Executive Summary

Domestic Homicide Review

Name: Jane

Died: December 2016

Author: Ged McManus
Date: May 2018

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1 The Review Process

1.1 This summary outlines the process undertaken by the Middlesbrough Community Safety Partnership Domestic Homicide Review panel in reviewing the homicide of Jane, who was a resident in their area.

1.2 The following pseudonyms have been in used in this review for the victim and perpetrator and the victim's partner to protect their identities and those of their family members:

Name	Who	Age	Ethnicity
Jane	Victim	44	White British
Roger	perpetrator	23	White British
Henry	Jane's partner	53	White British

1.3 Criminal proceedings were completed on 9 October 2017. The perpetrator pleaded guilty to murder and was given a life sentence with a minimum tariff of twenty two years and two months.

1.4 This review began on 22 September 2017. The start of the review was delayed by complicating factors within the police investigation. Initially there were a number of lines of enquiry into Jane's murder and until a suspect had been formally identified and charged it was not thought appropriate to make decisions on the progression of a DHR. Once that stage had been reached an independent chair and author was appointed and the DHR panel was constituted. The DHR panel met on five occasions, the last meeting being on 12 April 2018. The report was concluded on 10 May 2018, following consultation with Jane's family.

2 Contributors to the review

Agency

Cleveland Police

South Tees CCG

Tees Esk and Wear Valleys NHS

Foundation Trust

South Tees Hospital NHS Foundation Trust

National Probation Service

My Sister's Place

Middlesbrough Recovering Together

Youth Offending Team

Middlesbrough Borough Council Adult Social Care

Thirteen Housing

3 The review panel members

3.1 Member

Ged McManus	Independent Chair and author
Paul Cheeseman	Independent support to Chair and author
Claire Moore	Domestic abuse coordinator, Middlesbrough Borough Council
Darren Birkett	Detective Inspector Cleveland Police
Barbara Potter	Head of quality and adult safeguarding, South Tees Clinical Commissioning Group
Karen Agar	Associate Director of Nursing [safeguarding] Tees Esk and Wear Valleys NHS Foundation Trust
Helen Smithies	Assistant Director of Nursing, Safeguarding, South Tees Hospital NHS Foundation Trust

John Bagley	Probation manager, National Probation Service – Cleveland
Kirstie Madden	Safeguarding manager, My Sisters Place
Gary Besterfield	Hospital Intervention Liaison Team manager [Middlesbrough Recovering Together]
Rachel Burns	Health improvement specialist, Middlesbrough Borough Council
Paul Harrison	Operations manager, South Tees Youth Offending Service
Danielle Chadwick	Service manager, Harbour
Eric Scollay	Director Middlesbrough Adult Social Care and health integration
Chris Joynes	Director of customer services, Thirteen group [housing]

3.2 The review chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

4 Chair and Author of the overview report

Ged McManus was chosen as the DHR Independent Chair and Author. He is an independent practitioner who has chaired and written previous DHRs and was judged to have the skills and experience for the role. He is currently Independent Chair of a Safeguarding Adult Board in the north of England. He was assisted by Paul Cheeseman, another independent practitioner who has experience of the Chair and author role. Neither of them has previously worked for any agency involved in this review.

5 Terms of Reference

5.1 The purpose of a DHR 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 inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

[Multi Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

Timeframe under Review

The DHR covers the period 28 April 2012 to the date of Jane's murder in December 2016.

Specific Terms

1. How did your agency identify and assess the domestic abuse risk indicators in this case; was the historical domestic abuse taken into account when setting the risk levels and were those levels appropriate?

2. What indicators of domestic abuse, including coercive and controlling behaviour,[1] did your agency identify?

[1] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

3. What consideration did your agency give to any mental health or substance misuse when identifying, assessing and managing risks around domestic abuse?

4. How did your agency manage those risks?

5. What did your agency do to keep the levels of risk under review?

6. What services did your agency provide for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?

7. How did your agency ascertain the wishes and feelings of the victim and perpetrator about their victimisation and offending and were their views taken into account when providing services or support?

8. Were there any opportunities for professionals to routinely enquire regarding domestic abuse with the victim which might have been missed?

9. How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies who needed it?

10. What did your agency do to establish the reasons for the perpetrator's abusive behaviour and how did it address them?

11. Was there sufficient focus on reducing the impact of the perpetrators abusive behaviour towards the victim by applying an appropriate mix of sanctions [arrest/charge] and treatment interventions?

12. Were single and multi-agency policies and procedures, including the MARAC[2] and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?

13. How effective was your agency's managerial oversight of this case?

14. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?

15. What knowledge did family and friends have of the adults' relationship, that could help the DHR Panel understand what was happening in their

[2] Multi-agency risk assessment conference. This is a process in which agencies meet to consider what action can be taken to protect the victims of domestic abuse. Generally only those victims that are considered to be at high risk of serious harm are referred to a MARAC.

lives; and did family and friends know what to do with any such knowledge?

16. The review must take full account of issues raised by the victims' family and represent the voice of the victim and her family, in its narrative

6 Summary chronology

6.1 Jane had two children, Roger and an older son who had a different father. From an early age the older son spent much of his time with his father whilst Roger lived with Jane. Roger's father Henry, whilst not living with Jane, visited almost every day.

