domestic abuse services in the local area could go some way to providing opportunities to creatively overcome some of these barriers and we have seen that more could have been done in this case to try to secure her engagement.

Sexual abuse

6.1.7 As early as 2016, Julie disclosed the perpetrator's sexually abusive behaviour to the police. At the time, both she and agencies appeared to interpret his wanting her to have sex with other men in the woods, to be a deterioration in his mental health. It is

not known whether it formed part of a pattern of sexual coercion as despite their efforts, the police were unable to engage with Julie further at the time.

Animal Abuse

6.1.8 During the violent assault that led to Julie being considered at MARAC, the perpetrator had also kicked the family's dog and was prosecuted for criminal damage. Research has revealed a significant link between animal abuse[14] and domestic abuse and it has been shown to be a strong indicator of domestic homicide (Arkow,2014). It has been established that perpetrators who abuse animals will use significantly more dangerous and varied controlling behaviours and forms of violence towards their partners as compared to those domestic abuse perpetrators who do not (Volant et al., 2008; Coorey et al, 2018). They are considered to be more prone to rape, sexual violence, stalking and emotional violence (Arkow, 2014) and may be five times more likely to physically or sexually abuse their partners than those who do not abuse animals (Conroy, 2015). The perpetrator's violence towards the family dog should therefore have contributed to the indicator of high risk that was missed by the Police as it was only by virtue of the repeated reports that Julie was considered at MARAC.

Isolation, economic abuse and coercive control

6.1.9 MARAC partner agencies were also made aware that Julie was isolated from her friends, although the source of the information was not recorded. The police would have been aware that the relationship with her grown-up children had deteriorated as soon as the relationship began as they had been called to respond to a violent incident involving them, and her daughter was later threatened by the perpetrator with a knife. Nevertheless, agencies at the time will not have known that her isolation represented a significant change in her lived experience as she had formerly been a highly gregarious individual.

[14] Animal abuse is defined as the deliberate harm, neglect or misuse of animals by humans resulting in animals suffering physically, mentally and/or emotionally

6.1.10 We have seen that since Julie's relationship with the perpetrator, that she had lost her employment, friends, family and financial independence. It was thought that she could not work because of her own mental ill-health and, whilst not stated, she may have had a degree of caring responsibilities for her violent partner. It was disclosed at MARAC that she had rent arrears[15] and this combination of loss of work and debt should be seen as indicators of economic abuse.

6.1.11 Isolation in this context creates a framework for coercive control, depriving victims of independence, support and sources of help (Wiener, 2017). Julie was therefore exposed to a high risk of serious harm as a result of experiencing the combination of serious violence and abuse, threats to kill, harm to family and harm to animals in an environment in which she was isolated, with depleted economic resources and most likely, subject to coercive control from a perpetrator with a history of extreme violence, deteriorating mental health and increasing paranoia. From the information that was known at the time, it was not evident that this combination of factors had raised agencies concern to a sufficient level of concern.

The perpetrator's deteriorating mental health

6.1.12 Julie commonly referred to the perpetrator's deteriorating mental health as the cause of his violence towards her and sought mental health services to treat him. Indeed, when the perpetrator become paranoid and had hallucinations, his violence was targeted both to those close to him, as well as to random members of the public. This could be interpreted that he had no control, at least at times, over his violence. Whilst the extent of the perpetrator's intent to coercively control his partner is not known, the impact of injury, threat, fear and isolation have become manifest.

6.1.13 A perpetrator's mental health has featured in a significant number of domestic homicide reviews nationally (Chantler, 2020). These reviews have often cited missed opportunities to identify and respond holistically to the potential for violence and

[15] Note that rent arrears were recorded at MARAC in October 2017 but she only had low rent arrears by the time that she died the following year.

abuse towards intimate partners and family members from those receiving treatment for their mental health (Home Office, 2013a; Neville and Sanders-McDonagh, 2014; Sharp-Jeffs and Kelly, 2016;). This review has indicated similar findings.

6.2 Routine enquiry in health settings

6.2.1 Indicators of domestic abuse were missed in most health settings. The review recognised that health professionals have a privileged position in identifying potential domestic abuse.

6.2.2 The National Institute for Health and Clinical Excellence provides a list of evidence-based health markers that are indicators of abuse including injuries, depression, sleep disturbance and alcohol use (NICE,2016). Appropriate and sensitive routine enquiry must be standard practice across all services that women with experience of abuse come in to contact with and it was reassuring to the panel to see the improvements that were already being made in respect of training for staff within the standards required of the Royal Colleges' Intercollegiate Documents on the roles and competences for health care staff (Royal College of Nursing, 2018 & 2019).

Recommendation: Routine Enquiry

East Sussex Community Safety Partnership should seek assurance that all health services in their area have implemented policies, pathways and staff training to support routine enquiry in domestic abuse.

6.2.3 We have seen that East Sussex Healthcare NHS Trust was unable to identify clinicians from their case notes. The review reflected that this was a common problem across health agencies.

Recommendation: Identification of clinical staff

Health agencies in East Sussex should ensure that all clinicians are readily identifiable in case notes and in the decisions they have made.

6.3 Domestic Violence Disclosure Scheme

6.3.1 Although the probation officer advised mental health services that Julie was aware of her partner's previous violent history, the extent of her knowledge was unknown, and

it may well have been that she was only aware of her partner's version of events. Sussex Partnership's lead practitioner was therefore right to put pressure upon the probation officer to request a formal disclosure under the Domestic Violence Disclosure Scheme in these circumstances. Mental health services were in a good position to be able to see the global view of the perpetrator's violent history and recognised the need for Julie to be fully aware of the threat that her partner posed to her.

6.3.2 We have seen that there was no evidence that the probation officer completed an application for disclosure to Julie under the Domestic Violence Disclosure Scheme as had been agreed. However, there was no evidence that other agencies, particular MARAC partner agencies, had identified that a disclosure needed to be made. Indeed, the Domestic Violence Disclosure Scheme provides an opportunity for any agency to raise the need for a disclosure with the police (Home Office, 2016a).

6.3.3 A disclosure at this point would have given her an opportunity to consider the perpetrator's behaviour in the context of her own safety and safety plan accordingly if she had concerns. Moreover, Julie mostly disclosed her partner's abuse in the context of his deteriorating mental health. Had she known about the previous conviction for domestic violence, she may have been able to consider the particular risks to herself and her family more fully. In this way, agencies appeared to lack professional curiosity and awareness of the potential benefits of disclosure for victims.

Learning Point:

All practitioners need to be alert to the benefits and opportunities provided by the Domestic Violence Disclosure Scheme when any concerns about risk to others arise.

Recommendation: Domestic Violence Disclosure Scheme

East Sussex Community Safety Partnership should raise awareness amongst partner agencies of the benefits and opportunities of the Domestic Violence Disclosure Scheme and the process of applying for safe disclosure to victims of their abuser's history of violence and abuse.

6.4 **MARAC**

6.4.1 The MARAC Support Team received a referral in October 2017 from Sussex Police, eleven days after the incident and the case was listed for the next available weekly MARAC. The reasons for the delay have already been considered.

6.4.2 The MARAC referral provided detailed information from the police and was supplemented at the meeting by detailed information from a wide range of other agencies. Information was also provided, although the source was not stated in records, referring to Julie's mental health, rent arrears and isolation from friends. Recording the source of the information provided is clearly important for the future management of risk and safety planning.

6.4.3 Although the actions for the police and IDVA service, requiring them to seek to engage with Julie, were all functionally completed without success, we have already seen that the IDVA could have considered broader means by which to engage. The MARAC Support Team had progress chased the remaining action for probation to contact mental health services and request a further consultation with the perpetrator. They were told that it had been completed, although we have seen that it did not appear to have actually been done. This was a significant missed opportunity, given that the perpetrator's threat was seen to emanate from his deteriorating mental health. This calls into question the accountability of agencies to the MARAC.

6.4.4 Whilst actions to secure Julie's engagement were critical, there did not appear to have been consideration given to the specific need to ensure that Julie understood the threat that the perpetrator posed through the Domestic Violence Disclosure Scheme, which was considered above. Beyond this, there was some discussion in the panel on the amount of detail retained in MARAC records at the time and this has been addressed since, with the chair's summaries now being minuted in full.

6.4.5 A common finding from domestic homicide reviews has been a tendency for practitioners at MARAC to focus solely or predominantly on certain aspects of risk and to exclude or fail to recognise other aspects (Robinson et al., 2018). In this case, the perpetrator's deteriorating mental health was clearly of greatest concern, as it was known to be a factor in the escalation of his paranoia and his experiencing command hallucinations. However, he had been issued with bail conditions to stay away from Julie and the Police had considered that a Domestic Violence Protection Notice was

not therefore needed as it would provide the same protection as the bail conditions. The perpetrator had also been invited to meet with the probation officer under his period of post-sentence supervision, although this was arranged for a month later, demonstrating no urgency. In this way, aside from lack of consideration of disclosure to Julie, the MARAC was using a variety of actions at its disposal, but they lacked a housing perspective.

6.4.6 We have seen that the GP Practice was not aware that Julie and perpetrator were living together and were in a relationship, and that there was no pathway for information sharing between GPs and the MARAC in the local area. The review heard how the Clinical Commissioning Group and MARAC team are working together to establish a pathway for the sharing of high-risk information and a recommendation has therefore been made to formalise this development.

