Bristol Community Safety Partnership

Domestic Homicide Review

Overview Report

8th January 2018

Victim, Adult Female, Maggie Johnson (pseudonym)

Author, and Independent DHR Chair,
Ian Kennedy BA (Hons)

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Appendices

1. Introduction

1.1. This review is into the death of Maggie Johnson who died in August, 2016, in Bristol. Following a police investigation by Avon and Somerset police a Coroner's Inquest concluded that she killed herself.

1.2. Maggie was a woman in her 40's who had struggled with alcohol and drug misuse for some years. She had a history of being a victim of domestic violence from a number of partners but most recently from her partner at the time of her death, Jim Trainor (pseudonym). She had confided to professionals that as well as being a victim of domestic abuse she was also a perpetrator of violence towards her partner. Prior to her death, she had spent a number of years sleeping rough, or in tents and temporary supported accommodation, mostly in or around her home town of Bournemouth.

1.3. Agencies first became aware of her death when police and ambulance were called to a tent on rough land in Bristol. She had what proved to be a self-inflicted knife wounds to her neck, one of which had fatally pierced her jugular vein.

2. Circumstances leading to the review

2.1. On the afternoon of Maggie's death, police were contacted by a relative of Jim Trainor's after he came to her house to say he had just found Maggie dead in the tent in which they had been living together for several weeks in Bristol. There are unconfirmed reports that they had moved from Bournemouth due to trouble arising from an unresolved drugs debt. Both Maggie and Jim had a history of drug and alcohol misuse going back a number of years.

2.2. On the afternoon of her death, Jim told police he had been with Maggie at the tent when she sent him to obtain some illicit drugs for their use. He had returned instead with alcohol. Angered by this, Maggie sent him away again to buy drugs, threatening to kill herself with a craft knife if he would not. She had held it to her own throat. When Jim returned some time later he found Maggie lifeless in a pool of

blood in the tent. She had a number of wounds to the side of her neck. Paramedics attended but were unable to save her life.

2.3. The police arrested Jim Trainor initially on suspicion of murder. In interview, he outlined the circumstances above and also punching Maggie in the face in frustration earlier in the afternoon when she was annoyed with him about the lack of drugs. A subsequent post mortem identified that the wounds to Maggie's neck, one of which had cut her jugular vein, were self-inflicted. Jim Trainor was released without charge. A forensic examination of the craft knife identified Maggie's fingerprint in blood on the blade.

2.4. In view of the above, this review will focus on the agency involvement with Maggie, and her relationship with Jim Trainor, which started in 2009. The vast majority of this agency service provision was in Bournemouth, as the pair had only moved to Bristol in recent weeks. Maggie and her partner paid two visits to the Needle Exchange in the week after they arrived in Bristol. Other than that, the only agency involvement with them in Bristol, was when the police and ambulance service attended to the report of Maggie's death.

3. Decision to undertake a review

3.1. Maggie Johnson did not die as a result of homicide, she died as a result of her own actions. However, her death does fall within the broader parameters for the requirement for a Domestic Homicide Review (DHR), given she killed herself and also had a recent, and longer standing, history of being the subject of domestic abuse and recipient of agency intervention. This is as set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016).

3.2. The circumstances were reported to the Bristol Community Safety Partnership for their meeting on the 30th September 2016. They agreed that Maggie's death did meet the criteria, so a DHR would be carried out and they informed the Home Office of that decision. As initial scoping took place it became clear that virtually all agency involvement had been in Bournemouth due to Maggie and her partner living there for many years and only very recently having moved to Bristol. Liaison took place with

Bournemouth Community Safety Partnership (CSP), and protocols were agreed around assistance with, and signing off, of the review and this overview report.

3.3. The Independent Chair and author of this report, Ian Kennedy, an independent practitioner who has Chaired a number of Domestic Homicide Reviews, was appointed to lead the review. He is a former senior police officer who amongst other things prior to his retirement in 2012 led major crime investigations into unlawful or unexplained deaths, and incidents of child and domestic abuse. He has never been employed by, or worked with, any of the agencies involved in this DHR and was considered to have the necessary skills and experience for the role.

3.4. To ensure the most effective interaction with Bournemouth based statutory and voluntary agencies, all DHR meetings were held in Bournemouth and this report will be presented to the CSP there prior to being presented to the Bristol CSP for consideration of agreement and onward transmission to the Home Office.

3.5. The panel comprised of-

Helen Holland, Policy and Service Development Officer, Bournemouth Borough Council- Adult Social Care

Siân Jenkins, Community Safety Partnership Officer, Bournemouth Borough Council.

Michelle Hopkins, Deputy Director (Safety, Improvement and Effectiveness), Dorset Healthcare NHS University Foundation Trust.

Donna Martin, Housing Support and Wellbeing Manager, BCHA.

Sarah Webb, Joint Service Manager, Statutory Services, Adult Social Care, Bournemouth Borough Council

Pam O'Shea, Head of Quality Improvement, NHS Dorset CCG on behalf of GP Services

Debbie Bilton, named Professional Safeguarding, South Western Ambulance Service.

Tracey Kybert, Housing Manager, Bournemouth Borough Council Strategic Housing Options.

Sarah Sanford, Contracts Officer, Bournemouth Drugs and Alcohol Commissioning Team (DACT), Bournemouth Borough Council.

Karen Wood, Senior Commissioner, Bournemouth Drugs and Alcohol Commissioning Team (DACT), Bournemouth Borough Council.

Stuart Balmer, Dorset Police Review Officer.

The Terms of Reference can be found at Appendix A.

4. Context and Purpose of this Overview Report

4.1. The purpose of any DHR is to examine agency responses and support given to a victim of domestic abuse prior to their death. Lessons learnt, and a full understanding of what happened, can inform changes to practices and policies to improve services to others and help reduce the number of avoidable similar deaths.

4.2. This report will have a number of potential audiences and readers, including agency managers and staff, the Home Office, press and media, the general public, academics, people involved, plus friends and family of the deceased. It must meet all their needs, so it is written in a style that will be accessible and informative to all parties in order to achieve its aim, inform decision making and ensure transparency. Whilst some anonymisation must take place to properly protect some individuals' confidentiality, it has been kept as open and direct as possible. Care will be taken to explain agency specific terms whenever possible. A glossary of terms will also appear at Appendix B for easy reference.

5. Agencies involved in the review and Independent Chair

5.1. The agencies who were invited to be part of the Review Panel and to complete Independent Management Reviews (IMR's) had, or may have had, an involvement with Maggie in the years prior to her death. These reviews are carried out by a senior manager or other nominated independent person, not involved with the direct delivery of service to the person whose death triggered the DHR.

5.2. In smaller agencies where it is not possible to identify such an independent manager or person, arrangements are usually in place for someone from another associated group to conduct the IMR on their behalf. For example, in a GP's surgery every doctor may have seen the person at some point so an independent person from the local Clinical Commissioning Group may carry out the review for them.

Agencies involved in this DHR as members of the Review Panel/creating IMR's were-

Avon and Somerset Police

Avon and Wiltshire Partnership Mental Health NHS Trust

Bournemouth Borough Council- Adult Social Care Teams: Social Work Bournemouth Assessment Team(SWBAT) now Drug and Alcohol Statutory Services Team, Statutory Services Team, Policy and Service Development Team

Bournemouth Borough Council Community Safety Partnership

Bournemouth Borough Council Strategic Housing Options

BCHA

Bournemouth Drug and Alcohol Commissioning Team (DACT)

Bournemouth and Poole Rough Sleeper Team (invited to take part but declined due to lack of contact by their agency)

Dorset Police

Dorset Healthcare University Foundation Trust

NHS Dorset CCG on behalf of GP Services

South Western Ambulance Service

5.3. Lead professionals from each agency met on a number of occasions at meetings Chaired by Ian Kennedy and work continued between meetings, communicated by secure e-mail to complete the work in a timely and appropriate manner.

6. Involvement with family and associates of Maggie Johnson

6.1. Maggie Johnson had had a challenging life by any standards. She had been brought up by her maternal grandmother, after being adopted by her at an early age. Her mother who was very young when Maggie was born, had been brought up as her sister. In recent years, she was known to services as a result of her chaotic lifestyle and risks deriving from sex work, drug and alcohol use, self-neglect, risk of overdose and domestic abuse.

6.2. She had three children who were adopted when they were very young (in 1995 (aged 3-4years), 2003 and 2008 (both at birth)) and it is not thought she had any further contact with them, apart from some contact with the oldest child who sought

her out when he turned 18. The third child had been removed for reasons including domestic abuse. This was a different partner to the father of the other two children and not her partner at time of her death, which suggests that she was in her life the victim of domestic abuse at the hands of more than one partner.

6.3. She was not believed to have had any contact with her natural family for many years. Consequently, the Independent Chair decided that it was not productive to contact her family for assistance with the DHR as it may actually have been unnecessarily intrusive, especially for the children, who could have nothing to add or may not even have been aware of their mother.

6.4. Jim Trainor was not contacted during the review. As will be seen later in this report there were three well documented incidents of violence by him towards Maggie- assaulting her in the street in May 2010 during a drunken argument, then once by hitting her in the face with a mop handle, in October 2014, and once by punching her in the face, 'in frustration' on the afternoon of her death. There are also well catalogued incidents of what could be controlling and coercive behaviour by him towards Maggie- keeping her drugs, not letting her be on her own, controlling her life. This could also be behaviour to support and protect her, as described by Maggie herself. It is interesting to note that when he was separated from her due to bail conditions and not able to look after her drugs for her, she suffered a drugs overdose and was hospitalised. There are no recorded incidents of violence towards Maggie after the 'mop handle assault' in 2014 until the punch on the day of her death.