6.1.1 Following the death of a sibling, Jane began to misuse alcohol excessively. According to her family she had always enjoyed drinking alcohol from being a teenager, but this seemed to be the catalyst for heavier alcohol use. This coincided with the time when Roger was a young teenager.

6.1.2 From as early as 2007 Roger came to the attention of the youth offending team and was supervised for five offences, two of them being assaults on Jane. Work that was done with Jane and Roger at that time was considered to be successful.

6.1.3 From 2012, Roger's offending against Jane increased in frequency. He was arrested on a number of occasions and went to prison twice for offences of assault against Jane. The court imposed a restraining order preventing Roger from contacting his mother, but he breached this on many occasions, most of which did not come to the attention of any agency. Sometimes Jane allowed him in and fed him because he was cold and hungry despite the order being in place. On other occasions the review heard that Roger would beg her to let him in. It is difficult to know now what pressure she was under to do so, or if she was acting entirely of her own free will.

6.1.4 Jane's misuse of alcohol undoubtedly reduced her resilience to Roger's behaviour. She was admitted to hospital on many occasions when she had been drinking and had other health conditions. Although she was offered many different services, Jane would often disengage from them quickly and no service was ever successful in helping Jane over a meaningful period of time. Her mental health was often questioned and Jane herself believed that she had a mental health condition on some occasions. Despite a number of referrals to mental health services no mental health condition other than depression was ever diagnosed and Jane's symptoms were always found to be due to alcohol misuse.

6.1.5 Jane's mother told the chair of the review that Jane was often pressured by Roger to give him money. She pawned personal items and electrical goods in order to give him cash which it is thought was spent on drink and drugs. In effect Jane was subject to financial abuse but this was never reported. Despite Roger's poor behaviour towards her, Jane was unable to break off contact with him. In the last month of her life Jane was not in touch with any agency. Information from police statements indicates that during that month Roger spent much of his time at Jane's house and they both misused alcohol on a daily basis.

6.2 Key events

6.2.1 In April 2012, Jane contacted the police to make a complaint that Roger had stolen £40 from her. Following enquiries to trace him, Roger was arrested charged with robbery and kept in police custody to attend court.

6.2.2 In July 2012, Jane attended an appointment at a substance misuse service managed by Tees Esk and Wear Valleys NHS Foundation Trust. She remained engaged with the service until September 2013. Jane missed many appointments but kept others and attained periods of abstinence from alcohol but relapsed on several occasions. Alongside her treatment for alcohol dependence she was supported to improve her physical and mental health, promoting her independence by addressing housing, employment and financial difficulties and providing support to enhance her social support. Jane disclosed on a number of occasions that she continued to have contact with Roger. On every occasion she was advised to contact the police and stop contact with Roger.

6.2.3 In August 2012, Roger pleaded guilty at Teesside Crown Court to the robbery of property from Jane in April 2012. He was released with bail conditions not to approach Jane whilst a pre-sentence report was prepared. However, Jane contacted the police later the same evening and reported that Roger had been to her house. Roger was arrested and remanded into custody until the case was heard.

6.2.4 In September 2012, Roger appeared at Teesside Crown court. He was made subject to a Suspended Sentence Order comprising nine months detention in a Young Offenders Institution suspended for two years. The Order contained requirements for two years Supervision and for Roger to complete 160 hours

unpaid Work. A Restraining Order was also imposed indefinitely prohibiting him from

I) Either by himself or his agents directly or indirectly in any way whatsoever from contacting, harassing, alarming or distressing or molesting Jane.

II) Notwithstanding the generality of the aforesaid, he is prohibited either by himself or his agents by any means whatsoever from.

Telephoning, faxing, texting of communicating by letter, electronic mail or internet, or the sending or soliciting to send any item or correspondence whatsoever to the said Jane or attending her home address at **** or attending any address the said Jane may move to in the future.

6.2.5 In June 2013 Jane reported to the police that Roger had punched her. Police attended at her home address and arrested him. Jane was taken to hospital and admitted for treatment to a head injury caused by the assault. She disclosed drinking approximately 35 units of alcohol per week and was seen by the PADS [Primary alcohol and drug service]. She was discharged the next day.

6.2.6 Roger was charged with assaulting Jane and breach of a restraining order. He was kept in police custody to attend court where he was remanded to prison. A DASH risk assessment was completed and was initially classed as medium risk by the attending officer. This was then raised to high risk by the risk assessment officer in the vulnerability unit. A referral was made to My Sisters Place and the case was considered by the police for a referral to MARAC as it had been assessed as high risk. A decision was made not to refer to MARAC 'as there was already a restraining order in place, no children were involved and Jane had allowed Roger access to the house'.

6.2.7 In September 2013, Roger appeared at Teesside Crown Court for breach of the suspended sentence order, breach of restraining order and common assault, which took place in June 2013. He was sentenced to six months Detention in a Young Offenders Institution.

