SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Incorporating an

NHS INDEPENDENT INVESTIGATION [MENTAL HEALTH]

EXECUTIVE SUMMARY POST QUALITY ASSURANCE PANEL

'Nina' and 'Jenny'

November 2017

Chair: David Hunter

Author: Paul Cheeseman

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1. INTRODUCTION

1.1 This case is about the homicides of Nina and her adult daughter Jenny. The perpetrator of the homicide was Dean. This Domestic Homicide Review discovered that at the time of the deaths of his sister and mother, Dean had a substantial history of criminal offending for possessing drugs, burglary, damage and assault. He also had mental health needs that were identified within the prison system in 2010, although a formal diagnosis was not achieved until 2013. This was, and remains, a diagnosis of paranoid schizophrenia and personality disorder.

1.2 In June 2016 Dean appeared before a Crown court. He admitted the manslaughter of Nina and Jenny. He was sentenced to life imprisonment and will serve a minimum of twelve years and seven months with a hospital treatment order.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW (DHR)

2.1 Introduction

2.1.1 Sefton Safer Communities Partnership (SSCP) decided the deaths of Nina and Jenny met the criteria for a Domestic Homicide Review. They appointed David Hunter as the Independent Chair; he was supported by Paul Cheeseman. They are independent practitioners who have chaired and written previous Domestic Homicide Reviews, Serious Case Reviews and Multi-Agency Public Protection Reviews. They have never been employed by any of the agencies involved with this Domestic Homicide Review (DHR). A DHR panel was assembled which represented local agencies and included independent members, some with detailed knowledge of domestic abuse.

2.1.2 An NHS Independent Investigation should be undertaken when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the event. These investigations are conducted under the Serious Incident Framework for England (2015) issued by NHS England. Maria Dineen, an approved independent contractor for NHS England, was commissioned to attend panel meetings and to ensure that the mental health components of the Domestic Homicide Review met the standard required by NHS England. Paul Cheeseman was the author of the report, and the sections concerning mental health were written by Maria Dineen.

2.1.3 Ten agencies submitted Individual Management Reviews (IMRs). Other agencies provided chronologies and relevant information when requested.

2.1.4 David Hunter met with members of Nina and Jenny's family. These included Nina's sister and Nina's two nieces and nephew. The family was kept informed of the review's progress and was provided with a copy of the draft report. They did not respond to several requests to see them. At the time of the final panel meeting, no response had been received from the family.

2.1.5 As she is a survivor of domestic abuse, the panel felt it was important that the views of Female One[1] were considered. Attempts to contact her have not been successful; these included a personal visit to her last known address.

2.2 Terms of Reference

2.2.1 The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses, including changes to policies and procedures as appropriate;

[1] Dean claimed Female One was his girlfriend. This is something she rejected.

- 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.

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

2.2.2 Case-specific terms

Term 1

Review the mental health care, treatment and services provided to Dean by the NHS and other relevant agencies, identifying both areas of good practice and areas of concern for the period 1 January 2010 to the date of the homicides.

In analysing your agency's involvement, please pay specific attention to the following sub-terms.

Sub-terms

1.1 Determine whether professionals:

a. recognised any domestic abuse indicators for the principals

b. completed risk assessments [including self-harm] and risk management plans [RMPs] and managed them appropriately

c. reviewed or amended RMPs in response to new or changing information

1.2 Were the services provided for the principals appropriate to the identified levels of risk?

1.3 Examine the effectiveness of Dean's mental health care plans, including the involvement of the service user and the family.

1.4 Review the application of the Mental Health Act for Dean in both the criminal justice system and health services.

1.5 Review the effectiveness of discharge planning and the application of appropriate aftercare for Dean.

1.6 Were single and multi-agency policies and procedures adhered to and effective in the management of this case?

Term 2

What knowledge did your agency have about domestic abuse between the principals? What risk assessments were undertaken and what actions were taken to ensure the safety of those at risk?

Term 3

What knowledge did the victim's family and friends have about domestic abuse within the family, and what did they do with it?

Term 4

If there were lapses in service provision to any of the principals, were there issues in relation to capacity or resources in your agency that impacted the ability to provide services to the principals and to work effectively with other agencies?

Term 5

Establish what lessons are to be learned regarding the way in which professionals and organisations work individually and together to safeguard future victims.

Term 6

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.

Term 7

Were equality and diversity issues – including ethnicity, culture, language, age, faith and disability – considered?

Term 8

Were issues with respect to safeguarding (adults) adequately assessed and acted upon?

Term 9

Determine through reasoned argument the extent to which the deaths of Nina and Jenny were either predictable or preventable, providing detailed rationale for the judgement.

Term 10

Provide a written report to the Home Office and NHS England North that includes measurable and sustainable outcome-focused recommendations.

3. BACKGROUND

3.1 Nina was born on Merseyside. She was the youngest of nine siblings. Her parents are deceased. She had three children; Jenny was one, and Dean another. Their father died in 2008. Nina had not worked for several years. At the time of her death she lived in sheltered accommodation in Bootle. Her family described her as caring, funny, generous, kind and very well liked.