6.5. There is clear guidance in the HO Guidance that approaches should be made to the 'perpetrator' in cases of Domestic Homicide Reviews. However, it is unclear if this is the perpetrator of the homicide or of previous domestic abuse. Maggie died at her own hands. She was the perpetrator of her own death. This has caused some confusion and whilst the Data Protection Act allows for disclosure between agencies to 'prevent crime', there were concerns raised by one agency about the release of information identifying a new address for Jim Trainor to the Chair. The Chair in the conclusions of this report will seek clearer guidance from the Home Office on the legality of accessing personal data of a current or previous partner in DHR's

involving suicide rather than homicide. Normally with homicides it is public knowledge where the perpetrator is. It is not always clear from open source material, in cases of suicide, where former partners may be living.

7. Background to the death.

7.1. Maggie and Jim Trainor had been in a relationship from 2009. Between then and Maggie's death in 2016 they had regular contact with various agencies in Bournemouth. This was in relation to their homelessness and periods sleeping rough/ in tents/ in supported accommodation, their drugs and alcohol misuse, Maggie's health issues, and incidents in public when they used violence towards each other or other people.

7.2. Their engagement with agencies was sporadic and was of varying quality. Agencies had to regularly pro-actively seek them out to maintain contact and try to get them to engage with services such as detoxification which would have been in their best interest. Maggie had, on a number of occasions, sought detoxification help from the agencies. On one occasion, she was admitted for residential detoxification but this was not completed due to her being suspected of taking drugs after a visit by Jim, and she was discharged. She never did complete a full programme and often would find other reasons why she could not attend, for example needing care for her dog, from which she was inseparable, whilst she was in residential care. It was unclear whether this was a reason to put off the treatment or a genuine blocker for her. Her dog was very important to her so it did need to be part of any plan for the treatment.

7.3. Between 2009 and 2016, Maggie had confided in some agencies that there was violence between her and Jim Trainor, and she was both victim and perpetrator of that. On other occasions, she would play down or deny any suggestion of violence. A number of multi-agency meetings would be held to discuss the circumstances and how to safeguard Maggie but it is clear these were often overshadowed by the very real concerns for Maggie's health from self-neglect, as well as the drugs and alcohol use. Her multiple complex needs made it difficult for any agency to address individual issues with her.

7.4. Any planned action from the meetings was stymied by her apparent reluctance or inability to commit, and commonly her determination to persist in her relationship with Jim Trainor, which Maggie described as being mutually supportive. It is of note that, despite Maggie identifying that violence was mutual between her and her partner, she was invariably dealt with/referred to by agencies as 'victim' and Jim as 'perpetrator', which suggests a gender bias exists in how domestic abuse was viewed by those professionals and was at play in how they were each treated.

7.5. The minutes of the multi-agency meetings were reviewed to establish their effectiveness in addressing Maggie's complex needs. The first meeting on 28th February 2014, raises some issues about the effectiveness of this meeting regime. It was attended by the main agencies but apologies were received from her GP, Housing and Independent Domestic Violence Advisor (IDVA). Clear and robust actions were set in relation to safeguarding Maggie and her health with a clear action plan and accountability.

7.6. However, it is unclear from the minutes of the subsequent review meeting if the actions were all completed, highlighting either a shortcoming in service delivery or proper record keeping of it. The absence of key individuals from the meeting also raises the issue of how well informed the decision making could be.

7.7. In October 2014, Jim Trainor was arrested after Maggie complained to police that he had hit her in the face with a mop handle after they had a verbal argument in St Paul's, where they were staying, a hostel providing short term supported accommodation for the homeless. He was arrested, put under an order to keep away from her and banned from the supported accommodation. She subsequently withdrew cooperation with the prosecution and left the supported accommodation to be with him. Engagement with them both in 2015 was sporadic and Maggie spent long periods out of contact with the agencies that were trying to help her.

7.8. Maggie moved to Bristol with Jim Trainor in late July 2016. There are suggestions that this was due to difficulties arising from a drugs debt with a dealer in

Bournemouth. After sleeping in a relative's garden shed for one or two days, they camped in three tents, with her dog, on rough land near Bristol city centre.

8. Circumstances of Maggie Johnson's death

8.1. A couple of weeks after their arrival in Bristol, in early August, police and ambulance were contacted after Jim Trainor found Maggie in their tent with the cuts to her throat. Ambulance staff attending were unable to save her life. Jim Trainor was arrested to allow enquiries into the death, and in interview told police that earlier in the day Maggie had sent him to buy drugs for their use. He had returned with alcohol instead which had caused an argument between them, during which, as he described it, "out of frustration" he punched her, strongly, once in the face. She went on to produce a craft knife that she kept with her and threatened to cut her own throat if he did not go to buy the drugs. He returned some time later in the afternoon to find her bleeding from cuts to her throat and unconscious. He summoned help but it was too late.

8.2. A post mortem later showed that the cuts to Maggie's neck were consistent with being self-inflicted and one had cut her jugular vein. A finger print in blood on the knife was identified as hers. Jim Trainor was released without charge. The Assistant HM Coroner for the Area of Avon, Mr Moore, later concluded at Inquest that Maggie had died as a result of suicide.

9. Review of agency involvement

9.1. Each of the agencies represented on the DHR Panel prepared Independent Management Reviews (IMRs) of their involvement with Maggie. The focus was on the period from the start of her relationship with Jim Trainor in 2009 as this was her last close relationship and it was known to have included domestic abuse. It was also left open for IMR authors to look further back in to their records for any information that may be relevant outside that period. It is of note that there were records of Maggie being the victim of two previous abusive relationships prior to 2009.

9.2. The findings of each agency and lessons learnt are summarised in the following paragraphs.

9.3. Police

9.3.1. Avon and Somerset Constabulary. Following Maggie's death in Bristol, the police locally carried out a full investigation into the circumstances and reported to HM Coroner to ensure the inquest was properly informed. They had no other involvement with Maggie or her partner since they arrived in Bristol so there are no lessons to be learnt from reviewing their activity. Unless someone seeks assistance from, or comes to the adverse notice of, the police they cannot be expected to track and then safeguard all people passing through their area.

9.3.2. Dorset Police. Given Maggie's chaotic lifestyle, drugs and alcohol use and minor offending it is natural that she had a significant amount of interaction with the police in her home town of Bournemouth. The first police involvement with Maggie and her partner Jim Trainor, as a couple, other than routine stops in the street, had been in May 2010 when it was reported that he had been hitting her following a drunken argument in public. No complaint was made but a Domestic Abuse, Stalking and Harassment (DASH) risk assessment was carried out and recorded on the relevant document. This incident is important as it shows violence in the relationship, and towards Maggie; information which should have been available to all officers dealing with her subsequently.

9.3.3. Police attended a very similar incident in January 2012 involving Maggie and Jim Trainor. Again, DASH forms were completed. On both occasions the DASH forms were uploaded to police systems and would be accessible to any police officer or staff member dealing with Maggie. There was no record of these having been shared with other agencies. This was in keeping with the standards at the time, due to no children being involved and the risk level recorded. Current practice would be that such information about Maggie would be shared across agencies. This is seen as an improvement in processes to assist with safeguarding.

9.3.4. The police were also party to information sharing between other agencies that were supporting Maggie. A number of formal meetings had been called to which the

police were invited and they were of course party to the information from all their dealings with her. The formal meetings included a MARAC referral leading to a Vulnerable Adult Conference in February 2012. MARAC stands for multi-agency risk assessment conference, which will be attended by staff from various agencies, e.g. police, social services, housing, health etc.

9.3.5. Where an individual is assessed as being at great risk due to health or their lifestyle and in need of coordinated support their case can be referred to such a meeting to allow professionals to decide if they can assist and how best to do that. The risks identified for Maggie at this time were risk of harm from her partner, and also her health, stemming from her drug and alcohol abuse and homelessness. Support workers were updated and tasked, though their work was compromised by Maggie's subsequent lack of engagement.

9.3.6. In October 2014 police arrested Jim Trainor after he assaulted Maggie with a broom handle at St Paul's. Again, a vulnerable Adult Conference was held and appropriate action identified but this was frustrated once more by Maggie's lack of engagement and her continuing to be with her partner despite his bail conditions and him being barred from the Hostel. The DASH assessment correctly set the risk to Maggie as being high risk and the Multi-Agency Risk Assessment Conference (MARAC) process that followed shows effective information sharing between agencies.

9.3.7. A full review of Dorset Police's involvement with Maggie was carried out going back to 2009 when she was known by them to have started her relationship with Jim Trainor. It assessed the police response and application of policies particularly in relation to her as a victim of Domestic Abuse. The review period covers a time frame that has seen a great deal of change in the way police record and deal with incidents of DA and contact with vulnerable adults.

9.3.8. During the review period, there were 3 separate incidents involving Maggie and Jim Trainor in Domestic Abuse incidents. Other matters tend to be in relation to their homeless situation or incidents of anti-social behaviour which was usually dealt with by way of dispersal notices.

9.3.9. After the final event in 2014 Jim Trainor was arrested but Maggie would not pursue a complaint. Despite this, the Crown Prosecution Service pursued a victimless prosecution, which only later failed due to Maggie's continued relationship with Jim Trainor in breach of his imposed bail conditions to keep away from her. The matter was referred to a MARAC conference, and there is good evidence of professionals working together in an attempt to try and support Maggie out of the situation in which she found herself.