6.2.8 In December 2013, Jane reported to the police that Roger was at her house trying to force his way in. This was in breach of the restraining order. Following a further incident the following day, when Jane alleged that Roger made threats to her, the police located and arrested Roger. In her statement, Jane described how she had allowed Roger to stay at her house a couple of times as he was

freezing and hungry. Roger was remanded into custody until sentencing in March 2014. He was made subject to a Suspended Sentence Order comprising twelve months custody suspended for eighteen months. The Order contained requirements for eighteen months supervision and for Roger to complete 150 hours unpaid work. The Restraining Order was extended until March 2016.

6.2.9 In October 2014, Jane contacted the police to report that she had been assaulted by Roger causing a head wound. He was charged with assault, breach of a restraining order and threats to kill. He was remanded in custody until November 2014, when he was sentenced to 86 weeks imprisonment.

6.2.10 Following the assault of October 2014, a referral was made to MARAC. The single action arising was for a joint police and IDVA visit to Jane to take place if she did not attend a planned appointment. In November 2014, a joint visit to Jane at her home took place with an IDVA from My Sisters Place and a police officer attending. Jane was not seen and although records are unclear it is believed that a business card was left with Henry with a request for Jane to make contact. No further contact was received and no further action was taken.

6.2.11 After his release from prison for the assault of October 2014, Roger continued to breach the restraining order by visiting Jane, some of those contacts were disclosed to his probation officer. On 3 December 2015, Roger was served with a warning letter by the Probation Service regarding his contact with Jane. He was also told that the police would be making spot checks at Jane's house and a request was made to the police by email to do this. The checks were allocated to a neighbourhood officer who visited the house on two occasions in December 2015. The officer received no reply and no further action was taken. There is no record of the result of these checks being reported to the Probation Service.

6.2.13 On 27 April 2016, a final OASys assessment [the nationally accredited offender assessment system] was completed marking the termination of Roger's licence period on 31 March 2016. This concluded that Roger posed a medium risk of causing serious harm to a known adult, his mother Jane and a medium risk of causing serious harm to the public. That assessment was based on the fact he had complied with Licence conditions and reached the end of it without re-offending and there was no evidence from the Police that he was in contact with his mother.

6.2.14 The end of Roger's license period coincided with the end of the court imposed restraining order. After 31 March 2016, Alex was not under the supervision of any agency and there was nothing to stop him visiting Jane. Services had little or no contact with Jane until November 2016

6.2.15 In November 2016, Jane was assessed by the HILT team [Hospital Intervention and Liaison Team – alcohol service] after an admission to hospital following a collapse at a local supermarket. An AUDIT[3] was completed which scored 40 indicating alcohol dependence, Jane reported drinking half a litre of vodka daily. She said that her partner provided her with the alcohol but that she lived alone. Jane agreed to a referral to community substance misuse services and the Liver Harm Reduction Clinic but did not attend appointments.

6.2.16 In late 2016, Roger subjected his mother to a sustained assault over several hours. Henry found Jane injured. He later told the police that he did not realise how badly hurt she was and tried to care for her. He telephoned for an ambulance, when he thought that Jane had stopped breathing. Paramedics were quickly on the scene but were unable to save Jane.

7 Key issues arising from the review

1. Jane's alcohol misuse and other medical conditions meant that she had limited resilience in dealing with Roger's persistent poor behaviour.
2. Roger misused alcohol and drugs and continually pressured Jane for money to support him.
3. The panel felt that Roger's conduct amount to coercive and controlling behaviour.
4. Jane's family knew some of what happened, but she was a private person who kept many things from them.
5. When the case was referred to MARAC the response was ineffective.
6. Roger breached the court imposed restraining order regularly. Some of these breaches were known to professionals and the overall response was ineffective.
7. In the nine months before her murder, both Jane and Roger were not engaged with services.

[3] Alcohol Use Disorders Identification Tool. A ten item screening tool developed by the World Health Organisation to assess alcohol consumption, drinking behaviours and alcohol related problems.

8 Conclusions

8.1 Jane suffered from violence at the hands of her son Roger for at least nine years. The first record of an assault by Roger on his mother was in 2007. Over the following years Jane reported four assaults on her by Roger as well as a robbery, breach of bail conditions and breach of restraining order. She disclosed in police statements that there had been other assaults, but she had not reported them.

8.2 Despite Roger's assaults on her and his other poor behaviour Jane was unable to break off contact with him. A restraining order was in place preventing Roger from contacting Jane for much of the review period, but it is known that this was breached regularly. It is difficult to know whether this was because of an unbreakable bond that she felt to her son or whether her resilience to his behaviour had simply been eroded over the years and she was unable to say "no". Jane told her mother that she loved Roger but didn't like him because of his behaviour.

8.3 Jane's life was severely affected by her alcohol misuse. She sometimes engaged with substance misuse services and disengaged with them as was her right. In the last two years of her life Jane did not accept help for her alcohol misuse and was not engaged consistently with any support.

8.4 Individual agencies provided services to Jane according to their own policies and procedures. When Jane did not keep appointments, standard processes were followed, and she was offered further appointments and reminders before being discharged from services.

