

NUNEATON & BEDWORTH COMMUNITY SAFETY PARTNERSHIP



Domestic Homicide Review Executive Summary (DHR NB01)

**Report into the death of a domestic homicide victim
on 2nd January 2012**

**Report produced by Kathy McAteer
Independent Chair and Author
Publication Date: 14th May 2015**

INTRODUCTION

This report of the Domestic Homicide Review (DHR) examines the circumstances and agency responses leading up to the homicide of the victim, 38 years, by her ex-partner. On 2nd January 2012, police were called to an address where the body of the victim was found in the boot of her car. Her ex-partner has subsequently been found guilty of murder. Forensic and post mortem evidence showed that the victim died at her home address as a result of receiving blunt force trauma to her neck.

The victim lived with the perpetrator and her adult son, and had just ended the relationship, having told the perpetrator that he must move out of her house. Records indicated that there was a history of domestic abuse incidents between the perpetrator and victim and between the perpetrator and his previous partners. The victim and perpetrator were known to MARAC (Multi Agency Risk Assessment Conference) and a long term risk management plan was in place.

Purpose of a Domestic Homicide Review

Domestic Homicide Reviews were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and criminal courts. Neither are they part of any disciplinary process. The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

The review was conducted to fulfil the requirements brought in under Section 9 of the Domestic Violence, Crime and Victims Act (2004) and was delivered in accordance with the Home Office guidance - 'Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews' and followed the key processes that are outlined within the 'Warwickshire Domestic Homicide Review - Multi Agency Policy and Procedures'. Real names have not been used in public documents including the terms of reference, the overview report and executive summary.

The Review Process

The homicide happened on 2nd January 2012 and Nuneaton & Bedworth Community Safety Partnership (NABSCOP) was notified by Warwickshire Police on 5th January 2012. The review was commissioned jointly by Nuneaton and Bedworth Borough Council and Warwickshire County Council on behalf of NABSCOP and the Home Office were notified of the decision to undertake the review on 2nd February 2012. An independent chair and author was selected from a pool of chairs/authors through a selection process. The Panel was selected by the respective agencies on the basis that they had no direct operational responsibility for the case. This included representation from a voluntary sector specialist domestic violence organisation. There were no conflicts of interests. A Terms of Reference was agreed at the first meeting of the Panel on 5th March 2012. Panel Membership:

Agency	Position
Independent Chair & Author	Independent social care consultant
Warwickshire Probation Trust	Assistant Chief Officer
Warwickshire Police	Detective Chief Inspector, Protecting Vulnerable People Department
Warwickshire County Council Children's Services	Operations Manager
Coventry & Warwickshire Partnership NHS Trust	Lead Nurse for Safeguarding Children and Vulnerable Adults
Warwickshire County Council Community Safety and Substance Misuse Team	Domestic Abuse Manager Domestic Abuse Admin Officer
Nuneaton & Bedworth Borough Council – Housing & Communities	Housing and Communities Manager Communities Manager Communities Officer
NABSCOP (Nuneaton & Bedworth Safer Communities Partnership)	Chair
Refuge	Senior Operations Manager
North Warwickshire Borough Council	Policy Support Manager (Observer)
Warwickshire North Clinical Commissioning Group (CCG) (NHS England)	Lead Nurse Safeguarding Adults Warwickshire

The process began by identifying agencies that had contact with the victim and/or the perpetrator and/or his previous partners and children. This included 17 agencies, all of which were potential support agencies for the victim or had knowledge of or

contact with the perpetrators, or his ex-partners and children. Information on the deceased and perpetrator and their key relationships was collected from 2008, with agencies asked to include the date of their first contact with any of the parties, and to highlight any relevant information prior to 2008 that the Panel should consider.

Agencies submitting information to the review included:

The following 10 agencies had recorded contact with one or more of the parties identified within the review timescale and held information relevant to the review:

- Coventry & Warwickshire Partnership NHS Trust
- George Eliot Hospital
- GP Practice
- Refuge (including IDVA)
- South Warwickshire NHS Foundation Trust
- Warwickshire County Council Children's Services
- Warwickshire Domestic Violence Support Services
- Warwickshire Police
- Warwickshire Probation Trust
- West Midlands Ambulance Service

Of these, only 5 agencies had any contact with, or knowledge of, the victim prior to her death. They are:

