SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

RUTH

EXECUTIVE SUMMARY

Author and Domestic Homicide Review Chair

David HUNTER September 2016

CONTENTS

1. INTRODUCTION

1.1 This report is about the homicide of Ruth. In September 2015[1] Ruth was found dead in the flat she shared with her partner Harry. His account of finding her dead was not believed and he was arrested for murder. A post mortem found Ruth died of head injuries and chest wall trauma. She also had a large number of variable aged injuries. Harry was later charged with Ruth's murder.

1.2 The trial started on 07th March2016 and Harry pleaded not guilty to murder, having had his first day offer to plead guilty to manslaughter rejected by the Crown Prosecution Service. On 14th March 2016, part way through the trial Harry changed his plea to Guilty and was sentenced to life imprisonment with a minimum tariff of twenty years.

1.3 The Judge's sentencing remarks appear in full at Appendix A and make very difficult reading as they reveal the detail of Harry's brutality towards Ruth. The following is an extract.

"*Having heard that evidence and having considered all the medical and scientific evidence, I am quite satisfied that over a period of a month prior to her death, you caused her untold physical and mental suffering as a result of your ever increasing violence, culminating in a ferocious and sustained attack upon her on the night she died."*

1.4 The main people referred to in the report are:

Name	Relationship	Ethnicity
Ruth About 50 years	Victim and partner of Harry	White British
Harry About 55 years	Offender and partner of Ruth	White British
Tony	Son of Ruth [2]	White British
Adele	Daughter of Ruth [2]	White British
Georgia	Daughter of Ruth [2]	White British

[1] The date of the homicide has been included so as to give context to the events concentrated in the last few weeks of Ruth's life.

[2] All are adults

Emily	Daughter of Ruth [2]	White British
Former Husband 1	Ruth's first husband and father of the three daughters	White British
Former Husband 2	Ruth's second husband	White British

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

Decision Making

2.1 The Chair of Sefton Safer Community Partnership decided that Ruth's death met the criteria for a domestic homicide review and appointed David Hunter as the Independent Chair and Author. He was supported by Paul Cheeseman. A Panel was established and comprised local agencies with additional independence being provided by two not-statutory organisations.

Information Considered

2.2 Six agencies submitted written information. A meeting was held between David, Paul and seven senior staff from Southport and Ormskirk Hospital NHS Trust to establish exactly what happened during Ruth's admission. The Hospital undertook a Root Cause Analysis which was provided to the Panel. Ruth's four adult children were seen and gave a detailed account of their mother's suffering and their attempts to engage Merseyside Police. Harry declined to take part in the review. It was agreed the review would be completed by the end of September 2016. All relevant parties were informed.

Terms of Reference

2.3 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 policies and procedures as appropriate
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working [3]

Timeframe under Review

2.4 The DHR examines the period 23rd January 2015 when Harry was released from prison on licence to the date of the homicide.

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7

Specific Terms

1. What if any indicators of domestic abuse did you agency have in respect of the subjects and what was the response in terms of risk assessment, risk management and services provided?

2. How did your agency ascertain the wishes and feelings of the adults in respect of domestic abuse and were their views taken into account when providing services or support?

3. Were single and multi-agency policies and procedures, including the Multi-Agency Risk Assessment Conference protocols, followed; are the procedures embedded in practice and were any gaps identified?

4. What knowledge of domestic abuse did the victim's and offender's families, friends and employers have of the relationship that could help the review Panel understand what was happening in their lives.

5. Did the families and friends know what to do with any such knowledge and if they brought their concerns to the attention of an agency, how did they view the response?

6. How effective were agencies responses to the concerns raised by the victim's family and friends that she was subject of domestic abuse?

7. How effective was inter-agency information sharing and cooperation in response to the subjects' needs and was information shared with those agencies who needed it?

8. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects?

9. How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

10. 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?

3. BACKGROUND

3.1 Ruth

3.1.1 Ruth was born and educated in the North West and spent all her life in the area. She had four children and most recently qualified as a senior carer a job her family say she excelled at. She had been married twice. The family would like Ruth remembered as an unbelievably kind and very loving person. They felt they could not have had a better mother. She adored and loved her grandchildren and loved life.

3.1.2 The family were candid about their mother's use of alcohol and when asked what term they thought best fitted her pattern of drinking said she was, 'a problem drinker' who was able to function effectively.

3.1.3 Ruth was involved in domestic incidents with her first husband. He is recorded as being the victim fourteen times and Ruth once, after she reported being assaulted.

3.1.4 In June 2013 Ruth entered a relationship which ended in March 2015. During this period she lost her job as a carer for the elderly because of alcohol misuse.

3.1.5 In July 2014, Merseyside Police made a referral to Sefton Women's and Children's Aid following a report by Ruth that her partner [not Roger] had assaulted her. The partner received eight weeks imprisonment and a Restraining Order prohibiting him approaching Ruth.

3.1.6 Merseyside Police recorded that two of Ruth's daughters were victims of domestic abuse at the hands of their mother; one on three occasions, and the other on one occasion. None of the mother/daughter incidents resulted in formal complaints to police and happened in the context of the daughters trying to support their mother and keep her from harm.

3.2 Harry

3.2.1 Harry, the eldest of three children, was born and brought up in Oldham. Harry's brother describes how they were left to roam the streets after school until their parents returned from work. He described Harry as always being a violent person and recounted many stories of his cruelty to animals and serious assaults on their sister. Harry's bother also spoke of the domestic violence Harry perpetrated on his partners, on occasions viciously assaulting them. Harry has been estranged from his family for many years because of his violence. His brother summed Harry up by saying, "He was a brute and a bully who had the gift of the gab". He has long term dependency on alcohol and used his physical size to intimidate vulnerable people in furtherance of his criminal activities.

3.2.2 He has twenty eight convictions. In 1998 he was convicted of offences of violence against his wife and his daughter. He was also convicted of the rape and indecent assault of a female under 16 years of age. He received a seven

year prison sentence. He was a Registered Sex Offender for life. His most recently released from prison was in late May 2015.

3.3 Ruth and Harry's Relationship

3.3.1 Ruth and Harry began their relationship after his release from prison in May 2015. In July 2015 they moved into separate rooms within the same multi-occupancy house. However, it appears Ruth spent the majority of the time living in Harry's room. Around this time Ruth's friends and family noticed a decline in her appearance and health. They were evicted in the first week of September 2015 and moved to the address where Ruth met her death.

3.3.2 It was known by the family that Harry was violent towards Ruth and they reported their concerns to Merseyside Police. Ruth also disclosed domestic abuse to Southport and Ormskirk Hospitals NHE Trust following her admission in the first week of September 2015. Following Ruth's murder it emerged that Harry had committed despicable acts of domestic abuse, including sexual violence and cutting her with a knife. He threatened to kill her and her family should she ever report him to the police.

