Western Suffolk Community Safety Partnership

Domestic Homicide Overview Report Executive Summary regarding the death of Carol, who was killed in January 2020

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A message of condolence

The Domestic Homicide Review Panel wishes to express its condolences to the family and friends affected by the events described in this report. The panel hopes that the process will provide some answers to their questions.

Introduction

This Domestic Homicide Review (DHR) Overview Report examines agency responses and support given to Carol, a resident of West Suffolk, prior to her death in January 2020.

Carol's death was notified to Western Suffolk Community Safety Partnership (WSCSP) on 20 January 2020. She died as a result of 10 stab wounds and compression of her neck. The perpetrator, her ex-partner Colin, was arrested and charged with Carol's murder.

Carol was a white British woman living in Suffolk. She had had a number of relationships with male partners over the past two decades. Many of these relationships had been characterised by domestic abuse perpetrated against her.

The perpetrator, Colin, had been in a relationship with Carol for a relatively short period of time. Colin originates from Essex and there are relevant criminal convictions relating to domestic abuse apparent on his criminal record.

Carol and Colin were both living in Suffolk, although are understood to have been residing separately at the time of Carol's death.

Police had been in contact with Carol in the days immediately preceding her murder. She had contacted them to say that she had broken up with Colin and that he had not taken this news well. He had continued to try to make contact with her by phone and had stated that if she stopped seeing him she would regret it.

In the late evening of the day of her death, one of Carol's relatives called the police to report that a man was threatening her with a knife. The police contacted the ambulance service and having arrived on scene, called for a second ambulance. It has been stated that Carol had been stabbed ten times and had also suffered a compression of the neck.

Ambulance crews administered basic life support but Carol was declared deceased at the scene. Colin was arrested and subsequently charged with murder and remanded in custody to await trial. The trial concluded in June 2021, when Colin was convicted of murder.

The DHR process

This DHR was commissioned because it meets the definition detailed in paragraph 12 of the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2016). The review has followed the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

The police made the referral to the Western Suffolk Community Safety Partnership (WSCSP). The WSCSP commissioned the DHR in January 2020. The independent chair and author was appointed in May 2020. The impact of COVID-19 on local authority operations meant there was some delay in the appointment of a Chair and author for this DHR.

At the time of the DHR there was one other parallel review in progress. This was a review being conducted by the Independent Office for Police Conduct (IOPC). It was instigated following a complaint from Carol's family in respect of contact by both Suffolk and Cambridgeshire police in the weeks prior to her death. The IOPC investigation was suspended in September 2020 pending the outcome of the trial of the perpetrator.

A pre-inquest hearing took place in mid-June 2021. The Suffolk Coroner has determined that an inquest will be held. This has been listed for May 2022.

A first panel meeting was held in May 2020, following a period of scoping and then Individual Management Review (IMR) completion and submission. The process was concluded in September 2021. The DHR panel met virtually four times, as well as additional discussions by teleconference. The Chair also held discussions by phone with the DHR lead within the CSP.

The Domestic Homicide Review has been conducted in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004. It has since been updated and was republished in December 2016.

Contributors to the Domestic Homicide Review

Individual Management Reports (IMRs) were requested from the agencies that had been in contact with or providing services to Carol. The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both the subjects of the DHR.

The IMRs were to review and evaluate this thoroughly, and if necessary, to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

Ten agencies contributed to the review through the submission of Individual Management Reviews and the provision of initial scoping information. Those agencies were:

- Suffolk Police
- Cambridgeshire Police
- Cambridgeshire Independent Domestic Violence Advisor Service
- Cambridgeshire & Peterborough Clinical Commissioning Group
- Cambridgeshire & Peterborough NHS Foundation Trust
- Cambridgeshire Children's Services
- East of England Ambulance Service NHS Trust
- Cambridgeshire County Council
- Cambridgeshire & Peterborough Domestic Abuse and Sexual Violence Partnership
- Ipswich, East Suffolk and West Suffolk Clinical Commissioning Group

The agencies identified above each provided IMRs that were reviewed by the panel and used by the panel in reaching their conclusions.

Other contributors to the DHR

As part of the DHR, the Chair was able to speak with Carol's father, along with his advocate from Action After Fatal Domestic Abuse (AAFDA).

The Domestic Homicide Review Panel Members

Steve Appleton	Independent Chair and author
Cllr Joanna Spicer	Western Suffolk CSP Chair
DCI Barry Byford	Suffolk Police
Linda Coultrup	Cambridgeshire & Peterborough Clinical Commissioning Group (CCG)
Christine Hodby	Ipswich, East Suffolk and West Suffolk Clinical Commissioning Group (CCG)
Mercedes Macfarlane	East of England Ambulance Service Trust NHS
Julie May	Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) (Children)
Julia Cullum	Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership
DCI Andrea Warren	Cambridgeshire Police
SIO Pushpa Guild	Cambridgeshire Police
Jim Bambridge	Cambridgeshire Police
Darren Butler	Cambridgeshire and Peterborough NHS Foundation Trust
Aidan O'Reilly	Cambridgeshire County Council Social Care (Children)
Melanie Yolland	Suffolk County Council, Domestic Homicide Review Lead

The members of the panel were independent and had no prior contact with the subjects of the DHR or knowledge of the case.

The Overview Report author

The independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time, he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently, he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written a number of DHRs for local authority Community Safety Partnerships across the country. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation.

Steve has had no previous involvement with the subjects of the review or the case.

Terms of Reference

Terms of Reference were developed and agreed jointly. Panel members and the independent chair discussed these. The Terms of Reference were as follows:

- Consider the three-year period between January 2017 to January 2020, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant. Where such relevant information from outside the timeframe is available it will be taken into account.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

- Take account of the coroners' inquest in terms of timing and contact with the family.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Aim to produce the report within six months[1] after completion of the criminal proceedings, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

- To discover if the perpetrator was subject to a Domestic Violence Protection Notice or Domestic Violence Protection Order.

- Were there any disclosures under 'Right to know' or 'Right to ask'.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

[1] See mitigations relating to COVID and delayed trial on page 4.

- Was the victim known to local domestic abuse services, was the incident a one off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?

- Were there any barriers experienced by the victim or family, friends and colleagues in reporting the abuse?

- Consider the impact of any cross-border (local authority boundary) issues relating to access to services, service responses.

- Take account to and be cognisant of any ongoing review, for example the Independent Office for Police Conduct (IOPC) referral and review.

- Was abuse present in any previous relationships, did this affect the victims decision on whether to access support?

- Where there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?

- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?

- Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children.

- Was the perpetrator known to have a history of domestic abuse, if so what support was offered to the perpetrator?

- Were staff working with the perpetrator confident around what service provision is available around domestic locally?

- Give appropriate consideration to any equality and diversity issues that appear pertinent to the perpetrator.

Key findings and conclusions

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided, the panel has drawn the following conclusions:

The principle conclusion of the DHR panel is that Carol was subjected to domestic abuse in the period leading up to her death. This manifested itself through both previous coercive and controlling behaviour as well as physical abuse.

Coercive control 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. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour. The inclusion of coercive control in statutory legislation is still relatively recent, only being included in Section 76 of the Serious Crime Act 2015. By its nature it can often be hidden from others, notably family and friends as well as professionals.

This case demonstrates that coercive control may not always be recognised as such by the victim. The lesson to be learnt is that work remains to be done to raise awareness of coercive control, encouragement to victims to recognise and report it, and for agencies to respond to it appropriately.

The agencies that had contact with Carol treated her with respect and their inputs. However, not all interactions and interventions provided were in line with relevant policy and guidance.

Carol appears to have moved addresses frequently. It is understood that she resided in both privately owned and rented accommodation as well as that provided by local authority housing services. She also resided temporarily with members of her family at certain times. There is no evidence that these moves had any direct impact on the ability of agencies to offer or provide responses or services to her.

There is a significant amount of information that confirms that Carol was subjected to domestic abuse over a sustained period and by a number of her previous partners, before and including Colin. She had been in relationships with seven different men between 2007 and January 2020 when she was killed. Two of those former partners were the fathers of her children. In each of these relationships domestic abuse had been recorded at least once with each of those men.

A common theme to have emerged is Carol's reluctance to expose what was happening within her relationships. She was clearly reticent to reveal what was really happening in her life and in the view of some professionals this created barriers in being able to support her. Whether this is because she feared the consequences for herself or that she did not recognise the abuse as such is harder to quantify.

There was a willingness to accept the lack of perceived co-operation or wish for support and so referrals were closed at the earliest opportunity, indicating that there was no appetite for exploring further evidential opportunities.