- Coventry & Warwickshire Partnership NHS Trust
- GP Practice
- Refuge and IDVA
- Warwickshire Police
- Warwickshire Domestic Violence Support Services

Each agency and/or service that has had contact with victim and/or perpetrator, their previous partners or children, was asked to submit 2 key documents as follows:

- A chronology of events detailing in date order all contacts with the named individuals
- An individual management report (IMR) detailing key information, based on the key lines of enquiry, including:
 - An analysis of the involvement of all services within the agency including contact and actions taken, outcome of any assessments undertaken, support and services delivered and offered, decision points and reasons for decisions taken
 - the effectiveness or otherwise of inter-agency working, the triggers for information sharing and any missed opportunities to share information
 - learning points and proposed actions for the agency/service
 - learning points and proposed actions for improving inter-agency working

A standard format for both the chronology and the IMRs was used for consistency and ease of analysis. CWPT completed an internal Serious Incident Report in conjunction with the IMR.

The Panel also considered the following additional information:

- MARAC processes, using the IMR format
- MARAC minutes
- a presentation by a CAADA accredited independent consultant on the DASH risk assessment process and what constitutes best practice
- Warwickshire Police Standard Operating Procedure
- Preliminary report of the MARAC Quality Assurance programme for Warwickshire North MARAC
- A copy of the court transcript relating to psychiatric evidence, the Judge's summary and sentencing.

Family & friends: In addition, contact was made with family, friends and employer and they were invited to contribute following conclusion of the criminal trial. This included contacting the victim's and the perpetrator's parents and other family members, the perpetrator via the prison governor, the victim's employer, and 8 other friends and acquaintances identified during the police investigation. Of these, 4 people responded, including two friends of the victim, one close relative and her employer. One friend was unable to contribute due to illness. Contributions were through a mixture of face to face meetings, telephone calls and written submission. The perpetrator responded to decline to be involved.

Terms of Reference of the Review:

The Terms of Reference were agreed by the Panel and NABSCOP as follows:

- To establish whether it was known, or could have been suspected, that the perpetrator posed a serious risk to the victim or other partners, and whether any action could have been taken to prevent the homicide. To establish whether the homicide was predictable or preventable.
- To establish how effective agencies were in identifying the victim's vulnerability to domestic abuse and the level of risk to which she was exposed, and whether the single agency and inter-agency responses were appropriate and proportionate in supporting the victim and her family.
- To establish how easily the families of both victims and perpetrators of domestic abuse are able to access appropriate and timely support.
- To establish how well agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency practice, policies and procedures to improve the identification of, and safeguarding of, people subject to domestic abuse in Nuneaton and Bedworth, Warwickshire, and perhaps more widely, in the future.

- To identify from both the circumstances of this case, and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office

Key Lines of Enquiry

Records suggested that there have been known incidents of domestic abuse since 2008. The review requested information focussed on the period from 2008 to the date of homicide, but with the proviso that any relevant information preceding this date is also brought to the attention of the panel.

- a) History of Events and Relationships:** What was the history of the relationship between the victim and perpetrator, between the victim and previous partners and between the perpetrator and his previous partners, and, in each relationship, their children? How were these linked? What was the sequence of events up to the date of the homicide?
- b) Information:** How was information about the victim and perpetrator received and addressed by each agency and how was this information shared between agencies? What were the trigger points for sharing information, and were there missed opportunities when sharing information may have made a difference? What were the thresholds for decision making?
- c) Risk Assessments:** What assessments were completed to assess the risks to the victim? What risk assessments were completed on the perpetrator and how did these impact on the risk assessment? What were the outcomes of assessments and what actions were taken? Which of these were completed by a single agency and which were multi-agency?
- d) Contact with and Support from agencies:** What contact did each agency have with the victim and perpetrator, wider family members and children from their respective relationships? What support did each receive and from whom? What processes were followed and what were the key decision points, and why? Was there any additional action that could have been taken, and would it have made a difference (missed opportunities)?

SUMMARY OF EVENTS:

On Monday 2nd January 2012, police were called to the home of the perpetrator's parents by his father. The perpetrator was present at the address having arrived there in a car belonging to the victim. On police attendance the victim's body was found in the boot of the car. The perpetrator was arrested on suspicion of murder. Police enquiries indicated that the victim died at her home address and that her death was caused by a neck injury. The perpetrator was charged with murder and found guilty in June 2013. Forensic and post mortem evidence found that the victim died at her home address as a result of receiving blunt force trauma to her neck.