6.4.7 Although a representative of housing providers from each district in the MARAC area was routinely invited, Julie's social landlord at the time, Hyde Housing, did not appear to have been invited to this MARAC. It was recognised that there will commonly be a great many social landlords covering properties in the MARAC area, making representation at the MARAC difficult. However, it was noteworthy that it also took some time to identify the relevant landlord for the purpose of this review, indicating that arrangements for the identification of tenure and landlords were not in place. Housing providers have a crucial role to play in the management of domestic abuse: having significant opportunities to identify domestic abuse within their households; having opportunities to engage with their tenants; having powers of entry and enforcement of tenancy conditions and civil orders. Their role at MARAC should therefore be treated as critical.

6.4.8 A further common finding from domestic homicide reviews is the responsibility of all agencies at MARAC to consider how risk can be managed and to pro-actively work together outside of MARAC meetings (Sharp-Jeffs & Kelly, 2016:8). This appeared to be lacking and is reflected in consideration of partner arrangements to manage offenders below.

6.4.9 It was noted that since this case, referrals to the MARAC have been increasing and, as a result, partner agencies are reviewing their MARAC operations. Within this context, the following recommendations have therefore been made.

Recommendations: MARAC

MARAC Steering Group

- all MARAC partners to send a representative from the relevant service/team to take part in the MARAC where there is involvement (current or historic) that impacts on current risk management and safety planning
- to take pro-active steps to take further actions or alternative actions to address the risk/issue identified at MARAC, including all realistic means of managing the offender
- to consider how MARAC action plans and case management can be overseen and by whom
- An information sharing mechanism to be developed between GP Practices and the MARAC

The MARAC Support Team

- to consider how to identify the relevant social housing provider so that they are invited to MARAC for cases where their tenants are featured
- to ensure that records of MARAC meetings accurately reflect the sources of information received

6.5 Holding the perpetrator to account

6.5.1 There seemed no doubt for most agencies that the perpetrator was a very violent man, and the police demonstrated good practice at the outset by recognising that his random violence to others inferred a threat to his partner, and they visited her twice to offer support as a result.

6.5.2 At times, there was evidence of good information sharing. For example, information sharing between the police and domestic abuse services was robust and informed their risk assessment. Probation and mental health services shared information and tried to arrange joint meetings; the hospital, minor injuries unit and mental health services shared information with the GP until the perpetrator was de-registered.

6.5.3 However, there were other times when information was not shared when it should have been. For example, the police did not notify probation services when the perpetrator had held a knife to Julie's daughter's throat and both Julie, and her daughter, had to lock themselves in the garden for their own protection. At that time, the perpetrator was under licence and probation could have issued a warning or potentially recalled the perpetrator to prison because of his behaviour.

6.5.4 In East Sussex, arrangements for multi-agency responses to risk can emanate from the information shared through the Single Combined Assessment of Risk (SCARF). We have seen that there were occasions when the SCARF was not submitted to Adult Social Care and the Portal Domestic Abuse Service because risk had been minimised by agencies.

Responding to the perpetrator's history of abuse

6.5.5 The review considered the extent to which the perpetrator's history of abuse informed future assessments of the threat that he posed to others thereafter.

6.5.6 Mental health services clearly identified the perpetrator's broad history of violence and aligned it with understanding his increased risk from non-compliance with medication. However, aside from asking probation to make sure that Julie was aware of the extent of his violent past through a disclosure, they did not appear to apply this knowledge to their own protective engagement with Julie, who was their patient's family and potentially his carer.

6.5.7 Information about the perpetrator's violent past was available to the police from the outset through Police National Computer and intelligence checks. Although the police were proactive in their engagement with Julie in his random attack of another person, and the information they provided to the MARAC was robust, we have seen that the police often minimised the risk that the perpetrator posed. On the basis of his history, he should have been considered high risk straight away. Likewise, in June 2017, when he held a knife to Julie's daughter's throat, he should have been assessed as high risk and referred to MARAC. This latter occasion demonstrated the danger inherent in reducing the risk from domestic abuse perpetrator's because on they are held custody. Compared to many other violent offences, and for many reasons, domestic abuse has a comparatively low rate of effective prosecution and it is not safe to assume that a perpetrator in custody will automatically be charged, denied bail, prosecuted and sent to prison. Neither is it safe to rely upon a system to update the risk assessment if the perpetrator is released. Indeed, the risk level was not changed when the perpetrator was released without charge. Minimisation in this way demonstrates a fundamental misunderstanding of the application of risk assessment.

Learning Point: risk should not be downgraded because a domestic abuse perpetrator has been taken into custody, until he has been charged, denied bail and sentenced to a reasonably long term of imprisonment

Opportunities for 'evidence-based' prosecution

6.5.8 Given the level of threat that the perpetrator posed, it is not surprising that both Julie and her daughter withdrew their complaints against the perpetrator after he had attacked them. It is common for victims of domestic abuse to retract their statements for a variety of legitimate reasons including fear of reprisals, intimidation or not wanting to feel responsible for their partner being prosecuted (CPS, 2020). The perpetrator had threatened Julie that he would kill her if she went to the police, so she faced a high threat of reprisals. Moreover, Julie and her daughter often identified the perpetrator's deteriorating mental health as the cause of his violence and wanted help

for him in this way. Research has found high rates of victim retractions particularly in the first 5-8 days after an incident (Myhill, 2018).

6.5.9 Sussex Police should therefore be commended for having pursued an 'evidence-based' prosecution in the absence of a witness statement on the second report. They were able to do this more easily than previously as the first-response officers wore body-worn cameras and could provide digital evidence to the court.

Action commensurate with the offence

6.5.10 There were several occasions when no further action was taken against the perpetrator. Although out of scope of this review, no further action was taken against him after he attempted to suffocate his ex-partner in 2008 and she was left to take a civil non-molestation order against him, which he went on to breach in an alarming manner. No further action was taken against him after he held a knife to Julie's daughter's throat as Julie and her daughter declined to provide a statement and the police could offer no other evidence. Finally, and despite the police's best efforts, the case against the perpetrator for attempting to strangle Julie was eventually dropped when she said that she had lied. In this way, the perpetrator may not have always felt accountable for his violence.

6.5.11 In regard to the serious, unprovoked attack on bystanders in October 2017, Sussex Police considered that there could have been more dialogue between themselves and the Crown Prosecution Service. Had they been aware that the perpetrator intended to accept a lesser plea of *actual bodily harm*, they could have made representations for the offence of *inflicting grievous bodily harm* to be charged[16]. It is not within the scope of a domestic homicide review to comment on sentencing and the review was not aware of all the facts involved. However, in respect of the multi-agency working element of this case, the review has not been able to establish why the police were not aware of the perpetrator's intention to plea to the lesser offence. It was noted that the

[16] After consultation with the Crown Prosecution Service, it appears that the sentence was comparable with the sentence that would have been provided to the higher charge, had medical records been available at the time.

multi-agency Domestic Abuse Scrutiny Panel, referred to earlier, which is being introduced, will include representation from the Crown Prosecution Service and improve lines of communication between the two services. The specialist domestic abuse provider in the area, CGL, will also serve on this Scrutiny Panel.

Opportunities for multi-agency collaboration in the management of risk

6.5.12 Aside from the MARAC, there were a number of opportunities to bring practitioners together to manage the threat that the perpetrator posed. This was particularly evident when the perpetrator was disengaging with probation and mental health services from early 2018 onwards. Sussex Partnership made some attempts to arrange a professionals meeting with the probation officer in April 2018, when the perpetrator was not attending appointments. Indeed, Kent Surrey and Sussex CRC recognised that the second probation officer should have called a professional's meeting at that time.

6.5.13 Consideration was also given to whether the perpetrator should have been managed under the Integrated Offender Management Framework. In 2016, the Integrated Offender Management scheme in Sussex was recognised as one of the leading schemes nationally (HMIC, 2017). At the time, Sussex Police had been subject to an inspection, which concluded that the Force could do more to target perpetrators of domestic abuse as, by targeting prolific perpetrators of theft, burglary and robbery, it was not targeting the offenders who caused greatest harm (HMIC, 2017). Whilst the perpetrator's offending was always of a serious and violent nature, the frequency of his offending would unlikely have met the criteria for Integrated Offender Management at this time as he had only four convictions by the age of 50 years.

6.5.14 However, we have seen that his case should have been escalated to the National Probation Service by the Community Rehabilitation Company at various points because of the high risk of serious harm that he posed. The National Probation Service have both the experience and systems to be able to manage high risk offenders more robustly.

6.5.15 It was considered whether greater attention could have been given to his suitability for MAPPA, as Sussex Partnership had requested. Indeed, any agency can make a referral to MAPPA. However, the fact that his conviction at this time was for *actual bodily harm,* rather than the *grievous bodily harm*, which was initially indicated, may well have impacted adversely upon this consideration for MAPPA, as the offence for which he had been convicted needs to indicate that the person may be capable of causing serious harm to the public[17] (HM Prisons and Probation Service, 2019a). In this way, a combination of factors was contributing to minimising the risk level assessed and risk management that was needed.

6.5.16 Nonetheless, it was considered that had the perpetrator's licence conditions been robustly managed through multi-agency risk management, including mental health and domestic abuse services, it is arguable that agencies could have sufficiently managed his risk outside of the IOM or MAPPA framework during his final period under licence.

Learning Points:

A perpetrator's violent history should be the starting point for all assessments of risk and proportionate enquiries need always to be made.

In complex situations, practitioners need to have confidence to arrange a multi-agency professional's meeting to manage the risk that an individual may pose to others, whether this be by statutory or informal processes.

Recommendation: Managing Perpetrators of Domestic Abuse. East Sussex Safer Communities Partnership should seek assurance from agencies that they are capable of harnessing multi-agency action to effectively manage and constrain perpetrators of domestic abuse.