There is clear evidence that agencies undertook appropriate risk assessments in relation to Carol. A Domestic Abuse Stalking and Harassment risk assessment (DASH) was used on a number of occasions and recognised risk ratings were applied. These were reviewed and amended where the evidence indicated that this was necessary, primarily by the police. The risk rating was raised where appropriate. However, the outcomes of those DASH assessments were not always shared between agencies, notably between the two constabularies.

Police referrals to the Cambridgeshire Multi Agency Safeguarding Hub (MASH) were all timely and accurate. There were delays in the processing of referrals by the Multi-Agency Referral Unit (MARU) and the MASH. The delays were in the recording and referrals to other agencies, although these were not detrimental and were due to a significant increase in all types of safeguarding referrals on the occasions experienced.

Colin had a history of domestic abuse offences. Both Suffolk and Cambridgeshire police were aware of Colin's history of offending through recognised information and intelligence networks. They involved breaches of a non-molestation order, breaching a suspended sentence for a domestic abuse offence and breaching a restraining order. He was therefore a known offender with a history of perpetrating domestic abuse.

A key theme to emerge from this DHR is the reluctance of Carol to support police action against her perpetrators. Although there is information that suggests she did, at times, recognise that she was subjected to domestic abuse, there is also evidence to indicate that her attempts to minimise it, not report it, or not support police action was borne of her concern about the possible consequence. Not least of these is the potential concern about the implications in relation to her children and the possible intervention of Children's Services. This had a direct impact on the ability of the police in particular to take forward criminal proceedings.

There are many reasons why an individual may not immediately make a report of domestic abuse. It may not be apparent to the victim that a relationship is abusive.

They may be afraid of the abuser, and fear the consequences for themselves or others if they disclose the abuse. The victim may not know where to turn for help.[2] They may also fear for the implications on their children, for example their removal by statutory services.

Carol's delay in making a formal allegation against a previous partner, known in this report as Trevor, did weaken the totality of her allegations but there were also evidential weaknesses that impacted on the decision-making. She was not considered to have been an unreliable witness but her reluctance to report and progress the incidents at the time, the varying versions of events that she gave and the other occasions that had gone unreported, impacted considerably.

The evidential weaknesses that undermined the case were identified within the reporting of the case by the police to the CPS, although the police did seek a prosecution decision to be made. The police must present a balanced case and the weaknesses seemingly influenced the decision by the CPS not to prosecute. The CPS do not suggest victim blaming, rather the focus is to the inherent evidential difficulties that undermine the case.

A delay in reporting does not diminish the impact of the abuse, nor should it be considered as a failure on the part of the victim. However, the evidential test still has to be applied. The police did not challenge the decision of the CPS not to prosecute, which was based on the evidential test.

There is no evidence that there were any organisational or systemic barriers to reporting of domestic abuse present in this case.

There was appropriate consideration of the needs and welfare of Carol's children. CSC were engaged in proceedings relating to their care and these resulted in Carol no longer having care or custody of them. On the majority of occasions that meetings took place Carol was invited but did not attend. There is no evidence to indicate that any follow-up was done to explore why she did not attend, and what steps were considered to ensure she was present so that she was engaged in those discussions.

The nature of the relationship between alcohol misuse and domestic abuse was recognised but the conclusion of the DHR is that it was not adequately considered or addressed. The misuse of alcohol can place individuals at greater levels of risk in relation to physical and mental health, their financial circumstances and their relationships, as such the Institute of Alcohol Studies suggests that it can increase an

[2] Safe Lives https://safelives.org.uk/policy-evidence/about-domestic-abuse/how-long-do-people-live-domestic-abuse-and-when-do-they-get Accessed March 2021

individual's overall risk and also in some cases their own vulnerability. Carol did not seek support from her GP for substance misuse, but it is not known if this was due to concerns about their being a formal record of this and its implications in relation to her children.

Research to indicate that alcoholism and drug abuse causes domestic violence is limited but that which exists indicates that among men who drink heavily, there is a higher rate of assaults resulting in injury. [3] Evidence suggests that alcohol use increases the chance and gravity of domestic violence, showing a direct correlation between the two. Because alcohol use affects cognitive and physical function, it reduces a person's self-control and lessens their ability to negotiate a non-violent resolution to conflicts.[4]

EEAST did not raise a safeguarding concern in respect of Carol's daughter. This is because she was not resident with Carol at the time of their attendance. However, changes have been made to the pathway for raising such a concern. This was not done as a result of Carol's death, but means that now a check will be made in relation to children who may be related or known to a patient being attended by the service. This shows that the service is continuing to review and improve local practice and process.

There is no evidence that the cross-border nature of this case had any direct impact on the immediate response of local services, in particular of the two constabularies that had contact with Carol. However, Suffolk and Cambridgeshire police did not always communicate effectively with each other, especially in the sharing of DASH risk assessment outcomes.

Recording of contacts and interactions with Carol by the agencies covered by this DHR were largely of the standard that would be expected. There were some gaps identified but there is no evidence that these had any detrimental impact on the response to Carol. However, accurate and timely recording remains something for all agencies to ensure takes place.

The use of recording systems to ensure that communications between professionals and agencies is critical in making sure that these interactions are known and that all involved have an up to date picture. These should be based on existing sharing agreements and the consent of the individual. This DHR has shown that there were some inconsistencies in both the recording of contacts and communication. These specifically related to contradictions about the contact between the MIU and the GP

[3] Very Well Mind – international online research library accessed February 2021
[4] American Addiction Centers alcohol.org accessed February 2021

practice. Such contradictions serve to hinder reviews such as this and can lead to omissions of knowledge.

The impact of the domestic abuse against Carol must have had an impact on her children, in particular her elder child. Although there was a period when neither of her children were living with her, her daughter in particular was exposed to the impact of the domestic abuse against her mother. CSC did take appropriate steps to safeguard Carol's children in the period covered by this DHR, but what further support either her daughter or son may have received is not known.

This case is one where the victim was subjected to domestic abuse by a number of partners over a significant period of time. While agencies did their best to offer support and help, their efforts were constrained by her reluctance to report, engage and work with those agencies. The DHR has highlighted some of the reasons for this. These only serve to reinforce the need to ensure that agencies prioritise the recognition of and response to domestic abuse. In particular in relation to women who experience multiple incidents and put in place strategies that can enable them to better recognise abusive behaviour, to report it and feel supported in the pursuance of action against perpetrators.

Lessons to be learnt

Domestic abuse and violence (DVA) is highly prevalent, particularly among women.[5] It accounts for 11% of all crimes reported to police in England and Wales, and more than one in four women and around one in six men have experienced DVA since the age of 16. However, official figures are likely to be an underestimate, because much DVA remains hidden.[6]

It is widely acknowledged that asking individuals about their experiences of domestic violence and abuse is more likely to encourage disclosures.[7] "It has been found that routinely asking women about domestic violence is more appropriate than an 'ad hoc' enquiry that may rely on stereotypical views around which groups of women are likely to experience domestic violence. Routinely asking gives the message that it is acceptable to disclose domestic violence and that no one is being specifically targeted for enquiry (which could have safety implications)"[8] Routine Enquiry is simply finding a way of asking people directly and confidently about DVA.

Given that on average high-risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before getting help[9], the use of routine enquiry can be an effective method, not only in identifying domestic abuse, but doing so more swiftly than might otherwise be the case.

Despite her reluctance to engage, there were programmes that Carol could have been more proactively directed to. These included the Freedom Programme, which might have assisted her in being able to recognise abusive behaviours. While it is important to state that it is not possible to compel a person to engage or participate, being able to clearly articulate the benefits of such a programme, including the online version could usefully form part of the work of the IDVA services locally.

[5] Routine enquiry for domestic violence and abuse in sexual health settings, Lyus, L. & Masters, T. British Medical Journal http://dx.doi.org/10.1136/sextrans-2017-053411
[6] ibid
[7] Piloting Routine Enquiry in Leeds GP Practices 2016 https://www.leeds.gov.uk/domesticviolence/Documents/GP%20Pilot%20Report%202016%20Final.pdf
[8] Domestic violence in work with abused children, Hester, M. and Pearson, C. JRF 1998
[9] SafeLives Insights Idva National Dataset 2013-14. Bristol: SafeLives 2015

Recommendations

The Domestic Homicide Review Panel made the following recommendations arising from the review. They were developed in direct response to the key findings and conclusions. The full Overview Report describes the linkages between the findings and recommendations in more detail.