9.3.10. The review identified that when Maggie, usually in company with her partner, did come to notice there did seem to be a willingness by police and other agencies to try and help her. She did not often seek, or engage with, these efforts to help her. From the various contacts, it is apparent that Maggie was dependant on Jim Trainor and he had an emotional hold over her which was demonstrated at the vulnerable adult conference.

9.3.11. The Reviewing Officer was satisfied that positive action had been taken by the police and incidents were dealt with properly in line with policies in place at the time. These policies did not differentiate between domiciled and homeless persons and were applied consistently to Maggie and Jim Trainor whatever their housing situation was at any point.

9.4. Avon and Wiltshire Partnership Mental Health NHS Trust

9.4.1. This agency conducted a review of their involvement with Maggie from the time when they took over the commission for treatment services from the previous treatment provider in 2013. This involvement was in relation to the prescribed drugs treatment to address her substance misuse. The main focus of the work of the agency was found to be in relation to her medication and some opportunities to enquire in to Maggie's relationship and domestic abuse between her and her partner were missed. The situation was not helped by Maggie being unpredictable in her engagement with the service and there being long periods when she was out of contact with them.

9.4.2. Lessons learnt by them in relation to Domestic Abuse and examples of good practise included-

- Lesson learnt was the lack of enquiry about relationship between Maggie and her partner both of whom were under the service. Usually they were seen at the same time but in separate appointments by the same keyworker. Whilst this may have maximised the chances of seeing both parties as they were always in each other's company, it may inhibit either person from disclosing concerns or talking openly about domestic abuse. There was also an identified lack of recording of team meeting discussions in Maggie's notes. The reviewer would have expected complex and risky patients to be discussed in management meetings and the key discussion points and actions recorded in the case-notes.
- Another lesson learnt was the lack of recording of domestic violence issues in Maggie's partner's notes. It also appears the potential for him to be the victim of domestic violence is overlooked, possibly in keeping with society's perceived bias of under-reporting domestic violence to males. This is significant as being both the victim and perpetrator of domestic violence increases risk.
- Good practice was identified from the treatment team, in their proactive attempts to try and continue engagement with Maggie and her partner despite their chaotic life-style and erratic attendance.
- There were also prescribing practises identified in the early part of the period reviewed that were out of keeping with National Guidelines (UK Clinical Guidelines on Drug Misuse and Maintenance 2015) and were addressed in the period up to Maggie's death. During the period of the review these were seen to be tightened up and are now in line with national guidelines.
- There was evidence of good communication with the pharmacies where Maggie and her partner collected their prescribed drugs in order to maintain a supportive relationship with Maggie.

9.4.3. In the main, it is appropriate to conclude that the service provided by this commissioned body understandably had as its focus drug treatment, though efforts were made to understand the domestic abuse issues and take some safeguarding

action. Improvements in this, by proper record keeping and supervisory review are part of the individual agency action plan.

9.5. Bournemouth and Poole Rough Sleeper Team.

9.5.1. Whilst this team would have known Maggie through their work in the area, a review of their systems showed they had no involvement with her since April 2013, and no information to assist the review.

9.6 Bournemouth Council Adult Social Care Directorate, covering Social Work Bournemouth Assessment Team ((SWBAT), now Drugs and Alcohol Statutory Services Team) and Statutory Services Team, and Children's Social Care.

9.6.1 Maggie had had a significant involvement with Social Services in Bournemouth through much of her childhood and adult life. She was adopted by her maternal grandmother at a young age, and had a disrupted childhood and adolescence. As an adult, she had three children all of whom were adopted at an early age, in 1995, 2003 and 2008, due to Maggie's drug and alcohol use, self-neglect and, with the third child, domestic abuse issues. The children pre-dated her relationship with Jim Trainor. The period under review for this agency's IMR was from May 2012 to June 2015 at which point Maggie no longer took an active part in the service. Lessons identified and good practise identified from the review are:-

9.6.2. Record Keeping and Information Sharing.

- Minutes/notes from meetings were not always attached to case notes and checked – on one occasion an attachment on Maggie's file related to another person entirely. Also, no documents were attached to RAISE, the service software recording system, in relation to the Adult Protection Conference held on 15/5/14.
- Adult Social Care(ASC) and Health case note recording computer systems are not compatible with each other. ASC staff can access both systems and are expected by Commissioners to record on both. This caused a duplication of work for ASC staff and reduced efficiency of service. It also caused Health staff to not have access to records.

- Evidence showed that at times, different teams had different information about Maggie's situation which was not shared. This resulted in gaps in information, and officers making decisions on somewhat less than the full picture. Adult Social Care and Housing were at this time, and still are, part of the same organisation, yet information seems to have been overly protected and kept from workers whose work would have benefitted from having it. Access to information held by ASC should improve for Housing in early 2018, when they will be able to gain read only access to ASC's new case recording system, called Mosaic.

9.6.3. This caused the reviewer to question whether better information sharing protocols/shared recording systems would be an asset to risk reduction and practitioner effectiveness. There is hope that this situation will improve in 2018 with changes to software systems planned to come on-line then. This will allow information to be more available, even on a read only basis, to workers and also for workers in multi-agency settings to share information.

9.6.4. Routes to Detoxification Services. More consideration could have been given to Maggie and her partner's situation regarding detox and treatment at Flaghead In-patient Detox Service. Access to detox proved challenging as Maggie and Jim Trainor did not attend or cancelled appointments, e.g. to complete paperwork and ascertain levels of drug and alcohol use, with the Bournemouth Assessment Team. This is the agreed route to access detoxification within the drug detox system. Also, Maggie did not engage regularly with agencies. On those occasions when she did, she would say she wanted to detox but would insist on having back to back detox in-treatment with her partner so that one of them would be able to look after her dog throughout. That became difficult to arrange due to their challenging circumstances though staff did their best to accommodate it. It is not possible to tell whether this was an excuse for not engaging with detoxification services, or a genuine stumbling block. What is clear is that her dog was her constant companion and very important to Maggie. The requirement for patients to be going through Bournemouth Assessment Team to enter the detoxification treatment was also always going to be a bar to Maggie and perhaps other homeless drug users with a chaotic lifestyle. Detoxification services require patients to have been assessed, prepared for detox and tested before admission.

9.6.5. It became clear to the review that great efforts were made by various professionals in the service to get Maggie, and her partner, into treatment. It did happen once but was cut short when Maggie was suspected of drug taking after a visit by Jim Trainor. She was discharged. The stumbling block of her dog being cared for, did prevent Maggie entering the service on other occasions. Dog care being provided, or the treatment centre allowing dogs on the premises in controlled circumstances, may allow access for users who may not otherwise partake. There is budgetary provision for dog care in circumstances like these and has been for some years, so it may just be that professionals are not aware of what help can be accessed, which itself is a major bar to helping people such as Maggie. The review panel also noted that treatment was based on reducing drug use and it questioned whether a harm reduction model would have been better suited to Maggie to help mitigate the other complexities that were adversely affecting her life. This will be returned to later in this report.

9.6.6 Strategy Meeting Attendance. Evidence shows that there were apologies from some invited parties at each inter-agency strategy meeting. From reading the Bournemouth, Dorset and Poole, Multi-Agency Safeguarding Adults Procedures version 2.7 (April 2017) it is clear that the expectation of a strategy meeting (now called Section 42 Enquiry Planning Meeting) is

- "*To agree a multi-agency plan to undertake an Enquiry into the allegations*
- *To assess the risk to the person who is being harmed and address any immediate needs.*
- *To co-ordinate the sharing and collection of information about the harm or abuse*".

This review determined that clarity could be added to the procedures to ensure that all invited parties provide information and/or a substitute attendee should they be unable to attend. It was not within the remit of the review to determine why people do not attend but it would be useful for the Community Safety Partnership to understand why. Questions that spring to mind in this regard - are meetings held at a time to allow attendance, are the correct people invited, are unnecessary people invited, with shrinking workforces are people just too busy to attend, is technology used to its best effect to allow virtual meetings to take place, rather than everyone

having to waste time travelling to a physical meeting room, etc.? There has to be a clear understanding of the dynamics of this critical area of multi-agency work. There is no point in having well intentioned policies in place if they cannot translate into productive operational activity and risk reduction.

9.6.7. Strategy Meeting Review Procedures

Following a strategy meeting there is a requirement that a review meeting be held. The Bournemouth, Dorset and Poole, Multi-Agency Safeguarding Adults Procedures version 2.7 clearly states the expectations of the review meeting are:

- *"To ensure risks are managed effectively*
- *Ensure progress is made against actions*
- *Identify any further actions required*
- *Record the actions decided*
- *Keep the individual informed of any progress".*

9.6.8. The evidence is not clear, in the review meeting minutes examined throughout this IMR, that these expectations were met. A mandatory action review mechanism in the review minutes would be useful in future notes to identify why actions were not completed and how this can be rectified.

Closure Summary.

Information recorded in closure summaries was helpful in setting the scene for the next referral and summarising what occurred within this specific referral. The authors recommend that a case closure summary should become a mandatory part of case recording.

Multi-Agency Working

- In February 2014, evidence of partnership working within Regency House, by SWBAT and CJIT in arranging an opportunity for Maggie to discuss her housing needs whilst other agencies engaged Jim Trainor, allowed Maggie to speak freely. The authors consider this to be excellent practice.

- Evidence of inter-agency working, appropriate advice/signposting being given to other providers (St Pauls) by Social Worker and knowledge of available services for Maggie.