3.2 Jenny, who didn't work, was described by her family as a very clever person who was top of the class at school, and a gifted musician who played the guitar and piano. Children loved her. She lived separately, but near to her mother, and they had a warm relationship. The review panel heard that Jenny had some mental health needs resulting in challenging behaviour towards her mother and others. Many of these incidents brought her into contact with the police who dealt with her formally and sympathetically.

3.3 Dean had a troubled past. When he was eight years of age he was aggressive and didn't take part in lessons or mix with children. He was referred to Child and Adolescent Mental Health Services. He had special educational needs and was considered by his school to have been one of the most difficult children they ever had to deal with. He had a poor attendance record.

3.4 In school he became distracted, and would defy staff, swear and throw objects at them. Nina told an Education Welfare Supervisor that when Dean could not get his own way, he would punch her in the stomach.

3.5 Dean has fifteen convictions, including ones for drugs and violence. He served several terms of imprisonment and developed a pattern of attacking staff. He was a habitual user of cannabis and was suspected of using other illegal drugs. He has never worked.

3.6 This family tribute appeared in a local newspaper: 'We are absolutely devastated following the loss of Nina and Jenny and are still trying to come to terms with what has happened to them … They will both be greatly missed.'

4. KEY LEARNING

4.1 The following paragraphs summarise Dean's history of domestic abuse and mental health illness. Where learning is identified, a cross reference in bold is made to the relevant lesson in section 5 below.

Domestic abuse

4.2 The family say Nina was frightened of Dean. He would telephone and demand her return, and he could be heard screaming down the telephone at her. The family say Dean would take advantage of his mother's kind nature by taking money from her **(lesson five)**. Friends believe Dean was responsible for fracturing Nina's shoulder. His mother never reported him. There was one report to agencies of a verbal domestic dispute between Dean and Jenny and several reports of disputes between Jenny and her mother, although Nina and Jenny's relationship was, generally speaking, a warm one.

4.3 The panel considered whether there was evidence of controlling and coercive behaviour and financial abuse by Dean against his mother and sister. There were reports by neighbours to Your Housing Group staff that Nina had to sleep elsewhere when Dean stayed at her flat. That was explored at the time by Your Housing Group and no evidence was found to support the reports. There is no evidence that Dean was financially exploiting his mother or sister. That is different from saying those things did not happen. There is no doubt that Dean exerted significant influence over his mother for all his life. She could see no bad in him and was always ready to defend him. It is very likely that over his lifetime that Dean was receiving money from his mother and whether she gave it freely cannot be ascertained. It is known that he assaulted her and therefore the panel felt it was reasonable to conclude that he did exert controlling and coercive behaviour over his mother and because of his nature probably his sister; he assaulted her at least once. Whether his mother recognised his behaviour as controlling and coercive is a different question that cannot be answered with confidence.

4.4 There were some missed opportunities by agencies to identify that Nina may have been at risk of domestic abuse. For example, Nina lived in sheltered accommodation and a risk assessment was undertaken when she moved there. The section concerning domestic abuse was left blank. A routine older person assessment was also undertaken and Nina was not asked direct questions about domestic abuse.

4.5 Dean entered the sheltered scheme freely and had access to Nina's flat even when she was not there. On occasions, he stayed over in the flat, which meant she had to sleep in other residents' flats. The family believe Dean was highly manipulative and felt he should not have been staying with Nina. The housing provider knew little about Dean's background and felt he was shy and polite **(lesson four)**.

4.6 When Nina had contact with Aintree Hospital following the fracture of her collar bone, safeguarding was not considered at the hospital presentation **(lesson three)**.

4.7 In December 2014 Female One complained that Dean had assaulted and harassed her. He was arrested, charged and remanded in custody. On his release in February 2015 the court imposed a restraining order. Dean went to Female One's address and breached this order. He left the scene and, because of an oversight, was not

circulated as wanted for this offence. Consequently, an opportunity to arrest him was missed a few days later when he was stopped by a police officer, checked and cautioned for possessing cannabis **(lesson seven)**.

4.8 Fifteen days after being stopped in the street, Dean entered the sheltered accommodation where Nina lived and killed her. He then went to Jenny's home where he killed her. He left the area and travelled by train to London, where he was arrested.

Dean's mental health

4.9 Between 2010 and 2015 Dean had contact with many specialist mental health services in prison and the community. In 2010 he was seen by the Criminal Justice Liaison Team at Bootle Magistrates' Court. This followed a referral from G4S, who reported he was talking to himself in his cell and that he was aggressive to police during arrest and detention. The mental health professional wrote:

'He gave the impression that he wanted me to believe he had mental illness. Referred to himself as Schizo and mental. He did not receive a diagnosis at this point. There were no indications at this time that he required ongoing mental health input.' Dean was offered a referral to drug and alcohol services, which he refused.

4.10 In March 2011 Dean was sentenced to thirty-five months' imprisonment for burglary and breaching a suspended sentence. Within weeks of his admission he was referred to an NHS-managed medium-secure hospital because of his paranoid and psychotic behaviours. He was assessed and commenced on antipsychotic medication. The plan was to review him in two weeks. The working diagnosis was paranoid schizophrenia.