1. Suffolk polices' processes for information sharing have developed and evolved through operational practice. Suffolk police should undertake a process of work to ensure that their processes for information sharing and cross-border working with colleagues in Cambridgeshire are robust and operationally effective in relation to domestic abuse. They should provide assurance to the CSP within six months of this report being approved by the CSP. They should conduct an annual review of these arrangements.

2. Cambridgeshire polices' processes for information sharing have developed and evolved through operational practice. Cambridgeshire police should undertake a process of work to ensure that their processes for information sharing and cross-border working with colleagues in Suffolk are robust and operationally effective in relation to domestic abuse. They should provide assurance to the CSP within six months of this report being approved by the CSP. They should conduct an annual review of these arrangements.

3. Suffolk police should review their practice in relation to the use of the provisions of both DVPN's and DVPO's to ensure they are well understood by officers and effectively used. They should share their practice and learning with colleagues in Cambridgeshire as a means of promoting collaborative learning and development.

4. Cambridgeshire police should review their practice in relation to the use of the provisions of both DVPN's and DVPO's to ensure they are well understood by officers and effectively used. They should share their practice and learning with colleagues in Suffolk as a means of promoting collaborative learning and development.

5. Although there was an understanding of issues relating to safeguarding and how to raise concerns, the panel was of the view that there would be benefit in highlighting the need for greater understanding of different organisational processes and when to raise a concern. In particular safeguarding, although considered, did not always appear to be a process, which would necessarily have led to any greater or more effective action to reduce risk to Carol. Local practice should be reviewed and compared with other similar local authority areas to determine where and how current processes, understanding and practice in safeguarding, both adults and children, can be improved.

Appendix A: Action Plan

Quarterly updates to WSCSP

Scope of Recommendation	Action to be taken	Outcome	Lead Agency	Target date	Progress	Agency response to recommendations and outcomes	Date of completion
Local, County, regional or national level?	How relevant agency will make this recommendation happen? What actions need to occur?	What difference will it make? How will the public know?		Date the recommendation /actions should be implemented by	**Red** **Amber** **Green**	Quarterly Updates	
In addition to the Recommendations identified during this Review, some of the organisations that submitted IMRs made recommendations within those reports. These are set out here for information, as they were presented in the IMRs. These will be monitored as part of the action plan arising from the DHR alongside the DHR panel recommendations							
Recommendation 1 **Suffolk Police**							
6. Suffolk police's processes for information sharing have developed and evolved through operational practice. Suffolk police should undertake a process of work to ensure that their processes for information sharing and cross-border working with colleagues in Cambridgeshire are robust and operationally effective in relation to domestic abuse. They should provide assurance to the CSP within six months of this report being approved by WSCSP. They should conduct an annual review of these arrangements.							

Local	To ensure compliance, to regularly audit domestic abuse cases through internal processes and DA scrutiny panels and in particular any cross border cases Check MARAC High Risk cases for MARAC transfers through minutes and review	The Constabulary is subject to HMICFRS inspection where these areas will be audited and reported on. The external scrutiny panel has representation from a number of people from the voluntary sector adding to levels of accountability.	DCI Angus Moir, Crime, Safeguarding and Incident Management Suffolk Constabulary	**By June 2022**	**Green**	**Update:** Suffolk Constabulary have internal DA scrutiny panels in each of the three geographical policing commands. In addition, the Constabulary has an external DA scrutiny panel, which examines cases which have resulted in a no further action decision by police. DA crimes are also form part of ongoing crime investigation audits to improve investigative standards. Cambridgeshire police have access to both Suffolk Constabularies Crime and intelligence through the shared Athena system. In addition, staff within Suffolk Constabularies DA and intelligence teams are aware that they should liaise with any other force area where there is an identified interest. A desktop review of MARAC in Suffolk has been undertaken and review of	**COMPLETE** 01/11/2023

					Green **Green**	meeting minutes did not identify any cases relevant to this action. **Update:** The Constabulary has a continuous improvement plan in relation to Domestic Abuse with strategic oversight managed by Supt Cutler. This includes ongoing audit, investigative standards and organisational provision. **Update:** Previous updates still relevant and MARAC restructure still to be decided.	

Recommendation 2
Suffolk Police

Positive action via arrest and the appropriate use of police bail could have provided protection by restricting the movement of Colin or preventing access to Carol or locations where the parties might encounter each other.

a) A programme of messaging across the Constabulary highlighting the positive action policy and ensuring that it is understood and implemented by all staff at all times.

a) DASH risk assessments. Ensure Officers check for previous DASH risk assessments and do not treat a domestic abuse incident in isolation. (104) **By September 2022**

	b) DASH risk assessments. Ensure DASH risk assessments are consistent and timely including any DASH reviews. (234) **By September 2022** **c)** DASH risk assessments. Suffolk Police are to undertake a process of work to ensure that their processes for information sharing in relation to DASH assessment outcomes and cross-border working with colleagues in Cambridgeshire are robust and operationally effective in relation to domestic abuse (240) (323) **By September 2022** **d)** Safeguarding Referrals. Ensure Officers know to complete and submit Safeguarding Referrals in a timely manner if children are present during attendance for a domestic incident (161) By June 2022 **e)** Ensure Officers undertake all enquiries in accordance with regulations and procedure and all evidence is captured (mobile phone for download and analysis) and followed up in a timely manner. (233) **By June 2022** **f)** Ensure all enquiries including speaking with independent witnesses (neighbours) and taking witness statements are followed up and in a timely manner.(205) **By June 2022** **g)** Ensure Officers collate evidence and complete intel reports in a consistent and timely manner and in accordance with regulations and procedure. **By June 2022**						
Local	Audit processes for reviewing safeguarding referrals MASH pick up from DA team where that hasn't happened and actions need to be taken. DA Continuous plan is in place and the voice of the child is detailed within the plan For Recommendations D,E and F Operation Investigate	The Constabulary is subject to HMICFRS inspection where these areas will be audited and reported on. The external scrutiny panel has representation from a number of people from the voluntary sector adding to levels of accountability	DCI Angus Moir Crime, Safeguarding and Incident Management	See target date against each Recommendation	**Green** **Amber for implementation of DARA**	**Update**: The Constabulary has reviewed its strategic approach to DA and has a continuous improvement plan in place overseen by Supt Kerry Cutler who chairs a DA delivery board. The voice of the child is integral to the plan and reflected are impending legislative change.	**COMPLETE** 01/11/2023

	programme which seeks to improve investigative standards and this covers this work and is led by a Superintendent, Jeff Yaxley.		Suffolk Constabulary			The need for positive action is enforced within the Constabulary. Supervisory oversight for circumstances where arrested are not undertaken and clear timescales for outstanding suspects to be dealt with and for additional resources to locate priority suspects are in place. This is evidenced through the Constabularies tasking and daily management processes. Suffolk Constabulary is undertaking a review of risk assessment processes undertaken in relation to DA. This includes the need to ensure early detailed research of various systems to recognise the nature of previous reported incidents. DASH will be replaced with DARA in 2022 and will be completed electronically. These will be recorded onto the police Athena system and will be accessible to other police areas utilising Athena	

						Cambridgeshire being one. At the current time Cambridgeshire do have access to all documents scanned and added to Athena. Audit processes are in place in relation to police MASH and include supervisor assessments and actions. Officer completion of referrals are documented within investigative plans and are audited as part of investigative audits, as are investigative actions utilising a minimum 8-point plan, which includes lines of enquiry such as media and witness actions. The Constabulary has clear processes for the capturing of digital evidence in line with National guidance and is subject to external audit. Operation Investigate is Suffolk Constabularies approach to improving investigative standards and is overseen by D/Supt Jeff Yaxley.	