4. COMMENTARY

4.1 Ruth and Harry met in May 2015 after he was released from prison and almost immediately they formed a relationship. A human error in the Multi-Agency Public Protection Arrangements within the National Probation Service meant no agency was managing his high risk. The police knew where he lived because he had to tell them as part of his sex offender registration. Ruth and Harry moved into together in July 2015.

4.2 Harry came to the relationship as a registered sex offender with convictions for rape against a child and violence against a former female partner. He also brought with him dependency on alcohol, use of illegal drugs and a disregard for authority as evidenced by the many breaches of his parole licences and arrests for theft and violence, including robbery. He used his large physique to bully vulnerable people so that he could obtain goods or money to support his addictions.

4.3 Ruth was a vulnerable person who was also dependent on alcohol. She was known to Merseyside Police as a victim of domestic abuse. As recently as May 2015 her case as a victim of domestic violence was presented to a Multi-Agency Risk Assessment Conference. The offender was not Harry which meant she was a multiple victim. She had strong support from her four adult children and father.

4.4 It is believed that Harry first began abusing Ruth soon after they started their relationship. The first opportunity for an agency to intervene came on 15th July 2015 when the family report their concerns to Merseyside Police. That call for help was effectively ignored and the family told to make their own enquiries. That response was unhelpful and set the tone for what the family describe the police not being interested.

4.5 On 13th August 2015 Adele reported to Merseyside Police that her mother was the victim of domestic abuse and had not been seen by the family for a few months. The police took almost 48 hours to trace her and observed she had a facial injury, but were told by Ruth and Harry that there was no domestic abuse; the injury having occurred when she fell over. The attending officer did not recognise the incident as domestic abuse but several days later a supervisor did and directed the officer to complete a risk assessment. This was done without Ruth or her family being seen, or without a thorough check on their backgrounds. Unsurprisingly, but disappointingly, Ruth was assessed at the lowest risk level [Bronze]. This low level was confirmed by a specialist officer the following day. There is no doubt in the minds of the family, and the Panel, that Ruth faced a high risk of serious harm from Harry and should have been referred to a Multi-Agency Risk Assessment Conference.

4.6 Within a week there was another opportunity to assess the risk to Ruth but again the officer who attended [a different one to the previous call] did not believe he was dealing with a domestic incident. A thorough investigation by

him would have provided information to the contrary. Roger was arrested for theft of a mobile telephone and on 19th August 2015 he was bailed by a Magistrates' Court and subjected to electronic monitoring [a tag] with a curfew tying him to the home he shared with Ruth. The Panel felt that the lone female worker who fitted the tag late at night was at potential risk and that the curfew meant Ruth was confined with Roger which increased her exposure to harm.

4.7 Thereafter events gathered momentum. At the end of August 2015, Ruth told a friend that she could not take another beating. In the first week of 2015 she asked her son Tony to help her move and insisted he also move Harry's belongings or she would face serious consequences. Tony saw she had two healing black eyes and some healing scratches around her nose. He described the flat as dirty and the scene of obvious violence as evidenced by holes punched in doors and walls, with indications of drug abuse and blood stains on the settee. He became very concerned and with the help of his sisters persuaded their mother to stay with a family member which she did for a few hours.

4.8 In the first week of Harry was evicted from his flat and moved with Ruth to the property where she died. He bullied another resident in the multi occupancy house and moved into a larger room than the one he had been allocated.

4.9 The following day a member of Ruth's family expressed their concerns about her to her general practitioner who noted it in her records and advised them to bring Ruth to the surgery or take her to Accident and Emergency.

4.10 In the first week of September 2015 Ruth was persuaded by her family to go to hospital where she immediately disclosed to staff a catalogue of abuse, including that she feared for her life because Harry had threatened to kill her. The Hospital's response was ineffective and an opportunity was missed to refer her case to the police, for the threats to kill, and to Adult Social Care for domestic abuse. Internal safeguarding procedures were poor and some staff's safeguarding knowledge was limited. The Hospital did not consider the General Medical Council's protocol of informing the police of gun and knife wounds. Staff thought Ruth's absences from the ward were for 'smoke' breaks. Some were, but others resulted in her meeting Roger who continued to abuse her and regain power and control.

4.11 A few days later Ruth's resolve to break free from Harry waned. In the morning and early afternoon she was still saying to Hospital staff that the relationship with Harry was over. Adele telephoned Merseyside Police on 101 to report her Mother's victimisation but was given inappropriate advice by the call taker. The advice that Ruth should report the domestic abuse herself was patently wrong and an officer should have been sent to the hospital to take

her complaint. This was a significant missed opportunity to help Ruth. She was in a safe place surrounded by family.

4.12 Later that afternoon she was seen in the Town being dragged along by Harry who had a knife and was threatening her. That evening Ruth returned to the ward with Harry and told one of her daughters that she loved him. Harry had reverted to type. He used violence and intimidation to regain his control over Ruth.

4.13 The following day Ruth was seen with Harry near their flat. He was physically abusing her by kicking her posterior to reinforce his desire to get her indoors. She later returned to the ward but in the early hours of the next day and discharged herself against medical advice. She was killed by Harry about twenty four hours later.

4.14 The Panel felt there were many opportunities missed to support Ruth with her duel aim of leaving Harry and reporting his violence. The failings are shared between the Merseyside Police and Southport and Ormskirk Hospitals NHS Trust. Both organisations let down Ruth and her family; a point they acknowledge. The Hospital does so in the following terms.

'Throughout this incident there was a failing to follow or understand adult safeguarding procedures which resulted in the patient not being protected from domestic violence and allowed the perpetrator to continue offending. The Trust did not safeguard the patient from harm and did not have a plan in place to address the risks'.

4.15 The need to arrest Harry and ask him to account formally for the catalogue of injuries he caused Ruth should have been identified. With Harry under arrest, Ruth may have re-found the will to make a complete disclosure which would have included her reasons why she felt it necessary to have previously underplayed her victimisation. It was a serious error not to have arrested Harry.

4.16 On several occasions the safety net of management and supervision within the Police and Hospital did not identify the errors.

4.17 Ruth's family is devastated by the homicide and believe they received a very poor and ineffective service from the police and the Hospital, who between them squandered excellent opportunities to support Ruth and end her victimisation. The family firmly believe that had positive action been taken by either organisation Ruth would not have been killed.