The victim and perpetrator had been living together at the victim's house, along with her adult son. Though they spent Christmas together, they were splitting up after the New Year holiday, and the perpetrator was due to move out on 3rd January. On the night of the homicide, the perpetrator was working as doorman at a local pub, and the victim was at the same pub as a customer, enjoying the celebrations. They returned home together and were arguing prior to the victim getting undressed and getting into bed. The perpetrator strangled the victim and hit her with some force. Despite the risk of being disturbed by the victim's son and his girlfriend, the perpetrator showered, subsequently concealed the victim's body in the boot of her car, and told plausible lies to explain her absence. The body remained in the car boot for 30 hours, during which time the perpetrator was driving the car and had his young children present.

The Victim

The victim was a 38 year old woman who at the time of her death was living in Nuneaton with the perpetrator and with her 20 year old son from a previous relationship. Described as confident, strong and independent, she was attractive, popular and fun to be with and was someone who knew her own mind. She did not see herself as a victim of domestic violence and abuse and thought she could handle the perpetrator. The victim met the perpetrator in March/April 2010. Having separated from the perpetrator in March 2011, the relationship had resumed a few months prior to the homicide. However, at the time of the homicide the victim had tried to end the relationship and asked the perpetrator to leave.

The Perpetrator

The perpetrator was 31 at the time of the homicide and had been in a relationship with the victim since March/April 2010, having separated from his wife. Evidence suggests that the perpetrator was manipulative and charming, he could be kind and loving, but would quickly turn nasty. He often lied, but was very plausible. He frequently stole from the victim. The perpetrator was a strongly built man whose behaviour was driven by jealousy and wanting to control the victim, often by making threats or damaging her property, than through actual physical violence.

The perpetrator was known to Mental Health services during May/June 2009 and then from August 2011 until the homicide. There was no specific diagnosis and the episodes were initiated by overdoses/suicide attempts, usually while under the influence of drugs or alcohol. There was no evidence of, or diagnosis of, a psychotic illness. Psychiatric evidence presented during the trial suggested that the perpetrator may have a personality disorder characterised by jealousy, being impulsive, frequent aggression and being a habitual liar, but did not have a truly psychotic illness.

The perpetrator has 2 known previous partners, with whom he has a total of 4 children, and there is a known history of domestic abuse against partners, not all of which were disclosed to the police. Evidence from the trial suggests that jealousy contributed to the break-up of his relationships with women. The judge, in his summing up, describes the perpetrator as a threat to any woman with whom he has an intimate relationship.

The perpetrator was well known to the police with 12 previous convictions for 24 offences including driving offences, burglary, theft, common assault, criminal damage, breach of community orders, and a caution for handling stolen goods. He was also arrested but not charged for 4 domestic abuse incidents including assault occasioning actual bodily harm and criminal damage, threats to kill and theft, in relation to the victim, and common assault with a previous partner. In addition there were warrants issued in relation to civil matters – that is, by the Child Support Agency (CSA) in relation to unpaid child support.

Timeline

A friend of the victim witnessed what she believes to have been the first incident of domestic abuse around August bank holiday 2010, when the perpetrator hit/pushed the victim in the street causing her to fall. This was not reported to police or any agency. The first incident of domestic abuse to be reported to the police was in March 2011, when he damaged a phone, resulting in the perpetrator being bailed with conditions not to contact the victim. The victim withdrew her complaint in early April 2011, when it was also known that the perpetrator was in breach of the bail conditions. At this point the victim was stating that they were not in a relationship.

The second and most serious incident of domestic abuse happened later in April 2011 in front of the perpetrator's children, when he allegedly attempted to throttle the victim. Initially, the victim refused to give more information about this, until there was a further incident in May 2011, when the perpetrator damaged her car. At this point the April incident was assessed as high risk and referred to MARAC.

Evidence suggests that the perpetrator was extremely controlling, using threats and fear more than actual physical violence. Though the perpetrator was bailed with conditions during this period there were 2 further incidents reported, in May 2011 and in August 2011.

Bail conditions were lifted in September 2011 when all charges against the perpetrator were dropped due to lack of supporting evidence. Records suggest, and friends confirmed, that he and the victim had recommenced their relationship and were living together, and continued to do so until her murder in January 2012. During this latter period, the victim was reported by friends as becoming more secretive – the victim had also started a new job and told work colleagues that she was single. Prior to Christmas, the victim told the perpetrator, friends and family that she was ending the relationship and that the perpetrator was moving out on 3rd January 2012.