[17] Certain offenders are automatically managed through MAPPA including registered sex offenders and violent offenders sentenced to twelve months or more imprisonment or a hospital order. Other violent offenders could be considered under Category 3 of the criteria in certain circumstances (HM Prison and Probation Services, 2019a)

6.6 Identifying Carer's Risks and Needs

6.6.1 Little is known of the couple's day-to-day relationship or the extent of any caring role that Julie may have had for the perpetrator. We have seen that Sussex Partnership have made recommendations for themselves to be considering the family and potential carers and the same could be said of other agencies with active involvement. Whilst there is an expectation of agencies such as primary care to identify carers, the GP practice had not identified that their patients were a couple living together during this period.

6.6.2 The perpetrator had a severe and enduring mental health condition which relied upon his compliance with medication. Those with caring responsibilities have a significant role in alerting mental health services when problems arise, as Julie did on many occasions, including the final day of her life. Under section 10 of the Care Act 2014, carers should be active partners in key care and support processes, including the assessment, support planning and review with the person they care for.

6.6.3 Whilst not everyone who undertakes some caring responsibilities will consider themselves, or be considered, formally as a carer, had consideration been given to this role, Julie could have been referred to the local authority and offered a carer's assessment where an opportunity to discuss her own needs as well as caring responsibilities could have taken place.

Learning Point: Practitioners have safeguarding responsibilities towards the family members and carers of service users. In order to understand the risks that they may face, practitioners need to encourage dialogue and engage with family members, wherever possible. They also need to be offering a carer's assessment if they become aware that a household member is providing significant caring responsibilities to someone with severe and enduring mental health problems

Recommendation: Identification of Risk to Family Members and Carers. East Sussex Health and Wellbeing Board seeks assurance from its agencies that they are delivering their responsibilities to carers under the Care Act 2014.

6.7 Co-existence of severe mental illness and substance misuse

6.7.1 Mental health services were aware from the perpetrator's history that he had taken cannabis on a regular basis from the age of 15 years and that this had continued into his adult life. He was reported to have been a heavy user at times and that he had also used Amphetamines, LSD and cocaine on a semi-regular basis. The degree of his dependency was not known but it had been reported that at the peak of his use, he was spending up to £150 per day. They were aware that he had also been a heavy drinker at times.

6.7.2 During his period as an in-patient in a secure hospital following domestic violence towards his ex-partner in 2008, his use of illicit substances had been found to have compounded his mental illness. More recently, probation services were aware that substance misuse was an issue for the perpetrator during both his periods on licence to them. In 2016, his licence conditions on sentencing required him to address his alcohol misuse with a designated provider, although he was not known to drug and alcohol services and this condition did not appear to have been progressed. In his 2017 conviction, substance misuse was not made a licence condition, despite use of cocaine being known to be a risk factor in his reoffending and risk of violence to others. He had also made a disclosure about recent cocaine use to his GP before his random assault outside the GP surgery.

6.7.3 However, his disclosures to mental health services about substance misuse were rare and he was more likely to minimise his use, referring in assessments to social drinking only. After his arrest, he went on to admit to the doctor assessing his mental health that he had been using Amphetamines a week prior to the homicide of his partner.

6.7.4 Whilst dual diagnosis appeared to have been an issue, it was recognised that mental health services would not have been in a position to make a judgement on this in view of their limited contact and the perpetrator's minimisation of his drug and alcohol use.

Probation services, however ,were well placed to recognise a relationship between mental health and substance misuse but there was no evidence that they had alerted mental health services to the potential for dual diagnosis and had not made attendance at both mental health and substance misuse treatment services a condition of his licence. The National Collaborating Centre for Mental Health (NCCMH) established that substance misuse effects approximately 40% of users of secondary care mental health services (2016). Research also suggests that outcomes for people with a dual diagnosis are worse than for other groups of service users of these services and that they are more likely to disengage with services (NCCMH, 2016). It is therefore incumbent upon all agencies to recognise the potential for dual diagnosis and enable dual diagnosis protocols to be enacted.

6.8 **Probation Capabilities**

6.8.1 Whilst the manifest shortcomings of the temporary probation officer in Kent Surrey and Sussex CRC have drawn much attention in this case, it was noted that there was a significant shortage of staff nationally to undertake the role of probation officers. This has meant that probation services are having to recruit from abroad. However, following enquiries with the Ministry of Justice, the Kent Surrey and Sussex CRC found that there was no list of internationally equivalent qualifications, as there are for other professions. It was also noted that there was no national register for probation officers or means by which those falling significantly below expected standards of practice could be held accountable, as would be the case for most other professions. This combination of shortages and the inability to de-register poorly performing staff meant that those staff were mostly able to seek alternative work with other Community Rehabilitation Companies with little accountability.

6.8.2 We have seen that Kent, Surrey and Sussex CRC have put in place a more robust recruitment regime for the recruitment of probation officers through a single agency. Although at the time of writing, there are plans to unify the probation services once more (HM Prison and Probation Services, 2019b), the review panel sought to bring

these concerns to the attention of the Ministry of Justice as they may be pertinent to probation services nationally.

Recommendation:
That the report is shared with the Ministry of Justice in order that:

- the implications of shortages of probation officers on professional standards are noted
- consideration is given, within the restructure of the probation services, to the professional registration of probation officers to ensure that individual standards of professional practice can be regulated
- consideration is given to providing a list of internationally commensurate probation qualifications

7. Conclusions

7.1 This review has considered the nature of the domestic abuse that was perpetrated against Julie by her partner, and the nature of agencies' responses over the twenty-eight months before Julie was killed.

7.2 The perpetrator had an extensive forensic history of violence and a severe and enduring mental illness including schizophrenia which was affected by his substance use. He also had a history of domestic abuse involving attempts to suffocate and smother his former partner and a fellow prison inmate, which was the method he finally used to kill Julie.

7.3 The review recognised the attempts made by mental health services and probation to engage the perpetrator in mental health treatment after his release from prison five months before the homicide. However, risk assessments undertaken by agencies were mostly insufficient and generally did not take into account the extent of his previous violent history or apply this to the potential for domestic abuse.

7.4 The perpetrator was evasive with both mental health and probation services. Nevertheless, his release from prison and period of supervision under licence was

managed poorly by probation which meant that he was not supervised sufficiently in the community. Moreover, the perpetrator should also have been subject to Section 117 aftercare after being a hospital involuntary in-patient, which would have required health and social care agencies to provide regular review and aftercare to prevent his relapse. However, it was noted that the perpetrator would have been under no obligation to accept the after-care services had they been offered, without any other legislation or orders being applied.

7.5 Julie was often reluctant to support prosecutions and it was recognised that there are usually a range of barriers that prevent victims of domestic abuse from doing so. It was understood that Julie was isolated and exposed to the coercive control of an extremely violent perpetrator who presented her with a high risk of serious harm or death and in this context, the dangers of her engagement with services were apparent. Furthermore, Julie generally considered her partner's violence to be a consequence of his deteriorating mental health. The Police and IDVA tried unsuccessfully to overcome these barriers and maintain engagement with her and when she did disclose domestic abuse in health settings, discussion and safety planning was not taken up. At other times, routine enquiry in health settings was missed when Julie presented with indicators of domestic abuse.

7.6 Julie was not identified as a carer despite her caring responsibilities and so her voice was rarely heard by the services treating her partner. Although she was living with a very violent man, had been reporting his threats to kill her and been subject to MARAC, her partner's history of violent offending and domestic abuse was not disclosed to her. Despite this, she understood a degree of the threat that he posed and disclosed that either he would kill her or that she would end up killing him in self-defence.

7.7 This tragic case demonstrates clearly the need to listen to victims, to use every opportunity to engage with them and every power available to manage their abusers through a co-ordinated, multi-agency response.

8. Recommendations

8.1 Overview Recommendations

Recommendation 1: Routine Enquiry

East Sussex Community Safety Partnership should seek assurance that all health services in their area have implemented policies, pathways and staff training to support routine enquiry in domestic abuse.

Recommendation 2: Identification of clinical staff

Health agencies in East Sussex should ensure that all clinicians are readily identifiable in case notes and in the decisions they have made.

Recommendation 3: Domestic Violence Disclosure Scheme

East Sussex Community Safety Partnership should raise awareness amongst partner agencies of the benefits and opportunities of the Domestic Violence Disclosure Scheme and the process of applying for safe disclosure to victims of their abuser's history of violence and abuse

Recommendation 4: MARAC

MARAC Steering Group

- all MARAC partners to send a representative from the relevant service/team to take part in the MARAC where there is significant involvement (current or historic) that impacts on current risk management and safety planning
- to take pro-active steps to take further actions or alternative actions to address the risk/issue identified at MARAC, including all realistic means of managing the offender
- to consider how MARAC action plans and case management can be overseen and by whom
- An information sharing mechanism to be developed between GP Practices and the MARAC

The MARAC Support Team

- to consider how to identify the relevant social housing provider so that they are invited to MARAC for cases where their tenants are featured
- to ensure that records of MARAC meetings accurately reflect the sources of information received

Recommendation 5: Managing Perpetrators of Domestic Abuse. East Sussex Safer Communities Partnership should seek assurance from agencies that they are capable of harnessing multi-agency action to effectively manage and constrain perpetrators of domestic abuse.

Recommendation 6: Identification of Risk to Family Members and Carers. East Sussex Health and Wellbeing Board seeks assurance from its agencies that they are delivering their responsibilities to carers under the Care Act 2014.