Understanding Domestic Abuse

- Evidence was found that her social worker took her concerns about Maggie's lack of engagement to supervision and was advised to call a Multi-Agency Strategy Meeting, which she did.
- Evidence of good understanding of the Domestic Violence cycle by Bournemouth Assessment Team.
- Evidence of her social worker attempting to get Maggie to communicate with her and keeping the lines of communication open, despite explicit refusal of social worker support.
- Evidence of good practice – a social worker requesting of AWP that Jim Trainor's pharmacy be changed. This was an attempt to be able to engage with Maggie as an individual to meet her needs as opposed to always one half of a couple. An individual's needs can be missed if they are only ever seen as one half of a couple.
- Good understanding of domestic abuse – the social worker's understanding that Maggie may not be ready, or willing, to separate from her partner but assuring that they will continue to work with Maggie anyway.

Following Policy and Procedure

- Evidence seen for use of protocol for working with adults at risk who do not wish to engage with services.
- Evidence seen of interagency information sharing and following safeguarding protocol.
- Evidence of adherence to confidentiality guidelines as well as making use of shared computer systems.

9.6.10. In general, this review highlighted some very good practice from the workers involved and of those, one or two individuals who put significant extra personal effort into making sure that services communicated and all opportunities were taken to try

to engage and safeguard Maggie despite her own risk-taking and lack of engagement. No action was identified that would have changed the outcome in this case.

9.7. BCHA

9.7.1. BCHA is a Housing and Support provider. Their services include homeless, substance misuse, assertive outreach and floating support. They run St. Paul's in Bournemouth. Prior to 2012 it was a direct access hostel and after 2012 all referrals went through the St. Paul's hub. Since the change, Maggie had two periods of residence there, from September 2012 to February 2013 and July 2014 to March 2016. On both occasions the residency ended with Maggie and her partner successfully moving to independent rented accommodation.

9.7.2. Whilst resident at St Paul's, she was involved in a number of serious incidents, including 6 drug overdoses, 4 anti-social incidents, a hospitalisation through overdose and the already mentioned incident of domestic abuse, when hit by her partner with the mop handle. All risk assessments completed in the period show chronic historic illegal drugs use including heroin, cocaine, crack cocaine and Valium. There were also regular incidents of aggressive or disruptive behaviour towards staff.

9.7.3. Maggie did not regularly engage with staff and was more likely to do so only in crisis situations. Her situation was further aggravated by her severe physical and self-disclosed, but undiagnosed, mental health issues. She did engage positively for a period with a Dedicated Mental Health Practitioner who ran a drop-in service at St Paul's. This service was reviewed after the retirement of the professional involved and has now been replaced by a mental health service for homeless rough sleepers only. It is no longer open to St Paul's residents as a drop-in service, based on a position that they should rather be encouraged to register and seek help from a GP. Whether or not those residents are willing or able to do that is another matter and perhaps a flexible approach would be helpful to include people resident at the Supported Housing Accommodation on a short-term basis, prior to them aligning with a GP service.

9.7.4. The Independent Management Review conducted a full review of contact with Maggie and identified the following lessons learned-

- A greater understanding of Domestic Abuse is required for all staff, especially in understanding what controlling and coercive behaviour may look like.
- There were inconsistencies in risk management assessment and implementation. Training may address this and also how best to deal with victims of Domestic Abuse who are homeless and have multiple vulnerabilities.
- Limited attempts were made to engage with Maggie by the BCHA IDVA after domestic abuse incidents that the staff were aware of. Maggie did not want to engage, or was not able to at that time. The reviewers believe that the circumstances of this case indicate that the aspired for position of any IDVA policy set up by an agency should include a minimum number of three attempts to engage with a victim.
- The reviewers found that an invitation had been received for a multi-agency Vulnerable Adult Conference after the mop handle assault but the IDVA appointed to Maggie had not attended as Maggie was not engaging with the IDVA service. Greater understanding needs to be applied, and attendance should be mandatory to both share and receive information.
- The reviewers believe a positive approach that is trauma informed should be taken to providing support to people such as Maggie, with supportive action plans rather than warnings. This is based around seeing Maggie as a victim.
- Having seen the positive interaction with the Dedicated Mental Health practitioner while the service was open to homeless people, the review highlighted the benefits for such a service at St. Paul's to help those who are homeless, have severe multiple disadvantages and are suffering domestic abuse, living in supported accommodation.
- It was noted that Maggie's partner was re-referred to St Paul's, sometime after being evicted due to the assault of Maggie with a mop handle. The reviewers recommend that such a referral to a housing provider should not be made when the victim continues to live at the accommodation. In addition, that the supported housing service has the right to refuse a referral under this circumstance. This is to ensure professionals do not mistakenly collude with

an ongoing domestic abuse situation and that protection of the victim remains paramount.

- The Independent Chair recognises such circumstances provide a dilemma for providers, to provide accommodation or refuse and initiate homelessness. Which is better in the long term for the most vulnerable of people? Careful consideration of the conflicting complexities and management of the risk seem the appropriate path. That seems to be what happened in this case, though in the end it was to be short lived as other issues in their lives forced Maggie and Jim Trainor to move to another town and return to living in a tent on rough land.

9.8. Bournemouth Drug and Alcohol Commissioning Team (DACT)

9.8.1. Due to commissioning processes, a number of organisations involved with Maggie, including the Bournemouth Assessment team, could not contribute to the DHR as they were no longer based in Bournemouth or commissioned by Bournemouth Borough Council, but the DACT did their best to extract any relevant information they could for the review from their central case management system. A point for wider consideration is the impact of changing commissioned services and accessibility of legacy information. Some information on legacy systems from a previous statutory provider could not be accessed for this review. Potentially valuable information was therefore not available and it is worth reflecting how this impacts on potential operational decision making if professionals also cannot access it.

9.8.2. Maggie engaged with drug treatment services from 2005 till her death. At the time the ratio of worker to service users was around 80:1. The Care Co-ordinator role involves assessing and coordinating the individual's journey through treatment, delivering motivational workshops in preparation for treatment, writing reports for, and attending, meetings where required. There is a record in their notes of the abuse in her relationship with her partner but the primary focus of the dealings with Maggie was, understandably, in relation to her drug usage. In 2014, a disclosure of domestic abuse was made to a worker but no records kept on file of the details of that. Some work was done to raise the incident with Adult Social Care who spoke to Maggie by phone. A safeguarding plan was put in place and the case opened to

SWBAT. As there were no active safeguarding investigations, SWBAT closed it four months later but Maggie remained 'open' to Drug and Alcohol services prior to being 'closed' 12 months later as she was not engaging.

9.8.3. A MARAC meeting that was held was attended by a member of staff from the service but no record of what was shared or agreed was placed on the service's systems.

9.8.4. There were some other shortcomings identified in relation to risk assessment completion after key events. Maggie's risk to her partner in terms of Domestic Abuse is noted but little more done than that.

9.8.5. Lessons learnt within this agency- As a result of a previous DHR, the Commissioner has recognised the need to offer support flexibly to cohorts deemed hard to engage. The following (which reflects findings in this report) have now been implemented in Bournemouth to promote engagement with services:
a) Joint working with partners to provide a drop-in support facility to homeless people in one venue. This will include the opportunity to access drug and alcohol workers for assessments and support, needle exchange, motivational workshops, clinical support and general healthcare.
b) A worker from the Care Coordination service will actively outreach people who are homeless on a weekly basis in partnership with the street homeless team. The aim is to provide advice to minimise harm and support people to engage with treatment.

9.8.6. The current Service Provider of the Assessment and Care Coordination service, and any future Service Providers will be informed of the following to safeguard victims, promote their welfare and identify and manage risks posed by perpetrators:

- There is a shared protocol in place for working with people who are chaperoned at appointments. There must be a single standard for all services across the treatment system to adhere to e.g. all appointments must be with the individual for at least ¾ of that appointment.
- The pan-Dorset Risk Assessment and Management processes for treatment need to be adhered to. Services need to routinely audit the quality and

compliance of risk assessment processes. Commissioners need to audit independently to assure compliance.

- The content of Risk Forms could benefit from more tangible actions beyond 'monitoring'. Commissioners need to further develop training opportunities so staff can improve practice in risk assessing.
- Communication of risks including evidence of that communication beyond completion of the Risk Forms could be improved. Commissioners need to ensure this is communicated within risk training.
- Case notes need to contain more detailed information (including the reasons for making decisions and the reason why people accessing services cancel appointments). Services need to routinely audit the quality and compliance of case notes. Commissioners need to audit independently to assure compliance.
- Staff require a greater understanding of domestic abuse, ways of working with victims and perpetrators and how they can actively contribute to MARAC.

As a result of de-commissioning the Statutory provider in 2013, it is now a condition that all commissioned providers only use the Central Case Management System (HALO). All commissioned providers at the end of the term of their contract are required all paper documentation pertaining to service users seen during their contract period to the Commissioner. This may alleviate some of the problems encountered during this review accessing information fork a previous commissioned service and also ensure professionals can get access to the best information.

9.9. Domestic Violence Floating Support Team (CRI)

This team had no information to assist due to, on their account, having no record of contact with Maggie, or her partner.

9.10. Dorset CCG for GP

9.10.1. This review was conducted by a member of Dorset CCG on behalf of the GP Surgery at which both Maggie and her partner were registered. Due to the dynamics of a GP's surgery it is difficult to ensure Independence in review, often due to difficulty identifying an individual who has not had some professional involvement.

