SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

'Nathanial'

JULY 2016

Panel Chair: David HUNTER

Author: Paul CHEESEMAN

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

Person	Role	Relationship	Ethnicity
Nathanial	Victim	Brother of Kristian	White British
Kristian	Offender	Brother of Nathanial	White British

1.2 On a Sunday in early autumn 2014 police and ambulance attended address 1. The body of Nathanial was found in the house, he had been beaten by Kristian. Kristian was arrested and later charged with the murder of Nathanial. He appeared before a Crown Court and pleaded guilty to the manslaughter of Nathanial. This was accepted by the prosecution and he was sentenced to 7 years imprisonment.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Sefton Safer Communities Partnership [SSCP] decided the death of Nathanial met the criteria for a DHR. David Hunter was appointed as the Independent Chair. He was responsible for managing and coordinating the review process. Paul Cheeseman authored the report. Both are independent practitioner who between them have chaired and written previous DHRs, Child Serious Case Reviews and Multi-Agency Public Protection Reviews. Neither have been employed by any of the agencies involved with this DHR and were judged to have the experience and skills for the task. A DHR panel was assembled which represented local agencies and included members with detailed knowledge of domestic abuse. The Chair and Review Panel considered the scope of the review and draw up clear terms of reference which they felt were proportionate to the nature of the homicide. Five panel meetings were held and attendance was good with all members freely contributing to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone. The panel held detailed discussions about the contents of the IMRs and ensured the Overview Report brought these together. The panel then drew together conclusions, lessons and recommendations.

2.2 Fifteen agencies submitted written information. The victim's mother spoke to David Hunter by telephone and acted as a voice for the victim. The perpetrators wife met David Hunter and Paul Cheeseman and provided background information. The perpetrator Kristian was interviewed in prison by Paul Cheeseman. Their views were included in the report and credited accordingly.

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. BACKGROUND

3.1 Nathanial (Victim)

3.1.1 Nathanial was the eldest of two children, Kristian being his younger brother. His mother and natural father divorced not long after the birth of Kristian. She remarried and this ended in divorce after eleven years. She then married for a third time and the couple living at Address 1 at the time of Nathanial's death. Nathanial and Kristian were exposed to domestic abuse during the first two of their mother's marriages and they also suffered violence at the hands of her second husband.

3.1.2 Nathanial received a local secondary education and had trained as a painter and decorator. However he found it difficult to hold down work because of the problems he had with alcohol which made him unreliable. Nathanial's mother said he was a loving lad whose personality changed after he was involved in a road traffic accident aged 11 years. He became aggressive and had a bad temper.

3.1.3 Nathanial had several relationships with different female partners that were often tainted by domestic abuse. During one of these relationships he fathered a son. Nathanial regularly abused alcohol and controlled drugs and frequently displayed aggressive and violent behaviour. He suffered from mental health issues and depression. He was arrested or summonsed by the police on fifty two occasions for offences of violence, damage, public disorder, drugs and motoring offences. He had twenty five criminal convictions and had served several short terms of imprisonment. He had also been the subject of several supervision orders including an alcohol treatment order. At the time of his death Nathanial was on bail to the courts charged with an offence of criminal damage.

3.2 Kristian (Perpetrator)

3.2.1 Kristian was contrite and keen to contribute to the review. He described his childhood as difficult. In particularly he remembered the physical cruelty meted out to him and Nathanial by their first step-father. He painted a harrowing picture of how Nathanial was beaten regularly with an old cast iron soup ladle by this person. Kristian attributed Nathanial's personality change when he was about 10 years of age to this abuse.

3.2.2 In contrast to Nathanial, Kristian achieved academically and qualified as a registered mental health nurse. Kristian moved away from home to get away from Nathanial. However Kristian was often called by his mother to come and sort Nathanial out when he misbehaved. When Kristian met his wife, who was also a nurse, he said that these calls started to damage their relationship. Kristian described how he suffered from anxiety. He also abused alcohol and recreational drugs including cannabis, cocaine and ecstasy. He felt Nathanial would not engage with services and agencies really needed to take firmer action against Nathanial.

4. COMMENTARY

4.1 Nathanial's erratic and violent behaviour went back many years. The panel believe both he and Kristian experienced significant trauma in their childhoods and were exposed to male adults who abused alcohol and perpetrated domestic abuse. Nathanial was the focus for the most violence and that may be a reason why he became violent himself.

4.2 As children the boys suffered other traumas including witnessing the sudden death of a grandfather who was said to be Nathanial's only male role model and a serious attempt by their first step-father to hang himself. Nathanial's behaviour had a significant impact upon the family and on Kristian who after meeting his wife was eager to put some distance between himself and his brother. However Nathanial continued to intrude into the couple's life even after they married.

4.3 Nathanial had an extensive history with agencies, principally in the criminal justice system. Therefore as a point of reference the panel decided to look at the first occasion on which the police held information that Nathanial caused a disturbance at Kristian and address 1 in May 2006. They then analysed fifty three incidents of violence, disturbance or crime that Nathanial was involved in between then and his death in 2014.

4.4 Because he had a history of aggressive and violent behaviour almost always involving excessive consumption of alcohol Nathanial was never considered to be at risk from anyone other than himself. Merseyside Police recorded Nathanial as the perpetrator of domestic abuse on thirty five occasions; his victims included females he was in relationships with as well as his mother. During thirty of those incidents he was under the influence of alcohol and on thirteen of them he caused injury to victims or inflicted damage.

4.5 Kristian was recorded by Merseyside Police as being the victim of domestic abuse on four occasions at the hands of Nathanial. These were all recorded as low level incidents and only one physical assault was recorded by Nathanial on Kristian. The panel found no records or evidence that Kristian ever perpetrated domestic abuse on Nathanial until the day he killed him.

4.6 Both Kristian and his wife were recorded as having perpetrated domestic abuse on each other. On two occasions Kristian was recorded as the victim of domestic abuse with his wife recorded as the perpetrator. Kristian was recorded by Merseyside Police as the perpetrator of domestic abuse on his wife on four occasions. He was intoxicated during three of these incidents all of which were classified as low level. On one occasion he physically assaulted her although she later retracted the allegation.

4.7 Kristian willingly engaged with agencies to address his behaviour as a perpetrator and his abuse of alcohol and drugs. As a qualified mental health nurse he recognised what was happening and sought help and engaged with professionals. His wife was arrested on one occasion for assaulting her mother-in-law and for possession of drugs. As a result of these incidents, Kristian and his wife had their child temporarily removed. Kristian's wife also willingly engaged in programmes to address her behaviour and eventually their child was returned to the couple.

4.8 While some minor shortcomings have been identified in processes it is clear that agencies acted in a coordinated and appropriate way to protect the child. While there was a lack of routine enquiry and inquisitiveness by some health professionals in respect of domestic abuse there were no major shortcomings by agencies in the way they handled abuse perpetrated on by Kristian on his wife.

4.9 Nathanial was known to many agencies and his misuse of alcohol and drugs and his violence were well documented. While there were some minor issues in respect of the way in which incidents were recorded these had no impact at all on the way agencies dealt with Nathanial. The risks he presented towards others were well known and documented and he was correctly classified as a Multi-Agency Public Protection Arrangements (MAPPA) nominal and had been the subject of four Multi-Agency Risk Assessment Conferences (MARAC).

4.10 The panel felt Nathanial was given every chance possible by agencies to address and modify his behaviour and yet seemed either unwilling to engage, or having engaged, to remain so. While he is the victim in this case he seemed to care as little for his own wellbeing as he did for those he abused. He was reckless in the way he considered the risks to himself.

4.11 The panel felt agencies recognised the risk to Nathanial's child and took steps to protect him. These included child protection plans and case reviews. Issues were complicated as the risk to the child was not just from Nathanial. The child's mother also had risks arising from another relationship she had after separating from Nathanial. Part of the plan to reduce the risk to the child from Nathanial was to ensure he did not have unsupervised contact with him. A concern the panel expressed was that, after Nathanial assaulted his mother, she continued to be entrusted with supervising Nathanial's contact with her grandson when she was actually vulnerable and at risk from Nathanial.

4.12 His mother's actions in trying to minimise the consequences for her son are perhaps understandable, her efforts were eventually counter-productive. As Kristian recognised, having failed to take the chances he was given, Nathanial's behaviour really needed to be addressed through the criminal justice system.

4.13 The panel felt that agencies such as Merseyside Police and the Crown Prosecution Service recognised that and took the correct steps in initiating proceedings against Nathanial. This was despite his mother and second step-father appearing unwilling to support a prosecution after they were violently assaulted by Nathanial. He escaped a custodial sentence after they pleaded for him. There are indications that after he was given that chance he responded positively to an Alcohol Treatment Order (ATR). He self-reported as abstinent by December 2013 and the frequency of incidents he was then involved in declined markedly.

4.14 However, the description of his intoxicated state on the day he died revealed that his abstinence was only short lived. While Kristian was convicted of killing Nathanial, and accepts his actions were wrong, the description of Nathanial's violent behaviour that day indicates that his propensity to extreme violence after drinking was undiminished.

4.15 Finally, the panel felt this case demonstrated all too well the inter-generational impact on the behaviour of persons who grow up as children in households where violence is endemic. As a child, Nathaniel was both the victim of violent behaviour

by an adult (his first step father) and also witnessed violent behaviour between adults. This had a profound impact upon him. The panel believe it is entirely possible that Nathaniel's experiences as a child were the reason that he turned to alcohol at a very early age and displayed violent behaviours himself.

5. CONCLUSIONS

5.1 Even though Nathanial is the victim in this case it is clear he was a man who misused drugs and alcohol and perpetrated violence on many people, male and female, partners, friends and family and often without any apparent reason. Given his history of behaviour and reckless lifestyle it was always a possibility that his death would not occur from natural causes.

5.2 He was a violent offender as recognised by his Multi Agency Public Protection Arrangements classification and he presented a high risk to others. It was more likely that he would continue to be a perpetrator of domestic abuse as opposed to becoming the victim of a domestic homicide. Given the lack of any information that Kristian presented a risk towards Nathanial it could not be predicted that he would kill him and consequently Nathanial's death could not have been prevented.

6. LESSONS IDENTIFIED

Lesson 1 (Recommendations 2 and 4 applies)

Unfamiliar patterns of abuse

Narrative

Nathanial was murdered by his brother Kristian. There was no evidence that Kristian had ever used violence or perpetrated any other form of domestic abuse upon Nathanial. There was evidence that Nathanial used violence towards Kristian. In fact on occasions Kristian was seen as a protective factor and someone to whom the family could turn for help in controlling Nathanial's behaviour. This is the second recent homicide case in the SSCP area that has involved violence between family members that were not in an intimate relationship.

Lesson

This was not intimate partner abuse or violence and for this reason the normal channels of referral for domestic abuse did not apply in this case.

Lesson 2 (Recommendations 1 and 3 applies)

Embedded Behaviours

Narrative

Nathanial and Kristian were raised in a household in which they were exposed to domestic abuse. Both experienced violence as children and, according to Kristian, Nathanial was the target of particularly brutal assaults which involved a weapon. Kristian felt that Nathanial's personality changed when he was about 10 years of age because of the abuse he received. As Nathanial got older he became violent himself and turned his aggression towards others. Nathanial consumed alcohol from an early age and eventually abused both alcohol and drugs. Kristian also abused alcohol and drugs. Nathanial perpetrated abuse and violence on partners on numerous occasions. Nathanial used violence towards his mother on one occasion.

Lesson

Examination of the family history of Nathanial and Kristian show these behaviours were well embedded many years ago.

Lesson 3 (Recommendation 3 applies)

Presence of the Toxic Trio

Narrative

Nathanial abused alcohol and drugs from an early age. Apart from some short periods of abstinence his patterns of consumption continued until his death. All the occasions he committed assaults on other people or abused partners occurred when he was intoxicated and/or had misused drugs. Nathanial suffered with mental health problems and that appears to have impacted upon the way he behaved to others. Kristian also abused alcohol, misused drugs although to a much lesser degree than Nathanial. On one occasion Kristian abused his wife. Nathanial and Kristian had both consumed alcohol when they were engaged in a fight that ultimately resulted in Nathanial's death. There were concerns amongst agencies about the risk of harm to children because of exposure to these behaviours.

Lesson

The term 'Toxic Trio' has been used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred. They are viewed as indicators of increased risk of harm to children and young people.

7. RECOMMENDATIONS

7.1 The DHR recommendations appear at Appendix B.

Appendix 'A'

Definitions

Domestic Violence and Abuse

1. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 and is:

   "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

   - psychological
   - physical
   - sexual
   - financial
   - emotional

   Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

   Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

2. Therefore, the experiences of FA and FD fell within the various descriptions of domestic violence and abuse.

Risk Assessment Terms

Merseyside Risk Identification Toolkit (MeRIT)

3. MeRIT is the risk assessment model currently by Merseyside Police and partner agencies. MeRIT is an essential element to tackling domestic abuse. It provides the information that would influence whether or not to refer the victim to a Multi-Agency Risk Assessment Conference [MARAC].

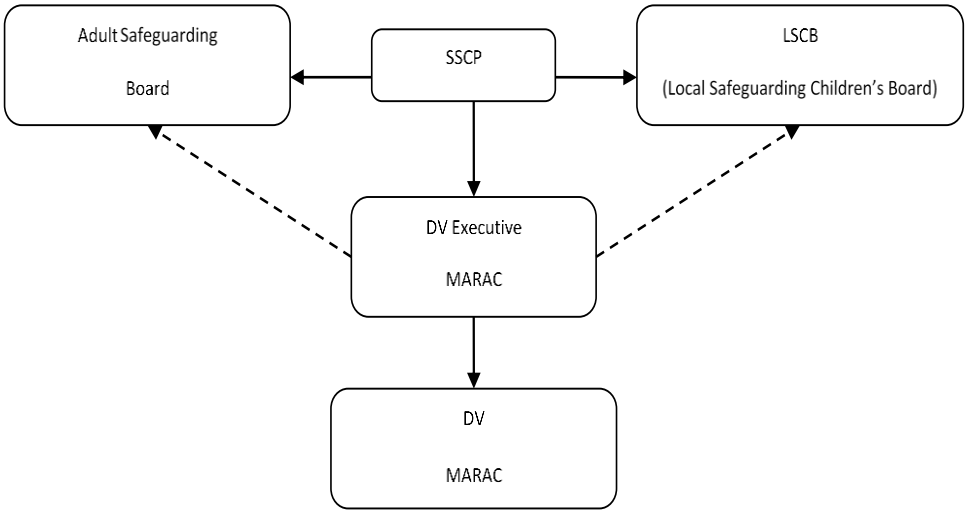
4. Police officers who attend domestic abuse incidents use the MeRIT tool to identify the level of risk faced by the victim. Information gathered, together with any additional comments by the officer are submitted to the Family Crime Investigation Unit (FCIU) using a Vulnerable Person Referral Form 1.

5. A trained assessor in the FCIU reviews and categorises the risk to the victim of abuse. The FCIU risk assesses victims of domestic abuse and categorise them as Gold, Silver or Bronze. Gold victims suffer the highest risk of further abuse which could amount to serious harm.

6. The FCIU use the information contained in the VPRF 1 document to populate a database entitled 'PROTECT' where all incidents of domestic abuse are held. During the risk assessment process the FCIU identify actions designed to reduce known risks to the victims and this can include referrals to other agencies or a multi-agency risk assessment conference (MARAC).

7. MARACs are meeting where information about high risk domestic abuse victims is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim.

Governance arrangements in Sefton



8. Sefton Safer Communities Partnership (SSCP) and Local Safeguarding Children's Board (LSCB) have identified Domestic Violence as a core priority recognising the significant impact upon Communities.

9. SSCP has responsibility for all crime and community safety issues in Sefton. The CSP is chaired by the Cabinet Member Safer Communities and Neighbourhoods.

10. DV Exec is a specific group to look in detail at the top level repeat cases and identify specific MARAC actions to address what is causing the repeats.

11. DV MARACs are meetings where information about high risk domestic abuse victims is shared between local agencies and appropriate actions defined.

12. LSCB (Local Safeguarding Children's Board) is the key statutory mechanism for agreeing how organisations will cooperate to safeguard and promote the welfare of children and young people.

Support to Victims

13. Currently those individuals experiencing domestic violence have access to a range of support services provided through the Council and voluntary sector these include the following.

14. VVAT Support high risk domestic violence victims and all high risk sexual violence victims and all MARAC cases; provide crisis interventions, undertake full needs and risk assessment and sanctuary assessments; assist with safety and support plans and act as an advocate on behalf of the victim in dealing with other agencies. VVAT also provides support to male victims of domestic abuse at any risk level.

15. SWACA Offer long term specialist support for women who experience domestic abuse, Refuge accommodation and children's service for children and young people who have experienced or lived with domestic violence.

16. Venus Women's organisation offering info & support (on issues such as housing, benefits, etc.), volunteering, day trips, residential.

17. Voice4Change. An Independent support and counselling service for male and female victims of Domestic Violence.

18. RASA Sefton provides essential crisis and therapeutic support to survivors of sexual violence by offering support and counselling. RASA works with all individuals who have been victims of sexual violence at any time in their lives.

19. Aspire (Sefton) Female offenders access supervision appointments within SWACA. Packages of support are developed by Offender managers and SWAN centre.

20. Probation perpetrator programmes. For male offenders who are convicted of any offence related to violence against their partner or ex-partner.

21. NoXcuses: Approx 30 week Voluntary Perpetrator Programme facilitated by Sefton Family Support Workers. Referrals made by Social Workers. Partner support offered by SWACA. Currently a pilot programme. VVAT can also provide partner support for Noxcuses programme.

22. InPACT, a Knowsley based organisation, is also delivering a pilot programme in Sefton. Funded by the Police and Crime Commissioner via the Sefton Safer Communities Partnership they focus on targeting perpetrators not eligible for the Noxcuses programme. InPACT is a programme for men aged 18 or over who want to stop being violent or abusive, or look at changing their past behaviour. 26+ week group programme and individual assessments.

Review of Domestic Abuse

23. A sub group of the LSCB agreed a review of domestic violence should be carried out to provide an up to date picture of the key issues facing Sefton. From this a Domestic and Sexual Abuse Strategy for the next 3 years has been developed and has now been approved by Sefton Safer Communities Partnership. A Domestic Violence Executive Group is being established to take this forward, develop the action plan and to oversee the lessons learned from DHRs on an ongoing basis.

Appendix B

Panel Recommendations						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Raise with Merseyside Local Criminal Justice Board (LCJB) the issue of the disclosure of expert health reports and request the LCJB consider whether, when such reports are commissioned by the court, the defence or the prosecution, steps can be taken to ensure they are also provided to the subjects GP;	Chair of the SSCP to write to the LCJB	Letter and response from LCJB	Relevant health information is shared with GPs	SSCP	March 2016
2	Work with partner agencies, and request them to review their own services in respect of domestic abuse and ensure they meet the needs of persons with similar issues to NATHANIAL. In particular as a child who had himself survived abuse and as someone who suffered with drugs, alcohol and mental health problems through his adolescent and adult years.	Mapping work with agencies to look at current domestic policies they have in place – this has already been started so review of what agencies have already done this Support from IDVA and MARAC team around domestic abuse awareness and staff training if needed – ongoing piece of work	Mapping work completed –know what agencies have reviewed their policies Agencies accessed training support	Agencies have appropriate policies in place which reflect the wider definition of domestic abuse and how they respond this as services. Agencies have a clear understanding of support and referral processes in Sefton	SSCP	Mapping by March 2016 First round of training/briefings by April 2016
3	Share the findings of this review as a case study with other agencies so as to ensure they recognise the long term impact of domestic abuse on children and understand the impact it can have upon them and their behaviours as they reach	Work with Sefton's LSCB (Local Safeguarding Children's Board) Business Manager to share this learning across the	Briefing information shared Case study built into training/awareness	Increased awareness of the impact of domestic abuse on children	SSCP	March 2016

	maturity.	partnership agencies	raising sessions			
4	Ask the Home Office whether they are able to identify the profile of offenders that have committed a domestic homicide (i.e. age, sex, relationship) and whether there are any emerging patterns such as an increase in the number of siblings who commit such offences.	Chair of the SSCP to write to the Home Office	Letter and response from Home Office	Shared learning around any trends nationally emerging DHRs	SSCP	March 2016

Agency Recommendations Merseyside Police						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	When it is identified that a person involved in a 'domestic incident', is suspected of suffering with mental health issues, then that person must be referred to Adult Social Services.	Merseyside Police Force policy will be amended to ensure that all persons suffering mental health issues are referred to Adult Social Care	Force DA policy	The number of referrals to Adult Social Care will increase	DCI Middleton	01/05/15
2	When dealing with repeated low key 'domestic incidents' that involve alcohol abuse as a continued factor, then interventions and referrals to other agencies must be considered.	A briefing document highlighting the need to make enquiries with DA perpetrators around voluntary attendance at alcohol programmes is to be circulated to front-line staff. This is to include instruction on Alcohol Treatment Orders should the perpetrator be convicted of an offence.	Briefing document and Force DA policy	Increase in referrals to alcohol programmes and requests for Alcohol Treatment Orders	DCI Middleton	01/05/15
3	Consider changes to the manner in which the Force records the part played by individual parties involved in 'domestic incidents' to encompass the	The situation in relation to conducting a risk assessment on both parties (when it is not clear who is	Force Policy	Risk assessments conducted for both parties when it is not clear who is the	DCI Middleton	01/05/15

	situation when there is no clear victim or perpetrator.	the perpetrator/victim) is to be discussed during the consultation process for the new DA policy.		perpetrator and who is victim.		

Agency Recommendations GPs

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	(NEW) GPs and practice nurses to embed routine questioning about domestic abuse into consultations – particularly in ante natal and post-natal situations and in mental health presentations.	NICE guidance to be summarised and sent to practice safeguarding leads for implementation within their practices.	Training materials	Increased awareness of domestic abuse indicators and risk assessments.	LW	1/5/15
2	REVIEW Practice to ensure that safeguarding concerns are routinely considered for the "child behind the adult", particularly when toxic trio risk factors are present in the adult they are seeing (or reading correspondence about)	Practice to consider in-house meeting to discuss – with facilitation from safeguarding team if the practice wish.	Assurance from practice that this has been done	Revision of safeguarding training.	Practice safeguarding lead	1/7/15
3	REVIEW The practice to ensure that when coding child protection issues that the other family's records are also coded.	Practice to consider in-house meeting to discuss – with facilitation from safeguarding team if the practice wish.	Assurance from practice that this has been done	Improved accuracy of records will aid practitioners when dealing with family members.	Practice safeguarding lead	1/7/15

Agency Recommendations Lancashire Care NHS Foundation Trust

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	Increase awareness of routine enquiry into domestic abuse across the service and Network in line with NICE Guidance February 2014	Support attendance at domestic abuse awareness training of identified staff in children and families. Review standard operating procedure for core contacts to ensure that routine enquiry is recommended at each core contact and that this recorded and a rationale for noncompliance is recorded in records. Provide briefings regarding routine enquiry and advice re review of historical records if available.	Monitor take up of training of domestic abuse awareness. Standard operating procedure assured and ratified	Increased awareness of domestic abuse for key staff Routine enquiry will be embedded in practice	Service Integration Managers and Domestic Abuse Lead	July 2015

		LCT Dom Abuse action plan 2015.doc 	Briefing re team information boards regarding routine enquiry of domestic abuse.	Briefing on team information boards		
2	Share information from post incident review across Children and Family Network via governance arrangements.	Learning will be shared with teams in the Universal service line via the lessons learnt agenda item on the governance agendas from senior management to team level. The review will also be shared via the Quality and Safety meeting at which all the service lines are present and the lessons learnt shared in their governance meetings. Dare to Share Events to be	Evidence will be available from minutes of meetings	Increased awareness of staff across the Network regarding domestic homicide review and lessons learnt	Debra Wilson Clinical Leads	July 2015

		organised across the Trust to disseminate the information. Dare to share is part of the Networks governance arrangements to ensure all lessons learnt from any reviews are shared with practitioners	Dates for Dare to Share available and staff invited to attend	Increased awareness of staff across the Network regarding lessons learnt	Debra Wilson Clinical Lead Jo Counsell Named Nurse	September 2015

Agency Recommendations Southport and Ormskirk NHS Trust

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	Alerts for domestic violence victims	Comparison of what was in place for domestic violence victims in 2009 and now.	Safeguarding referrals for domestic violence through DATIX Training both Children and Adult safeguarding awareness	Vulnerable adults flagged and appropriately referred to services	Adults at risk team	April 2015

Agency Recommendations SWACA						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Ensure appropriate recording is in place. A particular emphasis on accurate recording of professionals involved in the case, response to risk, sharing information in a timely manner, evidence of information shared, and achieved outcomes.	Review current system of recording information. Delivery of case management training To ensure consistent input of information.	Team meeting minutes. Monitoring reports produced by Case management system. Case file audit records.	Increased awareness for staff and managers of expected standard of record keeping. Installation of Case management system. Review of Policy and procedure relating to case management system and recording of information.	CEO and Management team	December 2015.
2	Effective recording of management	Review existing	Case file audit	Improved evidence in ways in which	CEO	Review by

	oversight and case discussion	arrangements Review current policy and procedure Develop new policy and procedure if appropriate.	notes. Policy in place Minutes of Meeting	practitioners respond to change, risk, need etc.		Dec 2015 Policy by March 2016.
3	Share learning from agency and Homicide Review.	Share findings and areas of concern.	Minutes of meetings. Case file audit records.	Consistent and improved standard of record keeping. Team report increased awareness of agency standard.	CEO and Management team	Initial findings shared with team members within team meeting and group supervision relating to

						case file recording. Completed 04/02/15. Wider learning by Dec 2015.
Agency Recommendations Southport and Ormskirk NHS Trust						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	That a briefing is completed in relation to the learning from this IMR which is shared with all Team and Practice Managers within LCSC for inclusion on team briefings with front-line practitioners. In particular this will highlight: • The need for accurate and clear recording in relation to the action taken when following up any safeguarding concerns. • That risk assessments must clearly identify the risk posed by an adult to a child and how this will be	Briefing completed and sent to Head of CSC. Briefing to be included on the agenda for IRO and CSC Cluster Meetings to consider the learning.	Team Brief document distributed to all managers within CSC. Minutes of IRO and CSC Cluster Meetings.	Increased awareness of recording requirements. Improved quality of risk assessments. More robust assessments of home placements. Child in Need Reviews held in accordance with procedural	Sally Allen, Safeguarding Manager Diane Booth Head of CSC	31/05/15

	managed, in order to ensure children are appropriately safeguarded. • The requirement that Social Workers regularly see both parents as part of their ongoing assessment of the safety and well-being of children subject to home placement arrangements. • The need to undertake an assessment of siblings of the same household where a child is subject to home placement regulations. • The requirement to hold Child in Need Reviews in accordance with procedural requirements and to hold a Child in Need Review where consideration is being given to stepping down the case to universal services.			requirements. Appropriate decision making in Child Protection Conferences.		
2	The learning from this IMR will be shared with IROs at a team learning and development event. Specific consideration to be given to decision making in child protection conferences and the criteria for making a child subject to a Child Protection Plan.	IRO Learning and Development Event to be arranged. IRO attendance to be mandatory.	Agenda and Record of IRO Learning & Development Event. Learning from this DHR discussed at IRO Team Meeting.	Increased awareness of IRO responsibilities in relation to developing the Child in Need Plan when ceasing a Child Protection Plan at conference.	Sally Allen, Safeguarding Manager	31/07/2015

				Improved quality of Child In Need Plans.		

End of Executive Summary