Recommendation 7:
That the report is shared with the Ministry of Justice in order that:

- the implications of shortages of probation officers on professional standards are noted
- consideration is given, within the restructure of the probation services, to the professional registration of probation officers to ensure that individual standards of professional practice can be regulated
- consideration is given to providing a list of internationally commensurate probation qualifications

8.2 Individual Agency Recommendations

Change Grow Live Domestic Abuse Portal

- Where there is a discrepancy to a risk assessment based on a further assessment or professional judgement, it is first discussed with the referring agency, before implementing service processes relevant to that risk level.
- Creative engagement should still be a consideration, whilst following safe practices. Joint visits especially in services where the victim already attends is considered good practice, e.g. GP or Probation. If engagement is not possible the Portal will offer consultation to other professionals where the victim is likely to attend. This must also be balanced and in accordance with GDPR.
- Services to bring creative suggestions to MARAC, ensure that DVPO/DVDs and community and statutory services are considered for victim and offender.

East Sussex County Council Adult Social Care

- Ensure affected staff are accessing both IT systems as agreed
- Ensure all communication/ risks discussions at MARAC are appropriately updated onto both ESCC & SPFT IT systems ASAP but no longer that 24 hours following MARAC discussion.

East Sussex Healthcare NHS Trust

- Develop a health pathway and embed into routine enquiry & NICE standards in A&E.
- Demonstrate that efforts to improve staff awareness and responses to domestic abuse in recent times are proving successful.
- As well as training to identify signs and indicators of domestic abuse, training, procedures and pathways need to be embedded about how practitioners/clinicians respond effectively to domestic abuse.

- **Sussex Clinical Commissioning Groups**

- That codes on the case recording system are used to flag people at risk of domestic abuse. This will aid GPs and nurses in the identification of people at risk and prompt accessing historical records to allow previous concerns to be address on subsequent consultations
- That GPs and nurses refer to historical records during consultations to enable any outstanding health issues to be identified and discussed
- Following significant events at the surgery, where risk to individuals has been identified, that a review is undertaken to ensure all relevant information is shared around identified risks.
- That the practice implements a domestic abuse policy outlining the roles and responsibilities of staff, as well as resources to support people using and working for the practice.

Kent Surrey and Sussex Community Rehabilitation Company (KSSCRC)

- KSS CRC to meet the expected standards for pre-release contact.
- KSS CRC Senior Probation Officers to demonstrate professional curiosity and effective management oversight.
- KSS CRC to ensure that the competencies of temporary and/or agency staff are checked.

Sussex Community NHS Foundation Trust (SCFT)

- Uckfield SCFT Minor Injuries Unit to raise awareness of the signs of domestic abuse and the appropriate pathways to seek support for the victim
- Wider East Sussex SCFT Minor Injuries Units (Lewes and Crowborough) to raise awareness of the signs of domestic abuse and the appropriate pathways to seek support for the victim
- Wider SCFT Minor Injuries and Urgent Treatment Centres:
- To raise awareness of the signs of domestic abuse and the appropriate pathways to seek support for the victim
- Raise internal awareness of SCFT IMR findings

Sussex Partnership NHS Foundation Trust

- Lack of known and understood legal restrictions gave the perpetrator the choice to disengage with services and decline depot medication. His Care Plan and engagement was reliant on the perpetrator making contact and attending appointments when he was clear that he did not believe that this was necessary, there was no contingency for disengagement despite a history of disengaging and becoming unwell. All patients deemed at risk of disengagement from services will have a risk management plan.
- Positive plans for engagement to be clearly documented with any restrictions or alerts to be discussed with Multi-Disciplinary Team.
- Ensure that patients that have been de-registered from a GP are supported to re-register and that prescriptions are delivered to a community pharmacy so assurance can be sought re collection.
- Where engagement is an issue, consideration of use of mental health act should be discussed and documented with a rationale for decision making.
- HCR20 risk assessment to be completed for all forensic inpatients
- Protocol to be put in place to ensure that all eligible patients receive a Section 117 discharge meeting.
- Triangle of care to be fully implemented with all patients
- Protocol to be developed to ensure that information shared by MARAC is accessible, checked by all Lead Practitioners and incorporated into risk management plans.

Sussex Police

- The Head of Public Protection should ensure that a review of DASH risk assessment is incorporated within the ongoing force DA Improvement Plan to ensure that the level of risk is being appropriately identified / graded by officers and staff. This review should be undertaken as soon as practicable.

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Appendix 1: Key Lines of Enquiry

The review sought to address both the 'circumstances of particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the specific issues identified in this particular case, as follows:

- To analyse key episodes in agencies' response including the nature of assessments, decision making and responses and whether they met the expected standards of practice and procedures.
- To consider how agencies held the perpetrator accountable for his domestic abuse and violence to others and manage the risk that he presented?
- To consider how agencies' understanding of the perpetrator's mental illness impact upon their response to his domestic abuse or violence to others?
- To consider how barriers to engagement with the victim and perpetrator overcome?
- To consider, if domestic abuse was not known, how agencies identified the existence of domestic abuse from other issues presented? For example, were there policies and procedures for direct, routine or clinical questioning on domestic abuse and how were they followed in this case?
- To consider how robust was multi-agency working. To assess how effectively agencies worked together to assess, make decisions and respond to the risks, threats or needs identified. How did agencies share information concerning the perpetrator's risk to others? How did agencies access or work with specialist domestic abuse agencies? How robust and timely were Multi-Agency Risk Assessment Conference (MARAC) referrals and interventions and how were agencies made accountable for their actions?
- How well equipped were practitioners in responding to domestic abuse? How were staff supported to respond to issues of domestic abuse through policies, procedures, training, supervision, management and sufficient resources available at the time.
- To outline each agency process and practice in generating or responding to a Single Agency Combined Assessment of Risk (SCARF).

Family members added specific questions that they wanted answered within the review

- The perpetrator had a history of smothering and strangulation. How did this history feature in later risk assessments?

- Was the perpetrator let out of prison with enough supervision?
- Did the victim know about the perpetrator's violent past?
- Were there any indicators that the victim was vulnerable to grooming?
- On the day before she died, the victim had contacted the mental health service about him not taking his medication whilst taking other drugs. How did they respond?

In addition to addressing the key lines of enquiry, specific agencies were also asked to respond to the following additional questions within their IMRs:

- Adult Social Care (East Sussex County Council) to also
    - Consider what expectations there would be for an AMHP to access background information before a Mental Health Act assessment and why the AMHP did not have access to information concerning the MARAC or bail conditions for the perpetrator in this case.
    - Consider their engagement with the victim and whether opportunities to routinely enquire about domestic abuse could have been available
- Kent, Surrey and Sussex Community Rehabilitation Company to also
    - Outline the powers and responsibilities of managing an offender on licence, powers of recall and within post sentence supervision and how these were applied in this case
    - Outline the thresholds for approved premises; consider whether the perpetrator's circumstances met those thresholds and, if not, whether consideration or arrangements were made to secure alternative accommodation for him away from the victim
    - Identify opportunities for interventions with the perpetrator over his violence
    - Consider whether the perpetrator could have been managed under the Integrated Offender Management Framework and what additional interventions would have been potentially available to manage his behaviour under this scheme
- Sussex Partnership NHS Foundation Trust to also

- Identify how the perpetrator's diagnosis of paranoid schizophrenia in 2009 was addressed in subsequent assessments and treatment
- Outline how the perpetrator's compliance with medication was monitored and encouraged
- How the service engaged with the victim as a carer and/or a person at risk
- How the service responded to the perpetrator's complaint(s) that his partner (the victim) was not supportive
- Nature of communication between the primary care team and the forensic psychiatric team
- Assess the effectiveness of the prescribing method in final months before the homicide
- Whether the Sussex Partnership regularly attended MARAC at this time and improvements since

- GPs to also
  - Review the effectiveness of the 'special patient scheme' in enabling access to primary care services for the perpetrator
  - Whether there were opportunities to share information with other agencies regarding the perpetrator's violent behaviour or concerns that he did not feel safe at home (disclosed in October 2017)
  - Identify whether the victim was seen to have any caring responsibilities for the perpetrator, including assisting with compliance with medication, and if so, how she was responded to within this role
  - Consider the nature of communication between the primary care team and the forensic psychiatric team
  - Outline their domestic abuse procedures
- East Sussex Healthcare NHS Trust
  - to outline their domestic abuse practice and procedure and identify barriers to active engagement when the victim disclosed domestic abuse
  - to detail whether an Independent Domestic Violence Advisor was working within the Emergency Department at the time of the victim's disclosure of domestic abuse and since.

- National Probation Service to also
    - advise on their risk assessment and allocation of the case
    - Identify opportunities for interventions with the perpetrator over his violence
    - Comment on the absence of a pre-sentence-report prior to the perpetrator's sentencing
- Southern Housing Group
    - To outline processes and arrangements for identifying and responding to vulnerable tenants
    - How the family's mental health issues, which were identified at the start of the tenancy, were responded to in order to ensure that the tenancy was sustained.
    - Whether there were any indicators of domestic abuse throughout the tenancy, such as rent arrears, anti-social behaviour or repairs that may be domestic abuse indicative, and how these were responded to
    - Whether the Housing Group has domestic abuse policies and procedures and whether these were adhered to

Briefer and summary reports were requested from:

- CGL Domestic Abuse Portal to provide
    - a summary of the support that they provided to the victim regarding domestic violence that she experienced from others in 2012
    - to identify how engagement was sought with the victim in April 2016 and October 2017 and whether these attempts met expected standards of practice in engaging with 'hard to engage' victims.
    - To detail its response to DASH scoring in October 2017
- Crown Prosecution Service to advise on their decision making around charges brought against the perpetrator
- HM Prison Lewes regarding the perpetrator's periods in prison

- Hyde Housing in respect of their involvement with the victim and perpetrator during their ownership of the social tenancy prior to it being transferred to Southern Housing Group in April 2018.