During this period, the perpetrator was receiving support from Mental Health services for depression and suicide attempts, resulting in a short admission for treatment. Discharge was planned for 23rd December though he subsequently discharged himself against medical advice one day early, on 22nd December 2011. On the same day the victim was admitted to A & E following an overdose. She disclosed that the relationship was troublesome and she “wanted it all to stop”. The homicide happened one week later, on 2nd January 2012.

KEY FINDINGS

The general consensus of the review panel was that serious harm to the victim could have been predicted but it is less clear as to whether homicide could have been predicted, and that agency intervention is unlikely to have prevented the victim's death, given the information that has come to light through the review. No single agency held the full information about the circumstances, some of which was only known to the victim and friends. It is difficult to judge whether, had full information been shared in a timely manner, the multi-agency picture would have been different. There was a history of domestic abuse and clear evidence that the victim was at high risk of serious harm, based on the following factors:

- there had been a serious throttling incident and repeated threats to kill
- there was an emerging pattern of escalation
- the victim stated in May 2011 that he would kill her
- the evidence from friends suggest that the risks were very high – he was perceived as dangerous and they, and the victim, believed he was capable of killing her
- there was evidence from mental health services that the perpetrator had issues relating to anger and the breakdown of relationships
- the victim was trying to end the relationship

However, this is a fairly typical profile of many similar high risk domestic abuse cases referred to MARAC. The probability of homicide in similar cases with these factors is usually low, though this statement needs a cautionary note as it is not known whether this is because the risks were not as well managed in this case compared to other cases, and the risks would have been increased due to the victim's lack of engagement with support agencies. Though the review has identified a number of weaknesses in inter-agency practice related to domestic abuse, including improvements that are required to the MARAC process and how agencies implement MARAC procedures, the panel does not feel, on balance, that this would necessarily have impacted on the outcome. The Panel believes that the homicide could not be prevented for the following reasons:

- The full pattern and extent of the abuse was only known to the victim and a few close friends – when police were involved, the victim was reluctant to provide detailed evidence to support charges and would usually withdraw complaints
- There were regular attempts by support agencies to engage the victim and offer support – she did not see herself as a victim and was clear about her decision to decline support
- Despite appearing to understand the level of risk posed by the perpetrator (i.e. predicting that he would kill her and understanding that he was capable of doing so), she also appeared to believe that she could handle him.

None of this is unusual within a cycle of abuse and creates challenges for statutory agencies and voluntary organisations within the field of domestic abuse to reach out to victims and work effectively with them to both fully identify the risks and to put in actions to reduce them.

The overarching lessons that have been learnt from the review include lessons regarding agency and multi-agency intervention that may have impacted on the outcome, as well as general lessons on how practice could be improved and could therefore make a difference to how victims at risk of serious harm or homicide are supported across Warwickshire in the future.

1. The implementation of MARAC processes by agencies, and the MARAC administrative procedures that were in place at the time, were inadequate
2. Information that was known by agencies was not shared in a timely way.
3. There were missed opportunities by agencies to identify indicators of domestic abuse, or when they did, to assess the risks or develop appropriate strategies to address the issues or offer timely support.
4. The inability to apply sanctions following breaches of police bail conditions led to the victim believing that police were powerless to act
5. Each incident was risk assessed in isolation of the wider history and circumstances
6. There was a failure to refer repeat incidents to MARAC, who did not therefore have the full information available to enable an effective understanding of the escalation of risk and to develop an appropriate risk management plan
7. There were no strategies in place for identifying and engaging high risk victims who repeatedly decline support.

RECOMMENDATIONS

The recommendations of the panel are set out below. It should be noted that many of the recommendations set out in this report have already been implemented by the MARAC and by key agencies. The Action Plan arising from this review will therefore give timescales that may pre-date completion of the report.

Safer Warwickshire Partnership Board

1. Safer Warwickshire Partnership Board to develop Domestic Violence and Abuse Procedures that include:
 - a. Clear, written policies for all agencies in the county explaining when and how to refer to specialist domestic violence support services e.g. Refuge (for accommodation services) and Stonham Home Group (the organisation now running IDVA and outreach services in the county) to ensure vulnerable victims do not fall between services.
 - b. A process to ensure that feedback is requested and given on the outcome of referrals, especially if no contact can be made or support is declined, so that alternative options can be explored.