8.5 The referral to MARAC when it was made offered the only opportunity within established protective procedures that the review has seen for a multi-agency overview of the case. The result was ineffective, and the case was closed to MARAC without anything having been achieved. The Probation Service asked the police in December 2015 to conduct spot checks at Jane's home to see if Roger was there. This was never followed up and there was no further communication between the two agencies on the matter.

8.6 For much of his time under the supervision of the Probation Service, Roger admitted to having continued contact with Jane despite this being in breach of the restraining order. On many occasions he said that Jane had invited him into her home and on others they had gone on family days out. From 3 December

2015, when he received a formal warning from the Probation Service about his contact with Jane, nothing further was reported and by the end of his licence period on 31 March 2016, the risk of him causing serious harm to Jane was said to be reduced to medium risk. This was in part influenced by the fact that the police had not reported any breach of Roger's licence conditions following the Probation Service request for them to do spot checks at Jane's home. However there had been no further communication between the two agencies on the issue and the Probation Service were unaware that that the scale of the checks had been two unanswered visits in December 2015.

8.7 The end of Roger's licence period coincided with the end of the restraining order. From 31 March 2016, there was no legal barrier to any contact between Roger and Jane. Despite the fact that Jane had previously been seen as a high risk victim of domestic abuse at MARAC and by the Probation Service, there was now no monitoring of risk by any agency.

8.8 In the nine months that followed, up until her murder in December 2016, Jane's contact with agencies almost ceased. She was taken to hospital in November 2016 following a collapse and was assessed as alcohol dependent. She was offered and accepted follow up appointments but did not keep them. Despite her previous difficulties and ongoing alcohol misuse she had become almost invisible to services.

8.9 In the days before her murder, police statements show that Jane was drinking large amounts of vodka, at least one bottle per day and perhaps more. Roger was spending time with her and was also drinking large amounts of alcohol. Why Roger beat and murdered his mother may never be known. He declined to reply to any questions that the police asked in interview and has declined the opportunity to take part in the review.

9 Lessons to be learned

The DHR panel identified the following lessons. The panel did not repeat the lessons identified by agencies. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to a recommendation a cross reference is included in bold.

9.1 Narrative

Jane's illnesses brought her into contact with many services. She engaged and sometimes disengaged with them. The panel recognised that there are many reasons victims feel unable to engage with services. This made it challenging

for any one service to have a holistic view of the issues affecting her. It is not now possible to know whether this was an active choice that Jane made, or whether she was simply unable to engage with services on a consistent basis due to her alcohol misuse.

Lesson

People with multiple needs may find it particularly difficult to engage with services. A coordinated case management approach may help to support service users who for whatever reason engage in risky behaviours.

9.2 **Narrative**

Jane declined support in relation to domestic abuse when it was offered. Following an appropriate referral to MARAC the single action taken was ineffective and engagement with Jane was not achieved.

Lesson

Victims of long term domestic abuse do not find it easy to seek help for a number of reasons including lack of self-confidence, fear, intimidation, financial dependence and guilt. Some of these indicators were apparent in Jane's relationship with Roger and a more assertive approach to supporting victims who do not easily engage is required.

Recommendation 2

9.3 **Narrative**

Jane had chronic alcohol misuse issues. She last had significant engagement with alcohol misuse services in 2013 and despite a number of referrals did not consistently engage with services after that. Professionals followed the established attendance policies of their organisations and accepted that it was Jane's right not to engage with services. Some of the features in Jane's case camouflaged her vulnerabilities and may have prevented services from regarding her as a victim of domestic abuse. It would appear that professionals did not see beyond the social norms and assumptions about addiction.

Lesson

People with long term substance misuse issues are vulnerable to a range of different abuses and may be unable to effectively protect themselves. Alcohol

Concern[4] say that the perception that if a problem drinker does not want to change, nothing can be done is untrue. Their Blue Light Project[5], supported by Public Health England challenges the traditional approach and radically changes the working agenda by showing that there are positive strategies that can be used with this client group.

Recommendation 3

9.4 **Narrative**

Roger had abused Jane for at least nine years. For much of the review period he was subject to some control measure whether that be prison, bail conditions, restraining order, suspended sentence orders or prison licence. It was known that despite those measures he had continued to offend, breach the restraining order and assault Jane. From 31 March 2016 there were no control measures in effect. Jane did not report any further issues and she was in effect invisible to services until her murder in December 2016.

Lesson

The risks to Jane did not abate simply because Roger came to the end of his licence period and supervision by the Probation Service. Services had last tried to engage with Jane in July 2015 and attempts could have been made to engage her in safety planning towards the end of Roger's sentence in 2016.

Recommendation 2

9.5 **Narrative**

Changes in the provision of substance misuse services over the several years of the period of this review have meant that available records of Jane's engagement with substance misuse services are incomplete.

Lesson

Commissioners should ensure that access to records is considered within the continuity arrangements when the provider of a service changes.

Recommendation 5

[4] A national charity working to help reduce the problems that can be caused by alcohol.

[5] https://www.alcoholconcern.org.uk/blue-light-project

9.6 **Narrative**

Roger had abused Jane for many years. Some agencies had worked with him to address his behaviour. Other agencies did not recognise that Roger's behaviour towards his mother was domestic abuse and had little or no awareness of Adolescent to Parent Violence and Abuse. It is also likely that Jane and her family did not recognise Roger's behaviour as domestic abuse.