4.11 Before his review he was transferred to other prisons. At these locations, it seems Dean was seen by three more psychiatrists, but was moved each time before receiving a firm diagnosis **(lesson two)**. Dean was recalled to HMP Liverpool in May 2013 for breaching his licence conditions. Within three days of his arrival in prison, Dean was assessed by a consultant psychiatrist and restarted on antipsychotic medication.

4.12 In July 2013 he was transferred from prison to the Spinney, a private medium-secure hospital. Dean's main risks at the time of admission to the Spinney are worth noting:

- Violence including assault with improvised weapons
- Psychologically driven threats/assaults
- Threats
- Frequent periods in segregation
- Persistent damage to property
- Suicidal thoughts and self-harm by cutting
- Poor treatment compliance
- Serial acquisitive offending

- Possible gang links and victimisation
- Persistent ill discipline
- Substance misuse
- Poor social stability

4.13 He remained at the Spinney for six months, transferring to HMP Manchester in January 2014 with the following diagnosis:

'Dean has … Paranoid Schizophrenia typified by persecutory paranoid delusions and hallucinatory experiences. It would seem, that he has been mentally unwell for two and a half years. He has been intermittently compliant with medication and has taken a large amount of cannabis in the form of Skunk.'

4.14 There are two technical terms relevant to his mental health and this review:

- Section 117 aftercare, which imposed a duty on health and social services to provide aftercare services for Dean;
- Care Programme Approach, for assessing, planning, coordinating and reviewing services for someone with mental health problems.

4.15 This meant that procedural conditions applied when he was released from HMP Manchester to mainstream mental health services in Liverpool in July 2014. At this point his case management became the responsibility of Mersey Care NHS Trust, which is now a foundation trust.

4.16 The transfer was not handled well and key information was not shared. The upshot was that Dean never received mental health treatment/support. He was offered appointments but did not keep them, and there was no compulsion to do so **(lesson one)**.

4.17 Dean was managed through Multi-Agency Public Protection Arrangements (MAPPA)[2] at Level 2, but was removed from the Level 2 agenda in August 2014. This was judged premature given his risks. He posed a very high risk of serious harm to staff and a high risk to the public **(lesson six)**.

4.18 In November 2014 Dean climbed a crane and hurled pieces of it to the ground. Merseyside Police detained him under Section 136 of the Mental Health Act and he was assessed at Aintree Hospital. The assessing clinician concluded:

'Dean, has historically been thought, to suffer with a psychotic illness, but I could elicit no evidence of any psychotic symptoms on assessing him today and would be sceptical about this diagnosis.'

4.19 He was discharged without follow-up by mental health services. Worryingly the psychiatrist recommended that Dean stop taking his antipsychotic medication.

[2] The Criminal Justice Act 2003 provides for the establishment of Multi-Agency Public Protection Arrangements (MAPPA) in each of the forty-two criminal justice areas in England and Wales. They require local criminal justice agencies and other bodies dealing with offenders to work in partnership in dealing with those offenders to protect the public from violent and sexual offenders. There are different levels at which offenders are managed and categories into which offenders are placed. Level 2 is active multi-agency management. A category 3 offender is dangerous: a person cautioned or convicted for an offence which indicates they are capable of causing serious harm and which requires a multi-agency approach.

4.20 There was no further contact between services provided by Mersey Care NHS Trust and Dean until 27 February 2015, when his solicitor opportunistically asked the Criminal Justice Liaison Team at Liverpool Magistrates' Court, where Dean was waiting to be sentenced for damaging the crane and a police car, to assess him. A Criminal Justice Liaison Nurse met with Dean but did not have time for a full assessment and arranged for him to be sent an outpatient appointment for a more complete assessment by his community mental health team. This appointment was booked for 18 March 2015. Dean did not attend.

4.21 He was offered another appointment, by which time he had been arrested for the unlawful killing of his mother and sister.

5. LESSONS IDENTIFIED

5.1 The IMR agencies' lessons are not detailed here because they appear as actions in the Action Plan at Appendix B. The DHR panel identified the following lessons:

Lesson one

Although the situation that arose between Mersey Care NHS Trust and Manchester Mental Health and Social Care Trust could not now happen, the incomplete information transfer in this case highlights the importance of information providers having a safety step in their processes so that they can ensure that all information provided has in fact been received.

Lesson two

Prisoners who enter the prison system with mental health issues are at increased risk of vulnerability. For those prisoners who require mental health assessments, moving them routinely around the prison estate is not a good plan, as it interrupts the process of assessment. Therefore, an approach needs to be developed within the prison system that enables the continuity of mental health care for those prisoners that may need to be moved.

Lesson three

Professionals should be empowered to make routine enquiries of patients or victims to establish if they can provide information that indicates they are at risk of domestic abuse or have been subjected to domestic abuse. Professionals need to be provided with clear pathways so they understand what should be done with any information they discover.