- c. A reminder to officers/agencies investigating or reporting domestic abuse incidents of the importance of recording the full names and home addresses of any children witnessing domestic abuse – this is especially important when they are visiting a parent and are not residing at their usual home address
- 2. Safer Warwickshire Partnership Board to direct the MARAC Steering Group to take the following actions to improve the DASH risk assessment process and :
 - a. Develop and implement multi-agency training on the use of DASH to assess risks and ensure that risk assessments are
 - i. in line with CAADA guidelines
 - ii. use professional judgement in cases where the victim is unable or reluctant to fully disclose information that might highlight the risks more
 - iii. take into account the history and full circumstances of the case
 - iv. repeated when circumstances change – i.e. following a withdrawal of statement, a breach of police bail conditions and when a decision is made not to charge
 - b. Explore the options for developing risk assessments of the risks posed by perpetrators, and linked to this, the identification of serial abusers.
- 3. Safer Warwickshire Partnership Board delivers a public awareness campaign (e.g. production of information leaflets / posters which can be distributed throughout agencies) that addresses the myths about stereotypical victims of abuse.
- 4. Safer Warwickshire Partnership Board develops an Information Sharing Protocol, with accompanying guidance, for all partner agencies regarding sharing information within DHRs. This should include guidance on collecting information in a timely way so that any information that cannot be shared with the Panel pre-trial has been secured internally, thus avoiding the difficulty caused by staff moving on or forgetting detail.
- 5. The Chair of the Safer Warwickshire Partnership Board raises with the Home Office and with CAADA the following national concerns:
 - a. The lack of sanctions available to police regarding breaches of police bail.
 - b. The need for CAADA to revise the guidance on the definition of repeat incidents, to include incidents where bail conditions have been breached
- 6. The Chair of the Safer Warwickshire Partnership Board raises with the CPS the following national concern: that the CPS explores whether there are opportunities to speed up the process for progressing charges to reduce the risks of withdrawal or retraction

Warwickshire County Council – Community Safety and Substance Misuse

7. Warwickshire County Council, as the commissioner of domestic abuse services, completes a review of the IDVA service to ensure that resources are maximised and deployed effectively to adequately support high risk victims across the County. This should include exploring alternative, flexible models of multi-agency support. The findings of the review should be reported to the Safer Warwickshire Partnership Board and identify the strategy for managing workload within the context of diminishing resources.

MARAC Steering Group

8. The MARAC steering group develops and ensures implementation of an induction programme for new MARAC agencies and representatives to support them in understanding their roles and the requirements of MARAC agencies.
9. The MARAC steering group implements the following improvements to MARAC processes and procedures, ensuring that these are all compliant with CAADA guidance and checklists:
 - a. Completes and circulates the revision of the MARAC Operating Protocol
 - b. Completes and circulates the MARAC Information Sharing Protocol
 - c. Improves and re-formats the MARAC minutes template to ensure that it includes:
 - i. Whether the victim is aware of the referral
 - ii. The contribution of each agency
 - iii. Detail of the discussion of the case
 - iv. The rationale of why actions were not pursued
 - v. The risks identified, how these risks will be addressed, by whom and by when
 - vi. Identification of the support agency for the victim to feedback the outcome of the MARAC to the victim
 - vii. That clear SMART action points are included in MARAC minutes following all MARAC meetings to prevent ambiguity.(refuge)
 - d. Clearly defines the role of the IDVA in relation to the MARAC, including the requirement to contact the victim prior to the meeting and to ensure that there is clarity about ongoing contact
 - e. Makes a formal decision regarding the flagging of files, and inform all agencies of the outcome and the procedure for doing so
 - f. Reminds all agencies of their responsibilities relating to attendance, including sending deputies and/or written notes in the absence of the usual representative
 - g. In view of the high number of cases referred to the North MARAC, to split the monthly meeting into 2 (if less than 20 cases referred, the second meeting can be cancelled).
 - h. Completes a feasibility study as to whether a multi-agency web-based database for MARAC cases (e.g. Paloma's MODUS database) would be beneficial.

10. The MARAC steering group develops a robust process for identification of MARAC repeat cases from other agencies along with subsequent MARAC referral, as part of the MARAC Improvement Plan.
11. The MARAC steering group ensures that all recommendations of the CAADA Quality Assurance assessment have been implemented.