Lesson

It is important that all professionals recognise patterns of behaviour in a young person that may indicate APVA and the risk that young person presents to others. Agencies need to have pathways in place so that professionals can recognise and respond appropriately to APVA.

Recommendation 4

10 Recommendations from the review

10.1 Recommendation one

Middlesbrough Community Safety Partnership should consider the feasibility of developing a coordinated case management approach to the care of vulnerable service users, who engage in risky behaviours, with full consideration of MARAC and other safeguarding processes.

10.2 Recommendation two

The Middlesbrough Community Safety Partnership should put in place processes by which it can gain assurance that:

1. MARAC actions are meaningful and contribute to the safety of the victim.
2. Agencies are held to account for the delivery of agreed actions.
3. Safety planning for victims of domestic abuse when offenders come towards the end of a sentence imposed by the criminal justice system can be made an integral part of domestic abuse services for example by being incorporated into MARAC.

10.3 Recommendation three

The Middlesbrough Community Safety Partnership should consider adopting an appropriate evidence based model for supporting victims of domestic abuse with complex needs [mental health/substance misuse], such as the Alcohol Concern Blue Light Project methodology and training materials.

10.4 **Recommendation four**

Middlesbrough Community Safety Partnership should circulate the Home Office Information booklet on Adolescent to Parent Violence and Abuse [APVA] to partner agencies and seek assurances they have pathways in place that ensure the appropriate response is delivered when APVA is recognised. Partner agencies should circulate the information to their staff and ensure it is included on new and refresher training.

10.5 **Recommendation five**

The Middlesbrough Community Safety Partnership should seek assurance from commissioners that access to historic records is considered as part of the continuity arrangements when commissioning new services.

10.6 **Single agency recommendations**

A further twenty nine single agency recommendations have been made as a result of this Domestic Homicide Review. They are contained in the action plan at Appendix A.

Appendix A

No	Recommendation	Scope	Action to take	Lead agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
Community Safety Partnership							
1	Middlesbrough Community Safety Partnership should consider the feasibility of developing a coordinated case management approach to the care of vulnerable service users, who engage in risky behaviours, with full consideration of MARAC and other safeguarding processes.	Local	Review process, systems and forums already established and consider how they interrelate. Consider system change needed in order to embed a case coordinated approach as part of new commissioning model across homelessness, substance misuse, domestic abuse and homelessness. Written into specifications and tender Process mapping workshop to take place between CSP and Adult SC re complex needs – internal review progressed Adult social care	CSP CSP CSP Adult SC	Shared Case load Management System implemented Policy and procedure & multi agency information sharing protocol developed defining case coordinated approach for vulnerable service users Services commissioned and developed to meet needs of vulnerable service users. Thresholds and Pathways agreed and shared widely	October 2019 June 2019 October 2019 March 2019	**Ongoing** **Ongoing** **Ongoing** **Ongoing**

2	The Middlesbrough Community Safety Partnership should put in place processes by which it can gain assurance that: 1. MARAC actions are meaningful and contribute to the safety of the victim. 2. Agencies are held to account for the delivery of agreed actions. 3. Safety planning for victims of domestic abuse when offenders come towards the end of a sentence imposed by the criminal justice system can be made an integral part of domestic abuse services for example by being incorporated into MARAC		MBC Representatives identified on strategic meeting and SPOC attending MARAC meetings consistently MARAC meeting. Information sharing Protocol shared with service leads Full review of MARAC process completed Independent MARAC chair recruited – funded collaboratively across agencies Letter prepared to CJMB requesting review across NPS, Prison Service and D&T CRC ensuring clear lines of responsibility agreed re how agencies are notified to ensure a victim in informed and safety planning is implemented with a victim if offender due for release from a custodial sentence	OPCC CSP Cleveland Police OPCC CSP Cleveland Police OPCC OPCC CSP Cleveland Police CSP CJMB	MCB representation strategic and operational level Procedure and policy developed re MARAC across Tees Review completed Post filled – funding agreed Tabled on CJMB and next steps agreed to ensure this recommendation is addressed	April 2018. April 2018 January 2018 April 2018 January 2019	**Completed** Governance **Completed** Policy launched **Completed** Review published **Completed** Independent chair appointed **Ongoing**
3	The Middlesbrough Community Safety Partnership should consider adopting an appropriate	Local	MBC to develop new commissioning approach to be developed across	CSP	Collaborative working across services	October 2019	**Ongoing**