Lesson four

Providers of housing occupied by residents who are elderly, infirm or suffer from mental health issues need to understand that these residents may be vulnerable to persons such as Dean who can exercise coercive behaviour towards them. Providers need to be alert to these dangers, be inquisitive about visitors and what they do, and take steps to protect their residents from the risks of controlling individuals such as Dean.

Lesson five

Families and friends of victims sometimes have valuable knowledge about the domestic abuse a victim has suffered or the way that a perpetrator has behaved that they do not repeat to others or report to agencies for many different reasons. Information needs to be made available to friends and family so that they know how best to support victims, which may include sharing the information with agencies, but at all times recognising the safety of the victim is paramount. This will empower families to have the courage to say something and to know where they can share information safely. Sometimes families stay quiet because they believe they will make it worse for the abused if they speak out.

Lesson six

Poor MAPPA management and adherence to its policies and procedures leads to risks being uncontrolled and potential victims unprotected.

Lesson seven

Police systems need to provide clarity at all times as to who owns an investigation; the actions that need to be taken in cases of domestic abuse; and who has responsibility for actions, together with realistic deadlines for these to be completed and monitored that balances urgency against the prevailing demand on, and availability of, resources.

6. CONCLUSIONS

6.1 The panel concluded there were two important issues to consider in respect of whether the homicides of Nina and Jenny were predictable and preventable. The first of these relates to the management of Dean's mental health. The second relates to the missed opportunity to arrest Dean after he breached a restraining order.

The mental health lapses of greatest significance were:

- Dean was not managed on the Care Programme Approach, nor did he receive his entitlement to Section 117 aftercare services following his release from HMP Manchester.

  And

- The recommendation from a psychiatrist to stop his medication was not helpful.

6.2 However, managing Dean under the Care Programme Approach would not have made him engage with mental health services. The Care Programme Approach would have afforded a more assertive and sustained effort to follow him up when he did not attend for outpatient appointments. Successful contact with Dean may not have been achieved even if assertiveness had been employed. The panel considered that the chances of successfully engaging with Dean were low. However, more effort should have been made.

6.3 The panel was unsure what difference it would have made had there not been a recommendation to stop his medication. Dean said he had stopped taking his medicine. Had subsequent prescriptions been issued, there is no guarantee that he would have collected them. In any event, he was not obliged to take them.

6.4 The panel concluded that in respect of his mental health, the opportunity to do things differently was missed. Had everything been done correctly, there is no confidence that the deaths would have been prevented.

6.5 Dean was not circulated as wanted following the breach of a restraining order. He was stopped and given a street caution for possession of cannabis. An opportunity to arrest him was missed.

6.6 Had Dean been arrested then, or at any time thereafter, for breaching the restraining order on his former 'girlfriend' and been remanded in custody, the homicides of Nina and Jenny might have been prevented on the day they occurred, although this would have provided no guarantee that they could have been avoided after his release.

6.7 Overall the panel concluded that on the balance of probabilities, the homicides of Nina and Jenny were neither predictable nor preventable; there were however missed opportunities to lessen the possibility of their deaths.

7. RECOMMENDATIONS

DHR panel recommendations

7.1 The panel recommendations appear in the Action Plan at Appendix A and are not detailed here. The NHS Independent Investigation identified the following.

Mental Health NHS Independent Investigation recommendations, improvements made and recommendations outstanding

7.2 At relevant stages throughout the previous pages, changes that have been made have been highlighted. The outstanding issues for mental health are set out here.

7.3 The only change that occurred as a consequence of this case review and other inquest comments is the new requirement in Lancashire Care Foundation Trust for their staff to review SystmOne for relevant information about newly processed inmates.

7.4 Mersey Care NHS Trust has made a number of changes[3] to its centralised approach to the referral and assessment process. While these have not been made as a direct consequence of this case, they do address features of the mental health omissions in this case.

7.5 Manchester Mental Health (HMP Manchester) has also made its changes for good practice reasons rather than as a consequence of this case. It is not thought they constitute 'lessons learned' as a consequence of the Dean case. However, this case has highlighted yet again the central importance of:

- Uncompromising adherence to safe practice procedures such as Section 117 aftercare and Care Programme Approach discharge, as they are designed to ensure effective transfer of critical information about a service user.
- The need for relevant agencies to have access to complete information about a service user. This case has highlighted the importance of SystmOne prison records to Hospital Psychiatric Liaison Teams, Criminal Justice Liaison Teams and, I would argue, Crisis Intervention Teams.

Mersey Care NHS Trust's internal assessment and referral processes

7.6 An outstanding action for Mersey Care Trust is to establish the reliability with which its staff ensure they have read and assimilated all the information provided about a new patient at the point of referral and acceptance. This did not happen in this case. There are a number of ways the trust could achieve this:

- Via survey method
- Via simulation method, in conjunction with safety tools such as Failure Modes and Effects Analysis
- Via observation and interview methods

[3] All referrals are received by the newly arranged access team. The patient is physically assessed as part of the triage and then allocated to the appropriate part of the service.

The trust is required to set out its action plan for achieving assurance and to share this with Sefton Safer Communities Partnership.