9.10.2. The reviewer sets the scene with a very stark but realistic description of the setting, *"Providence Surgery has a practice population of 7400 patients; with only 400 being age over 65 years. There are approximately 2000 active drug users on the case load, and 300 – 400 homeless patients. It is reported that the local council, do not count rough sleepers within their deprivation statistics for the area. The area was well known for its high level of crime... The surgery used to have dedicated funding to support the detoxing of patients however since 2014, patients requesting detox are referred to BAT (Bournemouth Assessment Team). BAT assesses individuals in collaboration with the Avon and Wiltshire Mental Health Trust who prescribe treatment and refer patients back to their GP for shared care."*

9.10.3. Against this background, the following points deserve special merit to complete the context, *"Providence Surgery was inspected by the Care Quality Commission (CQC) in March 2016 and the published overall rating was Outstanding. The CQC inspection noted that staff are aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. It is reported GPs attend safeguarding meetings when possible and always provide reports where necessary for other agencies ".* The surgery should be justifiably very proud of achieving this recognition of their outstanding work in such challenging conditions.

9.10.4. As an important element of the review for this DHR, Maggie's GP was interviewed. A significant event review had also been carried out in the surgery following Maggie's death.

9.10.5. Maggie's visits to the surgery were numerous over the seven years prior to her death. Most visits arose from her drugs misuse and alcohol addiction, and even her more routine medical matters were aggravated by these. There is also a clear pattern of her not attending appointments, consistent with her chaotic lifestyle and the same non-engagement as was seen with other agencies. Maggie was often intoxicated when she did attend, and could be angry, aggressive and challenging.

9.10.6. There is good evidence of the surgery going to great lengths to help her and trying to mitigate identified risks (most of which were as a result of Maggie's own

lifestyle choices). GP's questioned injuries and considered whether they may be as a result of domestic abuse. Multi agency meetings were attended when possible or reports prepared for these. When minutes were sent to the surgery post meeting a note was made of them in Maggie's records and the risks that were identified.

9.10.7. There is a very good record and evidence of her GP taking a lot of time with Maggie, following the assault with the mop handle by her partner in October 2014, to discuss the incident, examine her and discuss a way forward including a holistic view of housing situation, etc.

9.10.8. In the context of domestic abuse, and any suggestions of controlling and coercive behaviour by Jim Trainor, there are records of some strong contra indicators amongst her medical records. There is a supportive picture of partner making her eat, and not eating her food or controlling her intake. Interestingly, she suffered a drugs overdose while he was banned from seeing her following the 'mop handle assault'. This was against anecdotal reports that he withheld her drugs from her, possibly for controlling rather than caring reasons. Also, no domestic abuse injuries were noted by the GP's, though some injuries were put down to general falls. No complaints were made about her partner in the numerous and detailed visits she had with GP's at the surgery.

9.10.9. The surgery had been able to maintain a good level of continuity for Maggie which enabled GP's to give her person-centred care and understand where she was in her journey at any given time and to be able to act accordingly. This was demonstrated by a large percentage of the consultations being carried out by the same GP which helped provide continuity of care and an in-depth knowledge of the patient.

9.10.10. The surgery was aware of the concerns about domestic violence and also safeguarding concerns. There was a safeguarding meeting report documented on the notes from the 3rd of May 2014. However, Maggie denied domestic violence in the consultation of the 9th of May, 2014, despite previously disclosing to a psychiatrist that there was mutual violence by both parties in the relationship.

9.10.11. The surgery had ensured notes from the safeguarding team she was open to, were on the GP notes. These were referenced in two consultations in October 2014, showing full GP awareness. Maggie did not talk about violence in her relationship after that and she did not present with any suspect injuries. Her consultations showed the prominence of drugs and alcohol in her life and her focus on meeting those needs.

9.10.12. In the light of much good practice there were not many adverse lessons to be learnt from the work of the surgery.

- There is no evidence within the records that indicate anything different could have been done to prevent Maggie's death. She was a vulnerable lady with mental health and major physical difficulties alongside addiction issues. Due to the addiction issues, no one was able to make a sound assessment of her mental health difficulties to know whether her suicide could have been prevented. There was no indication that suicide was a possibility which suggests that while it may have been an intentional act, it was not necessarily one that was intended to result in her death.
- Providence surgery provides an outreach service to St. Paul's, where Maggie resided much of the time. This is unusual and would have enabled Maggie to access health services more easily than otherwise she might have. This should be seen as a positive and an example of good practice.
- The surgery had themselves reflected upon the care they had given to Maggie following notification of her death. They acknowledged how the effect of her chaotic lifestyle created difficulties in following her up. The surgery had acknowledged the need in future to raise mental health difficulty more frequently even with the knowledge it is difficult to assess patients while under the influence of drugs and alcohol.
- All GP's within Providence surgery are trained to level 2 on drug and alcohol issues. This gives all them a greater understanding of the issues and difficulties patients like Maggie face and would therefore have increased their chance of being able to support Maggie appropriately.
- The surgery also ensured all safeguarding documents were logged and the patient highlighted as vulnerable. There was reference to safeguarding documents in consultations showing it was at the forefront of practitioner's

minds. However, when questioned about them Maggie denied the occurrence even though she had previously disclosed these to other agencies.

9.11. South Western Ambulance Service

9.11.1. A review was carried out by an identified independent individual. The service's interaction with Maggie and Jim Trainor resulted from emergency situations due to violence or complications caused by drug and alcohol misuse. According to that reviewer, records show that Maggie and Jim Trainor seemed to exist for many years in a chaotic lifestyle embroiled in addiction to drugs and alcohol. They also seemed totally committed to each other. There were periods of stability and improvement but these were fairly short lived and almost inevitably always deteriorated.

9.11.2. St. Paul's seemed to be a safe haven especially for Maggie and no doubt helped to support and protect her. Despite this, she continued to 'relapse' with her drug and alcohol misuse, together with the pull of her relationship with Jim Trainor. There were opportunities missed which may have given Maggie a voice, when injuries were not questioned in depth by paramedics but they were dealing with other critical health issues which understandably would have been their focus.

9.11.3. Maggie was very unwell on a number of occasions which required hospital attendance and her long term medical problems, in particular, her weight, cannot have been overlooked. However, she did have mental capacity and the other complexities in her life and substance misuse may have prevented her having the willingness or ability at any time to address matters for herself.

9.11.4. The review identified good practice and lessons learnt for the SWAST:-

- There is an extra risk posed by being homeless especially when unwell and having to leave a short stay hostel, such as St. Paul's, during the day. When unwell there is no opportunity to rest, and recover, causing risk of rapid deterioration. On one occasion, good practice was identified in relation to a paramedic arranging two days' bed rest for Maggie at St. Paul's when she had flu.

- It seems that Maggie had periods of being more in control of her addictions which then lapsed. There appears to be some evidence that she was more stable in Jim Trainor's presence. It is unclear how much significance was given to this by all the agencies, particularly when dealing with domestic abuse issues, such as the assault with the mop handle, when the natural risk management would involve separation.
- On occasions, there seemed to be a lack of professional curiosity around some of Maggie's injuries. They do not appear to have been explored as potential domestic abuse. That is a learning for this agency.

This agency has not prepared a Single Agency Action Plan as the issues identified by them have already been addressed. This related to reinforcing Professional Curiosity around Domestic Abuse situations. This can be difficult due to the nature of the service but is now being highlighted in their Training Updates, a service Bulletin article and Newsletter all of which are taking place prior to the end of December 2017.

9.12. Dorset Healthcare NHS University Foundation Trust

9.12.1. This agency provided support to Maggie on limited occasions in 2010, 2012 and 2014 when she attended drop in sessions run by their Homeless Team at St Paul's. Her poor state of health and regular intoxication were noted. She was treated for medical matters and on one occasion, in August 2014, disclosed to staff that her partner Jim Trainor was 'financially abusing her and had hit her'. This was referred to Adult Social Care and a case conference was held two months later. It is unclear if any safeguarding action was taken prior to that, due to inadequate notes.

9.12.2. Lessons learnt in this agency include better and more timely completion of DASH forms, some shortcomings in knowledge levels of staff around domestic abuse, and the completion of risk assessment forms in relation to domestic abuse. It also concluded that there was no information held within the agency that could have led to Maggie's suicide being predicted.

10. Timescales for the review

10.1. Maggie died on the 9th August 2016. The circumstances were brought to the attention of Bristol CSP who made a decision that the criteria were met for a DHR to be carried out, when they met on the 30th September 2016.

10.2. The need for an Independent Chair was advertised and Ian Kennedy was appointed to that role on 19th December 2016. He was briefed by Stuart Pattison and Lynne Bosanko, on behalf of Bristol CSP on the 11th January 2016. Statutory and relevant agencies were identified by scoping and attended their first DHR meeting on Monday the 27th February, 2017. At that meeting, they were tasked to assess their agencies' involvement with Maggie and her partner in so far as that related to domestic abuse and to commence their IMR's. Further agencies involved with Maggie were identified at the 2nd Panel meeting on Wednesday the 17th May, 2017.

10.3. These further agencies were approached and also asked to prepare IMR's. The delay caused by the late identification of these agencies, and the time to complete IMR's generally, led to the 3rd planned Panel meeting being moved from Tuesday the 8th August, to Monday the 25th September to allow the completion of the IMR's.

10.4. The re-scheduled 3rd meeting took place on 25th September, when cross cutting issues were identified and the first draft Overview Report discussed. Subsequent to that meeting Individual Agency Action Plans were created and the draft Overview Report was further amended, then re-circulated.

11. Significant themes for learning from the review

11.1 There are several significant themes that arose from this review-

- The need for information to be accurate, available and understood by the individuals delivering services for persons with complex need such as Maggie. There were identified occasions when information was not complete on records and meeting minutes. Furthermore, information was not always available to professionals delivering the service due to computer systems that did not talk to each other or it was over protected.