	evidence based model for supporting victims of domestic abuse with complex needs [mental health/substance misuse], such as the Alcohol Concern Blue Light Project methodology and training materials.		substance misuse, homelessness, domestic abuse and sexual violence & abuse The approach will incorporate triage, case coordination and assertive outreach and will embed evidence based models such as person centred & trauma informed practice. This will also link with Navigator Partnership which is a Regional Project for victims with complex need funded by Ministry of housing & the aligned Ministry of Justice Bid for female offenders experiencing DA Develop vulnerable women's case conference This will provide governance and case coordination for all female victims of DA / sexual violence and abuse with high vulnerability/ high risk issues	DA Lead MBC DA Lead MBC	Improved information sharing & monitoring Improved engagement and oversight for DA victims with complex need Project Management Board for Navigator overseeing work carried out and feeding this into Local Domestic Abuse Strategic Partnerships Terms of reference agreed and ensure this is promoted across agencies.	October 2018 April 2019	**Completed** Funding secured until March 2020 **Ongoing**
4	Middlesbrough Community Safety Partnership should circulate the Home Office Information booklet on Adolescent to Parent Violence and Abuse [APVA] to partner	Local	Booklet circulated to Middlesbrough Domestic Abuse Strategic Partnership, Middlesbrough Children Safeguarding Board &	DA Lead MBC	Guidance shared via network	July 2018	**Completed** Information shared across DASP network and children /

	agencies and seek assurances they have pathways in place that ensure the appropriate response is delivered when APVA is recognised. Partner agencies should circulate the information to their staff and ensure it is included on new and refresher training.		Teeswide Adult Safeguarding Board. Information, Briefing & link for booklet added to Middlesbrough Council website and LSCB site re APV LSCB level 1 and 2 training adapted to include APV and learning from DHR DA Coordinator attended LSCB to update on theme identified in DHR re APV 7 minute Briefing Paper re DHR overview and learning shared with directorate & included on MBC website APV pathways presentation developed for YP Risk Roadshow for multi- agency professionals	DA Lead MBC/ LSCB DA Lead MBC DA Lead MBC DA lead MBC DA lead MBC	Updated website and materials re APV DA training incorporates APV for refresher / Induction training across multi agency professionals Strategic Briefing completed Increased awareness across partnership	July 2018 August 2018 November 2018 October 2018	adult safeguarding **Completed** Information readily available **Completed** Revised training materials **Completed** Increased awareness **Completed** Presentation to delivered and be rolled out further if required
5	Middlesbrough Community Safety Partnership should seek assurance from commissioners that access to historic records is considered as part of the	Local	Appointment of commissioning officer to support commissioning activity within public health Guidance has been developed regarding the	Commissio-ning & public health Team MBC	Commissioning process and procedures reviewed	June 2018	**Completed** January 2019

	continuity arrangements when commissioning new services.		decommissioning of service provision which includes the transfer of records.				
Cleveland Police							
6	PC *******is spoken to and debriefed around actions when attending the incident on 11th December 2013	Local	Officer concerned spoken to in person by D.I Birkett around his sequel of event - that T.M did not want to provide a statement against A.M when the day before she had provided a statement. As this event was 5 years ago, officer could not recall this event although he knew he had dealt with T.M at some point. He could not account for why she would not provide a statement on this occasion.	Cleveland Police	This was a specific incident with no long term learning from it.	July 2018	**Completed** July 2018
National Probation Service							
7	The Probation Service Individual Management Review should be shared with the probation officer and the three managers responsible for supervision during the period of Roger's contact with the Probation Service so that its findings can influence and improve future practice relating to risk assessment, enforcement and	Local	IMR to be disclosed to LN and 3 managers involved -Learning points to be shared with all managers -Focus on false optimism and information sharing	Head of Area	Meeting has taken place	Meeting with those involved in IMR – June 2018. Meeting with all managers – July 2018	**Completed** Meeting has taken place. Lessons learned discussed and plan made for implementing lessons in future practice

	seeking guidance from a manager						
8	The probation officer's present manager to conduct a "deep dive" assessment of ten of the cases which the probation officer managed at Middlesbrough Probation Office to seek assurance about enforcement and risk assessment practice and the extent of case referral to a manager for advice.	Local	Deep dive into 10 cases	Head of Area	Audit successfully completed and report submitted	September 2018	**Completed** No Further concerns
9	All staff of NPS Cleveland to be issued with a reminder from the Head of Area that all contacts and telephone calls must be recorded on Delius within 24 hours.	Regional	Email guidance Feedback DHR learning points to all staff	Head of Area	Learning points to be shared with all team managers July LMM	July 2018	**Completed** Learning points shared July 2018
10	All staff of NPS Cleveland to be issued with a reminder of enforcement processes from the Head of Area in respect of Court Orders and Prison Licences and the need to seek approval from a manager if they wish to depart from the process in an attempt to achieve improved compliance.	Regional	Email about enforcement processes Feedback DHR learning points to all staff	Head of Area	Since this offence was committed all Cleveland staff have had briefings and Guidance about 'achieving better compliance" – including guidance on enforcement steps and a framework for applying professional judgement to enforcement and compliance decisions	August 2018	**Completed.** New guidance has been implemented across the area