- Joint Domestic and Sexual Violence and Abuse and Violence Against Women Unit was asked

    - To provide an outline of MARAC processes and agencies participating in the area at the time.

    - To identify referrals to MARAC in this case; the nature of abuse and history identified; the agencies involved; the actions recommended and how actions were progressed.

    - To identify whether there have been any changes in the process and procedure of MARAC since which could have impacted upon this case?

- Sussex Police to provide

    - a summary of the perpetrator's contact with the police prior to March 2016 and outcomes of any criminal proceedings taken

    - a summary of the victim's contact with the police prior to March 2016 in respect of domestic violence and abuse from any perpetrator

Appendix 2: Action Plan

Overview Recommendations:

Ref No	Recommendation	Action	Key Milestones	Target Date	Lead	Progress	Outcome	RAG Rating *
OVERVIEW RECOMMENDATION 1: Routine Enquiry								
1.	**East Sussex Community Safety Partnership should seek assurance that all health services in their area have implemented policies, pathways and staff training to support routine enquiry in domestic abuse.**	East Sussex Health Care Trust to have a Domestic abuse policy in place and domestic abuse workshop sessions.	Policy was updated 2020 Implementation of Domestic Abuse workshops June 2019 Implementation of Think Family approach to training November 2019 to include Domestic abuse	March 2021	Head of safeguarding ESHT	Complete Workshops continue to be delivered since the implementation date and are now supported by the HIDVA. The Domestic Abuse policy has been updated to reflect work with staff members who are also victims of abuse.	Victims of domestic abuse are identified and support at the earliest opportunity in health settings	
		Pathway within ESHT to be developed with occupational health to support staff that are victims.		March 2021	Head of safeguarding ESHT	Complete.	Staff that are victims of domestic abuse are identified and supported at the earliest opportunity	

		ESHT to implement a rapid assessment tool in the emergency departments to support routine enquiry.	Meetings have taken place with clinical staff from the Ed and the HIDVA. The HIDVA will support the roll out and training needs therein.	Dec 2020	Head of safeguarding ESHT	Complete. Audit of compliance after 6 months.	Victims of domestic abuse that attend A&E are identified and supported at the earliest opportunity	
		HIDVA (Health Independent Domestic Violence Advocate) post and funding to be re-instated. Both patients and health professionals to have access to expert support and advice from the HIDVA, based in East Sussex hospitals.	Funding confirmation and contract start.	Oct 2020	ESHT/CCG/ Commissioner for DVA/SVA/VAWG	Complete; The CCG have committed long term funding to the HIDVA in East Sussex, with the HIDVA contract starting on 01/10/2020.	Increased awareness of domestic abuse and it's impact on health amongst healthcare professionals Increase support and early intervention for victims of domestic abuse who attend A&E	
		SPFT; have a recently revised DVA policy which includes pathways and have recently developed	- Circulation of revised DVA policy - SPFT having access to	Oct 2020	SPFT	Complete	Holistic support for victims of domestic abuse with mental health issues.	

		bespoke DVA training for all staff in SPFT.	bespoke DVA training					
		The CCG develop a policy for primary care services which highlights routine enquiry as good practice.	- Policy to be written and circulated	Dec 2020	CCG	In progress Policy for adoption by primary care practices is in development has been circulated	Victims are supported to disclose domestic abuse in healthcare settings	
		CCG to provide resources for primary care and deliver training that encourages routine enquiry for DVA	- Training was updated in April 2019 to include routine enquiry for DA - Briefings circulated to primary care including need to use routine enquiry and signposting to additional DA resources	April 2019	CCG	Complete		
OVERVIEW RECOMMENDATION 2: Identification of clinical staff								
2.	**Health agencies in East Sussex should ensure that all clinicians are readily**	Within carenotes (SPFT IT system) it is standard	N/A	N/A	Named Nurse: Adult Safeguarding on behalf of SCFT Health	Complete SCFT provide NHS community health and care services across	Increased support and improved risk assessment for	

	identifiable in case notes and in the decisions they have made.	practise to record all clinical decisions, and all clinicians are identified.			Record Keeping Policy Author: Records Management Facilitator/ Information Governance Lead	West Sussex, Brighton & Hove and High Weald Lewes Havens area of East Sussex. SCFT Health Record Keeping Policy provides staff with the standards of professional and administrative practice relating to health record keeping. The policy applies to: All staff working within SCFT: - Including temporary and contracted staff, students and volunteers that use; access; handle; or manage health records at any time. - All health records, manual and electronic (or other) used within SCFT. - All processes and systems used to	victims of domestic abuse	

						manage those health records.		
		East Sussex Health Care NHS Trust; Audit of records to analyse whether clinicians are identifiable within the records and that the decisions therein are documented. Information to be added to clinical training.	This was delayed due to Covid and the inherent operational impact.	May 2021	Head of Safeguarding	Complete and feedback to be incorporated into clinical training.		
OVERVIEW RECOMMENDATION 3: Domestic Violence Disclosure Scheme								
3.	**East Sussex Community Safety Partnership should raise awareness amongst partner agencies of the benefits and opportunities of the Domestic Violence Disclosure**	The Joint Unit for DVA/SVA/VAWG to circulate information and a briefing around agencies on DVDS. This includes promotion during the 16 days of action	- circulation of information on DVDS and briefing to agencies - promote DVDS during the 16 days of action.	Ongoing	Joint Unit for DVA/SVA/VAWG	Complete with ongoing actions One of the daily themes of the East Sussex 16 days of action social media campaign is the DVDS and will be circulated and accessible to all partner agencies.	Increased use of DVDSs across East Sussex Increased public and agency awareness of DVDS Increase in DVDS referrals to MARAC	

	Scheme and the process of applying for safe disclosure to victims of their abuser's history of violence and abuse.	against gender-based violence and as part of the White Ribbon activities.				Sussex Police are circulating a video on DVDs as part of the 16 days of action campaign. Borough and Districts are supporting raising awareness of the DVDS, including during the 16 days of action, led by Hastings and Rother Councils. DHR learning event hosted by the Joint Unit for DVA/SVA/VAWG on 15th June; DVDS, the benefit of, referral process and case examples was shared to over 80 participants to a range of professionals from a variety of agencies. The webinar is going to be adapted into online training		

						available to all staff in ESCC and agencies. MARAC has seen an increase in referrals for DVDs in the last year (Nov 2019- Nov 2020) by 40%, demonstrating an increase in awareness of DVDs and referrals.		
		A recommendation to be made to the CSP Board to circulate information contained within the DHR Briefing Paper presented to the Board on DVDS around their networks.	- Recommendation made and information contained within the briefing paper on DVDS	Nov 2020	Joint Unit for DVA/SVA/VAWG	Complete DVDS briefing was circulated to CSP Board members for sharing with networks and communities on 26th November 2020.	Increase in agencies members of the CSP Board referring into Sussex Police for DVDS	
		Promotional materials on DVA to be developed in partnership with agencies in East	- Promotional materials developed in partnership with commissioned	July 2021	Joint Unit for DVA/SVA/VAWG & commissione	Promotional and information materials, including leaflets, info cards etc to be developed following the	Increased awareness of DVDS in the community and members of the public, measured	

		Sussex including information about DVDS when branding and service details of commissioned Provider are updated.	DVA provider and agencies.		d DVA Provider	contract award for the recommission of the DVA service in East Sussex and following implementation of the Service. Planned for Q2 of the new contract (from July 2021).	by an increase in referrals for DVDS from members of the public, friends and family members.	
OVERVIEW RECOMMENDATION 4: MARAC								
MARAC Steering Group								
4i	**All MARAC partners to send a representative from the relevant service/team to take part in the MARAC where there is significant involvement (current or historic) that impacts on current risk management and safety planning.**	MARAC partners who do not usually attend MARAC will confirm to the MARAC Support Team when their agency has significant involvement in a case. Then relevant meeting details will be sent to the agency representative by the MARAC Support Team.	N/A	N/A	MARAC Team Leader	Complete This process is set out in the revised Virtual MARAC Arrangements issued by the MARAC Support Team and will be made clear in the next update of the MARAC Operating Protocol (due Jan 2021). The MARAC team leader and MARAC Coordinators have immediate access to the	Representation from agencies involved with a victim and/ or perpetrator according to data available on agency attendance.	

						data on agencies attendance and written submission levels following a MARAC meeting. Where attendance from any MARAC agency dips below 80% attendance, the MARAC team will write formally to agencies to address the issue and resolve.		
	To take pro-active steps to take further actions or alternative actions to address the risk/issue identified at MARAC, including all realistic means of managing the offender.	MARAC agency representatives follow up on any actions and MARAC Coordinators will follow up on any outstanding actions to ensure they are completed.	N/A	N/A	MARAC Team Leader	Complete	MARAC actions are completed within timeframes or alternative actions agreed and completed within agreed timeframes.	
	To consider how MARAC action plans and case	It is standard practice to ensure relevant	N/A	Dec 2020	MARAC Team Leader	Complete	Lead agencies are completing actions within	

	management can be overseen and by whom.	professionals are informed of any actions. MARAC Actions plans should be overseen by the designated Lead Agency and partners known to be working on the case. The MARAC minutes and summary go to all MARAC partners which are explicit about who is the lead agency and actions are allocated and followed up by MARAC Coordinators.				The role of Lead Agency to be made more explicit in the next update of the MARAC Operating Protocol (Jan 2021) and in MARAC Representative Development training.	agreed timescales Lead agencies are supporting the victim and or perpetrator and feeding back to MARAC with updates pertaining to risk including non-engagement	
	An information sharing mechanism to be developed between GP Practices and the MARAC.	Resources to be identified to develop link between GP Practices and the MARAC.	- Resource in place to develop link between GP practices and MARAC in East Sussex	Dec 2020	CCG Safeguarding Lead	Feedback from MARAC to GP practices – options continue to be explored but capacity and resource issues are delaying this part of the action.	Relevant information is provided by GPs to MARAC to facilitate information sharing and risk management.	