					Amber for implementation of DARA **Green** **Green**	Numbers of Intelligence reports submitted by officer level are monitored. This is not to duplicate information already recorded within Crime or vulnerability reports. **Update:** DARA has yet to be formally introduced due to delays in developing the APP to host the risk assessment tool for frontline officers. The project board estimated implementation is now end of October 2022. **Update:** DARA has been implemented within Suffolk Constabulary with training provided to staff. As a result of a review of Domestic Abuse, officers now complete a recorded summary of previous domestic abuse incidents and crimes, so there is a requirement to review past recorded incidents and risk assessments. Removing any	

						concern over incidents being viewed in isolation. **Update:** In addition to previous updates DARA has now in the main replaced DASH as the initial risk assessment used by first responders. The Domestic Abuse research document is a rolling log updated by responders which provides a chronology of domestic incidents and as such makes it easier to quickly assess previous domestic incidents. As these documents are held upon Athena they will be accessible by Athena forces including Cambridgeshire. Children present at domestic incidents are engaged with and their information is recorded specifically under the Athena tab 'Voice of the Child'. Op Encompass referrals are made to education establishments when a child is encountered by police at domestic incidents. Officers are	

						directed to consider evidence lead prosecution in domestic abuse cases and therefore supervisors ensure that lateral lines of criminal enquiries are followed such as 'hear say' evidence from witnesses/neighbours, and Body Worn Video use at domestic incidents is mandated.	
Recommendation 3 **Cambridgeshire Police** 1. Cambridgeshire police's and processes for information sharing have developed and evolved through operational practice. Cambridgeshire police should undertake a process of work to ensure that their processes for information sharing and cross-border working with colleagues in Suffolk are robust and operationally effective in relation to domestic abuse. They should provide assurance to WSCSP within six months of this report being approved by WSCSP. They should conduct an annual review of these arrangements.							
Local	The Constabularies have sufficiently robust arrangements in place to ensure that cross-border information concerning DA/DV is communicated to the respective force's MASH through recognised channels. Other formalised arrangements are unlikely to enhance the current operational practice in place.	That the constabulary continues to deliver a robust and public-facing policy and practice for victims of domestic abuse. Policy and practice are transparent and promoted through targeted campaigns and other initiatives. Safeguarding the vulnerable is a publicised force priority and	DI Savill for PVPD Cambridge-shire Constabulary	By June 2022 then reviewed annually (June 2023)	**Green**	**Update:** There are no formalised cross-border information sharing arrangements in terms of DA/DV with Suffolk however, the MASH regularly shares relevant DA/DV information via the Suffolk FCR for all medium and high-risk cases that have relevancy to the victim/perpetrator's home area and locations	**COMPLETE** 20/12/2022

	National guidance issued by the College of Policing (CoP) and the National Police Chiefs Council (NPCC) will be followed and local policy and practice in line with any emerging best practice and that nationally issued guidance is regularly reviewed against force policy.	forms part of the mission statement.				frequented for 'cross-border' information purposes. MARAC cross-border protocols are in place through the MASH process. Standard DASH risk assessments are not generally shared but key information may be shared on review by the MASH in exceptional circumstances and professional judgement. In addition, all nominal information is accessible to all police forces via the Police National Database (PND) From May 2018, Suffolk/Norfolk have been linked to Cambs via the Athena operating system, so all updates are attached to the person record for the individual enabling a full search history to be viewed by either force or other forces utilising the same operating database. Notifications and allocations can be sent from one Incident Management Unit (IMU) to the other to ensure	

					Green **Green**	further investigations and there is less chance of failing to share relevant information as it is recorded within the same database. The Cambs MASH shares information to other police forces on a common-sense approach as well as Probation and other key partners. Established ISPs are in place with partnerships for relevant information sharing. **Update:** This remains as RAG status green with no changes to the MASH protocols since the last update in March 2023. **Update:** This remains as RAG status green with no changes to the MASH protocols since the last update in September 2023. **Complete.**	
Recommendation 4 **Cambridgeshire Police**							

	1. The Cambridgeshire Constabulary has taken a decisive step to ensure that front-line officers are given direct support and advice in respect of the issuing of DVPN's and applying for a DVPO where any such opportunities occur. This will be a default position underpinned by the recently formed 'Vulnerability Focus Desk' with effect from April 2021. a) All Domestic abuse reports will be quality assured to ensure that a DVPN has been considered. b) Where suspects for domestic abuse are not proceeded against or where the victim declines to support action, VFD staff will critically assess what other safeguarding actions may be taken and advise and guide the reporting officers accordingly through the application process where a DVPN is a realistic opportunity.						
Local	The current processes in place are robust and aligned to the force priority of safeguarding the most vulnerable. All DASH risk assessments are reviewed by a supervisory officer before submission to the MASH. Additionally, officers can advise victims of alternative DA support through charitable organisations such as the NCDV for civil action in particular non-molestation orders. Dip sampling of cases to assess the robustness of current practice and identify any gaps in process are apparent.	Early intervention support ensures that a robust process of evaluation and assessment of victim needs commences from the initial contact with victims. Provides victim confidence. The HMIC PEEL inspection programme is an assessment of the effectiveness, efficiency, and legitimacy of police forces in England and Wales. HMICFRS will assess how the force carries out its responsibilities (including cutting crime, protecting the vulnerable, tackling anti-social behaviour, and dealing with	DI Savill for PVPD Cambridge-shire Constabulary	By June 2022 then reviewed annually (June 2023)	Green	**Update:** In April and June 2021, two additional safeguarding functions were introduced in Cambridgeshire to support frontline decision making. The Early Intervention Domestic Abuse Desk (EIDAD) went live in June 2021. This function exists from the point the call is received by the FCR. When identified as a domestic abuse incident, the EIDAD will commence a research package which will involve identifying previous domestic related incidents, warning markers for parties at the address and any previous	**COMPLETE** 20/12/2022

	The number of DVPNs issued will vary month on month and should not be regarded as being a useful assessment figure based purely on the volume of applications made as domestically related incidents will fluctuate month on month.	emergencies and other calls for service), how it provides value for money, and whether it operates fairly, ethically and within the law. The evidence collected during the inspection allows HMIC to make, and publish, graded judgements that highlight where the force is doing well and provide information about areas where it needs to improve.			**Green**	MARAC involvement. This information is then formulated into a research package which is then sent to the attending officer. Officers can also liaise with the research team directly from the scene. The purpose of the EIDAD is to improve frontline decision making by providing staff with as much information as possible to make informed decisions at the scene. This also builds in an additional layer of safeguarding from a dedicated team. **Update:** VFD and EIDAD functions are now well established across the Constabulary and continue to intervene at both the initial response and investigation phase. Interventions include research and the provision of a historical summary to response officers as well as scanning of the custody system throughout the day to identify DVPO and SPO	

					Green	opportunities. Officers are also able to approach the VFD for safeguarding advice bespoke to their investigation. VFD have also developed the 'Vulnerability Information Portal', a safeguarding application using the SharePoint technology, which is available on officers desktops and smart phones. The app provides safeguarding advice to staff and also includes trigger plans and child abduction warning notices for persistent and at risk missing persons and children. **Update:** Above processes are now fully embedded and continue to add value to the safeguarding process. **Complete.**	
Recommendation 5 **Cambridgeshire and Peterborough NHS Foundation Trust**							
a) All CPFT staff should complete a Datix if they have domestic abuse concerns disclosed to them by a service user. b) Staff should document safeguarding concerns on System 1/other relevant medical record in a detailed manner cross referencing the Datix report number.							

c) Staff should have awareness that they can contact the Named Nurse for Safeguarding/CPFT Safeguarding team to raise and discuss domestic abuse concerns.

d) Staff should have an awareness of and be able to complete a DASH assessment.

e) Staff should be aware of Domestic Abuse (risk types of, how to recognise and support, sign posting etc).

f) Staff should know how to refer to the MASH.

g) Staff should be aware of consent-based referrals and when to override consent (public interest, threat to life & limb, risk to children etc).

h) CPFT should provide regular up to date training in line with Trust policy.

i) CPFT should provide regular one to one and group supervision for staff.