11	All staff of NPS Cleveland to be notified by the Head of Area that they must bring cases assessed as posing a medium risk of causing serious harm in the context of domestic violence to a manager for discussion when new information is received and/or when they are to re-assess the level of risk of causing serious harm.	Regional	Re-issue current guidance. Feedback DHR learning points to all staff	Head of Area	DHR learning points to be shared with all team managers in July LMM Head of area has met with police and agreed to be part of the new MATAC process – which aims to pick up on offenders not discussed ad MARAC / MAPPA	July 2018	**Completed** There is now lead SPO for MATAC to ensure appropriate attendance at meetings across the area
12	All staff of NPS Cleveland to be issued with guidance from the Head of Area about the need to pass information about possible new offences and breaches of Court Orders and Prison Licences to Cleveland Police Intelligence Hub.	Regional	Re-Issuing of guidance. Feedback DHR learning points to all staff	Head of Area	DHR learning points to be shared with all team managers in July LMM	July 2018	**Completed**
13	All staff of NPS Cleveland to be re-issued with guidance from the Head of Area as to when referrals to MARAC, MAPPA and Adult Safeguarding should be made.	Regional	Reminder to be sent to all staff regarding current processes which are all mapped on EQUIP Feedback DHR learning points to all staff	Head of Area	In addition to managing domestic abuse offenders via MAPPA and victims via MARAC Head of Area is also signed up to working with police on MATAC system for managing repeat Domestic Abuse situations where MAPPA and MARAC are not involved	August 2018	**Completed** attending MARAC and MATAC

South Tees Hospitals NHS Foundation Trust							
14	The development of a management of domestic abuse policy	Local	Develop policy Ratify and launch policy	STHFT	Policy in draft for consultation Ratify policy	December 2018	**Completed** Policy Launched Dec 2018
15	To audit A&E staff response to disclosures of domestic abuse	Local	Audit to be undertaken	STHFT		May 2018	**Completed** Significant improvement demonstrated.
South Tees Clinical Commissioning Group							
16	GPs to input into the frequent attenders at Emergency Departments.	Local	The CCG is exploring with the Trust ways of sharing information to the frequent attenders meeting and out to the GPs	CCG	The ED has a frequent attenders process that the CCG had a lot of input into and GPs are now asked to participate	June 2018	**Ongoing** An audit of all frequent attenders will be carried out to see if the GPs had input 1.3.19
17	GPS to input into case management of patients with severe chronic dependence on alcohol.	Local	GPS are carrying out MDTs in relation to this group of patients	CCG	GP's have been carrying this out independently the CCG is looking at a way of formalising this process	June 2018	**Ongoing** Work has been ongoing since DHR to find a way of case managing pts
Middlesbrough Recovering Together							
18	Provide staff training around DASH Risk Identification Checklist and MARAC process	Local	Training was delivered to the HILT team by a specialist DA provider My Sisters Place, which	MRT	Training sourced and provided to all Substance Misuse Teams in MRT	November 2018	**Ongoing** Further training to be delivered

			included DASH Risk Identification training. Internal DASH training has been delivered to the CGL team within MRT, around recognising signs and using the tool, in November 18.		There is a MARAC lead for the partnership who represents MRT at MARAC meeting and feeds back to the partnership. There are also 2 dedicated Safeguarding Leads within the partnership to lead on staff/service development and risk management. Current briefings on MARAC, the DASH risk assessment and Claire's Laws are being delivered to all teams in March 2018.	November 2018	in 2019 – dates to be agreed
19	Ensure quality standards for case note recording and assessments are being met	Local	A national quality review process is in place, and additional local processes have been agreed to support quality and staff development, including Quality Improvement Framework audits, shadowing and observation which feeds into supervision, protected professional development time, reflective practice sessions, etc.	MRT	A quality review process has been implemented and embedded. Systems are in place to action learning needs identified within the review process on an individual, service and partnership level. There is a Quality Lead in post to focus on quality and performance.	June 2018	**Ongoing**

20	Provide risk identification and management training for all members of staff in HILT team.	Local	Risk identification and management training was delivered to the HILT team in June 2017, in addition to any previous training the team had received. All new staff were trained in risk identification and management as part of their induction process. Safeguarding and risk management is discussed within monthly supervisions and team meetings, to support ongoing learning and development and to ensure risk management is effective.	MRT	Training has been completed with all members of the team, and processes are in place to ensure new staff are trained and that training needs are reviewed regularly.	June 2017	**Completed**
21	Ensure community teams are following up none attendance via the Did not Attend policy.		The DNA policy (Missed Appointment Checklist) is in place with an auditing process through management to support.	MRT	The process is in place with regular auditing to feed into quality assurance and development.	October 2017	**Ongoing**
Tees Esk and Wear Valleys NHS Foundation Trust							
22	To raise the profile of Domestic Abuse in TEWV services through training to equip practitioners	Local	Delivery of Domestic Abuse Basic Awareness.	TEWV	Training has already been made available to Trust staff.	Already in place prior to review.	**Completed.** Training has been available

	with information and tools on best practice when addressing concerns related to domestic abuse. This should cover topics such as the Toxic Trio and the Safe Lives DASH (Domestic Abuse, Stalking and Harassment and Honour Based violence) 2009) risk assessment.		Training priority to be given to the teams involved in the review Safeguarding training to incorporate Domestic Abuse within it.		8 bespoke training sessions were delivered for the identified areas. Safeguarding Adults training has already included Domestic Abuse Basic Awareness. Domestic Abuse Basis Awareness has been incorporated as part of the Safeguarding Children's Level 3 update programme to be delivered until October 2019.	December 2018. Already in place prior to review.	since August 2016. **Completed** **Completed.** Training has been available since August 2016. Completed.
23	To provide information and guidance for information sharing with other agencies when it is vital in the best interests of people who are experiencing domestic abuse. This should include when confidentiality and consent issues arise to reduce the impact of further risk of abuse or harm.	Local	Domestic Abuse Procedure.	TEWV	Domestic Abuse Procedure to be readily available to Trust staff. Communication to the workforce of the Domestic Abuse Procedure via e-bulletin.	Already in place prior to review. March 2018.	**Completed.** Procedure available on Trust intranet site since 02/04/2017. **Completed.** Email sent to communication team to include on next e-bulletin 09/05/18. **Completed.**