Warwickshire Police

12. Warwickshire Police review the investigative decision-making process relating to 'high risk' domestic abuse incidents, to ensure that the appropriate level of skill and type of resources and supervision is allocated to each specific Domestic Abuse investigation.
13. Warwickshire Police ensure that the findings of the review of the police Referrals & Assessment Unit (RAU), which identified the need for better levels of supervision and processes to facilitate more efficient management of caseloads of staff, has been fully implemented, including:
 - a. Development of a policy that identifies acceptable levels of inputting backlogs dependant on risk level, and that includes a mechanism for reporting when the levels are exceeded.
 - b. Embedding the new process that has already been introduced to actively manage and triage any backlog to identify any case that relates to either a pre-existing or subsequent 'high risk' incident is working effectively
 - c. That the business case to introduce a new structure within the RAU with dedicated supervisory roles has been fully implemented. (This was accepted as part of the new joint policing arrangements between Warwickshire Police and West Mercia Police with new posts to be in place by December 2013.)
14. Warwickshire Police share the learning points from the IMR and the DHR as a whole with all police officers and staff using DASH to ensure that the risk assessments are applied with consideration of all available information.
15. Warwickshire police ensure that they take positive action to:
 - a. Arrest perpetrators of all alleged crimes relating to domestic violence when the opportunity arises
 - b. Collect all available evidence including at initial call-out to increase chance of prosecution (always assume the victim will not support the prosecution.)
16. Warwickshire Police to review the DASH "aide memoire" card to include breach of bail conditions as a high risk indicator

Local Criminal Justice Board

17. The local Criminal Justice Board to improve the process for completing inter-agency checks by:
- a. Considering prioritising resource allocation to the information exchange process
 - b. Liaising with the HMCTS/sentencers to tolerate adjournments for this to take place where it is recommended by the Probation Court Duty Officer

Probation Trust

18. The Probation Trust ensures that the actions, set out below, that were agreed in relation to the Serious Further Offence (SFO) investigation have been fully implemented in line with agreed timescales:
- a. Previous convictions must be used to inform every Pre-Sentence Report risk screening or their absence should be noted and corrected as soon as possible:
 - i. All court duty staff to be reminded of this core practice expectation
 - ii. Take appropriate internal action in relation to the conduct of officers not following procedures
 - iii. Area Office Administrators to review court administrative practice to ensure pre cons are collected and passed to Unpaid Work immediately post sentence
 - iv. Unpaid Work operational managers to be reminded that previous convictions must be checked before risk screenings are signed. Also that in signing risk screenings they are confirming they are satisfied themselves that the information is accurate
 - b. Address the potential for inconsistency and inappropriate judgements in relation to enforcement when offender reporting illness or death of significant others: the Unpaid Work manager to circulate guidance to all operational managers on decision making in relation to this issue.
 - c. Ensure that these requirements are incorporated into new contracts/SLAs with the new Community Rehabilitation Company.

19. That information provided by friends and family is shared with the Offender Manager who is preparing post-sentence assessments as this will be of significant help in developing the perpetrator's profile.

George Eliot Hospital

20. George Eliot Hospital develops and implements a Domestic Abuse Policy and seeks multi-agency validation via members of the Review Panel to ensure that the policy is fit for purpose and reflects best practice.

21. George Eliot Hospital targets front line staff in A&E with specific domestic abuse training to enable them to identify people at risk and initiate appropriate supportive and preventative actions.
22. George Eliot Hospital put in place appropriate training for senior managers and ensures that there is effective leadership to support cultural change within the organisation to improve practice in domestic abuse cases.
23. George Eliot Hospital puts in place procedures to ensure that correspondence from A&E to GPs is legible and forwarded without delay following presentation of a patient with serious issues such as self-harm, a suicide attempt or abuse.
24. George Eliot Hospital to either explore the possibility of an IDVA being based on site, or to put in place a procedure by which A & E staff can contact the on call IDVA.