5. LESSONS IDENTIFIED

5.1 The IMR agencies lessons appear as recommendations in Appendix 'D'.

5.2 The DHR Lessons identified are listed below. Each lesson is followed by a short narrative for context.

Lesson One
Lesson 1 Not considering all pathways for assessing and controlling risk can leave potential victims of domestic abuse exposed to unknown risks.
Narrative In May 2015 the National Probation Service did not submit Harry's case for consideration of MAPPA registration because of an oversight.
Lesson 2 Not taking the family's concerns seriously meant that Ruth continued to be exposed to domestic abuse.
Narrative Ruth's family reported their concerns about Harry's perpetration of domestic abuse to Merseyside Police many times but did not receive an effective response. In particular the advice that Ruth should report the abuse in person was inappropriate.
Lesson 3 Not following all reasonable lines of enquiry to discover the truth can leave victims of domestic abuse vulnerable and perpetrators with a sense of invincibility.
Narrative The police were faced with conflicting evidence when Ruth said she had not been assaulted by Harry and the family said she had. No attempt was made to seek further and/or independent evidence.
Lesson 4 Not recognising when an incident is domestic abuse denies the victim access to justice and support.
Narrative On one occasion it took Merseyside Police about five days before it recognised an incident involving Ruth was domestic abuse and on a second occasion, the domestic abuse element of a call was overlooked.
Lesson 5 Failing to formulate risk accurately exposes victims to further domestic abuse.
Narrative In arriving at the Bronze risk Ruth faced from Harry, not all of the risk factors

were taken into account; specifically his violent history and her vulnerabilities.
Lesson 6 Failing to follow or understand adult safeguarding procedures does not protect victims of domestic violence and allows perpetrators to continue offending.
Narrative Southport and Ormskirk Hospital had some gaps in its safeguarding adult procedures [for example: what to do when a 'threat to kill' is disclosed; the processes behind Multi-Agency Risk Assessment Conference flags and the General Medical Council's protocols on gun and knife crime]. On some occasions staff did not follow procedures or were not fully aware of them.
Lesson 7 Not recognising that Ruth's absences from the ward were more than 'smoke breaks' denied her the opportunity for assessment and support.
Narrative There was no investigation into why Ruth absented herself from the ward, nor was there a complete record of those absences. The meeting with the Hospital staff discussed the practicalities of trying to log patients in/out who leave the ward for 'smoke' breaks or other short terms needs and conclude it was not practical or feasible and therefore there is no direct recommendation.
Lesson 8 Do not impose curfews on domestic abusers that ties them to an address where a victim also lives.
Narrative Harry was fitted with an electronic monitor as part of his bail curfew conditions for theft. No one seems to have considered that doing so tied him to an address where the victim of his domestic abuse lived.
Lesson 9 Supervisors cannot always be relied on to identify oversights and errors.
Narrative There are several examples in the report of deficient supervision.
Lesson 10 Not knowing the full criminal history of offenders can potentially expose-workers to unregulated risk.
Narrative Electronic Monitoring Services and Lifeline did not know the full criminal history of Harry before they provided services to him. Electronic Monitoring Services feel the current way they assess risk is fit for purpose and place the responsibility on their commissioners to reveal risk factors. Therefore they do not believe it is necessary to have a recommendation.

6. PREDICTABILITY/PREVENTABILITY

Family's View

6.1.1 The family has no doubt that it was predictable that Harry would kill Ruth and that her death was preventable.

6.2 Predictability

6.2.1 Harry was a violent man who had previously assaulted an intimate partner and raped a child. His, dependency on alcohol, misuse of drugs, propensity to rob, coupled with his imposing physique, made him a danger to the public, children and intimate partners. When he was released in May 2015 he was assessed as posing high risk to members of the public but errors in the Multi Agency Public Protection Arrangements meant his risk was unmanaged. During the short relationship with Ruth he was assessed as posing a Bronze risk of causing her serious harm. That was clearly wrong, he posed a very real risk of causing her serious harm.

6.2.2 The Panel felt that had the evidence available to agencies been properly collated the almost certain outcome would have showed Harry posed a very real risk of causing serious harm to Ruth. In that context it was possible to predict that he would cause her serious harm. In the end he carried out his threat to kill her.

6.3 Preventability

6.3.1 Ruth's evidence was supportable by eye witness testimony from several people which together with her noted injuries provided opportunities for Ruth's complaints against Harry to have resulted in his arrest. He was not arrested because the police procedure and assessment was not undertaken correctly. Had it been the evidence would be scrutinised to determine if it met the criteria for a prosecution.

6.3.2 The reasons why he was not arrested for domestic abuse appear in the report. Had staff in Merseyside Police and Southport and Ormskirk Hospital NHS Trust who had contact with Ruth and/or her family, done their jobs effectively, the opportunity to intervene and reduce the risk of serious harm to Ruth was very real, as was the likelihood of preventing Ruth's death.

7. RECOMMENDATIONS

7.1 Agency Recommendations

7.1.1 The Agencies recommendations appear below and in the Action Plan at Appendix D and deal with the failings in this case.

7.2 Merseyside Police

1. Ensure that Patrols attending at the scene of 'domestic abuse' incidents are fully aware of the dangers of speaking with a potential victim in the presence of the alleged perpetrator.

2. Ensure that Patrols attending at the scene of 'domestic abuse' incidents are aware of the content of the Storm log, in particular the comments of the informant. There should be evidence that such comments have been considered during the closure of a log.

3. When family members report concerns for the safety of a close relative that involve alleged 'domestic abuse', then positive action must be taken. This should include a full de brief of the evidence / information held by the relative and effective evidence gathering while at the scene, including house to house enquiries.

4. When a 'domestic abuse' incident is reported, control room supervision must ensure that the communication officer handling the call has made all necessary checks of the relevant IT systems, not just the PROtect history, and informed the attending patrol of the full history of all parties concerned.

5. When a 'domestic abuse' incident is reported which is the first recorded between particular parties, this alone should not be judged as a factor to consider the incident as low risk. Cognisance must be taken of the 'domestic abuse' history of the parties with previous partners, particularly when they may have been risk assessed as 'Gold' or been a perpetrator of a 'Gold' victim and subject of the MARAC process.

6. All calls for service that initiate as domestic incidents, should be monitored and subject to scrutiny by control room supervision. The relevant Storm log must be endorsed by the supervisor to ensure compliance.

7. A patrol supervisor should be informed when a 'domestic abuse' incident is reported and his or her details recorded on the Storm log. The supervisor should ensure that a VPRF 1 is submitted prior to the

end of the tour of duty, having quality assured it and having appended his or her name and signature.

7.3 National Probation Service

1. A more investigative approach to be taken (by offender managers) in terms of Offenders with Domestic violence backgrounds. Regular FCIU checks to be undertaken regardless of whether an offender reports to being in a current relationship.

2. Checks to be made to Prison establishment regarding visits/contact with unknown females when those with a DV history are in custody.

3. Increased Management oversight and discussion of Level 1 MAPPA cases with a view to increasing the level of MAPPA management if required.

7.4 Lifeline

1. Lifeline Sefton workers should always use the same file when an individual starts a new treatment episode, rather than closing one file and re-opening another, to ensure continuity and a full treatment history within a single file.

2. The service should lead a reflective practice session with the team, focussing on working with couples when both are known to the service. Key questions for practitioners to consider should include:

   In what circumstances is it appropriate to follow-up independently something that one partner has told the service about the other?

   How should we best record risks relating to the clients in each other's files when both are known to us? – How do we manage this for newly established couples?