						Complete; The NHS East Sussex Clinical Commissioning Group (CCG) has secured six months Covid-19 funding to support safeguarding children in MASH. As part of this pilot the MASH health administrator will look up GP information for all MARAC Victims and Children and send a letter to GPs asking them to send any relevant information to the MARAC Support Team.	Outcome of MARAC is fedback to GPs to facilitate information sharing and risk management and support	
The MARAC Support Team								
4 ii	**To consider how to identify the relevant social housing provider so that they are invited to MARAC for cases where**	MARAC Support Team will collate key contacts for social housing and supported housing in the local areas and	- Complete the key contact list and share with providers (Dec 2020) and schedule yearly regular update	Dec 2020	MARAC Team Leader	Not all social housing and supported housing providers in ES will be sent weekly MARAC agendas as this is viewed as not proportionate in the	MARAC co-ordinators are aware of social and support housing key contact for each MARAC area in East Sussex	

	their tenants are featured.	store it in the 'Guide for MARAC Coordinator' and share with the local DVA services.	of contact details.			sharing of personal sensitive information.		
		MARAC Support Team will adapt the MARAC referral form, to ask if the victim is in social or supported housing and the name of support worker if applicable. If this is clear at point of referral or becomes clear at MARAC, the team will then ask the social landlord or supported housing provider to share relevant details, including the	- Update MARAC referral form	Dec 2020	MARAC Team Leader	MARAC Coordinators are identifying cases where it is likely the victim may be in social housing or supported housing and if information isn't provided by the referring agency, will request this information of the referring agency as well as contact details for any key/support worker.	It is identified when victims are in social and supported housing and support workers requested to share relevant information and invited to MARAC meetings as appropriate.	

		contact details for support/ key workers if applicable (and attend the MARAC, if appropriate).						
		Consider how best to identity the relevant accommodation provider where in social or supporting housing and have a key worker/ case worker.	- Liaison and agreement with MARAC partners	Dec 2020	MARAC Team Leader	Complete		
		The local DVA services proactively identify with victim if they are in social or supported housing and liaise with the relevant provider around risk/ safety planning. Let the MARAC Support Team	- Agree this process with specialist services as part of mobilisation plan by April 2021.	April 2021	DVA Provider	The DVA Provider for East Sussex, CGL, ask for the type of housing a victim is accommodated in on their referral form. The Provider lets the MARAC support team know in their research notes under action taken or service offered if they think that the housing provider should		

		know if a social or supported housing provider needs to be invited to a particular MARAC discussion.				be invited to a particular MARAC discussion.		
	To ensure that records of MARAC meetings accurately reflect the sources of information received.	Additional Guidance to be given to MARAC Coordinators and recorded in the reference document 'Guide for MARAC Coordination'. Audit of MARAC cases	- Additional guidance shared and recorded in reference document.	Oct 2020	MARAC team leader	Completed	Sources of information in MARAC minutes are clear to ensure further information can be gained as necessary and risk management is effective.	
OVERVIEW RECOMMENDATION 5: Managing Perpetrators of Domestic Abuse								
5.	**East Sussex Safer Communities Partnership should seek assurance from agencies that they are capable of harnessing multi-agency action to**	Support funding bids for perpetrator programmes in East Sussex.	- Establishing funding for perpetrator programmes and commissioning of services for perpetrators outside of the	Ongoing	Joint Unit for DVA/SVA/VAWG/ OSPCC	Complete 'Make a Change' was a perpetrator programme that was Piloted in East Sussex from 01/04/2018 – 31/03/2019. It aimed to deliver an early response to those who are using abusive behaviour towards their	Multi-agency perpetrator programmes are funded in East Sussex and performance indicators and outcomes of programmes are met.	

	effectively manage and constrain perpetrators of domestic abuse.		Criminal Justice system (who have their own mandated perpetrator programmes).			partners and/or ex-partners. The programme was inspired by Change That Lasts, Women's Aid England's whole system approach to domestic abuse, The Pilot ran for 1 year and ended on 31/03/2019 due to lack of ongoing funding. Positive outcomes were evidenced in the levels of engagement with perpetrators and behaviour change. This pilot has informed both the pan Sussex DVA/SVA strategy and the OSPCC strategic work on perpetrators. Consequently, the OPSCC has commissioned two perpetrator programmes pan Sussex; one programme is the High		

						Harm Perpetrator Project - this not a referral programme - perpetrators are identified by Sussex Police or MARAC. The second is delivered by Cranstoun and is a 24 week rolling perpetrator intervention programme across Sussex called the 'Men and Masculinity Programme' delivering a range of interventions specifically targeted at supporting victims and survivors to safety by challenging perpetrators of abuse to take responsibility for their behaviour.		
		Ensure that work to manage and constrain perpetrators is incorporated into the Pan Sussex DVA/SVA/VAW	- That a response to perpetrators is incorporated within the Pan Sussex Strategy. - Clear actions are set in order	August 2021	Joint Unit for DVA/SVA/VAWG	One of the priority areas of the pan Sussex DVA/SVA strategy that has been developed, is 'pursuing perpetrators' and the final version of the strategy has been agreed and circulated to partners.		

		G Strategy and the action plan.	to deliver the strategy with regards to perpetrators in the action plan that sits beneath the Pan Sussex Strategy.			The Partnership Board formed as a requirement of the DA Act 2021 has been formed and responsible for ensuring delivery of the strategy and action plan and that this priority strategic aim is met.		
		OSPCC; a Sussex wide working group to be established to create an approach to tackling domestic abuse perpetrators in partnership.	- Pan Sussex perpetrator working group established. - Access to sustainable funding for this work.	March 2021	OSPCC	A Sussex wide working group is being established; the formation of this group has been delayed by the COVID-19 pandemic.		
OVERVIEW RECOMMENDATION 6: Identification of Risk to Family Members and Carers.								
6.	**East Sussex Health and Wellbeing Board seeks assurance from its agencies that they are delivering their responsibilities to carers under**	To list an agenda item for the next Health and Wellbeing Board seeking assurance from responsible agencies that they are delivering their	- Agenda item listed - Responses and assurances received from responsible agencies.	Jan 2021	Chair of the East Sussex Health and Wellbeing Board	Agencies have responsibility under the Care Act when assessing the care and support needs of adults and the support needs of carers then any DVA would be identified and	Carers are offered carers assessments routinely and supported to meet their needs and desired outcomes identified at assessment.	

	the Care Act 2014.	responsibilities to carers under the Care Act 2014 and to request evidence of this in response.				addressed within safeguarding policy and practice.		
OVERVIEW RECOMMENDATION 7: That the report is shared with the Ministry of Justice								
7.	**The ESCSP to ensure that the report is shared with the Ministry of Justice.**	The Joint Unit for DVA/SVA/VAWG will share the Report with the MOJ.	- Chair of the CSP Board to write to the Victims Lead, MOJ to notify of the DHR recommendation to share the report with the MOJ and agree process of sharing the report. - Report shared with the MOJ.	Dec 2020	Chair of the CSP Board	Complete – shared with the Victims Lead at the MOJ, agreed with the OPSCC as the most appropriate person to share the report with, the OSPCC have agreed to advise when the post has been filled and share contact details with the Joint Unit for DVA/SVA/VAWG, who will inform the Chair of the CSP. It is anticipated that this post will be filled in the coming weeks.	The implications of shortages of probation officers on professional standards are noted by the MOJ A professional registration of probation officers is in place to ensure that individual standards of professional practice can be regulated A list of internationally commensurate probation qualifications is collated and	

							published by the MOJ	

Individual Agency Recommendations:

Individual Agency Recommendations: Change Grow Live Domestic Abuse Portal

Recommendation 1: where there is a discrepancy to a risk assessment based on a further assessment or professional judgement, it is first discussed with the referring agency, before implementing service processes relevant to that risk level.						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	IDVA's will automatically contact the referring agency where there is a discrepancy in the risk rating based both on the referral or information held. A MARAC referral will be entered based on a further assessment or professional judgement without delay.	**Team Leaders**	**Active**	To ensure that high risk referrals receive a priority response regardless of the referrers initial risk assessment	Case management	Referrals of high risk service users into the MARAC where the initial referral risk assessment rating has been challenged and changed
1.2	The service will respond to all high risk referrals with urgency as is in accordance with our processes and safe practices					

Recommendation 2: Creative engagement should still be a consideration, whilst following safe practices. Joint visits especially in services where the victim already attends is considered good practice .e.g. GP or Probation. If engagement is not possible the Portal will offer consultation to other professionals where the victim is likely to attend. This must also be balanced and in accordance with GDPR.						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
2.1	Where there is no successful contact or agreement to engage with the victim, the IDVA should offer consultation or engagement via other professionals	**Team Leaders**	**Active**	To expand opportunities of specialist DVA support, directly or through professional consultation	Case Management and MARAC minutes	Improved and minuted creative discussion within MARAC Improved take up of direct service or professional consultation

Recommendation 3: Services to bring creative suggestions to MARAC, ensure that DVPO/DVDs and community and statutory services are considered for victim and offender.						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
3.1	The service to promote the use of DVPO/DVDs The service to be proactive in suggestions to engage or support the victim, bring professional curiosity into professional discussions on what other services need to support or engage the	Team Leaders	Active The service is working with Sussex Police as part of an initiative to increase the offer of DVPO's across East Sussex.	To widen opportunities for engagement into specialist services by providing enforced separation between the victim and perpetrator. Police to provide any relevant history that may inform the victim of the risk(s) the perpetrator presents.	The IDVA to ensure these considerations are usual practice during any safety planning including MARAC To be recorded as suggestions within MARAC minutes and on safety and support plans	Increased suggested and actual use of DVPOs and DVDs. Increased safety planning of Victims who do not engage with specialist DVA services

	Victim and the management of the offender			Question/open discussions on what is needed to improve safety, support and risk management within MARAC or Professional's meetings.		