	a) All CPFT staff should complete a Datix if they have domestic abuse concerns disclosed to them by a service user.						
Local	Current review of organisations Datix system to ensure easy useability for staff and specialist review of reporting safeguarding and DA. The previous process for safeguarding and domestic abuse via Datix reporting included is being reviewed, as routine, by team managers and heads of service. Since November 2021 and implementation of the CPFT Think Family single point of	**What difference will it make?** Datix now have a specialist lead who will provide written feedback on a standard template providing advice, guidance and support to the Datix reporter and those involved staff and Datix handler, ensuring best practice on domestic abuse. Contact with DA leads can be via telephone, virtual or face to face (within Covid guidelines). The completed template is uploaded into patient notes. The data on Datix reviews	Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By March 2022	**Amber**	**Update:** CPFT Staff are prompted to make a Datix report through the following: Domestic abuse policies and procedures, promotional material circulated to all directorates and cascaded through service and team managers. In addition, guidance is delivered to individual teams by DA Leads and access through CPFT dedicated domestic abuse intranet page and through	**COMPLETE** 13/09/2022

	access, and CPFT domestic abuse strategy, all Datix recording of safeguarding and domestic abuse is reviewed and responded to by a safeguarding band 7 specialist lead within the Think Family Safeguarding team. Updated guidance on use of Datix for disclosures of domestic abuse (direct and indirect consequence) along with recorded training to be circulated to all staff.	will be collected via Datix counting systems and through written feedback from reporters and handlers so that the domestic abuse leads involvement can be evaluated for improvement in overall response to DA through Datix. Data is collated on a 3 monthly basis and shared with the Think Family Safeguarding Team and the senior management board. **How will the public know?** This particular recommendation forms part of clinical practice.	Rachel Roberts on CPFT Safeguarding and DA Lead		**Green**	contacting specialist DA leads. Examples of Trust wide DA promo material raising awareness of DA, which includes reference to Datix for reporting disclosures of DA. **Update:** There has been a large increase in the use of Datix for reporting incidents / disclosures of DA and safeguarding. This has become the routine referral pathway for safeguarding. Where general enquiry emails are sent by staff to CPFT safeguarding, staff are advice and given and action which include an action to record a Datix. All Datix which tick the 'Safeguarding' box, are reviewed and responded to by a band 7 senior member of the CPFT Safeguarding team. a response target of 48 hours is achieved on the	

						majority of cases, (Excludes weekends and bank holidays)	
b) Staff should document safeguarding concerns on System 1/other relevant medical record in a detailed manner cross referencing the Datix report number							
Local	All safeguarding and domestic abuse concerns are now recorded on the systmOne template. This was launched in early December 2021. Guidance on completion has also been circulated to staff Review of data of uptake after 6 months to establish if any further actions are required. **How relevant agency will make this recommendation happen?** Staff complete SystmOne as routine for clinical records. All enquires / contacts / referrals to Think Family Safeguarding are recorded on standard templates and uploaded into SystmOne. All Datix for safeguarding and domestic abuse are reviewed by safeguarding band 7 leads and advice/guidance and support is recorded and uploaded into patients notes on SystmOne. Quality of record keeping is	**What difference will it make?** 1. Ensure contemporary records are stored securely 2. Aid information sharing/communication by the organisations system1 users and GP's. 3. Reduce risk where poor information sharing/communication or poor record keeping could be a factor **How will the public know?** Record keeping will be a part of the safeguarding policies which will be published on the Internet in due course	Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By January 2022	**Green** **Green**	**Update:** Staff complete SystmOne as routine for clinical records. All enquires / contacts / referrals to Think Family Safeguarding are recorded on standard templates and uploaded into SystmOne. All Datix for safeguarding and domestic abuse are reviewed by safeguarding band 7 leads and advice/guidance and support is recorded and uploaded into patients notes on SystmOne. Quality of record keeping is reviewed during line management supervision, organisation audits and through CQC visits. **Update:** Complete	Commenced 01/12/2021 **COMPLETE** 13/09/2022

	reviewed during line management supervision, organisation audits and through CQC visits. **What actions need to occur?** Introduction of regular peer review for quality control of case recording within specialist think family safeguarding leads.						
c)	Staff should have awareness that they can contact the Named Nurse for Safeguarding/CPFT Safeguarding team [updated to Think Family Safeguarding Domestic Abuse Leads] to raise and discuss domestic abuse concerns.						
Local	From Sept 1st 2021 a WTE band 7 specialist safeguarding domestic abuse lead(s) joined the Think Family Safeguarding Team and the Domestic Abuse Strategy was launched within CPFT November the 18th 2021 with support by the Chief Exec during her live virtual talk to Trust staff. All adult safeguarding and domestic abuse concerns are now dealt with via a single point of contact managed by the Think Family safeguarding team.	**What difference will it make?** This is a new service but so far, the feedback indicates staff feel supported by the domestic abuse leads in their role to identify and report domestic abuse. They also feel that contacting the domestic abuse leads has improved their practice in terms of asking service users about domestic abuse as routine, safety plan, referrals, signposting, supervision and support. Feedback is collated 3 monthly and will be available in the next quarter. **How will the public know?**	Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By January 2022	**Green**	**Update:** Contact details for the domestic abuse leads through the Think Family Safeguarding single point of access has been highlighted across the Trust and includes - Staff screen saver with contact details from October 2021 to 1st January 2022 - Call back service to reporters of abuse and domestic violence for case discussion, supervision, signposting and support - Virtual talks to teams - Regular Trust DA Champions sessions	**COMPLETE** 18/11/2021

	Continued programme of small and large team promo and awareness sessions.	The DA strategy will be cited as part of the safeguarding policies – which will be made visible on the trust internet site.				- Trust newsletter and launch with the CEO - Intranet page - Promotional material sent to directorates - systmOne template for safeguarding and template for domestic abuse also states contact details for the domestic abuse and safeguarding leads. - External agencies: Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence (DASV), local MARAC and IDVA service, CCG Safeguarding, Local police MASH, children's safeguarding and local authority MASH all aware of how to contact the single point of access for safeguarding and domestic abuse.	
d)	Staff should have an awareness of and be able to complete a DASH assessment						
Local	Sept 1st 2021 a WTE band 7 specialist safeguarding domestic abuse lead(s) joined the Think	**What difference will it make?** Improvement in quality of DASH risk assessment	Paul Collin for	By Janua	**Green**	**Update:** This has been completed through	**COMPLETE** 02/01/2022

	Family Safeguarding Team and the Domestic Abuse Strategy was launched within CPFT November the 18th 2021 with support by the Chief Executive during her live virtual talk to Trust staff.	**How will the public know?** Use and quality of DASH risk assessments is scrutinised by MARAC.	Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	ry 2022		• One to one sessions following Datix review or enquiry to the single point of access Think Family safeguarding • Through small and large team discussions led by the domestic abuse leads during prom sessions • Through signposting to local DASV boards training. The DA intranet page has a link to DASV training on completing a DASH, MARAC, IDVA and coercive control. The training is self-directed, lasts approx. 25 minutes. https://www.safeguardingcambspeterborough.org.uk/home/covid-19/e-learning-during-covid-19/completing-a-dash-risk-indicator-checklist/	

Local	As part of our quality improvement plan, we are in the process of uploading domestic abuse training on the CPFT learning platform.		Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By June 2022	**Amber** **Amber** **Amber** **Green**	**Update:** This is still in progress and is expected to be completed and available to staff on the e-learning platform by December 2022. Currently there are dedicated information slides on DA in the level 3 Safeguarding module. **Update:** These slides are in final approval stage and will be going as draft to the Jan 2023 safeguarding Committee to start the approval process **Update:** Our Domestic Abuse Training will be undergoing a new review, so there is a delay while this is being undertaken. **Update:** DA is included as part of the Think Family Training that is delivered via Teams and offered by our team members to all CPFT staff on a monthly basis. This allows discussion and questions in a way eLearning doesn't. In addition to this	**COMPLETE** 31/10/2023

					Green	bespoke training can be offered to individual teams and this has occurred. Individual advice and guidance is given when requested also which aids learning with a live situation. We can also signpost to Cambridgeshire County Council DASV Partnership - Home (cambsdasv.org.uk) and there are various support links on this site to support, IDVAs, training, eLearning and more. **Update:** CPFT DA training: Domestic abuse is included in CPFT mandatory safeguarding training which is provided both face to face and online. Staff are also signposted to Cambridgeshire DASV eLearning modules on DA. Cambridgeshire County Council DASV Partnership - Domestic Abuse Awareness (cambsdasv.org.uk) and in addition staff are encouraged to attend DASV 'DA	

						champion' sessions which are an excellent additional learning opportunity.	
e)	Staff should be aware of Domestic Abuse (risk types of, how to recognise and support, sign posting etc).						
Local	• All safeguarding and domestic abuse concerns are recorded on the systmOne template. This was launched in early December 2021. Guidance on completion has also been circulated to staff • The NHS safeguarding App is promoted within CPFT which is a point of reference and refresher for all safeguarding matters and domestic abuse. Guidance on how to upload it is on the CPFT intranet page.	**What difference will it make?** Our quality improvement training plan is essential for further raising awareness within our organisation of domestic abuse and supporting survivors in order to reduce risk, implement learning lessons from enquires and SI's, achieve best practice. **How will the public know?** Raising awareness of how to recognise, respond and review Domestic abuse is part of the DA strategy.	Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By January 2022	**Green**	**Update:** • The definition of domestic abuse and types of abuse are also on the systmOne domestic abuse template. • Indirect training for staff includes DA leads facilitating external specialist staff speakers at team meetings and DA Champion sessions • All safeguarding and domestic abuse leads band 7 have level 4 training each year. They also have/ are in the process of completing level 4 safeguarding supervision course	Commenced 18/11/21