ALL AGENCIES including Warwickshire Police, Probation Trust, Coventry & Warwickshire Partnership Trust, George Eliot Hospital, West Midlands Ambulance Service, South Warwickshire NHS Foundation Trust, Harmoni, Warwickshire County Council, Nuneaton & Bedworth Council, And Children's Services

25. All agencies disseminate the learning from this DHR and review the recommendations to identify any changes that need to be made to their internal practice or procedures
26. All agencies ensure that all 'client facing' staff, particularly those undertaking assessment, complete training regarding Domestic Violence and Abuse (DVA) awareness that is in line with the NICE Guidance (Feb 2014), proportionate and relevant to their role. This needs to include:
 - a. Understanding of indicators of domestic abuse from the perspective of perpetrators and / or victims, and the impact upon victims, particularly children
 - b. Responding to disclosures of domestic abuse including knowledge around specific assessment tools such as DASH, support services available and professional responsibilities.
 - c. Explicitly highlighting domestic abuse issues in the current safeguarding sessions delivered within induction to all staff, and including awareness of how to access specialist advice and support that is available both within and external to the agency
27. All agencies review administrative procedures and support within front line services to ensure that correspondence to other agencies is completed within an appropriate timescale.
28. All agencies include a link to the Warwickshire Against Domestic Abuse website on their safeguarding website.

Warwickshire North Clinical Commissioning Group and Local Area Team

29. The CCG and Local Area Team, as the commissioner of primary care services, ensure through their contractual arrangements that all GP practices are aware of, and complying with, guidance published by the Royal College of General Practitioners (RCGP), Identification and Referral to Improve Safety (IRIS) and CAADA on responding to domestic violence
30. The CCG considers commissioning the IRIS project, which is a general practice-based domestic violence and abuse training support and referral programme, based on collaboration between primary care and third sector organisations specialising in domestic violence abuse. The CCG should note that the Department of Health is also funding some roll-out of IRIS through its Innovation, Excellence and Strategic Development (IESD) Fund.
31. The CCG and Local Area Team, as the commissioner of primary care services, disseminates the learning from this DHR to all GP practices within the County and request that GP practices implement the following improvements to their administrative procedures:
 - a. When information in relation to correspondence is added to the electronic records a note of the date the information is received must be made in the record.
 - b. To introduce a flagging system for Domestic Abuse history to be recorded on the electronic record system
 - c. GP practices to consult their Software producer for the GP practice IT system to identify if an update to the electronic records system can be made to enable the system to make automatic links of registered patients by address
 - d. Safeguarding and Domestic Abuse training to be completed by all staff at the primary care practice, including awareness of MARAC process.
 - e. To introduce a system to ensure that unreadable & unclear correspondence received is requested in a legible format from the agency sending correspondence and to escalate concerns if a pattern or theme is spotted with an agency.
32. The CCG and Local Area Team, as the commissioners of health services, put in place measures to improve the sharing of information between health agencies around domestic abuse and violence, including:
 - a. Disseminating the new Code of Practice on Information Sharing within the NHS, when this is issued by the Department of Health
 - b. Focussing specifically on the context of deliberate self-harm and other mental health assessments within A & E.
 - c. Working with NHS providers to improve communication between services to highlight potential at risk individuals and families so these cases can possibly be picked up using early warning signs, including links to any "frequent flyer" programmes. This applies in particular to communication across mental health, A & E, GP and substance misuse services.
 - d. Reducing delays in sending correspondence to GPs especially related to a serious incident such as attempted suicide

- e. Improved clarity for the respective agencies of follow up arrangements following an attempted suicide with less reliance on the patient to make contact for follow-up
 - f. To ensure that reduced staffing services over Christmas and New Year or other holiday periods do not negatively impact upon communication to other health and social care agencies
33. That the CCG ensures that all NHS providers have a Domestic Abuse Policy in place as a contractual requirement.
34. The CCG/Local Area Team circulates information about the MARAC process to all GP practices along with the new CAADA Guidance for GPs.
35. The CCG, through the Health Panel, takes action to improve awareness of domestic abuse at a senior management level to ensure better leadership and cultural change across organisations. This could be linked to implementing the NICE guidance which is due to be published in February 2014 and should include embedding domestic abuse in the “Making Every Contact Count” approach to addressing health inequalities.

Warwickshire County Council - Children’s Services

36. Children’s Services ensure and reinforce that Children’s Teams follow the existing guidance in respect of referrals where children may be at risk of significant harm and the protocol for Domestic Abuse referrals in a timely manner.
37. Children’s Services to develop guidance/ process for frontline staff to support them in risk assessing victims when domestic abuse is disclosed by clients/ children. This should also extend to when historic abuse is disclosed by a partner who still has contact with the perpetrator due to child access arrangements.

Author: Kathy McAteer
Independent Social Care Consultant

Date: 29th January 2014