- The professionals in turn needed further training on occasions in relation to understanding domestic abuse, particularly controlling and coercive behaviour, and avoiding gender biases around victim and perpetrator stereotyping.

- Consideration of a Harm Reduction, rather than Recovery, model for dealing with individuals with complex issues who have drug and alcohol dependencies.

- The need for more refined parameters around the need for a Domestic Homicide Review to be held to ensure only appropriate incidents are reviewed to ensure best learning. This will ensure time and limited resources are not diverted from frontline services to engage in historical reflection where little benefit may be gained, or the same issues are revisited and debated to no avail. The needs of current victims of domestic abuse in ongoing abusive relationships need to be given priority for resources where appropriate.

- The effectiveness of multi-agency meetings given findings shown that attendance can be patchy, actions set in less than clear terms and not later checked for completion, information not circulated to professionals who need it to carry out their work.

12. Learning from previous Domestic Homicide Reviews

12.1. There is only one previous DHR published on the website of Bournemouth CSP. The recommendations from that are similar to those found here in relation to improved communication, training and sharing of information. That should not be surprising when one examines the findings of the review carried out by the Home Office of all 33 DHR's completed nationally between 2011 and 2015. In those, communication and information sharing was identified as an issue in 76%. These figures are shown in the document, "Domestic Homicide Reviews- Key Findings from Analysis of Domestic Homicide Reviews (December 2016)"

12.2 There is no evidence found by this review that any improved communication or information sharing would have brought about a different outcome for Maggie in this case. It was not predictable or preventable.

13. Conclusions

13.1. Looking across all the separate reviews and the records of each agency it is reasonable to say that Maggie approached, and worked with, agencies when she saw personal benefit, including-

- attending the GP's of her own volition, after a sequence of failed appointments, to ask for a letter to help with a housing application or further drugs
- engaging with her drug treatment provider when she wanted to try a period of detoxification
- reporting the assault with the mop handle to police to get her partner arrested to 'teach him a lesson' and then almost immediately withdrawing support for a prosecution.

13.2. Her situation was driven by choices she had made in earlier life and then driven by her drugs and alcohol misuse. We will never know if she intended to take her life when she cut herself to the throat to make her partner go and fetch her drugs. She had mental capacity and had never talked of suicide.

13.3. Had she died from her fragile health aggravated by her living conditions and substance misuse, as opposed to at her own hand, it would not have surprised some of those professionals with whom she had engaged. As such, it was the cause of death rather than the death itself which came as a surprise to professionals. It was neither predictable nor preventable.

13.4. This is not to say that in concluding the reviews a complacent attitude was taken of inevitability in the face of Maggie's death. Services have reviewed their work and in many cases found examples of excellent work to help Maggie beyond

what might have been considered acceptable, especially in a developing climate of financially stretched and under resourced public services, including-

- The GP's surgery going to great lengths to engage with Maggie and understand her many issues including those which were not purely health related.
- The Mental Health professional who engaged with Maggie in the drop-in session at the St. Paul's Shelter.
- The social worker who put in so much time and effort to support Maggie despite her inability or unwillingness to receive help, and her well recorded aggressive and combative behaviour.
- The workers at St. Paul's Short Stay Hostel who did all they could to support and protect Maggie despite her challenging and disruptive behaviour.

13.5. There were few warnings of domestic abuse in the seven years prior to her death. Maggie would tell professionals that there was mutual violence in the relationship and then deny it. There was the incident with the assault with the mop handle in 2014, but otherwise no injuries were noticed by professionals that could not be put down to falls, or the non-domestic related fights with other people, as explained by Maggie. Consequently, it is unclear what further steps could be taken to safeguard Maggie, or another in a similar situation.

13.6. In terms of wider issues, good practice identified in this report includes the-

- Outreach service from the GP surgery to St. Paul's to make GP services more available to those in need.
- Dedicated mental health professional running drop in clinics for the residents at the accommodation. This service remains at St. Paul's but is now only for rough sleepers as residents are encouraged to register with a GP. A more flexible approach to include residents on a short-term basis until they are willing/able to register with a GP may benefit such vulnerable people as Maggie who are suffering domestic abuse and mental health issues.
- Work by the social worker to ensure staff at the accommodation were kept up to date with Maggie's situation despite software systems that were not accessible to all.

- Significant efforts by treatment workers to get Maggie in to detox facilities. She was to use her dog, and its being looked after during her detoxification, as reason for not engaging in the service. The service does not allow dogs in the building but support is available for dog care and it could have been accessed. Alternately the service could review its provision of kennelling. Her dog was her constant companion and the importance of including it in consideration of her care package cannot be underestimated. If you are homeless and have little else in the world, a dog can be a very important companion.

14. Learning for individual agencies involved in the review

14.1. The single agency actions are incorporated into an overall Joint Action Plan and can be found at Appendix D. I do not intend to go into each one in detail in this overview report. They have been created by each body based on the work during their IMR, and much of that work has been implemented rather than waiting for the review to conclude. I will instead draw together some cross-agency themes for the relevant Community Safety Partnership, or the Home Office to consider.

15. Cross Agency Issues for local agencies to consider

15.1. The reviews identified some shortcomings in the way multi-agency meetings are held in Bournemouth and the information collated and subsequently disseminated. There were examples of non-attendance, actions not being checked for completion and information not being shared down to worker level due to a lack of understanding of what to do with the information or it being overly restricted in its protective marking. The agencies cover large areas and travelling time to and from physical meetings is wasteful of the time they have available to deliver their services. Whilst some meetings are conducted via telephone conference facilities, **further adoption of low cost IT solutions could improve attendance, information sharing and free up worker time in agencies that have seen a significant reduction in staffing levels in recent years**. It may also allow a better option for the likes of GP's who find difficulty in leaving their surgeries for long periods in the middle of the day, yet they have a wealth of information about the person concerned, as they did in this case with Maggie.

15.2. There was some evidence of information not being shared around agencies, sometimes due to systems that do not communicate with each other and sometimes due to overly protective access levels. Changes to IT may fix some of these issues and a less risk averse release of access to those who need it may prove fruitful. An approach to data sharing that enables it getting to those who need it, rather than restricting it unnecessarily, can only help with critical decision making and reduce risks to those people that agencies should be working to safeguard.

It is recommended that a full review is carried out of the multi-agency meeting structures in Bournemouth including how and when they are run, information sharing and dissemination from them, and action management.

15.3. Work has been done in other areas that shows most lessons that have been drawn for DHR's such as this often include the need for better information sharing and also further training in understanding domestic abuse. Those two issues have been identified here also. I know some professionals in this group felt frustration at meeting to discuss the same points as found in other DHR's. To prevent future reviews continuing to find the same issues there may be two approaches-

- A significant investment nationally to improve information systems across agencies. This may be hard to fund in current times of austerity and therefore a continued framework of disconnected standalone databases that cannot talk to each other will remain the norm. Consequently, better multi agency working and a meetings programme, based on an acceptance of the IT inadequacies, should be worked upon.
- The concept of having one named lead agency/Single Point of Contact for each complex individual identified as being most at risk would allow a situation where one person/supervisor can see all the risk and make proper plans to address them, with the help of partner agencies. That would get rid of the situation as here, where very hard working and well intentioned workers were sometimes working in isolation, and duplicating effort, as they were not aware of other work being carried out. Such duplication of effort in times of limited resources cannot be sustained or justified. Separate agencies conducting risk assessments in silos without the knowledge or consideration of useful information elsewhere is not helping the person receiving their

services. Ensuring all information on key individuals goes to one person/agency is achievable even with the current stand-alone IT systems.

These two points could be considered as part of the recommended review at points 15.1 and 15.2 above.

16. Learning for Bristol/Bournemouth Community Safety Partnerships

1) The last several years have seen a significant reduction in staffing levels across all agencies involved in this review. Whilst that is not seen as leading to any failings in provision of services in this case, it did cause issues. This includes for example, changes in staff levels and consequent availability of services. There was an understanding expressed within the review group that the full effect of austerity reductions is just properly settling in. In this situation, it would be timely for **the Community Safety Partnership to consider how it prioritises and delivers its services, and those for whom it can no longer provide**. This work may already be under way, but needs to be ongoing to address the ever-increasing complexities of those who require the services and to be able to provide sufficient service provision to those most in need within newly restricted budgets.

2) There was difficulty accessing information from some commissioned bodies that had been replaced when their commissioned period ended. I understand that such bodies are required as part of their contract to be able to provide access to information once their commissioning period is over. In some identified cases in our review, bodies were unwilling or unable to do this. When the local authority commissions a body to provide a service they must make it an enforceable position that information continues to be available. It caused some hindrance to this review but there are much wider and important issues for professionals being able to access all information held across service providers, whether current or no longer so.

3) A full root and branch review should be carried out of how multi-agency meetings are established and run. There was clear evidence of non-

attendance and also for those that did attend, examples of a lack of understanding of what could, and should, be done with information received. Meetings should be established to allow people to attend. If that is not a physical presence, modern technology can help with a virtual presence. Are the right people being asked, or are blanket invitations being sent out 'just in case'? What responsibilities are there on attendees in respect of the information they receive? Actions raised at meetings were on occasions not completed or it was not possible to tell if they had been due to poor record keeping and lack of formal checking of their completion. Other actions such as 'monitoring' were written in the passive as opposed to setting pro-active steps to negate risk. There was evidence of some information not being shared with frontline workers either through lack of understanding, or misunderstanding, of data protection principles. A review by Bournemouth CSP of current practise in relation to multi-agency safeguarding meetings would be advantageous to allow understanding and if necessary to change practices to improve safeguarding work. This point has arisen in two other ongoing DHR's in Bournemouth and the review panel are pleased to note this proposed work has already commenced.