7.7 Mersey Care NHS Trust has revised how it assesses new referrals, and a face-to-face meeting with its own team now occurs as normal practice. However, what happens 'as a norm' when a service user is allocated to a community mental health team needs to be established.

- How do community mental health teams ensure that they are appropriately knowledgeable about a service user?
- To what extent is the information known about a service user reviewed and assimilated by a community mental health team?

One way to test this would be to simulate Dean's referral and acceptance into Mersey Care NHS Trust as it occurred in June 2014 and to test its newly revised systems to determine what, if anything, would be different. Alternatively, the revised process could be visually mapped and a selection of staff working in and across the new system brought together to apply the principles of Failure Modes and Effects Analysis to identify any weak points in the system that reasonably could lead to the information loss that occurred in this case.

SystmOne records

7.8 Most mental health prison in-reach is provided by NHS trusts. However, the clinical data is documented on a clinical information system known as 'SystmOne', which a mental health trust would not have access to outside of the prison setting. The purpose of SystmOne is to enable all prison health teams to have access to relevant records regardless of what prison a prisoner resides in at any given point in time. For SystmOne to be delivered nationally, access also needs to be available to:

- The Criminal Justice Liaison Service on a national basis
- Section 12 Approved Doctors and Approved Mental Health Professionals (AMHP) when they are conducting an assessment under the Mental Health Act

Had the SystmOne records been accessible by these two groups of professionals in this case, the clinical knowledge about Dean would have been enhanced, and staff strongly believe that they would have acted differently to how they did in respect of:

- The management plan post-Mental Health Act assessment in November 2014.
- The two Criminal Justice Liaison Team contacts: one in January 2015, and the other in February 2015. The key difference here would have been the urgency of request regarding subsequent assessment of Dean.

Finally, the discharge letter from prison health to Dean's GP was not clear in respect of his diagnosis at the time of discharge. The formulation of discharge letters needs to ensure that the receiving health professional can quickly see what the current diagnosis and treatment needs are.

Appendix A

Action Plans

Panel Recommendations						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	That Manchester Mental Health and Social Care Trust (HMP Manchester) and Mersey Care NHS Trust report in writing to Sefton Safer Communities Partnership what actions have been taken to remedy the identified weaknesses when releasing prisoners who are entitled to Section 117 services.	SSCP to write to Manchester Mental Health and Social Care Trust (HMP Manchester) and Mersey Care NHS Trust to request an update report	Report	Improved processes for accessing Section 117 services Prisoners receive the appropriate support they are entitled to on release	SSCP	June 2017
2 (a)	That in cases in which prison mental health services have identified that a mental health assessment is needed, the National Offender Management Service ensures that when decisions are taken to move offenders between prisons, the assessment is completed prior to that move. If the prisoner is to be released before the assessment is	SSCP to write to National Offender Management Service to request a report outlining the procedures for mental health assessments for prisoners, particularly in relation to prison moves and release. This report should include any changes to processes since the time of this DHR and any lessons learned that have been implemented as a result.	Report	Clarity and resassurance for the SSCP that appropriate procedures are in place for assessing the mental health of prisoners, particularly if they move or are due for release.	National Offender Management Service	June 2017

	completed, the National Offender Management Service should ensure there is a process in place to highlight the incomplete assessment to the offender's current or last known GP, and request the GP to refer the offender to the nearest secondary mental health provider to the area in which they are released.					
2 (b)	Furthermore, that where a prisoner is already being assessed by specialist mental health services, the National Offender Management Service is asked to determine the risks to that individual, and of the individual reoffending, if a complete mental health assessment cannot be achieved as a direct consequence of the prisoner being moved or released.	As above	Report	Clarity and reassurance for the SSCP that the risks of prisoners are appropriately considered.	National Offender Management Service	June 2017
3	That Your Housing Group reports in writing to Sefton Safer Communities Partnership what action it has taken to ensure that its tenants are protected from	SSCP to write to Your Housing Group requesting an update report	Report	Reassurance that organisational polices and procedures are appropriate and are being	Your Housing Group	June 2017

	domestic abuse, including the need to fully complete its initial assessment.			followed. That policies and procedures have been updated as required and training for staff is included in this.		
4	That Sefton Safer Communities Partnership develops, publishes and publicises advice for family and friends on what to do [or not to do] when they receive disclosures of domestic abuse.	Information for friends and family is available on Sefton Council's website at www.sefton.gov.uk/behindcloseddoors Sefton also supported the public health led 'Lover not a fighter' domestic abuse campaign. The development of further public awareness campaigns, including further information for friends and family, is being looked at as part of Sefton's Domestic Abuse Strategy .	Information on website Development of further promotional materials	Awareness of domestic abuse amongst the general public is raised. Information for friends and family is readily available	SSCP	Completed September 2017
5 (a)	That Merseyside MAPPA Strategic Management Board reports in writing to Sefton Safer Communities Partnership what action it has taken to ensure that Section 6.15 of the MAPPA Guidance 2012 [Identifying MAPPA offenders] is adhered to.	This case was formally raised at Merseyside SMB and MAPPA Chairs briefings. A report has been provided by the Merseyside MAPPA Strategic Board to update the SSCP outlining the changes in practice and processes that have taken place since this case was managed. .	Report	SSCP is reassured learning from this DHR has been taken on board and practices have already been updated to ensure MAPPA guidance is followed.	Merseyside MAPPA Strategic Management Board	Completed