					Green	New CPFT DA patient leaflets are now available in public areas around the Trust Awareness campaign used bespoke posters to reach CPFT staff who may be victims of DA, which can be seen in staff areas. **Update:** Complete	**COMPLETE** 13/09/2022
Local	**What actions need to occur?** • We will upskill teams through direct training on safeguarding level 3 mandatory training for qualified staff which is on CPFT eLearning platform. Staff also have the opportunity to enhance their learning through a range of internal and external training sessions, including access to free training through DASV, the safeguarding board, and local authority training for section 75 social workers.		Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By April 2022	**Amber** **Green**	**Update:** Direct training on safeguarding level 3 is now available for qualified staff, but the uptake is currently low. More promotional / awareness coms is being sent to staff to increase the uptake. **Update:** Safeguarding level 3 training has improved and is being monitored through the Safeguarding Committee.	**COMPLETE** 20/12/22

Local	Ensure a separate domestic abuse training module is available on the organisations eLearning platform Due to the pandemic some plans for raising awareness have been put on hold and hope to resume within 6-12 months		Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By June 2022	**Amber** **Amber** **Amber** **Green**	**Update:** This is still in progress and is expected to be completed and available to staff on the e-learning platform by December 2022 **Update:** These slides are in final approval stage and will be going as draft to the Jan 2023 safeguarding Committee to start the approval process. **Update:** Domestic Abuse is included in the Think Family Safeguarding training – available to Trust staff, Our Domestic Abuse Training will be undergoing a new review, so there is a delay in sharing this with staff, while this is being undertaken. **Update:** Everyone's safeguarding training is recorded on their electronic system, and the learning and development team send reminders to managers when their staff member is scheduled to complete their	**COMPLETE** 29/09/2023

						training. Training requirements are dictated by the Joint publications on safeguarding responsibilities. The ThinkFamily team offer joint training monthly and any staff member identified as requiring L3 training can access this, failure to complete in sufficient time should be discussed at staff member supervision sessions, part of their appraisal and should form part of their pay progression. Training is also recorded on every staff members electronic staff record (ESR) and each line manager can access that data and the staff member is provided with sufficient reminders in advance to complete. Every staff member requiring this level will be a registered practitioner and it is their professional responsibility to complete.	
f)	Staff should know how to refer to the MASH.						
Local	• One to one sessions following Datix review or	**What difference will it make?**	Paul Collin	By Janua	**Green**	**Update:** DA promotion sessions commenced	Commence d 18/11/21

	enquiry to the single point of access Think Family safeguarding which will be forwarded to the domestic abuse leads • Through small and large team discussions led by the domestic abuse leads during prom sessions	Staff will feel more confident in liaising with the MASH and communication will be more effective. Staff are aware that often at the heart of lessons learnt after a serious incident, that poor communication is often a factor. **How will the public know?** This will be an internal process	for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	ry 2022	Green	November 2021 following appointment of DA practitioner post **Update:** Complete	**COMPLETE** 13/09/2022
Local	L3 adult safeguarding training contains details of how to raise a concern with the local authority via the MASH		Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By April 2022	Amber Green	**Update:** L3 adult safeguarding training relaunched 2022-23 **Update:** This is included in the L3 training and adult safeguarding policy	**COMPLETE** 13/09/2022
g) Staff should be aware of consent-based referrals and when to override consent (public interest, threat to life & limb, risk to children etc).							
Local	One to one sessions following Datix review or enquiry to the single point of access Think Family safeguarding	**What difference will it make?** Staff feel more confident in this area following one to one session	Paul Collin for Cambri	By Janua ry 2022	Green	**Update:** Through small and large team discussions led by the domestic abuse leads during prom sessions	Commence d 18/11/21

	Due to the pandemic some plans for raising awareness have been put on hold and hope to resume within 12 months	with the domestic abuse lead and information is shared lawfully **How will the public know?** Recognising, responding and recording about all kinds of abuse and how staff should make referrals to LA MASH will be part of the Safeguarding policies made visible on Internet for public	dgeshire & Peterborough NHS Foundation Trust (CPFT)		Green	• With the aid of guidance from the Information governance team, their intranet page showing guiding principles and legislation • Through tools such as the breaching confidentiality tool **Update:** Complete	**COMPLETE** 13/09/2022
	L3 adult safeguarding training contains details of how to manage issues of consent confidentiality and lawful information sharing		Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By April 2022	Amber Green	**Update:** L3 adult safeguarding training to be relaunched 2022-23 **Update:** This is now included in the L3 training	**COMPLETE** 13/09/2022
h)	CPFT should provide regular up to date training in line with Trust policy						
Local	Ensure a separate domestic abuse training module is available on the organisations eLearning platform	**What difference will it make?** Inhouse training on our eLearning platform enables the organisation to collect data and demonstrate	Paul Collin for Cambri	By June 2022	Amber	**Update:** This is still in progress and is expected to be completed and available	**COMPLETE** 31/10/2023

	Due to the pandemic some plans for specialist areas training on the eLearning platform, such as child to parent abuse, have been delayed and hope to resume within 12 months. In the interim, domestic abuse leads are signposting staff to external training sessions/opportunities.	compliance easier than when staff access training independently through external organisations. **How will the public know?** The adult and children training needs analysis will include training around domestic abuse. Mandatory training is monitored within the trust and compliance is reported to Board and CCG/ overseen by internal and external governance monitoring including CQC. Compliance will be addressed through Quality Improvement Plans where needed.	dgeshire & Peterborough NHS Foundation Trust (CPFT)		**Amber** **Amber** **Green**	to staff on the e-learning platform by December 2022. **Update:** These slides are in final approval stage and will be going as draft to the Jan 2023 safeguarding Committee to start the approval process **Update:** Domestic Abuse is included in the Think Family Safeguarding training – available to Trust staff, Our Domestic Abuse Training will be undergoing a new review, so there is a delay in sharing this with staff, while this is being undertaken. **Update: Complete**	
Local	L3 adult safeguarding training contains details of how to manage issues of consent confidentiality and lawful information sharing.		Paul Collin for Cambridgeshire & Peterborough	By April 2022	**Amber** **Green**	**Update**: L3 adult safeguarding training to be relaunched 2022-23 **Update:** This is now included in the L3 training	**COMPLETE** 13/09/2022

			NHS Foundation Trust (CPFT)				
	i) CPFT should provide regular one to one and group supervision for staff.						
Local	Within the wider organisation - Since the launch of the Think Family Safeguarding team and then the domestic abuse strategy in November 2021, staff have been able to contact the team and get a speedy response. The leads in safeguarding and domestic abuse offer one-to-one, supervision and group sessions. Feedback from staff accessing the services will be available in the next quarter.	**What difference will it make?** Staff will have access to specialists in safeguarding and domestic abuse and have an opportunity to reflect on and improve practice. Thereby improving victim support and safety planning. **How will the public know?** CPFT safeguarding team members will have access to bespoke formal training, Safeguarding Supervision training by March 22. Currently informal safeguarding advice/supervision is offered on a request basis through the Trust safeguarding think family single point of contact. While informal advice/supervision will still be offered, some teams/cases will	Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By January 2022	**Green**	**Update:** In relation to the specific case, a safeguarding lead (nurse) spent time with the team providing the following: Information on DA was provided to staff by email on 20 Nov 2020 A safeguarding supervision session was provided to the team 27/1/20. The domestic abuse lead and safeguarding lead nurse has been invited back to the team for an update and refresher for all staff on DA, which is expected to be arranged within 4 weeks.	**COMPLETE** 20/11/2021

		be offered regular formal safeguarding supervision Uptake of both informal advice/supervision and formal supervision sessions will be reported quarterly within internal governance systems and annually to the Board and CCG.					
	From April 2022 monthly reflective learning surgeries will be available for all staff provided by the think family safeguarding team. These will cover all aspects of safeguarding including domestic abuse.	Staff will have access to specialists in safeguarding and domestic abuse and have an opportunity to reflect on and improve practice. Thereby improving victim support and safety planning.	Paul Collin for Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	By April 2022	**Amber** **Green**	**Update:** Monthly Reflective Learning Surgeries is now available for qualified staff, but the uptake is currently low. More promotional / awareness coms is being sent to staff to increase the uptake Ward based surgeries now being rolled out **Update:** Monthly Professional Learning continues.	**COMPLETE** 20/12/22
Recommendation 6 **Cambridgeshire and Peterborough Clinical Commissioning Group Primary Care (Identified from IMR. Historic relationship) However, these actions may be relevant today if they are not routinely carried out**							
a) When a partner is in attendance at the appointment, ensure a record of partners' names or as a minimum, their initials are recorded **b)** Consider Did Not Attends – use of a 'Frequent DNA Register' which could be linked to a Safeguarding adult register.							

c)	Record safeguarding incidents on connected accounts i.e. parent and child
d)	It is recommended that domestic abuse training for primary care providers covers the importance of asking the question about how things are at home for the individual at increased risk (particularly for frequent attenders and frequent non-attenders and those where we know there is a history of domestic abuse) and that they know what to do when a disclosure is made including appropriate signposting to support services.