7.5 Originally Southport and Ormskirk Hospitals NHS Trust

7.5.1 Originally Southport and Ormskirk Hospitals NHS Trust included four recommendations in its Individual Management Report. The Root Cause Analysis produced an action plan with fifteen recommendations. While the format of the Root Cause Analysis action plan is slightly different to the other agencies format, it is comprehensive and therefore copied verbatim into Appendix D. The Hospital's action plan uses the following code.

8. RED	Little or No Progress Made
AMBER	Moderate Progress Made
YELLOW	Actions Almost Completed
GREEN	Completed

1. Immediate domestic abuse awareness and training for the following areas: A&E department: EAU and HALT team.

2. Staff do not understand the significance of MARAC; Safeguarding Adults Policy was and is not clear on processes / expectations.

   Staff do not recognise the significant risk when a patient reports a threat to kill/ know what the process are when a knife crime is

   The guidance regarding reporting of gun and knife crime will be circulated to key areas and will be included in the relevant safeguarding policies.

3. MARAC alerts on Medway to be amended so staff realise the significance of these alerts.

4. Staff must implement the Domestic Violence and Abuse Policy Clin Corp 18. Staff must receive education and training. Staff need to know who puts the flag on Medway and when to do so – Who has the access to do this and whose responsibility it is.

5. Safeguarding Adults Policy CORP 77- referrals must be made in accordance with Policy – staff must check the referral has been received. On admission staff should have contacted the Trusts Safeguarding Hotline (01704) 5248 and complete an incident report via DATIX. They should have contacted the Trust Safeguarding Adults Nurse Soh-tr.VulnerableAdultsTeam@nhs.net or via telephone (01704) 705248.

6. Safeguarding Adults Policy CORP 77 staff awareness and education – responsibilities/safeguarding and Mental Capacity Training (MCA), All Trust staff to realise that anyone who has contact with an adult at risk and hears disclosures or allegation has a duty to pass them on appropriately. When a crime has been committed capacity – consent is not relevant and the incident must be reported to the Police. Injuries must be body mapped as per Policy.

7. The Safeguarding Adults Flow Chart contained with the Safeguarding Adults Policy CORP 77; not clear that when a crime has been committed capacity/ consent is not relevant. The Safeguarding Adults Flow Chart does not stipulate how Section 2 Papers are to be sent to the team/ staff must check they are received. There are no examples of these papers within the Policy. Safeguarding Adults Policy CORP 77 Flow Chart to be amended to state Consider – Has Crime been Reported? from Has Crime Been Committed?

8. Staff did not implement the Smoke Free Policy Corp 06 to be implemented. Health Promotion occurs.

9. Staff must follow the Protocol for the Missing Patient (CLIN CORP 76) patients go missing. Risk Assessments must be completed highlighting the risks of leaving the Ward and the actions taken to mitigate the risks. A "contract" needs to be considered and reinforced on the wards to protect the patient and other patient's when someone chooses to leave the ward. There should be more robust monitoring regarding patients who leave the ward area with absences documented and discussion with the patient regarding expectations on leaving the ward / return to the ward / length of absence.

10. There must be greater staff awareness of the Domestic Violence lead throughout the Trust Greater awareness of the role of the Adults at Risk Team.

11. To include capacity and consent in Domestic Violence and Abuse Policy Clin Corp 18.

12. Clinical Record Keeping must be adhered too – clinical records must record the dates and the times patients leave the Wards. Record why the patient has left the ward and how they were clinically on their return. When nurses are concerned that patients are drinking alcohol this must be reported to the Doctor so the patient can be assessed and the issues addressed.

13. Correspondence to GP: The Trust must highlight the risks to GPs so they can take actions to safeguard their patients.

14. Staff must complete incident forms and inform the Police when visitors attend the Ward and they are subject to an injunction. The incident must be recorded in the patient's clinical records and a Risk Assessment completed.

15. NICE Pathway/ Alcohol Use Disorders Pathway required. Alcohol-use disorders: diagnosis and management quality standard. The quality standard defines clinical best practice in the care of people (aged 10 and above) drinking in a harmful way and those with alcohol dependence and should be read in full.

7.6 Domestic Homicide Panel Recommendations

1. That the Ministry of Justice considers how the courts can avoid issuing electronic surveillance orders in support of bail curfews for known domestic abuse offenders, to addresses where victims of domestic abuse live.

Appendix A

The Judge's Sentencing Remarks

You are … years of age have pleaded guilty to murdering your … partner … on 10.9.15; you entered that plea half way through your trial, having on the first day, pleaded guilty to manslaughter, thereby admitting at a very late stage in the face of overwhelming evidence that you had unlawfully killed her, but continuing to deny until almost all the evidence of the history of your relationship had been given by her children and friends, that you had the requisite intent for murder.

Having heard that evidence and having considered all the medical and scientific evidence, I am quite satisfied that over a period of a month prior to her death, you caused her untold physical and mental suffering as a result of your ever increasing violence, culminating in a ferocious and sustained attack upon her on the night she died.

During the month of August and into early September, your violent conduct to her built up, starting as it did with punches which caused her black eyes, a bite to her ear, a head butt which split her lip and loosened her teeth, numerous punches to her pelvic and pubic region, and culminating in an attack upon her with a knife, on which she cut her hand in an attempt to prevent you cutting her throat and a fork with which you stabbed her in the arm and in the thigh, leaving her to remove it herself. Your campaign of violence towards her was compounded by threats of further violence – you threatened to kill her which was bad enough, but, displaying an element of warped sadism and sheer cruelty, you threatened also to cut off her clitoris with a pair of nail clippers if she ever left you or reported you to the police. Small wonder it is that for some considerable time she sought to attribute her injuries to her own clumsiness in drink; I reject any suggestion that, apart possibly from the odd scrape, any of the injuries identified in this case were sustained in that way – as her son said, if that were right, she had sustained more bruising from so-called falls and clumsiness in the last month of her life than in the previous 20 years.

I am also satisfied that far from protecting her at a time when you knew, because you shared that vulnerability that she was vulnerable because of a dependency or near-dependency on alcohol, you preyed on that vulnerability and exercised ever-more control over her life and actions, thereby effectively depriving her of a free choice whether to stay with you or to leave you. You smashed her phone and flushed it down the toilet to restrict her means of contacting her family and even resorted to locking her in to your flat [even though I cannot be sure that you purchased a padlock for the flat for that sole purpose] to prevent her from going out and being seen with all the hallmarks of domestic abuse.

At the beginning of September 2015, 'Ruth' was admitted to Southport General Hospital and discharged herself 4 days later. Whilst there she was vacillating between saying that she was ready to complain to the police and that she loved you and wanted to return to you. As I have already stated, I am quite satisfied that she had been deprived of any real choice in the matter as a result of your controlling

behaviour and threats. In those latter days, whatever the position may have been in the early weeks of your relationship, you had no regard or affection for her. In so far as you may have appeared protective towards her, I have no doubt that you were in truth seeking to protect yourself from the consequences of your behaviour towards her.