5 (b)	That MAPPA-managed offenders are being managed at the appropriate level and that any substantial disagreement between agencies on which level a person should be managed at has a resolution pathway.	Report provided Escalation process into SMB formalised and issued to all MAPPA Chairs Feb 2016. This is the formal process whereby disagreements, agency non attendance can be raised, discussed and resolved at SMB. MAPPA Chair continuous improvement events (2/3 times per year) MAPPA SMB case Audits – 2 / 3 times per year, 2016 / 17 cycle considered Adult safeguarding, mental health, risk management plans, ARMS themes. 2017/ 2018 case audits to ensure that exit strategy is one of the areas considered and addressed. Learning to be provided to Chairs.	Report	SSCP is reassured learning from this DHR has been taken on board and procedures updated. Appropriate escalation policy is in place.	Merseyside MAPPA Strategic Management Board	Completed
5 (c)	That disclosure is always considered when there is a risk to others. Disclosure to a third party (Your Housing Group) was not made when Dean was assessed as presenting a risk to the public at the MAPPA meeting on 12 August 2014. It is not clear from the minutes whether or not residents at Your Housing Group were	There is a National MAPPA Key Performance Indicator: Disclosure to be considered and decision recorded in minutes at 100% of Level 2 and Level 3 meetings. Disclosure consideration must be recorded in every case. MAPPA Administrators collate quarterly KPI information and MAPPA Co-ordinator checks for any failures and feedback provided to relevant	Report	SSCP is reassured learning from this DHR has been taken on board and procedures updated.	Merseyside MAPPA Strategic Management Board	Completed

	specifically considered to be at risk from Dean. The learning from this event is that disclosure should always be considered when there is a risk to others. This learning should be fed back to those who chair MAPPA meetings.	Chair MAPPA Chair training includes briefings slides in regard of 3rd party disclosure, to ensure Chairs are aware of the importance and new legislation i.e. Child Sex offender disclosure scheme, domestic violence disclosure scheme. National MAPPA Audit template (issued Jan 2017) The role out of MAPPA Core Panels across Merseyside (Sefton implementing April 2017) will ensure a Local Authority Housing representative at all Level 2 meetings who can provide support and provide advise in regards of contact with registered providers.				
6	That Merseyside Police reports in writing to Sefton Safer Communities Partnership what action it has taken to ensure that its policies and practices for circulating wanted people are appropriate and followed.	SSCP to write to Merseyside Police to request an update report	Report	Reassurance for partners that Police policies and procedures are appropriate and being followed. That risks associated with wanted people are managed	Merseyside Police	June 2017

				appropriately.		
7	That the pan-Merseyside MARAC steering group considers the way in which the recording of MARAC meetings can be improved, how actions are recorded and allocated, and how agencies are held to account for their delivery. The steering group should consider whether meetings should be voice recorded.	Sefton MARAC Coordinator to raise this as an agenda item at the next Merseyside MARAC meeting To also be considered with the review of Sefton's MARAC currently being conducted	Minutes of meeting Sefton MARAC Review report	Improved recording of MARAC discussion, actions and outcomes. Clear evidence of how agencies are held to account for their delivery	Pan-Merseyside MARAC steering group	June 2017

Appendix B

Agency Recommendations: Merseyside Police						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	When a crime is recorded, officers responsible for allocation should research the incident Storm log and use it to assist in determining to whom it should be allocated.	Merseyside Police is about to adopt an Investigation Allocation Model (IAM) that will require a full review of all available information before cases are allocated for investigation on the basis of seriousness, complexity and risk. Information will be more readily available to the officers applying the IAM because of an IT solution (electronic version of the VPRF) that makes researching the background of the parties involved easier.	Copy of IAM training material	Relevant information is researched and taken into account prior to allocation of a crime for investigation	DCI Rooney	01/10/16 Complete
2	When a crime is allocated to an individual, the fundamental standard of investigation should commence with research of the	Merseyside Police is about to adopt an Investigation Allocation Model (IAM) that will require a full review of all available information before cases are allocated for investigation on the basis of seriousness,	Copy of IAM training material	Relevant information is researched and taken into account prior to allocation of a crime for investigation	DCI Rooney	01/12/16 Complete