Local	All these recommendations above are included in primary care network domestic abuse policies.	Section 11 Audit (Summer 2022)	Linda Coultrup, Named Nurse Safeguarding Adults Primary Care	By September 2022	**Red** **Green**	**March update:** The s11 audit is bi-annual and was last completed in May 2021. However, the response was less than ideal, and we were also mid pandemic, limiting the support to virtual only. The CCG made the decision to amalgamate the s11 statutory audit with the adult self-assessment (which is good practice not statutory.) This revised edition has not yet been introduced as it is in the process of being finalised. Plans are being made to re-launch shortly and should be prior to Sept 2022. **Revised Sept update:** A combined s11 and adult self-assessment audit has	**COMPLETE** 01/11/2023

					Green	commenced and the date for completion is 30 September 2022. Support sessions were offered by the ICB virtually and in person. Monthly webinars continue to be offered selecting topical concerns e.g. the DA act and the implications for PC was delivered recently. The ICB monthly newsletter contains a 'Spotlight on DHRs' and the ICB use this to share areas for improvement so all of primary care benefit and not just the practice involved. The ICB also offer fortnightly drop-in sessions for primary care which is well utilised and also gives the ICB an opportunity to make suggestions to include the DNA report, linking information confidentially, controlling partners and how to manage these situations. Recording of information on the ICB system has improved to ensure no misinterpretation of advice.	

					Green	**Dec update:** The audit is nearing completion, we currently have a return of 91% our target was 90%. We continue to support site visits date for completion-31 January 2023. A presentation and further discussion was delivered to the GP Safeguarding leads at their forum on 07/12/2022 following the publication of the DA Act and further emphasised the recommendation of asking all patients about DA. **Update:** The s11/adult self-assessment audit has been completed with 100% success. This enables the safeguarding team to prioritise the requirements for primary care and address each practice individually. We do not commission primary care services, we seek assurance about their safeguarding knowledge and practices.	

						We share lessons learnt across primary care via monthly safeguarding newsletters for Primary Care, we use every opportunity for sharing relevant information during safeguarding drop-in/supervision sessions, safeguarding GP forums and individual enquires. Updates are given to the ICB safeguarding team also and this action plan will be discussed on 26 April 2023. The DASV Lead and Independent Domestic Abuse Lead are offering bespoke training sessions to primary care either to individual practices or a group. They will attend in person to deliver these sessions or via Teams. The Named Nurses have continued to also visit primary care, and each practice will have their own agenda for the visit however, these are also opportunities for sharing lessons learnt.	

						The safeguarding team are very proactive and evolving all the time based on the think family approach. Reviewing recent notes evidenced good practices, including who attended with a patient – this was part of a different DHR. Failure to attend is always recorded and the action taken – this will include a follow up text and depending on the situation may also result in a call back. Not all primary care has implemented report running for missed appointments yet although where this has been specific to a practice it is known this has occurred. A review of notes identified every safeguarding incident was recorded on linked notes. In addition for consideration, there is multi-agency access to notes i.e. school nurses, Health Visitors, 0-19 team, MASH. Ambulance/police referrals will be sent to primary care	

					Green	and updated on the appropriate records, but it is not acceptable to record the victim on a perpetrator's notes. Experience evidences that primary care has good knowledge of signposting, they are also included in their safeguarding templates. Primary care increasingly make contact with the safeguarding team which evidences the benefits of our ongoing promotion of self and team and the support available to them. The safeguarding team have a generic inbox and a duty team daily so we are available to respond as soon as possible but we are not an emergency service, and they would all know to contact the emergency services as appropriate. Professional curiosity remains an area requiring ongoing promotion, training sessions were previously delivered by an external	

					Green	facilitator and well attended. The Safeguarding Partnership Board have a SWAY on professional curiosity which is readily available on their website, routinely advertised in our newsletters, the Primary Care weekly bulletin and via the GP Training Hub Website. Finally we also promote the LA MASH are happy to have what if conversations. **Update: Point of contact for updates has left the organisation. Updates provided by Designated Nurse Safeguarding Childre.:** *When a partner is in attendance at the appointment, ensure a record of partners' names or as a minimum, their initials are recorded.* Primary care were informed at the time of the review and will be covered in the next Safeguarding newsletter and the importance of recording details of all individuals in attendance with the patient is clearly	

					Green **Green**	documented in the Patients record. *Consider Did Not Attends – use of a 'Frequent DNA Register' which could be linked to a Safeguarding adult register*. Liaised with Primary Care and advised them that it would be best practice to monitor frequent "Did Not attends/ Was not brought" and consider this against patients already known on their safeguarding registers. We will ensure that this is included in the next newsletter to further reinforce this. *Record safeguarding incidents on connected accounts i.e. parent and child.* There have been regular discussions with primary care both in face-to-face support visits and via the ICB Primary Care forums and drop ins of the importance of ensure that	

						incidents are recorded in all parties records. *It is recommended that domestic abuse training for primary care providers covers the importance of asking the question about how things are at home for the individual at increased risk (particularly for frequent attenders and frequent non-attenders and those where we know there is a history of domestic abuse) and that they know what to do when a disclosure is made including appropriate signposting to support services.* Domestic Abuse training for Primary Care is being facilitated alongside support from the Cambridgeshire & Peterborough Domestic Abuse and Sexual Violence Partnership, this will include asking the DA question and selective and routine enquiries alongside how to make referrals to the domestic abuse services.	

						Information regarding this is also clearly available on the DASV website and Primary Care are signposted to this. primary care practitioners also have direct access to advice and support from the ICB safeguarding team and there is a duty worker who can provide a timely response, advice and offer signposting to appropriate services who can support.	

Appendix A : In addition to the Recommendations identified during this Review, some of the organisations that submitted IMRs made recommendations within those reports. These are set out here for information, as they were presented in the IMRs. These will be monitored as part of the action plan arising from the DHR alongside the DHR panel recommendations

Scope of Recommendation	Action to be taken	Outcome	Lead Agency	Target date	Progress	Agency response to recommendations/Outcome	Date of completion
Local, County, regional or national level?	How relevant agency will make this recommendation happen? What actions need to occur?	What difference will it make? How will the public know?		Date the recommendation /actions should be	Red Amber Green		

				impleme nted by			
Recommendation 7 (Identified from IMR. Historic relationship) **Suffolk Police**							
1. Ensure that staff across the constabulary are aware of Stalking Protection Orders (SPO) as a valuable tool in providing protection control and sanction in regard to high-risk Domestic Abuse matters including how an order can be written authorised and obtained outside of the wider investigative process. Confirm via audit that it is being used effectively and appropriately in regard to Domestic Abuse.							
Local	Geographical monitoring of where Stalking Protection Orders are obtained, length of period and any breaches. Auditing DA investigations where SPO's haven't been considered or obtained any rational for any missed opportunities	The use of protective measures have been identified by HMICFRS as areas for improvement and form part of a super complaint to policing. As such improvements are and will continue to be subject to reporting and accountability.	DCI Angus Moir Crime, Safeguar ding and Incident Manage ment Suffolk Constab ulary	By Dec 2023	**Green**	**Update:** The Constabulary monitors the use of Stalking Protection Orders. Records are held by both SCC legal services and the Joint Justice Command. Monthly reporting on the use of protective measures has been introduced into the Crime, Safeguarding and Incident management command. Actions to increase the use of SPO's and protective measures are documented within the Constabulary DA continuous improvement plan. This includes local policing command monitoring of DA cases through daily tasking	**COMPLET E** 01/11/202 3

					Green **Green** **Green**	process to consider early protective measures. **Update:** The use and monitoring of SPO's continues and is now being supported by Weightmans as the new contracted legal provider for civil orders. SPO's feature within the Constabularies formalised performance monitoring processes. **Update:** As of 1st April all stalking cases are assessed by a Detective Sergeant in the Crime-Co-ordination Centre and relevant cases are identified for early consideration of an SPO. All Sergeants and Inspectors have received a bespoke civil orders input form the law firm that represents Suffolk Constabulary. SPO data is to be presented and scrutinised at Force level performance panels. A civil-orders toolkit has been made available to all staff to assist in the process of SPO applications.	