When she left hospital, Ruth was weak and had been told that if she didn't stop drinking, she was not long for this world. Within 36 hours she was dead, the victim of yet more, and on this occasion, prolonged as well as severe violence. It has been submitted on your behalf that this prolonged outburst was caused by a regurgitation of old arguments about drugs and alcohol [to which you were no less partial than Ruth] and because you had – and I accept you were – beaten up – been attacked the previous Friday evening. I reject that explanation; it took something of massive significance in the context of your relationship to cause you to embark on the final prolonged and vicious attack upon Ruth which killed her. I have reflected carefully upon what that might have been and I am satisfied that in the early hours of that morning, Ruth at last summoned up the courage to tell you that it was over and that she was going to the police. It was that realisation that led you to behave as you did, inflicting upon her the savage beating from which she died. Whilst I have already indicated that the prosecution cannot satisfy me on the evidence to the criminal standard that you intended to kill her, I am quite sure that you intended at least to cause her really serious injury and, in truth, cared not one iota whether she lived or died. I don't suppose after what she had been through at your hands, she cared much either.

When you had killed her – when she was dead, and not before – you called the emergency services and, ironically enough, tried to persuade them that she had taken no drugs or alcohol, prior to complaining of feeling unwell and collapsing in the shower; you also tried to persuade a neighbour to back up your lying account. And lie, you continued to do to a greater or lesser extent, until yesterday, when finally you pleaded guilty to murder, but not before her children had to give evidence and be crossed examined about their mother's last days. Whilst it must be acknowledged that your late plea is better than no plea, and is a belated acknowledgment of what you did, the credit to which you are entitled is very limited indeed. I do however accept that you stopped short of giving a lying account in evidence, although I have of course rejected some of the basis of your mitigation

The effect and manner of their mother's death on Ruth's children and her father has been traumatic and life changing. Small wonder it is that they feel hatred towards you. They will understand that I cannot allow their understandable feelings towards you to influence my approach to sentence.

The sentence for murder is life imprisonment. It remains for me to determine the minimum term which you must serve before you can be considered for release on licence; the starting point is 15 years; I must however weigh up such aggravating and mitigating features as exist in this case and thereafter decide the extent to which that starting point should be adjusted, whether up or down.

In mitigation, I have accepted that there is no proven intent to kill. In the context of this case it counts for very little; not because of any premeditation, which I agree cannot be equated with a campaign of sustained violence, but because of the sheer brutality and duration of this attack – itself an aggravating feature – which, had you wished to, you could have brought to an end long before Ruth's death.

I agree that whilst drunkenness at the time of your attack upon Ruth affords no mitigation, your personality had become 'degraded' through a lifetime of drugs and alcohol.

There are a number of aggravating features, to which I must have regard, whilst being careful to avoid any double-counting, in other words not taking into account an aggravating feature more than once.

First, Ruth's vulnerability; you were not responsible for it in the sense that she was clearly vulnerable when you met, and had been drinking on and off heavily for some time, and there may have been a few weeks in the early days of your relationship in which she felt better for knowing and being with you and even thought she loved you – but you compounded that vulnerability and preyed on it.

Second, the prolonged campaign of violence in the 4 weeks prior to her death; it was a campaign of physical and mental cruelty, punctuated by the threats to which I have referred, the like of which, violence and threats combined, this court has rarely if ever heard before.

Third, it is inevitable that the duration and severity of the final attack will have caused acute mental and physical suffering to Ruth before, perhaps mercifully, she succumbed to the weight of your blows. Sadly for her, her suffering was not on that occasion numbed by the effect of drink or drugs.

Fourth, this was an attack which took place in her home, albeit one to which she had no opportunity to become attached.

And finally, you are, sadly, no stranger to violence generally, and in a domestic context, in particular. I am not going to prolong my sentencing remarks by rehearsing the details of your previous convictions. But they cannot be overlooked, despite the length of time since your last offence of domestic violence. You have in truth, by this crime, forfeited your right to live in society. Whether you ever regain that right will be for others to determine. Also, in the context of this case, although it pales into insignificance, at the time you killed Ruth you were on licence following your early release from a sentence of imp imposed for an offence of robbery, and you committed this offence within hours of the imposition of a condition order for an offence of theft.

The aggravating features in my judgement aggravate by far the limited mitigation available to you.

Had you been convicted following a trial, the minimum term would have been one of 21 years; I will reduce it to 20 years to take account of your belated plea.

The sentence of the court therefore is that you go to prison for life; the minimum term which I specify is one of 20 years, less 184 days which you have served on remand; you the press and the public would do well to remember that this is not a sentence of 20yrs imprisonment; it is a sentence of life imprisonment from which you will not be considered for release by the parole board until you have served a further 19 and a half years in custody – you may care to reflect that by then, you, a man of just 52, will be well into your 70's – but you will be released then, or at any time thereafter, only if the parole board consider that you are no longer a danger to society; I have no doubt that currently you represent a very significant danger, particularly to any woman who is unfortunate enough to become a part of your life.

If and when you are released, you will remain on licence for the remainder of your life, liable to recall at any time should the home office deem it expedient so to order.

Appendix B

Action Plans

Panel Recommendations						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	That the Ministry of Justice considers how the courts can avoid issuing electronic surveillance orders in support of bail curfews for known domestic abuse offenders, to addresses where victims of domestic abuse live.	Prepare a letter for the Ministry of Justice	The letter	Victims of domestic abuse will not have perpetrators tied to their address and this will lessen the opportunities for them to be assaulted or controlled	Jannette Maxwell Sefton Council	30.09.2016

Agency Recommendations **Merseyside Police**						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Ensure that Patrols attending at the scene of 'domestic abuse' incidents are fully aware of the dangers of speaking with a potential victim in the presence of the alleged perpetrator.	Delivery of Training through the CIC Module 1 to all first responders highlighting the requirement to speak to individuals independently	Merseyside Police Training Academy provides training entitled 'Coercion, Intimidation and Control'. This has been delivered to all first responders and staff involved in domestic abuse. This resulted in 1424 officers being trained through 97 sessions which included guidance to officer's in dealing with domestic abuse. All training plans have been uploaded onto PAM which is the central database which measures Merseyside Police's activity against the National Domestic Violence Action plan and the PEEL report 'Everyone's Business'. Section 4.9.1 in force DA	The increased awareness of first responders and the reinforcement of speaking to the victim and perpetrator independently should ensure that honest and truthful accounts are obtained from the victim without fear of reprisal and intimidation. This should enable Merseyside Police to increase victim satisfaction and trust in the services provided for Domestic Abuse	DCI Griffith	Completed Completed

		Ensure Force Policy reflects the requirement for first responders to communicate with both the victim and offender separately to ensure independent accounts are obtained and allow the victim to provide an honest account without intimidation. The introduction of the automated Vulnerability form will provide a tip point when completing the form to ensure	policy stipulates that both parties involved in a DA incident must be spoken to separately. Further excerpts of Force Policy Item 4.5.1e and 4.9.1 reinforce this message. The automated vulnerability form has incorporated the 'tip point' to ensure officers are reminded to speak to victims and perpetrators separately. This form is currently being piloted within the Merseyside area.	victims.		Completed

		that officers have spoken to the parties involved independently during any report of domestic abuse.				
2	Ensure that Patrols attending at the scene of 'domestic abuse' incidents are aware of the content of the Storm log, in particular the comments of the informant. There should be evidence that such comments have been considered during the closure of a log.	The introduction and development of the 'Bluestar' Vulnerability Persons Index and automated vulnerability form. Issue of	The 'Bluestar' Vulnerability Person Index is currently being trialled which allows the calls and response call taker and dispatcher to view all relevant information surrounding the caller via the telephone contact number provided. This application will provide safeguarding information and allow informed decision making regarding deployment and actions to be taken at the scene. This index will also be provided upon the automated vulnerability form currently being	The VPI will allow informed decision making and appropriate interpretation of the Storm log set against the recorded vulnerability information held by Merseyside Police on all force systems of persons involved in the incident. The personal issue laptops will allow	DCI Griffith	Completed Completed

		personal laptops to all first responders deployed to incidents of Domestic Abuse which will allow access to Storm. CCRD Governance Process.	piloted. Personal issue laptops have now been provided to all first responders. This laptop provides remote access to the Storm databases and provides the officer with current information and an accurate reflection of the contents of the Storm log rather than a third hand precis via a dispatcher, therefore reducing the likelihood of miscommunication CCRD staff are consistently reminded of NSIR and NCRS requirements for the updates and closure of logs. CCRD has its own 'incidents to crime' governance meeting which examines this issue and there are daily reports via the CCRD DMM which looks at all logs which	first responders to access the actual content of a Storm log and therefore the correct interpretation and application of the contents to the situation presented. The CCRD NCRS compliance DMM will ensure regular dip sampling of Storm logs to ensure the first account provided by reporting persons and victims has been actioned correctly in line with NCRS and Force policy.		Completed Completed

		FCC QA Process	include risk logs incidents, this process ensure that where allegation of a crime has been made on a log it is appropriately recorded or if not a full explanation and rationale is provided. Before closure of a log all information on the log is addressed and any allegations made should be NCRS compliant. There is a separate QA process recently been developed for dispatch whereby the supervisors will listen in to the dispatcher when they perform their role			
3	When family members report concerns for the safety of a close relative that involve alleged 'domestic abuse', then positive action must be taken. This should include a full de brief of the evidence / information	Ensure Force Policy reflects the requirement for third party reporting process	Force policy clearly outlines the responsibility of officers when a report is received from a third party at section 16.3. Policy instructs that this type of incident is processed in the same manner as if the report was made by the victim in	The activity undertaken and planned briefings will increase the awareness of officers and reaffirm the policy and procedure of Merseyside Police when they receive a	DCI Griffith	Completed Completed

	held by the relative and effective evidence gathering while at the scene, including house to house enquiries.	Increased awareness of the responsibility to be undertaken when relatives contact police to report concerns and the procedure to be followed.	person. An 'In Touch' has been created and circulated to all first responders and call handling staff to remind them with regard their responsibilities and the procedures that should be followed. A 7@7 briefing aimed at first responders and call handling staff will be prepared and circulated by the PPU and an intranet screensaver will be designed aimed at increasing awareness and reaffirming policy and procedure with regard third part reporting.	third party report of domestic abuse, including when provided through the MARAC. The circulated material will be aimed at first responders, detectives and staff employed within the FCC and provide the community with a better response to Domestic Abuse when reported through a third party.		
4	When a 'domestic abuse' incident is reported, control room supervision must ensure that the communication officer handling the call has	The introduction and development of the 'Bluestar' Vulnerability Persons Index	The 'Bluestar' Vulnerability Person Index is currently being trialled which allows the calls and response call taker and dispatcher to view all relevant	The VPI will allow informed decision making and appropriate interpretation of the Storm log set	DCI Griffith (Tony Jackson JCC)	Completed

	made all necessary checks of the relevant IT systems, not just the PROtect history, and informed the attending patrol of the full history of all parties concerned.	and automated vulnerability form. CCRD Governance Process.	information surrounding the caller via the telephone contact number provided. This application will provide safeguarding information and allow informed decision making regarding deployment and actions to be taken at the scene. This index will also be provided upon the automated vulnerability form currently being piloted. CCRD staff are consistently reminded of NSIR and NCRS requirements for the updates and closure of logs. CCRD has its own 'incidents to crime' governance meeting which examines this issue and there are daily reports via the CCRD DMM which looks at all logs which include risk logs incidents, this process ensure that where allegation of a crime	against the recorded vulnerability information held by Merseyside Police on all force systems of persons involved in the incident. The CCRD NCRS compliance DMM will ensure regular dip sampling of Storm logs to ensure the first account provided by reporting persons and victims has been actioned correctly in line with NCRS and Force policy.		Completed

			has been made on a log it is appropriately recorded or if not a full explanation and rationale is provided. Before closure of a log all information on the log is addressed and any allegations made should be NCRS compliant. FCC supervisors have been made aware of the IMR action for progression. The Blue Star vulnerability project is due to be piloted in April 2016. this will make the necessary checks of all relevant force IT systems without the requirement for a manual check by FCC staff			
5	When a 'domestic abuse' incident is reported which is the first recorded between particular parties, this alone should not be judged as a factor	The application of professional judgement by first responders though the use of the Merit risk	The College of Policing are currently reviewing risk assessment processes with a conclusion in 2018. At this time Merseyside Police utilise the Merit risk	A more holistic view of vulnerability will be available to first responders when deployed to incidents which can	DCI Griffith	Completed

	to consider the incident as low risk. Cognisance must be taken of the 'domestic abuse' history of the parties with previous partners, particularly when they may have been risk assessed as 'Gold' or been a perpetrator of a 'Gold' victim and subject of the MARAC process . 	assessment. The introduction and development of the 'Bluestar' Vulnerability Persons Index and automated vulnerability form.	assessment which provides a 40 question risk assessment which promotes the use of professional judgement based upon the circumstances presented to the first responder. These circumstances allow for an elevation in score and an increase in identified risk level. In addition this can be amended through the DARAS procedure where the office manager reviewing the case can use professional judgement regarding the risk level. The new automated form will answer some of the 40 questions through the use of known data in Merseyside Police systems. The VPI will allow previous safeguarding and risk assessment levels to be relied upon when officers use their professional judgement in applying risk assessment	appropriately inform risk intervention levels. The ability to view and draw through previous safeguarding information will allow a more detailed, appropriate and informed risk assessment which can allow first responders to take cognisance of previous Gold risk assessments.		Completed

			levels and intervention options. The system will take data from Niche which highlights previous Gold relationship which will assist in RA process.			
6	All calls for service that initiate as domestic incidents, should be monitored and subject to scrutiny by control room supervision. The relevant Storm log must be endorsed by the supervisor to ensure compliance.	Control Room Staff Audit CCRD Governance process	There is a separate QA process recently been developed for dispatch whereby the supervisors will listen in to the dispatcher when they perform their role. CCRD staff are consistently reminded of NSIR and NCRS requirements for the updates and closure of logs. CCRD has its own 'incidents to crime' governance meeting which examines this issue and there are daily reports via the CCRD DMM which looks at all logs which include risk logs incidents, this process ensure that where allegation of a crime	The process will quality assure the actions of the dispatcher to ensure the pertinent information is passed to the first responder to allow them to take informed and accurate assessment and actions at the scene of a Domestic Violence incident. The CCRD NCRS compliance DMM will ensure regular dip sampling of Storm logs to ensure the first account provided by	DCI Griffith (Tiny Jackson FCC)	Completed Completed

			has been made on a log it is appropriately recorded or if not a full explanation and rationale is provided. Before closure of a log all information on the log is addressed and any allegations made should be NCRS compliant	reporting persons and victims has been actioned correctly in line with NCRS and Force policy.		
7	A patrol supervisor should be informed when a 'domestic abuse' incident is reported and his or her details recorded on the Storm log. The supervisor should ensure that a VPRF 1 is submitted prior to the end of the tour of duty, having quality assured it and having appended his or her name and signature.	The introduction and development of the 'Bluestar' Vulnerability Persons Index and automated vulnerability form will negate the requirement for this recommendation.	Due to the volume of vulnerability forms being completed and processed Merseyside Police initiated an IT solution which improves data quality and risk assessment process through the use of an intuitive application that can utilise known information on all Merseyside Police systems. Any incomplete forms will be subject to auditing through the creation of a daily report in Corvus. The	The automated form will improve data quality and risk assessment process through the integration of police information systems.	DCI Griffith	Completed

			automated system will make fields mandatory and provide legislative and procedural tip points negating the requirement for quality assurance as information previously cleansed will be relied upon and therefore direct the officer accordingly. When a GOLD victim of DA reports a new allegation the CIM is notified. The Blue Star vulnerability project will ensure that any initiated form is completed prior to the end of duty or become subject to a daily report generated through Corvus and then discussed for compliance at the area DMM. Currently the VPRF1 is to be signed by the officer's supervisor before they go off duty.			

National Probation Service						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	A more investigative approach to be taken (by offender managers) in terms of Offenders with Domestic violence backgrounds. Regular FCIU checks to be undertaken regardless of whether an offender reports to being in a current relationship	The Development of practice guidance regarding the management of Domestic Violence Cases The development of an audit tool to enable monitoring and feedback on such cases	A copy of the Practice guidance and audit tool to be shared with the board Sample feedback from monthly audits (which will be undertaken by the area MAPPA coordinator and Risk Lead)	Increased awareness in respect of any potential relationships developing Greater management oversight in respect of audit completions and feedback	Tracey Lloyd (District Manager) Risk Lead. Area safeguarding lead to provide feedback to board	Completed
2	Checks to be made to Prison establishment regarding visits/contact with unknown females when those with a DV	This practice to be embedded via the implementation of the above practice guidance	As Above	As above	Tracey Lloyd (District Manager) Risk Lead	

	history are in custody ..				Area safeguarding lead to provide feedback to the board	Completed
3	Increased Management oversight and discussion of Level 1 MAPPA cases with a view to increasing the level of MAPPA management if required	The implementation of the MAPPA 1 review process as previously outlined The process to be shared with Offender Managers and Team Managers at team and Cluster meetings	Copies of new processes to be shared and explained to board members	More Effective management of MAPPA level 1 cases with timely referral into active MAPPA management if required Increased management oversight	Tracey Lloyd (District Manager) Risk Lead Jayne Phillips MAPPA coordinator	Completed

	Lifeline					
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Lifeline Sefton workers should always use the same file when an individual starts a new treatment episode, rather than closing one file and re-opening another, to ensure continuity and a full treatment history within a single file.	All staff to be informed of the requirement at a team meeting. Line managers to monitor on a monthly basis that all newly opened case files are for clients who have not previously accessed Lifeline STARS Safeguarding and governance lead to receive reports from line managers to confirm this	Minutes of briefing session at which the requirement was introduced Summaries of monitoring activity	Case files for individuals who have had several 'treatment episodes' should be more complete, and picture of an individual's progress, needs and risks over time	Safeguarding and Governance Lead	Completed
2	The service should lead a reflective practice session with the	Session to be organized	Email sent to staff team	Better understanding of	Safeguarding and	Completed

	team, focussing on working with couples when both are known to the service. Key questions for practitioners to consider should include: In what circumstances is it appropriate to follow-up independently something that one partner has told the service about the other? How should we best record risks relating to the clients in each other's files when both are known to us? – How do we manage this for newly established couples?	and facilitated Outcomes and learning from session to be typed up and circulated to the team	containing outcomes and learning from the reflective practice session	assessing and managing risk when working with couples who are both known to the service. Increased awareness of possible risk 'flags' requiring follow-up from staff	Governance Lead	

Southport and Ormskirk Hospitals NHS Trust

No	Issue	Recommended Action	Lead	Measure of Success	Date for Completion	Progress	Current Red Amber Green	Date Completed
1	Immediate domestic abuse awareness and training for the following areas: A&E department EAU 11B HALT team	The adults at risk team will provide concise training to all areas on the subject of domestic abuse. The E Reader will be given to all staff and followed up with face to face training Training Log will be provided Training materials will also be provided Incidents will be monitored to ensure that staff are aware and not missing	Director of Nursing and Quality Safeguarding Adults Nurse	Staff awareness will be improved in this area. Increased referrals to the AAR team for this issue More referrals through MARAC for this issue Improved patient safety and experience Upload the training onto DATIX	Feb 16			

		opportunities for reporting						
2	Staff do not understand the significance of MARAC; Safeguarding Adults Policy was and is not clear on processes / expectations Staff do not recognise the significant risk when a patient reports a threat to kill/ know what the process are when a knife crime is The guidance regarding reporting of gun and knife crime will be circulated to key areas and will be included in the relevant safeguarding policies	Policy will be fit for purpose – to include MARAC processes/ staffs duties/ Threats to kill/ knife crime –MARAC to be included within Safeguarding Training A protocol will be devised for the AAR team and A&E as to what steps should be taken following a patient being discussed at MARAC. This will include actions by the AAR team and the emergency care staff, both medics	Safeguarding Team	Policy reviewed Training includes MARAC Protocol devised Clear and detailed actions will be in place for any patient who is flagged on the A&E patient records system. Staff fully aware of their responsibilities No ambiguity in this area Improved patient safety	Dec 2016	The guidance regarding reporting of gun and knife crime circulated to key areas To be included in the relevant safeguarding policies (I have circulated this to training lead A&E, Consultant and Matron)- completed	Amber	Amber

		and nurses		Upload the training and policy onto DATIX				
3	MARAC alerts on Medway to be amended so staff realise the significance of these alerts	MARAC alerts amended so they are clear to staff Safeguarding Team	Safeguarding Team	MARAC alerts are meaningful to staff Screenshot to be uploaded	August 2016			
4	Staff must implement the Domestic Violence and Abuse Policy Clin Corp 18 Staff must receive education and training Staff need to know who puts the flag on Medway and when to do so – Who has the access to do this and whose responsibility it is.	Domestic Violence training to be delivered via the Safeguarding Training; When Domestic Violence is reported Staff must always believe what the woman is telling them patient most risk when they leaving their partners	Safeguarding Team	Training is deliveredd Upload the training onto DATIX	Dec 2016			

		Staff must interview the woman on her own in a quite private and safe area Inform the Domestic Violence lead The adults at risk team will provide concise training to all areas on the subject of domestic abuse. The E Reader will be given to all staff and followed up with face to face training						
5.	Safeguarding Adults Policy CORP 77- referrals must be made	Safeguarding Adults Policy CORP 77 staff	Safeguarding Team	Referrals are made in accordance	Dec 2016			

	in accordance with Policy – staff must check the referral has been received On admission staff should have contacted the Trusts Safeguarding Hotline (01704) 5248 and complete an incident report via DATIX. They should have contacted the Trust Safeguarding Adults Nurse Soh-tr.VulnerableAdultsTeam@nhs.net or via telephone (01704) 705248.	awareness and education Safeguarding Training to include referrals process		with Policy				
6	Safeguarding Adults Policy CORP 77 staff awareness and education – responsibilities/ Safeguarding and Mental Capacity Training (MCA) All Trust staff to realise	Safeguarding Training to include responsibilities / capacity/ consent / body mapping of injuries	Safeguarding Team Head of Nursing The Associate Medical	Safeguarding Adults Policy CORP 77 is implemented and followed Staff awareness will be improved in	Dec 2016			

	that anyone who has contact with an adult at risk and hears disclosures or allegation has a duty to pass them on appropriately When a crime has been committed capacity – consent is not relevant and the incident must be reported to the Police Injuries must be body mapped as per Policy		Director Urgent Care	this area. Increased referrals to the AAR team for this issue Improved patient safety and experience Upload the training onto DATIX				
7	Staff did not implement the Smoke Free Policy Corp 06 to be implemented Health Promotion occurs	Trust supports patients; we try and reduce the need for patients to go off the Ward for Cigarettes.	Head of Nursing	Smoke Free Policy Corp 06 is implemented and followed To be discussed in meetings/ huddles – upload actions onto DATIX	Dec 2016			
8	The Safeguarding Adults	Flow Chart to be	Safeguardin	Flow Chart and	Dec			

	Flow Chart contained with the Safeguarding Adults Policy CORP 77; not clear that when a crime has been committed capacity/ consent is not relevant. The Safeguarding Adults Flow Chart does not stipulate how Section 2 Papers are to be sent to the team/ staff must check they are received. There are no examples of these papers within the Policy Safeguarding Adults Policy CORP 77 Flow Chart to be amended to state Consider – Has Crime been Reported? from Has Crime Been Committed?	reviewed so it is fit for purpose – include capacity / consent when a crime had been committed / how to send: check receipt of referrals/ referral document to be included within the Policy. Safeguarding Training to include the appropriateness of capacity / consent when a crime has been committed / hoe to make a referral and the audit trail	g Team	Policy is fit for purpose Upload the Policy onto DATIX	2016			
9	Staff must follow the Protocol for the Missing	Staff must follow and implement	Head of Nursing	The Protocol for the Missing	Dec 2016			

	Patient (CLIN CORP 76) patients go missing Risk Assessments must be completed highlighting the risks of leaving the Ward and the actions taken to mitigate the risks A "contract" needs to be considered and reinforced on the wards to protect the patient and other patient's when someone chooses to leave the ward. There should be more robust monitoring regarding patients who leave the ward area with absences documented and discussion with the patient regarding expectations on leaving the ward / return to the ward / length of	the Protocol for the Missing Patient (CLIN CORP 76) Risk Assessments must be completed The Protocol for the Missing Patient (CLIN CORP 76) is implemented and followed / reviewed and includes the suggested Contract and Risk Assessments		Patient (CLIN CORP 76) is implemented and followed / reviewed and includes the suggested Contract and Risk Assessments Upload contract onto DATIX Upload the staff discussions regarding adherence to the protocol				

	absence							
10	There must be greater staff awareness of the Domestic Violence lead throughout the Trust Greater awareness of the role of the Adults at Risk Team	Lead to be highlighted during Safeguarding Training Electronic Communication to staff The profile of the AAR team will be raised through a media campaign across the trust	Safeguarding Team	Awareness is raised Increased referrals to the team for all matters concerning adults at risk and their safety Upload the training onto DATIX	August 2016			
11	Domestic Violence and Abuse Policy Clin Corp 18	To include when capacity and consent is not relevant on the Flow Chart – e.g. when a crime has been committed	Domestic Violence lead	Policy is fit for purpose Upload the training onto DATIX	Dec 2016			

		Policy due for review August 2016- this incident to inform the review						
12	Clinical Record Keeping must be adhered too – clinical records must Record the dates and the times patients leave the Wards Record why the patient has left the ward and how they were clinically on their return When nurses are concerned that patients are drinking alcohol this must be reported to the Doctor so the patient can be assessed and the issues addressed	Clinical Record Keeping must be adhered too – clinical records must reflect the episode of care	Head of Nursing	The Clinical Record Keeping is implemented and followed Upload the discussions with staff onto DATIX	August 2016			
13	Correspondence to GP	Letters must reflect the risks	Deputy Medical	Communication improves –	August 2016			

	The Trust must highlight the risks to GPs so they can take actions to safeguard their patients	and the actions taken to mitigate the risk/ highlight further actions needed	Director The Associate Medical Director Urgent Care	patient safety maintained Upload the discussions with staff onto DATIX				
14	Staff must complete incident forms and inform the Police when visitors attend the Ward and they are subject to an injunction. The incident must be recorded in the patients clinical records and a Risk Assessment completed	Clinical Record Keeping must be adhered too – clinical records must reflect the episode of care- RM 06 Policy for the Reporting and Management of Incidents-	Head of Nursing	Communication improves – patient safety maintained Upload the discussions with staff onto DATIX	August 2016			
15	NICE Pathway/ Alcohol Use Disorders Pathway required Alcohol-use disorders: diagnosis and management quality	The Trust has no Policy hway for Alcohol Use Disorders – Quality standards need to be adopted	HALT Team	Quality Care is delivered Patient Safety Maintained Upload the	Jan 2017			

	standard. The quality standard defines clinical best practice in the care of people (aged 10 and above) drinking in a harmful way and those with alcohol dependence and should be read in full			pathway				

End of Executive Summary