	Storm log, and basic intelligence checks on the subjects and addresses.	complexity and risk. Information will be more readily available to the officers applying the IAM because of an IT solution (electronic version of the VPRF) that makes researching the background of the parties involved easier.				
3	Any investigations involving a 'gold' victim should be dealt with by FCIU investigators. Every effort should be made to ensure that crimes against individual 'gold' victims are dealt with by the same investigator to ensure continuity, safeguarding and reassurance.	The IAM has been designed to ensure that crimes against 'gold' victims of domestic abuse are investigated by the most relevant person/department.	Copy of IAM training material	Crimes against 'gold' victims of domestic abuse are investigated by the most appropriate person/department	DCI Rooney	01/12/16 Complete
4	The force should produce a documented 'work allocation' and 'personal responsibility' procedure in	The roles and responsibilities of every officer/member of staff dealing with domestic abuse have been documented within the force's Domestic	Merseyside Police Domestic Abuse Policy	Police officers and members of police staff are aware of their responsibilities in relation to reports of domestic abuse	DCI Middleton	01/09/16 Complete

	relation to each role within an FCIU. This should be published and appended to the force's Domestic Abuse Policy and Procedure as a clear reference point, to avoid ambiguity. The same procedures should apply in every FCIU within the force.	Abuse Policy.				
5	When a victim is discussed at a MARAC meeting and the perpetrator is currently in custody, a documented safeguarding action plan must be completed to ensure the safety of the victim upon the perpetrator's release. This should include details of whom the actions are allocated to, and timescales for	This issue was raised at the pan-Merseyside MARAC Steering Group and leads from the five Local Authority Community Safety Partnerships agreed to implement action plans relating to perpetrators who are leaving custody.	MARAC minutes	Safeguarding action plans have been developed for victims by the time that perpetrators are released from prison	DCI Middleton	01/09/16 Complete

	completion.					
6	When there is sufficient evidence to arrest a 'domestic abuse' suspect following an allegation of crime involving a victim risk-assessed as 'gold', then that individual should be circulated as wanted on the PNC at the earliest opportunity and no later than twenty-four hours after the time of the allegation.	The Assistant Chief Constable with responsibility for domestic abuse has circulated an 'In Touch' document to all officers ordering that suspects linked to matters involving 'gold' victims of domestic abuse are circulated as wanted within twenty-four hours if they have not been arrested immediately. Compliance to this process will be tested via the monthly Senior Responsible Officer (SRO) meeting.	'In Touch' document and slides from the SRO meeting	Suspects linked to matters involving 'gold' victims of domestic abuse are circulated as wanted within twenty-four hours if not arrested immediately	DCI Middleton	01/11/16 Complete

Agency Recommendations: Merseycare NHS Foundation Trust						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key**	**Lead Officer**	**Progress**

				Outcomes/Updates		
9.7	An outstanding action for Mersey Care Trust is to establish the reliability with which its' staff ensure they have read and assimilated all the information provided about a new patient at the point of referral and acceptance. This did not happen in this case. There are a number of ways the Trust could achieve this: • Via survey method • Via simulation method, in conjunction with safety tools such as Failure Modes and Effects Analysis • Via observation and interview methods The Trust is required to set out its action plan for achieving assurance and to share this with Sefton Safer Communities Partnership.	1. A learning event (Oxford Model Event) to be arranged to invite key people to apply the principles of the Failure Modes and Effects analysis to identify any weak points in the system that reasonably could lead to the information loss that occurred in this case.	• Action plan from the day • Power point presentations from the day	To identify any weak points in updated system and identify any other key actions that needs to be taken to improve this. OME took place on 16th February 2017. This was well attended and positive feedback was received.	Denis Cullen Maria Dineen Suzi Lloyd-Ellington	

		A further OME is being arranged specifically around Risk management related to another SUI that will include reflection/discussion how we keep risk live.	• Action plan developed from the event. • Power point presentations from the day • Outcome to develop a Task and finish group.	Further actions and key learning was noted and will be actioned Oxford Model Event took place in November 2016 and task and finish group has been developed.	Steve Morgan Chris Fisher Richard Whitehead	
9.8	Mersey Care NHS Trust has revised how it assesses new referrals and a face to face meeting with its own team now occurs as normal practice. However, what happens 'as a norm' when a service user is allocated to a community mental health team needs to be established. • How do community mental health teams ensure that they are appropriately knowledgeable about a service user; • To what extent is the information known about a	Development of a triage tool for assessment. Develop Implementation plan for the role out of triage tool DNA policy to be reviewed	Triage Tool Implementation plan Copy of updated policy	Completed Following OME further actions agreed Completed. There is on-going work around more robust implementation plan	Chris Jackson Alex Henderson Jimmy Cousineau/Kieran Daley	

	service user reviewed and assimilated by a community mental health team	Audit of DNAs to be completed Develop standards for MDT meetings Audit of compliance of MDT standards.	Quarterly Audit results Audit Outcome Standards document	and further training is to be given to PAC staff. The introduction of SMS text reminder service will commence on the 1.3.17 and this will be audited quarterly to see the impact of this on DNA rates Audit completed in 2016/2017 audit cycle. Further audit to take place in 2017/2018 Completed Audit in 2017/2018 programme	Jimmy Cousineau/Kieran Daly Alex Henderson Joanne Bull/Audit Lead for Local Services Tony Ryan	

			Audit Outcome			
		Review of assessment/Stepped up care services	Review paper and recommendations Meeting Minutes	• The Draft report was presented by Tony Ryan at the Local Services Division Senior Managers on 7th March 2017. • Senior Manager comments to be forwarded to the Divisional Strategic Operations Manager by 16th March 2017. • Divisional Strategic Operations Manager to forward local division response to Tony Ryan by 20th March • Presentation to Commissioners by Tony Ryan on 8th		

				March. • Commissioners comments to be sent to Tony Ryan by 29th March • Final report will be received by the end of March • Transformation plans are currently being reviewed. Over the last 12 months there has been on going caseload review for Community Mental Health Team focusing on criteria for clusters to ensure appropriate service users are being seen.		

		To implement transformation programme for community services				

Agency Recommendations: Royal Liverpool and Broadgreen University Hospitals NHS Trust						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Illegible signatures: Documentation of ED Triage Nurse identity via a printed name accompanying a signature is not consistent. This could cause problems in identifying staff involved and hamper the investigation of any incident.	Continuing education in safeguarding training emphasising the importance of documentation including identities Documentation audits focusing on quality, including identifiable names/signatures, with results fed back to staff	Training records Documentation Audit results	ED records will clearly document staff signatures to allow for staff members involved in any investigation to be easily identified	Safeguarding Nurse for Children Practice Development Nurse	Complete Action plan will be monitored at Strategic Safeguarding Group
2	ED staff will consider and document their enquiries regarding any possible or suspected case of domestic abuse	Emphasis included in the ongoing Safeguarding training programmes for frontline staff to increase awareness that victims of domestic abuse may	Training records	Ensure that domestic violence cases are better assessed and identified	Safeguarding Lead for Adults	Complete Action plan will be monitored at

		present in different ways or be reluctant to disclose domestic abuse				Strategic Safeguarding Group

Agency Recommendations: Aintree University Hospital Trust						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Safeguarding assessment completed on the emergency care health records	Audit emergency care health records – completed July 2015 Results of records audit presented to Safeguarding Group – August 2015 Results of records audit escalated to senior nursing staff at Safeguarding Group – August 2015	Audit results presentation and date delivered to senior Accident and Emergency staff List of staff who attend the audit results presentation Training material to complete the safeguarding	Consistent safeguarding assessment on admission to Accident and Emergency Demonstrate improvements through audit – January 2016 Increased multi-agency referrals for early intervention and safeguarding	Angela Derbyshire, Safeguarding Nurse	Complete

		Results of records audit presented to senior Accident and Emergency staff – October 2015 Staff training on completion of the safeguarding assessment – October 2015 Re-audit of emergency care health records – January 2016	assessment	services		

Agency Recommendations: Your Housing Group						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Your Housing Group to review the YHG Domestic Abuse Policy and Safeguarding Policy and ensure that both policies adequately	Review and update of YHG Domestic Abuse Policy Review and update of	Revised policies Policy audit to demonstrate implementation of risk	Quality of risk assessment regarding domestic abuse Safer assessment of	Lead Director, Director of Compliance	Complete

	reflect the importance of comprehensive and routine risk assessment of all tenants within YHG Supported Living Schemes regarding domestic abuse to include coercive control. A referral pathway for domestic abuse to be included within YHG Domestic Abuse Policy with clear links to YHG Safeguarding Policy. This recommendation to be considered as a high priority for YHG and to be completed by December 2015.	YHG Safeguarding Policy Ensure that documentation used is representative of revised policy document e.g. Older Persons Assessment Documents Formal launch of new policy Ensure that training programmes include messages from new policy	assessment, quality of referrals and outcome from referral	service users Improved training and awareness		
2	Your Housing Group to include domestic abuse training for relevant staff within their training strategy and training plan. Training must be competency based and include training in risk assessment and routine enquiry. YHG to	Development of competency framework for YHG staff with particular focus on routine enquiry and risk assessment Develop training needs analysis	Training strategy Training needs analysis Training plan Training programme	Quality of risk assessment regarding domestic abuse Safer assessment of service users and quality of referral	Lead Director, Director of Compliance YHG Training Department	Complete

	consider this as a high priority and implement by March 2016.	Develop training plan Develop training programme to include case examples and learning from Domestic Homicide Review Ensure that training programmes include messages from new policy Develop evaluation tool	and evaluations	Improved training and awareness		

3	YHG Housing Officers and Scheme Managers to ensure that the risk assessment component of the tenancy application form for older persons is completed in full for every housing application and to ensure that each older persons assessment and review includes a full risk assessment and routine enquiry regarding domestic abuse. This is to be managed as a priority and implemented with immediate effect.	Amend procedure documents and relevant documentation Hold debrief and lessons-identified events for personnel, but ensure confidentiality regarding the DHR is maintained Develop audit tool and 'spot check' framework	Amended procedure and relevant documentation Minutes of debrief sessions Audit tool and spot-check framework	Quality of risk assessment regarding domestic abuse Safer assessment of service users and quality of referral Learning from critical incident	YHG Director of Supported Living	Complete
4	All YHG staff to be in receipt of an update regarding the importance of effective documentation to include data protection principles.	Briefing paper/team brief Check data protection policy and training Develop records audit tool to ensure effectiveness	Briefing paper/team brief Records audit tool Results of audit and audit plan	Improved documentation and record keeping Tenants' sensitive data protected	Director of Compliance Governance Team	Complete

End of Executive Summary