						Update: As per the previous update but with addition that the Constabulary is designing a new process to manage those individuals with an SPO and it is anticipated that this process will raise the awareness and effectiveness of SPOs and therefore increase applications. In addition a benchmarking request was completed by Suffolk Constabulary where all forces in England and Wales were asked to provide their data in relation to how many SPOs they have obtained. Suffolk still perform well in this area nationally compared to similar size forces.	
Recommendation 8 (Identified from IMR. Historic relationship) **Suffolk Police**							
1. Suffolk Police should review their practice in relation to the use of the provisions of both DVPN's and DVPO's to ensure they are well understood by officers across the constabulary as a valuable preventative tool and confirm via audits that they are being used effectively and appropriately in regard to Domestic Abuse. They should share their practice and learning with colleagues in Cambridgeshire as a means of promoting collaborative learning and development.							

Local	Geographical monitoring of where DVPOs and DVPNs obtained, length of period and any breaches. Auditing DA investigations where DVPOs and DPVNs haven't been considered or obtained any rational for any missed opportunities	The use of protective measures have been identified by HMICFRS as areas for improvement and form part of a super complaint to policing. As such improvements are and will continue to be subject to reporting and accountability.	DCI Angus Moir Crime, Safeguarding and Incident Management Suffolk Constabulary	By June 2022 then reviewed annually	**Green** **Green**	**Update:** The Constabulary monitors the use of DVPN / O's. Records are held by both SCC legal services and the DA team. Monthly reporting on the use of protective measures has been introduced into the Crime, Safeguarding and Incident management command. Actions to increase the use of DVPN / O and protective measures are documented within the Constabulary DA continuous improvement plan. This has included presentations to staff by legal services and MARAC chair. Briefings and guidance being communicated force wide. Local policing commands monitoring DA cases through daily tasking process to consider early protective measures. **Update:** The use and monitoring of DVPN / O's continues and is now being	**COMPLETE** 01/11/2023

					Green Green	supported by Weightmans as the new contracted legal provider for civil orders. DVPN / O's feature within the Constabularies formalised performance monitoring processes. **Update:** Similar to SPOs, all Sergeants and Inspectors have received a bespoke civil orders input form the law firm that represents Suffolk Constabulary with particular focus being placed on DVPO applications. DVPO data is to be presented and scrutinised at Force level performance panels. A civil-orders toolkit has been made available to all staff to assist in the process of DVPO applications. **Update:** DVPO applications within Suffolk has remained constant within this reporting period.	
Recommendation 9 (Identified from IMR. Historic relationship) **Cambridgeshire IDVA Service**							

1. Ensure IDVAs signpost clients to appropriate group or one-to-one domestic abuse group programmes, recognising where an individual feels overwhelmed by professionals and appointments or does not feel confident in a group setting, including the Freedom programme and online programmes							
Local	Adapted outcome monitoring service to enable to look at how many individuals have moved on to group work. Where commissioned services/programmes, follow up that referrals have been taken forward.	Group programmes have shifted to online since covid, which has increased choice and IDVAs can consider appropriateness depending on an individual's circumstances i.e. access to IT.	Julia Cullum, Domestic Abuse and Sexual Violence Partnership Manager	By June Sept 2023	**Amber** **Green** **Green**	**Update:** Case management system updated to allow recording of referrals to group programmes. Recording has been discussed at IDVA team meetings. **Update:** Recording of group programmes now takes place on case management system and options for group programmes are a regular item for team meetings. **Update:** Our new case management system is now in place.	**COMPLETE** 30/09/2023
Recommendation 10 (Identified from IMR. Historic relationship) (However, these actions may be relevant today if they are not routinely carried out) **Cambridgeshire Police**							
1. Cambridgeshire Police should review their practice in relation to the use of the provisions of both DVPN's and DVPO's to ensure they are well understood by officers across the constabulary as a valuable preventative tool and confirm via audits that they are being used effectively and appropriately in regard to Domestic Abuse. They should share their practice and learning with colleagues in Suffolk as a means of promoting collaborative learning and development.							
Local	See also response in recommendation 4 above. The processes for advice and guidance to officers in making	The force executive has confidence that the consideration of a DVPO is embedded for all domestic abuse investigations	DI Savill for PVPD Cambridge-shire	By June 2022 then reviewed annually	**Green**	**Update:** The Vulnerability Focus Desk (VFD) was introduced in April 2021 and is designed to support frontline decision making in two critical	**COMPLETE** 19/04/2023

	applications for DVPNs is actively monitored and supported by supervisory, line managers and MASH processes. Sharing practice between the respective forces has a limited practicality as all cases must be based on individual circumstances. National sharing of best practice takes place through the College of Policing and Approved Professional Practice. Since September 2020, all Cambridgeshire officers have had access to the 'We Protect' application on their work issued smart phones. This allows them to make a referral to the Domestic Abuse Alliance directly from the scene and ensures that those requiring immediate legal assistance to secure protective orders (such as Non-Molestation and Occupation Orders) can access such assistance without delay.	through the robust supervision processes and sampling in place. Continued Stakeholder support with both statutory and voluntary agencies. Dynamic response to emerging issues by partnerships. Publication of statistics in public arena.	Constabulary	(June 2023)		areas of Missing Persons and Domestic Abuse. In respect of Domestic Abuse, the team act as tactical advisors for the initial safeguarding of the victim, investigative considerations and any onward steps which may be necessary, such as Domestic Violence Protection Orders. The team advise frontline staff on which cases will be suitable for a DVPO and will support staff in preparing both the application and subsequent court processes. The Constabulary has also widened its own defined circumstances when a DVPO will be considered – medium and standard risk cases are now considered where there is an ongoing risk of harm identified and there have also been several cases where DVPO's have been successfully applied for alongside police bail conditions where the risk of harm is deemed to be exceptional. Based on all these steps, senior leaders within	

	Compliance with the requirement to consider a referral is tracked through every DA incident write off and is further tracked through the monthly DA Scrutiny Group which examines a sample of DA cases each month. Active monitoring will continue in accordance with the DA scrutiny groups activity.				**Green**	the Constabulary are confident that the consideration of a DVPO is embedded for all domestic abuse investigations. Between May and December 2021, 135 DVPN applications have been completed with 108 DVPO's (80% of the DVPN's issued) being granted at court. This represents a 440% increase on the amount of DVPO's granted compared to the whole of 2020. The Constabulary has regularly exceeded over 300 referrals a month through this service over the previous twelve months to December 2021. **Update:** The Constabulary continues to display encouraging trends in the area of DVPO and referrals for protective orders. Between January and August 2022, 107 DVPO applications have been made at court, with 88 of these having been granted. Compliance checks are managed through local daily management processes	

					Green Green	and the number of breaches has increased as a result. Disappointingly, we continue to receive a poor level of service from courts when hearing breaches of orders, with small monetary fines providing the bulk of court outcomes rather than custodial sentences. This is a worrying trend when prosecuting such orders and has prompted the head of Criminal Justice for the Constabulary to write to the national DA lead to raise awareness nationally. Referrals to the Domestic Abuse Alliance via the We Protect continue to flow strongly, with the Constabulary making between 275 – 300 referrals each month. We continue to work closely with the Domestic Abuse Alliance to develop our partnership. **Update:** DVPO numbers continue to trend upwardly	

						with very little lean in from the Vulnerability Focus Desks, indicating the process is now well imbedded. Number of applications is likely to be around 170 over the twelve months which is comparable with the same period in 2021. **Update:** This is now an embedded process and can be discharged. Complete.	

Appendix B: Home Office Feedback Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Melanie Yolland
Project Manager - Community Safety
Communities Team
Suffolk County Council
Public Health and Communities
Endeavour House
8 Russell Road
Ipswich
IP1 2BX

29th February 2024

Dear Melanie,

Thank you for resubmitting the report (Carol) for West Suffolk Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in February 2024.

The QA Panel concluded that good effort has been made to capture the voice of the Carol's family. There were thoughtful condolences and a pen portrait. The input of Carol's father helps to bring her to life with the tribute he has provided. The action plan has been updated with leads/dates and assurance of follow up which is positive.

The QA Panel noted that although some of the issues raided in the previous feedback letter were not addressed the view of the Home Office is that the executive summary and action plan may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the

report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.
Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel