EXECUTIVE SUMMARY

Plymouth Community Safety Partnership

Victim A

Year of Death October 2016.

Author: Paul Northcott

Date the review report was completed: 21st February 2018.

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1. The Review Process

1.1 This summary outlines the process undertaken by Safer Plymouth domestic homicide review panel in reviewing the homicide of Victim A who was a resident in their area.

1.2 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities, and those of their family members:

- Victim – Adult A (ethnicity- White European)
- Perpetrator- Adult B (ethnicity- White European).

1.3 Criminal proceedings were completed on the 19th January 2017, and Adult B was sentenced to life imprisonment for the murder of Adult A; to serve a minimum term of fifteen years.

1.4 Plymouth Community Safety Partnership (Safer Plymouth) commissioned this Domestic Homicide Review on the 20th February 2017. The delay in commissioning the review occurred as a result of internal restructuring within Plymouth City Council which affected the role of Community Connections Technical Lead, and the inability to find a qualified report writer within that period of time. All agencies that potentially had contact with Adult A, Adult B and their family prior to the point of death were contacted and asked to confirm whether they had involvement with the couple.

1.5 Nine of the ten agencies contacted confirmed involvement with the victim and/or Adult B and their children and were asked to secure their files.

2. Contributors to the Review

2.1 The contributors to the Domestic Homicide Review(DHR) were;

- Devon and Cornwall Police – IMR.
- Livewell Southwest- IMR.
- PDAS- IMR.
- Children Young People and Family Services- IMR.
- National Health Service England (NHSE) – IMR.
- Plymouth City Council – Community Connections- IMR.
- Plymouth Community Homes – IMR.
- Education – IMR
- Plymouth Hospital NHS Trust- IMR.
- Plymouth, Cornwall & Isles of Scilly National Probation Service – information.
- Family members- Information.

3. The Review Panel Members

3.1 The panel for this Review were made up of the following representatives;

- Paul Northcott-Independent Chair.
- Sue Warren – Community Connections Technical Lead
- Leanne O'Reardon – Children's Services- Independent.
- DCI Steve Davies – Senior Investigating Officer, Major crime Investigation Team, Devon and Cornwall Police.
- DS Phil Hale – Serious Case Review Unit, Devon and Cornwall Police.
- DCI Craig McWhinnie – Devon and Cornwall Police.
- Gillian Scoble – New Devon CCG -Safeguarding Nurse.

- Elizabeth Cox – Integrated Safeguarding Manager for Children and Adults Livewell Southwest.
- Lisa McDonald – PHNT.
- Anna Constantinou – PCC Community Connections.
- Sarah Pulley- Senior Safeguarding Nurse PHNT.
- Rachel Fox – Plymouth Community Homes.
- Gary Wallace – Public Health.
- Alison O'Neill – Plymouth Hospitals NHS Trust.
- Katy Fisher–Plymouth Domestic Abuse Service (PDAS).
- Andy Brettle- Plymouth Community Homes.
- Dan Monck – Senior Probation Office. Plymouth, Cornwall & Isles of Scilly National Probation Service

3.2 None of the panel members or IMR writers knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

3.3 Whilst the panel met on four occasions contact was made with panel members on a regular basis to clarify issues and matters of accuracy about their agencies involvement with the family.

4. Author of the Overview Report

4.1 Safer Plymouth appointed Paul Northcott as Independent Chair and author of the Overview Report on 20th February 2017.

4.2 Paul is a safeguarding consultant specialising in undertaking reviews (critical incidents, investigations, serious case reviews and safeguarding adult reviews) and currently delivers training in all aspects of safeguarding, including domestic abuse. Paul was a serving police officer in the Devon and Cornwall Police and had thirty-one years' experience. During that time he was the head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.

4.3 Paul left the police service in February 2017, but had spent the previous seventeen months working regionally and nationally. During that time he had no involvement with Safer Plymouth nor the policy and practices of the Devon and Cornwall Police. Paul also had no operational oversight of the resources that were deployed in this case.

5.0 Terms of Reference for the Review

5.1 The terms of reference for the Review (Appendix A) were set following consultation with all agencies involved in the process, and with the family of Adult A.

6.0 Summary

6.1 Adult A lived together with her husband and three children. They lived in a terraced house on a housing estate in Plymouth and had been resident at the premises for about two and a half years. Those that knew the couple describe them as having a loving relationship and the children appeared to be well cared for. Both adults were unemployed.

6.2 On Sunday 9th October 2016 police attended the home address having been called by Adult B who had stated that he had killed his wife. On attending the address officers found Adult A in an upstairs bedroom suffering from severe injuries. These injuries had been

inflicted using a knife. Adult A was taken to a Plymouth hospital where she was subsequently pronounced dead. A post mortem was carried out on Adult A and the cause of death was recorded as 'multiple stab wounds' to the major organs.

6.3 On the 10th October 2016, Adult B was charged with the murder of Adult A. Adult B appeared before Plymouth Magistrates Court where he was remanded in custody. He subsequently appeared before Plymouth Crown Court where he entered a guilty plea. Adult B did not challenge any aspect of the evidence that was presented and his guilty plea was based on the full facts. On the 19th January 2017 Adult B was sentenced to a life sentence.

6.4 Adult A and Adult B met in 2011 and were married in July 2014. Adult A had three children who were aged between twelve and seventeen years at the time of the incident. These children were from two previous relationships. The children lived at the home address although none of them were present on the night of the incident.

6.5 Adult A had experienced domestic abuse and violence as both a victim and perpetrator with several partners. The Police, PDAS and Housing all had information that detailed domestic abuse incidents between Adult A and Adult B. During the relationship Police attended three specific incidents, involving the couple, which were categorised as domestic abuse. Agencies offered appropriate help and support during these incidents and followed policy and practice.

6.6 The true extent of the abuse that was occurring in the relationship could not however be verified as Adult A's often contradicted herself about the relationship that she had with her husband. Neither Adult A or Adult B had ever stated that there was any violence in their relationship when interacting with professionals and insufficient information was disclosed that would have indicated to agencies that coercive and controlling behaviour was taking place.

6.7 The couple argued on a regular basis and Adult A would often 'throw' Adult B out of the home address. On these occasions, he would sleep rough in his car, the shed, and the woods near the house or occasionally in a neighbour's house. It was difficult to verify how many times the couple separated, and it would appear that Adult B would always return to Adult A within a few days of leaving.

6.8 The impact of domestic abuse on the family was however far reaching. Although the children appeared to have been well cared for, they had been exposed to, and affected by, domestic abuse at a number of stages in their lives.

6.9 There were many factors that had an impact on the relationship between Adult A and Adult B. These included Adult A's health, coercive and controlling behaviour, gambling and both of them would use drugs and alcohol.

6.10 In 2009 Adult A had an operation which was unsuccessful and as a result she suffered complications which apparently had left her in pain which she experienced on a daily basis. This pain would often leave her bed ridden and reliant upon Adult B to carry out all household chores and child care. This later became a dominating factor in their relationship.

6.11 Adult A was a regular user of health services and in particular inpatient and outpatient services, and her GP. Adult A attended (consultations) or had contact (letters etc.) with GP services three hundred and ninety-six times over the period specified in the terms of reference. Records indicate that there were numerous presentations for such issues as anxiety, depression, insomnia and general pain. She was prescribed numerous drugs to assist with her pain management and later became addicted to them. There were periods

in Adult A's life where her mental health deteriorated to such an extent that she had attempted suicide. Adult A had become increasingly reliant on prescription medication.

6.12 Adult A failed to attend many of her health appointments and as a consequence it was extremely difficult for professionals to diagnose the true extent of her medical problems. Every time that they came close to identifying the issues that were affecting her she would disengage.

6.13 Whilst Adult A may have presented to all agencies with complex needs any opportunity to diagnose an underlying cause was frustrated by her repeatedly failing to engage with services at critical points in her life. Despite repeated attempts to re-engage with her she would often decline this help, lie about the level of support that she was receiving and even attempt to divert professionals away from the issues that she was struggling with.

6.14 Both Adult A and Adult B would drink alcohol on a daily basis and Adult B had become dependent upon it. The review was unable to determine the true impact of alcohol on the couple's relationship.

6.15 The couple struggled to manage their finances effectively, and this was confirmed by Adult B and a close friend. There were frequent arguments about money between the two, and Adult A was described by those that knew her as being very money orientated. Adult A controlled the finances within the household and Adult B was almost entirely reliant upon her for money. Adult A also frequently gambled on the internet.

6.16 Whilst Adult B had allegedly exhibited elements of controlling behaviour it would appear from the information provided by the family of Adult A, Adult B himself, and a close friend of the couple, that Adult A exerted the greater control and dominance in the relationship. The components of coercive control exhibited by Adult A included unpredictable mood swings, excessive possessiveness, isolation (preventing partner from seeing family or friends) and control of her husband's money.

6.17 The controlling behaviour exhibited in this relationship was not recognised as abuse by those close to the couple. The review was unable to ascertain whether Adult A's complex needs were a contributing factor to her controlling behaviour.

6.18 Although Adult B had been dealt with by a number of agencies it would appear that none of them had considered that he may have been a victim. Likewise, no one had considered whether Adult A could have been a perpetrator in some of the incidents reported to agencies.

6.19 From the records held and from the information provided by those that participated in the review there is nothing to indicate that Adult A had become more vulnerable as a consequence of her relationship with Adult B, or that the vulnerabilities that had been identified had prevented her from accessing services. There is also no indication that she had become more vulnerable in the weeks leading up to the fatal incident.

7.0 Key issues arising from the Review

7.1 The review identified a number of areas where policy and operational practice could be improved and these have been addressed in the recommendations that have been made. These changes will enhance current operational delivery and ensure that victims and their families receive the highest standards of care and support.

7.2 In this case there were identified issues relating to coercive control and the need for professionals dealing with domestic abuse to keep an open mind-set when dealing with victims and perpetrators. Due to the presentation of Adult A, and the information that was provided by her to professionals, Adult B was always treated as the perpetrator. There was

no evidence found as part of the review that professionals exhibited gender bias, but the case reinforced the need to establish the true facts at every incident.

7.3 The Review also highlighted the need to increase the awareness of family, friends and victims of cohersive and controlling behaviour (either male or female) in relation to domestic abuse and the services that are available to them in the City.

7.4 In this case, it would appear that the family were not considered holistically by specific services, particularly the children in view of the fact that both parents had specific health and welfare needs.

7.5 Adult A habitually failed to attend appointments which made it difficult to assess risk and adequately address her welfare needs. All agencies therefore need to have clear policy and practice in relation to those who are deemed at risk or vulnerable who do not attend appointments to ensure that there is adequate follow up.

7.6 One of the outcomes of the review has been a recognition of the importance of supervisory oversight, and the need for comprehensive recording of detail within records, particularly the DASH. Such detail enables agencies to make an informed view of the risk and assists in identifying the level of support services that are required.

7.7 When considering whether the relationship was abusive the review panel identified that whilst there is sufficient support for victims of abuse in Plymouth there are no programmes available for perpetrators or those that exhibit coercive and controlling behaviour. Intervention at an early stage in a relationship could assist in the recognition and management of risk.

7.8 In this case a formal care plan, held within the GP notes, would have been beneficial to give clear direction and agreement about interventions, and may have been helpful in ensuring consistency of approach across the clinical team in primary care, particularly where the patients consult with a number of different GP's.

7.9 In order to enhance safeguarding within Adult A's GP Practice there was a requirement to introduce a formal notification system to ensure that the safeguarding lead is informed of all patients that have attempted suicide or who present with an ongoing risk.

7.10 In respect of information sharing between agencies PDAS raised an issue relating to the Police and the recording of perpetrator details. In this case the practice didn't prevent any action from being taken or have an adverse effect on any outcome for those involved but does however hinder PDAS's ability to carry out effective risk assessments for its professionals and for the victims.

7.11 National Health Service England identified in their IMR that enhanced electronic communication between and across agencies would be beneficial where patients with chronic pain are addicted to medications. This would enable timely and consistent approaches from all professionals involved including staff working in out of hours units and Accident and Emergency.

7.12 Whilst there was clear evidence of the implementation of training strategies across all agencies the review identified the continued need to refresh staff in relation to domestic abuse, and for this to include issues such as the impact of family breakdown. In relation to drugs training programmes there was also a need to include information relating to addiction to prescribed medication.

8.0 Conclusions

8.1 From the information that was gathered as part of this review it is clear that whilst Adult A and Adult B loved each other their relationship was complicated by issues of alcohol and drug misuse, gambling, mental health and the challenges faced by Adult A in respect to the post-operative pain that she suffered from on a daily basis.

8.2 The information gathered from agencies, family and friends would tend to indicate that there may have been elements of controlling behaviour exhibited by both Adult A and Adult B. On the balance of probabilities however it is clear that Adult A did exert the greater degree of control in the relationship. The Review did not identify any direct evidence of physical abuse in the relationship.

8.3 There was insufficient information available to agencies or to those professionals that came into contact with Adult A or Adult B to identify specific patterns of abusive behaviour in their relationship. There was also insufficient information available to suggest that Adult B posed any specific risk to Adult A on the days prior to her death.

8.4 Had Adult B posed any risk then there has been nothing identified to suggest that Adult A was prevented from reporting the matter. Adult A was fully aware of and had been exposed to the support services that were available in the City.

8.5 In this case it would be challenging to find any potential missed opportunities that may have prevented this homicide from taking place. From the information presented by agencies operational practices and policy were adhered to in respect of domestic abuse. Incidents were correctly documented and risk assessments completed. These risk assessments were graded correctly on the information that was provided by both individuals at the time of each incident, and referrals were made to the relevant agencies. Support and ongoing referrals were made to specialist support services.

8.6 Overall there was evidence of an empathetic and consistent approach, by agencies in supporting Adult A's welfare needs. What is clear is that Adult A was unwilling to attend or maintain contact with the services that could have provided her with help and assistance. In this case agencies repeatedly tried to re-engage with her, even when she failed to attend appointments, but their efforts went unrewarded. Adult A was an individual with a complex set of needs and without that engagement it was difficult to diagnose any underlying cause of the problems that she faced.

8.7 It is apparent that all agencies in the City continue to strive towards the delivery of comprehensive services for those suffering domestic abuse. The report has however identified a number of areas where improvements could be made to enhance service delivery and these are reflected in the recommendations.

8.8 From the detail recorded in the IMR's and through the collective assessment of the panel it has been identified that there would appear to be good understanding of domestic abuse amongst the professionals involved with the couple and their family. There would also appear to be a good understanding of safeguarding by all agencies in the Plymouth area. Current policy and practice would also appear to be robust and fit for purpose.

8.9 From the scrutiny of agency records and from the input from family and friends, nothing has come to light within the review to suggest the outcome in this case could have been predicted or prevented by the actions of the professionals that had contact with the couple.

9.0 Lessons Learned

9.1 Lessons learned are detailed at Appendix B.

10.0 Recommendations

10.1 Recommendations are detailed at Appendix C.

Appendix A – Terms of Reference

The following terms of reference were set by the DHR panel;

1. *To provide an overview report that articulates the victim's life through her eyes, her children and those around them including professionals.*

2. *Establish the sequence of agency contact with Adult A, the perpetrator and the members of their household (between the dates of 1st January 1996 and 9th October 2016) and constructively review the actions of those agencies or individuals involved.*

3. *Provide an assessment of whether the death of Adult A was an isolated incident or whether there were any warning signs that would indicate that there was any previous history of abusive behaviour towards the deceased and whether this was known to any agencies*

4. *Seek to establish whether Adult A or the perpetrator were exposed to domestic abuse prior to adulthood and impact that they may have had on the individuals concerned.*

5. *Establish whether family or friends want to participate in the review and meet the Review Panel.*

6. *Provide an assessment of whether family, friends, neighbours, key workers or colleagues (including employers) were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons); This assessment to include details of whether any disclosures were made by Adult A at her place of work.*

7. *Review of any barriers experienced by the victim/family/friends/colleagues in reporting any abuse or concerns in Plymouth or elsewhere, including whether they knew how to report domestic abuse.*

8. *Assess whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the household;*

9. *Establish whether improvements in any of the following have led to a different outcome for Adult A considering:*

   (a) Communication and information-sharing between services.
   (b) Communication within services.
   (c) Communication to the general public and non-specialist services in Plymouth about the role services available to victims and perpetrators of domestic abuse.

10. *Evaluate the effectiveness of training or awareness raising in agencies to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.*

11. *Establish whether the work undertaken by services in this case is consistent with each organisation's:*

    (a) Internal policy and professional practices.
    (b) Domestic Abuse policy, procedures and protocols.

and identify whether these policies and practices are effective to meet the needs of victims and their families.

12. *Establish whether thresholds for intervention were appropriate and whether they were applied correctly in this case.*

13. *Review any previous concerning conduct or a history of abusive behaviour from the perpetrator and whether this was known to any agencies.*

14. *Consideration of any equality and diversity issues that appear pertinent to the Adult A the perpetrator or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.*

15. *To review any other information that is found to be relevant.*

16. *The Review excludes consideration of how Adult A died or who was culpable.*

Appendix B - Lessons Learned

This part of the report will summarise the lessons which have been drawn from the case and how those lessons are to be translated into recommendations for action.

The learning opportunities identified in this case are listed by number and these correspond with the recommendations in the following section. The first seven learning opportunities relate to those lessons that apply to all agencies whilst the remainder were identified by individual agencies in their IMR's.

- **Learning Opportunity 1 (xref: Recommendation 1).**

  Whilst there was no evidence that professionals exhibited gender bias this case reinforces the need to ensure that professionals dealing with domestic abuse keep an open mind-set. Professionals therefore need to be trained and competent to be able to identify typologies of abuse that include female perpetrators and male victims. Local training courses should therefore include content and case studies on different types of abuse.

- **Learning Opportunity 2 (xref: Recommendation 1)**

  In this particular case, the family were not considered holistically by specific services, particularly the children. Safeguarding and domestic abuse training should therefore include consideration of the impact on any dependent children and young adults living in the household.

- **Learning Opportunity 3 (xref: Recommendation 2)**

  Agencies should ensure that their policy and procedures address the needs of both female and male victims.

- **Learning Opportunity 4 (xref: Recommendation 3)**

  This case highlighted that those close to the couple didn't identify the behaviour exhibited in the relationship as a form of abuse. It would therefore appear that an awareness campaign is required in the City regarding abuse that involves male victims.

- **Learning Opportunity 5 (xref: Recommendation 3)**

  In hindsight Adult B considered that he may have been subjected to coercive and controlling behaviour. He acknowledged that he didn't see this at the time whilst in the relationship and that he would not have known where to seek help and support. On reflection whilst there are services available in the City for male victims these have not been publicised.

- **Learning Opportunity 6 (xref: Recommendation 4)**

  The review highlighted that whilst there is sufficient support for victims of abuse in the City there are no programmes available for perpetrators or those that exhibit coercive and controlling behaviour. Intervention at an early stage in a relationship could assist in the management of risk and prevent the escalation of violence.

- **Learning Opportunity 7 (xref: Recommendation 5)**

  In this case Adult A habitually failed to attend appointments which made it difficult to assess risk and address her needs. Agencies therefore need to have clear policy and practice in relation to those who are deemed at risk or vulnerable who do not attend appointments.

- **Learning Opportunity 8 (xref: Recommendation 6)**

  Adult A's addiction to prescribed drugs had a profound effect on her life. The effect of prescribed addictive or stimulant substances and their effect on adults should be included in existing drug abuse training.

- **Learning Opportunity 9 (xref: Recommendation 7)**

  The examination of the GP's notes of the children of victims should be routinely considered as part of any multi-agency review, as this will provide a holistic overview of the issues faced within those families with complex needs.

Single Agency Learning

- **Learning Opportunity 10 (xref: Recommendation 8).**

  Devon and Cornwall Police identified that the DASH risk assessments completed in this case were variable in the standard of detail that was recorded e.g. single line entries such as 'violence' with no reasoning or the details of why a DASH was refused was not recorded. Professionals need to ensure that DASH risk assessments contain comprehensive details to ensure that supervisors and external agencies can offer an informed view of the actions that are required in the case. Current policy is that supervisors review the completed assessment but there is no requirement on them to comment unless they wish to raise a concern that the risk may be higher than indicated. This makes the process weak.

- **Learning Opportunity 11 (xref: Recommendation 9)**

  PDAS identified that they were unable to confirm whether Adult B was the perpetrator mentioned by Adult A on the 20.04. 2015. PDAS identified this as an issue that affects operational practice on a daily basis and makes risk assessment difficult.

- **Learning Opportunity 12 (Not subject of a recommendation)**

  At the time of this incident the policy and practice within PDAS, with regards to those appointments where victims 'did not attend', was inflexible with regards to follow up action.

  The Service has since amended its procedure with regards to file closure for victims who have failed to attend appointments, or whom PDAS have been unable to contact. This practice now ensures that PDAS works with agencies to enhance the chances of clients engaging with the service. Where a client fails to attend further attempts are made to engage with them and if unsuccessful then other relevant agencies are contacted. This learning opportunity has therefore not been made a recommendation.

- **Learning Opportunity 13 (Not subject of a recommendation)**

  As part of the Review PDAS identified that the procedures for file monitoring and closure could be more robust within their service.

  The service now ensures that all files for closure are reviewed by a manager and signed off prior to closure thus improving supervisory oversight and support for frontline staff. This learning opportunity has therefore not been made a recommendation.

- **Learning Opportunity 14 (xref: Recommendation 10)**

  This case highlighted that where Housing Officers identify or receive reports that there is domestic abuse in a relationship then best practice would be to discuss such cases with Neighbourhood Police teams.

- **Learning Opportunity 15 (xref: Recommendation 11)**

  Plymouth Community Homes identified that whilst staff have all been trained in relation to domestic abuse refresher training is being considered in the future. The importance of continuing professional development cannot be over emphasised.

- **Learning Opportunity 16 (xref: Recommendation 12)**

  The GP Practice in this case didn't have a formal notification system to ensure that the safeguarding lead was notified of all patients that have attempted suicide or who had presented with an ongoing risk such as Adult A. This omission makes it difficult to ensure that services are effectively co-ordinated to meet individual needs.

- **Learning Opportunity 17 (xref: Recommendation 13,17)**

  Record keeping and information management processes relating to the care of any adult at risk with complex needs should be comprehensively recorded and linked to the patient's electronic notes. This information needs to be flagged to ensure that there is a holistic approach to caring for all family members, and that professionals are aware of all of the facts.

- **Learning Opportunity 18 (xref: Recommendation 14)**

  The Health IMR highlighted the significance of professionals having knowledge and understanding about the impact of domestic abuse and family breakdown on children and young people, and the potential implication on their mental health needs both as children and potentially as adults.

- **Learning Opportunity 19 (xref: Recommendation 15)**

  GP records indicate that that there was no evidence of a complex care meeting to consider the needs of the whole family (including Adult A's children) in view of her medical needs and her medication use. This could have included the impact on Adult B as the main carer and identified any associated risks. A complex care meeting would have provided a holistic overview of the needs of the family.

- **Learning Opportunity 20 (xref: Recommendation 16)**

  There is a need to jointly consider the needs of patients (including the impact on their family), when GP/pain clinics are wishing to reduce morphine administration or any other addictive drug for a vulnerable individual such as Adult A.

- **Learning Opportunity 21 (xref: Recommendation 18)**

  The review of GP practice identified that there was a training requirement in relation to reminding staff of the thresholds for referral/monitoring within families where both adults have their own particular issues and mounting stress is evident.

- **Learning Opportunity 22 (xref: Recommendation 18)**

  In order to have confidence when dealing with complex cases staff working within the GP practice, used by Adult A, need to be trained in child safeguarding and domestic abuse. Such training would enable staff to identify risks and promote effective safeguarding both within the practice and when dealing externally with partner agencies.

Appendix C - Recommendations from the Review

The DHR panel therefore offers the following overarching recommendations for local action:

- Recommendation 1.

  All agencies should review the content of current domestic abuse training plans to ensure that they are;
  - include content relating to both female and male victimisation.
  - includes case studies on different types of abuse including female perpetrators and male victims.
  - includes consideration of the impact on any dependent children and young adults living in the household.
  - and for those agencies whose staff complete DASH forms emphasise the importance of including comprehensive details within the document.

- Recommendation 2.

  Domestic abuse policy and procedures should by reviewed by each of the agencies involved in this review to ensure that they are inclusive of the needs of both female and male victims[1].

- Recommendation 3.

  Safer Plymouth to implement a communications strategy to increase third party and male victim reporting in relation to domestic abuse. In relation to the latter, the strategy should also identify the services available to male victims in the City.

- Recommendation 4.

  Safer Plymouth should review the viability of commissioning a perpetrator programme in the City.

- Recommendation 5.

  All agencies within the Safer Plymouth area should have a clear DNA (did not attend) policy, accessible to all relevant staff. The policy should clearly indicate which professional/service/agency is responsible for follow up, when DNA's occur, and should demonstrate closure of the 'follow up loop'.

- Recommendation 6.

  Drug abuse training programmes being delivered in Plymouth should reviewed to ensure that they include effects of prescribed addictive or stimulant substances.

[1] *Devon and Cornwall Police have reviewed all policy and procedures and these address the needs of female and male victims..*

- Recommendation 7.

  All multi agency reviews being conducted in the City in relation to domestic abuse should routinely consider the examination of the GP notes of the victim's children as part of the process. Where the notes are not reviewed then the rationale for this should be documented.

Single Agency Recommendations

Some of the issues raised in the IMRs that have been analysed and commented upon in the overview report. These recommendations have been detailed within each of the Agencies IMR's and are as follows;

- Recommendation 8.

  Devon and Cornwall Police should review its current DASH practices and introduce a quality assurance audit in respect of the content of DASH forms.

- Recommendation 9.

  Devon and Cornwall Police to review existing practice regarding the disclosure of details on the non-crime low and medium risk perpetrators that are recorded as part of the DASH process.

- Recommendation 10.

  Housing providers in the Plymouth should review and amend policy and practice to ensure that their officers discuss all cases where domestic incidents are identified or reported with the police. This change in policy should be clearly communicated to all staff.

- Recommendation 11.

  Plymouth Community Homes to undertake a training needs analysis to ensure that its staff receive refresher training in respect of domestic abuse.

- Recommendation 12.

  The GP practice involved in this review should ensure there is a formal system in place which requires the safeguarding lead to be informed of patients within their practice, who have attempted suicide/present with an ongoing serious suicidal risk.

- Recommendation 13.

  Detailed conversations/meetings relating to the care of any adult at risk of abuse and neglect with complex needs in GP practices should be recorded /linked to the patient's electronic notes. This information should be "flagged" for practitioners, within the same Practice, caring for other family members.

- Recommendation 14.

  Any children and young people, currently registered with GP practices, who are exposed to domestic violence or subject to care orders, should be identified and flagged within the electronic records. Any appropriate support should be identified, and referrals made.

- Recommendation 15.

  Any adults at risk of abuse and neglect (previously known as vulnerable adults) within GP practices should be the subject of complex care meetings, where their needs and those of their children /family are considered.
  All meetings should be minuted. Date of meeting should be recorded in patients GP record and copy of minutes attached to notes electronically.

- Recommendation 16.

  There should be a clear multi-professional strategy for complex patients who demonstrate a dependency/addiction to prescribed pain relieving medication.

  The policy should include a formal requirement for:

  - joint case planning (when individuals are supported by a number of differing services at the same time).
  - Clarity about joint objectives and agreement around interventions.
  - A joint care plan format/template.

- Recommendation 17.

  Recording in GP records should consistently include:
  - Date & time of consultation.
  - Nature of consultation. i.e.: Telephone, face to face, home visit.
  - Record of formal Care Plans and agreed interventions, where required.

- Recommendation 18.

  All staff within the GP practice should receive updated training with regards to Child Safeguarding and Domestic Abuse.