Individual Agency Recommendations: East Sussex County Council Adult Social Care

Recommendation 1:
Ensure affected staff are accessing both IT systems as agreed

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured?
1.1	Revisit shared staffing agreement between Sussex Partnership NHS Foundation Trust and the County Council	Head of Service	COMPLETED	All AMHPs in ESCC have access to SPFT Patient recording system.	New AMHP staff are provided with login details for Carenotes (read only) following appropriate training.	All AMHP's having "read only" access to Carenotes

Recommendation 2:
Ensure all communication/ risks discussions at MARAC are appropriately updated onto ESCC IT systems ASAP but no longer that 24 hours following MARAC discussion.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured?
2.1	1) Records are created for all victims and perpetrators referred to MARAC within LAS (the Adult Social Care IT system)	Operations Manager, Safeguarding Development Team	COMPLETED	Records created for all victims and perpetrators referred to MARAC.	Spreadsheet and Administrative Support Officer line management	Records continue to be created for all victims and perpetrators referred to MARAC**.**
	2) Where a case has been heard at MARAC, warning markers to be added to the records in		15.9.20	Warning markers to added to all cases referred to MARAC	Spreadsheet and Administrative Support Officer line -management	Warning markers to added to all cases referred to MARAC

	LAS records of victim and perpetrator 3) Minutes of all risk discussions (and actions) are uploaded to LAS following circulation by the MARAC Coordinator, Safer Communities. .	As above	15.9.20	All minutes of risk discussions (and actions) to be uploaded to LAS records of victims and perpetrators	Spreadsheet and Administrative Support Officer line- management	All minutes of risk discussions (and actions) to be uploaded to LAS records of victims and perpetrators

Individual Recommendations: East Sussex Healthcare NHS Trust

Recommendation 1: Develop a health pathway and embed into routine enquiry & NICE standards in A&E.						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	To ensure that staff ask the questions and refer to relevant services. To identify if there are children in the household and to refer to SPOA. To complete a DASH and refer appropriately. To ensure that the patient is discharged with a safety plan and information is shared with the relevant agencies i.e. GP.	Head of Safeguarding	December 2020	To raise awareness and inform front line staff of actions in response to a service user that presents with Domestic Abuse.	Audit quality of number and Quality of DASH referrals. Feedback survey to practitioners to identify: If they have found the pathway beneficial to practice. Audit quality of information shared in the discharge letter when domestic abuse has been identified. Safeguarding team will continue to be a regular visible presence within the A&E departments to offer advice and support.	The safeguarding team will measure: How many referrals are made in which domestic abuse is cited. Feedback will be evaluated to measure improvement and this information will be delivered back to clinical leads.

Recommendation 2: Demonstrate that efforts to improve staff awareness and responses to domestic abuse in recent times are proving successful.						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	Auditing the numbers of safeguarding referrals where there is an allegation of domestic abuse.	Head of Safeguarding	December 2020	To be able to identify trends in the domestic abuse referrals.	A retrospective review of referrals will be collated. The audit will need to be registered with the trust audit team. It will then be presented to the quality advisory group and safeguarding strategic and operational groups and the professional advisory group.	The intention of the audit is to be able to evidence whether or not there has been a change in the trend of referrals. A key element of this will be domestic abuse workshops and training and impact upon professionals.

Recommendation3: As well as training to identify signs and indicators of domestic abuse, training, procedures and pathways need to be embedded about how practitioners/clinicians respond effectively to domestic abuse.						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	There needs to be a process in place for all clinicians to be able to access information regarding domestic abuse. There will be supplementary training available via workshops and also inclusion in the	Head of Safeguarding	December 2020 and ongoing.	To ensure all front line clinical staff are aware of domestic abuse signs and indicators. Increase knowledge identifying domestic abuse and making referrals to the relevant services for adults and children.	ESR has level 3 safeguarding training data	Review of clinician feedback in 6 months to ascertain if practice has improved. Audit of quality of referrals and documentation in clinical notes.

	level 3 "Think Family" safeguarding training package. To plan this, safeguarding named nurses will meet with A&E clinical education lead.					
1.2	Evaluate how confident staff feel in identification of domestic abuse and how to make a referral to support services.	Head of Safeguarding	December 2020	To identify areas of improvement and ensure staff competence and confidence.	A feedback survey will be undertaken and the learning from this will inform further training and information sharing.	Measure the feedback from front line staff.

Individual Agency Recommendations: Kent, Surrey and Sussex Community Rehabilitation Company

Recommendation 1: KSS CRC to meet the expected standards for pre-release contact.						
REF	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	Responsible Officers should consistently make pre-release contact with a service user and other agencies involved, prior to a person's release from Prison.	E&E Investigations Officer	30/03/20	For all custody cases to have had contact with their Responsible Officer prior to release. For Responsible Officers to commence risk management alongside other agencies involved prior to release of custody cases.	KSS CRC to conduct a Quality Assurance audit on one case per Responsible Officer within KSS CRC. This audit will identify if the appropriate pre-release contact has been made for custody cases.	E&E Officer and E&E Investigations Officer to analyse audit results to measure improvements to practice. If the required improvements have not been made, E&E Investigations Officer to make a recommendation for further developmental action. KSS CRC complete annual Local Quality Audits, and the impact of the developmental actions can be monitored within this structure.
Update – COMPLETE: KSS CRC conducted an internal quality audit in November 2019 which showed that 60% of cases had pre-release contact and 64% of Responsible Officers had sufficiently co-ordinated contact with other agencies. This has shown some improvements from the previous audit in November 2018 which showed 52% of cases had pre-release contact. There is still room for improvement and KSS CRC are continuing to address this by completing regular internal quality assurance audits and increasing the amount of dip sampling completed by Senior Probation Officers. From this point Senior Probation Officers						

are now required to complete a dip sample of three cases prior to each Responsible Officer's supervision. The dip sampling is to effectively communicate practice expectations and encourage improved practice.

Recommendation 2: KSS CRC Senior Probation Officers to demonstrate professional curiosity and effective management oversight.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured?
2.1	KSS CRC Senior Probation Officers to demonstrate regular professional curiosity and effective management oversight.	E&E Investigations Officer	30/03/20	For there to be evidence of effective management oversight on all cases where safeguarding issues present.	KSS CRC to conduct a Quality Assurance audit on one case per Responsible Officer within KSS CRC. This audit will identify any management oversight recorded and whether this oversight was effective.	E&E Officer and E&E Investigations Officer to analyse audit results to measure improvements to practice. If the required improvements have not been made, E&E Investigations Officer to make a recommendation for further developmental action. KSS CRC complete annual Local Quality Audits, and the impact of the developmental actions can be monitored within this structure.
Update. KSS CRC's internal quality audit demonstrated that the quality of management oversight has increased from 43% (November 2018) to 52% of cases having sufficient management oversight. Therefore, this has shown some improvements. KSS CRC are continuing to address the quality of management oversight. Since the review period Senior Probation Officers are now required to dip sample three cases prior to each Responsible Officer's supervision. This						

has also included KSS CRC then created two SPO roles that cover performance monitoring across KSS CRC. This enables operational SPOs to focus on the quality of practice and one to one work with staff (including the recording of such work).

Recommendation 3: KSS CRC to ensure that the competencies of temporary and/or agency staff are checked.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured?
3.1	KSS CRC to consistently implement the Agency Compliance Checklist during the recruitment of all temporary and/or agency staff.	E&E Investigations Officer	30/03/20	For all agency and temp staff members to have their competencies thoroughly tested prior to being placed into Responsible Officer roles.	E&E Investigations Officer to undertake an audit of all agency / temp staff recruited between May 2019 (when revised Agency Compliance Checklist was implemented) to January 2020. This will monitor the completion to the Agency Compliance Checklist and embedding of this revised process into the recruitment process.	E&E Investigations Officer to analyse audit results to measure improvements to practice. If the Agency Compliance Checklist is not being successfully completed in a consistent manner, E&E Investigations Officer to make a recommendation for further developmental action.

This action has been completed. The Investigations Officer has completed a dip sample of all agency cases recruited to KSS CRC between May 2019 and January 2020. The checklist has been consistently completed in recruitment for each agency member of staff, which specify the qualification that enables them to enter into the role of a qualified Probation Officer

Individual Agency Recommendations: Sussex Clinical Commissioning Groups

Recommendation 1: That codes on SystmOne are used to flag people at risk of domestic abuse. This will aid GPs and nurses in the identification of people at risk and prompt accessing historical records to allow previous concerns to be address on subsequent consultations.						
Desired outcome from the recommendation: Prompt identification of individuals potentially at risk, and quick access to records						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Progress**
1.1	Include read codes within safeguarding Level 3 training and direct practices to RCGP guidance	Pan Sussex	CCG Safeguarding team/ Named GP	Training package has been updated to include read codes.	June 2020	Complete (April 2020)
				Additional training pack sent out in April 2020 for virtual training also includes section on the importance of read codes	June 2020	Complete (April 2020)
1.2	Read codes to be circulated to practices with guidance from RCGP including importance of accurate coding of records	Pan Sussex	CCG Safeguarding team/ Named GP	Read codes information already shared in resource packs and practice briefings.	June 2020	Complete (ongoing)
1.3	Named GP to engage with practice teams to ensure understanding of read codes is widespread by practice teams including safeguarding administrative support.	Pan Sussex	CCG Safeguarding team/ Named GP	Named GP to establish meetings with practices	Oct 2020	
				Information sent out in Primary Care bulletins	June 2020	

Recommendation 2: That GPs and nurses refer to historical records during consultations to enable any outstanding health issues to be identified and discussed						
Desired outcome from the recommendation: Ensure previous records and medical history is reviewed as part of consultations						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Progress**
2.1	Encourage use of read codes to ensure practice teams are aware of concerns previously identified	Pan Sussex	Safeguarding Team	Named GP to engage with practice teams in team meetings, to ensure read codes accurately applied to enable timely follow-up	Oct 2020	**Complete**
Recommendation 3: Following significant events at the surgery, where risk to individuals has been identified, that a review is undertaken to ensure all relevant information is shared around identified risks.						
Desired outcome from the recommendation: Patient reviews take place where risks have been identified, and ensure relevant information is shared appropriately						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Progress**
3.1	Encourage practices to write up cases where harm or near harm has happened as significant or learning events and discuss in a practice meeting to ensure all relevant information is shared around identified risks and learning.	Local	CCG Adult Safeguarding Team	Briefings to be circulated to share learning from incident. Learning reviews within practices to be developed following significant risk incidents	Dec 2020	**Complete**

Recommendation 4: That the practice implement a domestic abuse policy outlining the roles and responsibilities of staff, as well as resources to support people using and working for the practice.						
Desired outcome from the recommendation: All practices to have a policy relating to Domestic Abuse and this is disseminated to all staff.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Progress**
4.1	Support primary care to implement practice domestic abuse policy and promote benefits of standalone DA policy modelled on CCG DA Policy and Toolkit.	Pan Sussex	Named GP/ Safeguarding Team	Develop a practice domestic abuse policy modelled on CCG DA policy	Oct 2020	**Complete**
				Circulate in briefings, newsletters and learning events	July 2020	**Complete**
4.2	Circulate of resources to promote awareness of local DA pathways and referral routes	Pan Sussex	Safeguarding team	Disseminate links to local DA services and pathways.	April 2020	Complete (April 2020)

Individual Agency Recommendations: Sussex Community NHS Foundation Trust

Key lesson	Recommendation	Action	Timescale
Uckfield SCFT Minor Injuries Unit: To raise awareness of the signs of domestic abuse and the appropriate pathways to seek support for the victim	To deliver L3 adult safeguarding training to Uckfield Minor Injuries Unit	To be delivered within October 2019 East Sussex MIU Team Meeting (all MIUs attend)	01/11/2019
Wider East Sussex SCFT Minor Injuries Units (Lewes and Crowborough): To raise awareness of the signs of domestic abuse and the appropriate pathways to seek support for the victim	To deliver L3 adult safeguarding training to Lewes and Crowborough Minor Injuries Unit	To be delivered within October 2019 East Sussex MIU Team Meeting (all MIUs attend)	01/11/2019
Wider SCFT Minor Injuries and Urgent Treatment Centres: To raise awareness of the signs of domestic abuse and the appropriate pathways to seek support for the victim	To ensure a Trust wide approach, deliver L3 adult safeguarding domestic abuse training to Bognor War Memorial and Horsham Minor Injuries Units and Crawley Urgent Treatment Centre	To be delivered within West Sussex MIU Team Meetings: Dates/times TBC	actioned by 01/04/2020
Raise internal awareness of SCFT IMR findings	Share IMR findings via SCFT local networks: Please note that this will not include identifiable details of the named individuals	Deliver a summary of SCFT findings and actions at the SCFT Safeguarding Steering Group	19/09/2019

Individual Agency Recommendations: Sussex Partnership NHS Foundation Trust

Recommendation 1:
Lack of known and understood legal restriction gave the perpetrator the choice to disengage with services and decline depot medication. His Care Plan and engagement was reliant on the perpetrator making contact and attending appointments when he was clear that he did not believe that this was necessary, there was no contingency for disengagement despite a history of disengaging and becoming unwell.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Progress
1.1	All patients deemed at risk of disengagement from services will have a risk management plan. To Rag rate Red this will ensure discussion at weekly team meeting.	Local	*Team leader*	MDT weekly team meeting minutes and Carenotes. Plan contained within care plan	**31st Jan 19**	Completed Jan 19

Recommendation 2:
Positive plans for engagement to be clearly documented with any restrictions or alerts to be discussed with Multi-Disciplinary Team.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Progress
1.1	Alerts to be discussed at MDT prior to putting on Carenotes.	Local	*Team Leader*	Put on forward sheet of community tracker for information Forensic Liaison Outreach Service weekly team meeting minutes which are uploaded onto care notes.	**31st Jan 19**	Completed Jan19

Recommendation 3:

Ensure that patients that have been de-registered from a GP are supported to re-register and that prescriptions are delivered to a community pharmacy so assurance can be sought re collection.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Progress
1.1	Lead practitioners to be aware of the importance of patients being registered with a GP. List of community pharmacy contact details to be available so that FP10 can be sent directly to community pharmacy. Lead practitioner to discuss preference with patient to aid collection	Local	*Team leader*	Contact details for local pharmacy to be held on the B drive in community folder	**31st Jan 19**	Completed Jan19

Recommendation 4

Where engagement is an issue, consideration of use of mental health act should be discussed and documented with a rationale for decision making.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Progress
1.1	Mental Health Act Assessment to be considered and documented if a patient misses more than 3 appointments with lead practitioner (MDT).	Local	*Completed*	Put on forward sheet of community tracker for information Team meeting minutes Rag to red in team meeting	**31st Jan 19**	Completed March 19

Recommendation 5:

HCR20 risk assessment to be completed for all forensic inpatients

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Progress
1.1	Inpatient wards to complete HCR20 prior to discharge Forensic Liaison Outreach Service staff to highlight to ward staff if this has not been completed	Local	*Ward Matrons*	Completed HCR20 Completed audit	31st Jan 2019	Completed JAN 19

Recommendation 6:
Protocol to be put in place to ensure that all eligible patients receive a Section 117 discharge meeting.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Progress
1.1	Follow CPA policy and ensure representative from community and Local authority are in attendance	Local	*Team leader*	Documentation in care notes and full representation at S117 meetings	31st Jan 2019	Completed Jan19

Recommendation 7:
Triangle of care to be fully implemented with all patients

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Progress
1.1	Identify carer champions within the CFOS Attendance at Trust ToC meeting Carer details to be completed on Carenotes for each patient	Local	*CLT*	Two Forensic Liaison Outreach Service staff identified Attended 1st ToC meeting 19.9.18 **Inpatient -Appointed Family /carers liaison support worker**	31/12/ 2018	Completed 24/12/18

Recommendation 8*:*
Protocol to be developed to ensure that information shared by MARAC is accessible, checked by all Lead Practitioners and incorporated into risk management plans.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Progress
1.1	Forensic Liaison Outreach Service representative to attend MARAC meetings Trust IG to advise if an alert can be put on the Carenotes system for any discussion about Trust patients open or closed to services.	Local	*CLT*	Attendance at MARAC meeting by FCDS Trust guidance from IG established and implemented as standard practise	**March 19**	Completed March 19

Individual Agency Recommendations: Sussex Police

Recommendation 1: The Head of Public Protection should ensure that a review of DASH risk assessment is incorporated within the ongoing force DA Improvement Plan to ensure that the level of risk is being appropriately identified / graded by officers and staff. This review should be undertaken as soon as practicable.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured?
1.1	The DASH form was not looked at as part of the Force DA Review, as this is a national template and subject to a national review. However, our Strategy and Compliance Team have completed a qualitative review of Safeguarding Templates which addressed this recommendation. The review provided an opportunity for competent practitioners to review the quality of the risk assessments and, specifically, to consider whether the measures implemented through the Safeguarding Templates actually addressed the risks identified.	Head of Public Protection	June 2020	Officers to consistently grade the level of risk on DASH correctly taking account not only the victim's responses but also the circumstances of the incident reported.	Progress is being monitored by Strategy & Compliance through ongoing DA audits. Oversight is provided by the bi-monthly Specialist Crime Command Investigation & Intelligence Learning Board (IILB) chaired by the Head of Crime / Head of Crime Operations. Oversight and scrutiny will also be provided by the monthly DA Scrutiny group, chaired by the Portfolio Lead.	1. Through a rolling audit and evaluation programme. 2. The DA Scrutiny group provide monthly oversight of cases by a panel of staff from across the force. This will highlight case specific issues, general areas for improvement, areas of good practice, and areas where there may be gaps in knowledge or response to DA. As there are local participants, these supervisors can feed back directly to officers where there are areas for development, making this an ongoing level of quality assurance and scrutiny.