					Circulate a SBARD (Situation, Background, Assessment, Recommendation, and Decision) to Trust staff highlighting the lessons to be learned from this review.	March 2018.	Email sent to patient safety to distribute 09/05/18.
24	To have a clear escalation process when risks of domestic abuse are identified which identifies where support can be accessed that is inclusive of the MARAC arrangements.	Local	Domestic Abuse Procedure	TEWV	Domestic Abuse Procedure to be readily available to Trust staff. Communication to the workforce of the Domestic Abuse Procedure via e-bulletin. Circulate a SBARD (Situation, Background, Assessment, Recommendation, and Decision) to Trust staff highlighting the lessons to be learned from this review.	Already in place prior to review. March 2018.	**Completed.** Procedure available on Trust intranet site since 02/04/2017. **Completed.** Email sent to communication team to include on next e-bulletin 09/05/18.
25	The Trust to adopt a more effective approach for practitioners to readily access information required for their assessments where MARAC	Local	Review of recording of MARAC on the Trust PARIS electronic records.	TEWV	MARAC information made accessible 24/7.	Already in place prior to review.	**Completed.** PARIS has already been reviewed and information has been made available since

	alerts have been placed on the system.						December 2016.
26	To have a recognised tool in the Trust electronic notes that capture safeguarding concerns, the consideration given to the risk and the justifications for decision making. This should take into account a person's capacity to understand and serve a purpose for formulating a decision for safeguarding.	Local	Review of Safeguarding documentation on the Trust PARIS electronic records.	TEWV	Recognised tool in place.	Already in place prior to review.	**Completed** PARIS has already been reviewed and information has been made available since December 2016.
Adult Social Care							
27	Staff should attend domestic abuse refresher training to ensure they have up to date knowledge and understanding of the issues relating to domestic violence.	Local	Provide domestic abuse refresher training for fieldwork staff in Adult Social Care	ASC&HI	Level 3 Domestic Abuse Safeguarding Training provided for fieldwork staff	May 2018	**Completed**
28	All staff should attend Care Act 2014 refresher training to ensure they are fully up to date with their duties and responsibilities under this legislation	Local	Provide Care Act 2014 refresher training for fieldwork staff in Adult Social Care	ASC&HI	Care Act 2014 training provided to all Adult Social Care fieldwork staff via CC Inform training platform	August 2018	**Completed**

29	Staff should attend refresher training on safeguarding and the referral criteria to ensure they are up to date with current practice and procedures.	Local	Provide adult safeguarding refresher training for all fieldwork staff in Adult Social Care	ASC&HI	Adult safeguarding refresher training provided to all Adult Social Care fieldwork staff via CC Inform training platform	August 2018	**Completed**
30	Female victims of domestic violence should be given the opportunity to be interviewed/assessed by a female social worker.	Local	Develop practice guidance to ensure female victims of abuse have the opportunity to be interviewed / assessed by a female member of staff	ASC&HI	Gender mix of Social Work staff within Adult Social Care's Access and Safeguarding teams now provides the opportunity for this.	October 2018	**Completed**
31	When individuals are signposted to other agencies there should be effective systems in place to ensure timely feedback/follow up on outcomes.	Local	Establish practice guidance and process around which elements of signposting require formal follow-up arrangements	ASC&HI	Appointment of Adult Safeguarding Lead Officer to lead review anticipated by Jan 2019	January 2019	**Ongoing**
32	Social work staff require in house comprehensive initial and refresher training on recording skills to ensure a full recording of events is completed for every contact.	Local	Provide information on recording standards as part of Adult Social Care induction and provide updated practice guidance on recording standards for all existing fieldwork staff	ASC&HI	Recording standards included as part of induction for field workers in Adult Social Care; updated practice guidance issued and case audits in place as part of approval panel process	October 2018	**Completed**

33	In house training on information sharing should be provided to all staff.	Local	Provide information sharing training to Adult Social Care staff	ASC&HI	Information sharing, data protection and information security training provided to all staff within Adult Social Care	December 2017	**Completed**
34	Cases that involve repeat contacts in respect of vulnerable/at risk individuals but currently do not progress from the Adult Access point require an agreed threshold point where the case requires allocation to a relevant social work team for a more in-depth assessment of the situation.	Local	Establish threshold and process around allocation to Social Worker	ASC&HI	Appointment of Adult Safeguarding Lead Officer to lead review anticipated by Jan 2019	January 2019	**Completed**