4) There was evidence of risk assessments being carried out at various points by individual agencies to address the needs for individuals and to identify that multi-agency work was required. Working individually, it is not surprising that these sometimes conflicted or did not address the whole picture. **A more comprehensive approach with a single lead agency being identified to collate and manage the risk for the most complex of individuals would be beneficial**. This may actually allow a reduced number of workers to be involved in overall service provision. The MARAC process goes some way to addressing this but perpetuates individual agency work and does not seem to identify the most appropriate agency or professional to coordinate and manage risk. Consequently, there is no one individual in any agency who is in possession of the complete picture, service delivery happens in silos and duplication of effort may take place. **Ownership by one identified professional/agency, who can be the recipient of all relevant information would allow for much better quality of risk management and therefore**

service provision. Given the demands of such a role it would perhaps only be achievable for those identified as being most at risk.

5) **For the Borough Council when commissioning Drugs Treatment Services to consider a Harm Reduction Model of service provision as opposed to solely a Recovery Model**. In cases such as this, addressing Maggie's all round risks may have benefitted her greater than a focus on providing the correct drugs. This approach would be in keeping with current thinking in the field, and it is about reducing the harm of the substance abuse rather than medicating a reduction. (Department of Health document, Drugs Misuse and Dependence, UK Guidelines on Clinical Management, July 2017)

17. Regional or national issues identified

17.1. This review was initiated on Home Office Guidelines despite the fact that it was a suicide, rather than a homicide. If this is to be continued practise, **it is requested that the Home Office review both the title of such reviews and the content of its Guidance document**. The title Domestic *Homicide* Review, suggests a third-party involvement in the death when that is clearly not the case and may suggest a conflict with the findings of HM Coroner. A more fitting title, such as "Domestic Abuse Related Death Review" would be more accurate and also prevent the situation of raising doubt in the minds of the deceased's family who, having come to terms with the suicide of their loved one, are informed that a review is to be carried out of the 'homicide'. Such a change in title could be mirrored in a Guidance Document that makes it clear that references, contained within it, to 'perpetrator', relate to a domestic abuser who may or may not have been involved in the death.

17.2. **As part of the consideration of the DHR process, greater flexibility could be given to Community Safety Partnerships to only review those suicides where Domestic Abuse appears to have been a significant and primary influence on the decision of the person to take their own life**. This may require some initial scoping work in establishing motivation, but would fall short of the sometimes cumbersome, time consuming and financially challenging processes of a full DHR review. Paragraph 18 of the Guidance goes part way to this situation but

could be more clearly set out. It may not always be possible to tell that it was a primary factor in the suicide decision until after such initial scoping, but there should be Guidance available to end the review at that point if clear evidence of intent deriving from domestic abuse is absent. This would allow a focus for DHR's only to be conducted for those most troubling deaths where there is most likelihood of, and need for, significant learning. It would also mean that time and money that could be devoted to supporting current victims of Domestic Abuse are not being unnecessarily devoted to costly and time consuming historical reflection that will produce little learning.

17.3. The Guidance also includes direction for Chairs/Panels to contact the perpetrator. Whilst the benefit of the insight they may provide may be very valuable, it is difficult in the case of suicide, where the perpetrator in the death of the deceased, is the deceased. To seek out and engage with a perpetrator responsible for the domestic abuse of the deceased during their life is made difficult by Data Protection legislation as in this case, where there was a reluctance to release details to the Independent Chair, of the new address for the partner who played no part in the death.

18. Summary of Recommendations

- Adoption of low cost IT solutions could improve attendance, information sharing and free up worker time in agencies.
- Full review is carried out of the multi-agency meeting structures in Bournemouth including how and when they are run, information sharing and dissemination from them, and action management.
- The Community Safety Partnership to consider how it prioritises and delivers its services, and those for whom it can no longer provide.
- A more comprehensive approach with a single lead agency being identified to collate and manage the risk for the most complex of individuals.
- Ownership by one identified professional/agency, who can be the recipient of all relevant information would allow for much better quality of risk management and therefore service provision.

- For the Borough Council when commissioning Drugs Treatment Services to consider a Harm Reduction Model of service provision as opposed to solely a Recovery Model.
- The Home Office review both the title of such reviews and the content of its Guidance document.
- As part of the consideration of the DHR process, greater flexibility could be given to Community Safety Partnerships to only review those suicides where Domestic Abuse appears to have been a significant and primary influence on the decision of the person to take their own life.

Appendix A

Bristol DHR Terms of Reference

The Terms of Reference

1. The purpose of this review of death of Maggie.

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- Highlight any fast track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

2. Overview and Accountability:

2.1 The decision for Bristol to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Bristol Community Safety Partnership on the 30/09/16 and the Home Office informed on 06/01/17.

2.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

2.3 This Domestic Homicide Review is committed to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner, within the spirit of the Equalities Act 2010

3 The Domestic Homicide Review will consider:

3.1 Each agency's involvement with Maggie from 2009 and the date of her death, except for any other relevant information relating to domestic abuse prior to this date.

Whilst checking these records we may identify any other significant individuals who may be able to help the review by providing information.

3.2 Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or her children, prior to the homicide (any disclosure, not time limited).

3.3 In relation to the family members, whether there were aware if any abuse and of any barriers experienced in reporting abuse? Or best practice that facilitated reporting it?

3.4 Could improvement in any of the following have led to a different outcome for Maggie considering: -

a) Communication and information sharing between services with regard to the safeguarding of adults.

b) Communication within services.

c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

3.6 Whether the work undertaken by services in this case are consistent with Each organisation's:

a) Professional standards.

b) Domestic abuse policy, procedures and protocols.

3.7 The response of the relevant agencies to any referrals relating to Maggie concerning domestic abuse or other significant harm from (to be confirmed at first review panel meeting). It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim, perpetrator or her children.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

d) The quality of any risk assessments undertaken by each agency in respect of, her children or the perpetrators

3.8 Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

3.9 Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

3.10 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

3.11 Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

3.12 Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

3.13 Keep these terms of reference under review to take advantage of any, as yet, unidentified sources of information or relevant individuals or organisations.

4. Media Strategy

4.1 A single point of contact has been identified to field all media enquiries in relation to this DHR and a position statement of “no comment” will be offered until the conclusion of the DHR process and sign-off of the overview report by the Home Office Quality Assurance Panel.

Appendix B

List of agencies contacted for this review

Avon and Somerset Police

Avon and Wiltshire Partnership Mental Health NHS Trust

Bournemouth Borough Council Strategic Housing Options

BCHA

Bournemouth Drug and Alcohol Commissioning Team (DACT)

Bournemouth and Poole Rough Sleeper Team (invited to take part but declined due to lack of contact by their agency)

Dorset Police

Dorset Healthcare University Foundation Trust

NHS Dorset CCG on behalf of GP Services

Social Work Bournemouth Assessment Team(SWBAT)now Drug and Alcohol Statutory Services Team

South Western Ambulance Service

Appendix C

Glossary of terms

ASC	Adult Social Care
BAT	Bournemouth Assessment Team
BCC	Bournemouth County Council
CCG	Clinical Commissioning Group
CJIT	Criminal Justice Intervention Team
CSP	Community Safety Partnership
DA	Domestic Abuse
DV	Domestic Violence
DACT	Bournemouth Drugs and Alcohol Commissioning Team
DASH	Domestic Abuse, Stalking and Harassment
DHR	Domestic Homicide Review
DPA	Data Protection Act 1998
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Review
GP	General Practitioner
MARAC	Multi Agency Risk Assessment Conference
SP	Supporting People
SWAST	South Western Ambulance Service NHS Trust
SWBAT	Social Worker, Bournemouth Assessment Team

Appendix D

Action Plan (Maggie)

Recommendation	Scope of recommendation ie. local/ regional /national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
1.The Home Office reviews both the title of Domestic *Homicide* Reviews and the content of its Guidance document in the context of deaths occurring from suicide	National	CSP to write to Home Office to request consideration of: 1. A more neutral title for domestic abuse related death reviews and 2. Revised national guidance to reflect this and clarify references to involved parties and disclosure of appropriate information in the circumstance of death by suicide.	Home office	Letter from Bristol CSP Chair to Home Office	November 2018	Outstanding
2. As part of the consideration of the DHR process, greater flexibility could be given to	National	Home Office to consider its DHR guidance and revised paragraph 18 to provide greater clarity for CSPs	Home Office	Letter from Bristol Chair of CSP to Home Office	November 2018	Outstanding

Community Safety Partnerships to only review those suicides where Domestic Abuse appears to have been a significant and primary influence on the decision of the person to take their own life.						
3. The Community Safety Partnership to consider how it prioritises and delivers its services, and those for whom it can no longer provide.	Regional – Bourne mouth and Bristol	Review crime plans as informed by accurate and up-to-date needs assessments and set out commissioning plans to meet identified needs and priorities	Bournemouth and Bristol CSPs	• Refresh annual Needs Assessments • Review and refresh local crime plans • Publish commissioning intentions and undertake evidence based, needs led commissioning	2018-2020	Ongoing through Partnership Strategic assessment. Mapping a whole system approach currently underway. Phase 1 = mapping – now COMPLETE (scale of issue, pathways, cohorts, provision – 50 offers). Phase 2 = Developing work programme for end of November to ensure the centrality of victim safety and reduce bureaucratic fragmentation. Creating outcome monitoring model.
4. Partners to consider whether alternative routes	Regional	Commissioners of drug and alcohol treatment services to consider how to communicate	Primary Care	Commissioners incorporate in specifications and plans	July 2018	Review of the Treatment System involvement with MARAC completed and

to detox may decrease risk, particularly in cases of domestic abuse. **Staff should and can challenge where only traditional routes to detox are being considered/ offered.**		alternative routes to treatment, particularly in instances of domestic abuse.		with service providers through commissioning processes		pathway developed. DACT now member of pan Dorset MARAC Steering Committee. BEAT champion in place. DA linked to Risk action. Risk Form refreshed around MARAC requirements. Panel in place whereby Staff can discuss complex cases with multi agency service managers and they can discuss whether a client can bypass traditional routes to detox and be fast tracked
5. Domestic Abuse training for all staff. (Not limited to domestic abuse services)	Local	Rollout Domestic Abuse training programme for all staff.	BCHA	Share action plan with HR department	02/10/2018	Domestic abuse training has been provided. Staff have undertaken training around DV awareness and MARAC at both Bournemouth and Poole refuge. Specialist support has also been offered and accepted by Bournemouth Council Domestic and Sexual Violence Co-ordinator; this has been offered to non-domestic violence services. BCHA have employed a head of Safeguarding with specialist Domestic Violence background for additional support. Quality Framework

						for forthcoming year also includes training and awareness in this area and trauma informed care. Other projects, not specific to domestic violence, have also undertaken training in domestic violence awareness. Current work is being undertaken to identify gaps in knowledge in all services and ensure all projects are delivered domestic abuse training.
6. Training – risk management planning specific to domestic abuse. (Not limited to domestic abuse services)	Local	Identify Domestic Abuse training with risk management planning incorporated.	BCHA	Share action plan with HR department	02/10/18	All risk assessments signed off by Project leads. Risk assessments also dip-sampled for quality in the new BCHA Quality Framework. Risk management training will also be delivered within the next month, including positive risk management and client centred approaches to risk management. Risk planning for domestic violence guidance is also being designed for each refuge and should be available within 2 months.
7. Ensure a	Local	Training in Trauma informed	BCHA	Shared action plan with Senior	02/10/2018	Trauma informed awareness

Trauma Informed Approach in all Supported Housing Services		approach for all supported housing staff. Embed Trauma informed approach throughout policies and procedures.		Leadership team	At Policy review date	and care is part of a new training structure/package for BCHA moving into the new financial year. Supported housing has had training in Psychologically informed environment building awareness of impact of work undertaken by Supported housing staff.
8. Risk Management: Non-acceptance of referral for perpetrator to same supported housing service when victim is still in residence.	Local	Service managers	BCHA	Share with Service managers	Immediate	Complete. Current practise is non-acceptance of referral for perpetrator to same supported housing service when victim is still in residence.
9. Consider provision of access to Adult Social Care case recording systems to relevant safeguarding experts in the Housing and Communities Service Directorate. **(Better**	Local	David Vitty, Service Director, has agreed that housing officers will have read only access to mosaic.	BBC – Adult Social Care (ASC)	Personal Information Sharing Agreement to be included with the implementation of mosaic, the new case recording system.	31st January 2018	Complete.
	Local	Promote and better facilitate the fact that Housing officers can contact ASC to ask for pertinent information in relation to a housing case. – This action was also a recommendation from the 2016 Safeguarding Peer Review Improvement Plan.	BBC – ASC and Housing and Communities Directorates.	Sarah Webb and Tracey Kybert to undertake “line of sight” visits to statutory services safeguarding team and housing customer services centre to gain better understanding of each service at a senior management level.	30th June 2017	Complete.

information sharing will enable better practice.)						
10. Line Managers to check case recording accuracy as part of the file audit that is undertaken at each supervision e.g. • **ensuring correct terminology is used** • **documents named and attached correctly** • **Case closure summary to be written in every case, in line with section 4.1 of "Recording Guidance: Principles and Standards when recording Client and**	Local	Follow quality assurance process for case file audits in supervision meetings.	ASC – Line managers.	Case file audit process to continue to be kept up to date in the Care Management Manual.	Ongoing	
	Local	Naming conventions for attachments to be agreed to ensure standardization across the both Adults and Children's Services.	Helen Holland/ Mosaic project team	• Naming convention 'formula' to be agreed by ASCCLT. • Naming convention to be used in the implementation of Mosaic – new IT system.	31st January 2018	Complete. Naming conventions agreed for attachments to MOSIAC ensuring standardization. Case closure summary now mandatory. this will be made available during Go Live planning

Carer Information"[1].						
11. Teams to follow the "Recording Guidance: Principles and Standards when recording Client and Carer Information"[2]. **If the need is identified as a result of this, practitioners to attend the "Recording Skills and report Writing" training.**	Local	Continue to provide core training – Recording Skills and Report Writing for staff.	ASC Practitioners, Managers and Workforce Development Unit.	• Recording Skills and Report Writing training will continue to be identified in staff Personal Development Reviews. • Recording Skills and Report Writing training to continue to be identified in annual training needs analyses carried out by directorate.	Ongoing.	Guidance recently reviewed and updated. Ongoing programme of training.
12. Additional clarity to be provided and added to the Bournemouth, Dorset and Poole Multi-Agency Safeguarding Adults Procedures;	Regional – Pan-Dorset, Multi Agency.	Sarah Webb to email Anne Humphries, Bournemouth and Poole Safeguarding Adults Board (SAB) Business Manager, a copy of these recommendations from this DHR, in order for the procedures to be amended.	Bournemouth and Poole Safeguarding Adults Board (SAB).	SAB to consider how this could be added to procedures.	31st July 2017.	The SAB action is to incorporate recommendations from DHRs into procedures –the Board's policy and Procedures are currently under review with an expected completion date of end of April.

[1] http://biz/BusinessUnits/CC/CM/Documents/Record%20Keeping%20Guidance%20version%202.pdf
[2] http://biz/BusinessUnits/CC/CM/Documents/Record%20Keeping%20Guidance%20version%202.pdf

• **Safeguarding Strategy Meeting Attendance. - To ensure that all invited parties provide information and/or a substitute attendee should they be unable to attend.** • **Review Templates - A mandatory action review mechanism in the review minute template to identify why actions were not completed and how this can be rectified.**				• Add "Review of previous actions agreed" to template forms: ○ AP0005 (Agenda, item 7 – Review of previous minutes) ○ AP00012 (Minutes)		Complete – as above
13. Domestic Abuse Awareness and MARAC training is made	Pan Dorset (Bourne mouth,	Incorporate into the Pan Dorset workforce guidance and notify service Managers at Standards and Quality Consortium meeting.	Bournemouth DACT (KW) (SS)	MARAC process meeting on 11/01/2017 Bournemouth Training dates	31/10/2017	Complete. MARAC process meeting on 11/01/2017

mandatory for all front line workers within the drug and alcohol workforce.	Poole and Dorset)			08/03/2017 19/09/2017 03/10/2017 All front line workers in Bournemouth trained by the time of the next workforce audit due in January 2018. Workers will gain a clearer understanding of the issue and MARAC process, and explore methods of responding to Domestic Abuse.017		Bournemouth Training dates 08/03/2017 19/09/2017 03/10/2017
14. Review the Treatment System Risk Assessment Process to make sure: **▯ the process identifies risk in relation to domestic abuse,** **▯ the appropriate risk status is identified,** **▯ actions are tangible,** **▯ risk information is shared,** **▯ Safeguarding information is up**	Pan Dorset (Bournemouth, Poole and Dorset)	1. Review current process. 2. Update risk guidance. 3. Incorporate learning from DHRs into risk training. 4. Produce a risk handbook for workers 5. Review current risk training.	Bournemouth DACT (MR) (SS	Agreement with Public Health Dorset necessary on future of pan Dorset risk training. Discussion taken place. Further discussion necessary due to a tendering exercise HALO 'editorial' group review of current risk guidance and risk forms. Discussions taking place.	30/09/2017 30/09/2017	Agreement with Public Health Dorset necessary on future of pan Dorset risk training. Discussion taken place. Further discussion necessary due to a tendering exercise HALO 'editorial' group review of current risk guidance and risk forms. Discussions taking place. New Risk Assessment forms have been produced and piloted across the Pan Dorset region. Nominated workers have reported back

to date and easily identifiable on HALO – the case management system **Staff to email new/updated risks to other appropriate workers and attach evidence.**						on the form. Second draft being produced and training to be rolled out in Spring 2019
15. Develop a Domestic Abuse Protocol for treatment providers to adhere to that links into Borough Policy and the Pan Dorset Strategy.	Bourne mouth specific. With a view to the policy being adopted on a pan Dorset basis.	1. Create protocol and align the protocol to current Bournemouth guidelines. 2. Share the protocol at the managers meeting so managers can roll out to staff.	1. Bournemouth DACT (SS), (LF) 2. Bournemouth DACT (SS)	1. Protocol taken to DACT Steering Board for comment / sign off 02/10/17. 2. Once signed off share protocol at managers meeting.	31/10/2017 Managers Meeting 15/11/2017	1.Protocol taken to DACT Steering Board for comment / sign off 02/10/17. 2. shared protocol at managers meeting 15 Nov 17. Protocol now in place. Audit on providers practise will be undertaken in 2019.
16. Develop a procedure for the drug and alcohol workforce in relation to working with 'couples'.	Bourne mouth specific. With a view to the procedure being adopted on a pan	1. Write procedure. 2. Share procedure at the Managers meeting so Managers can roll out to staff.	1. Bournemouth DACT (LF) 2. Bournemouth DACT (SS)	1. Protocol taken to DACT Steering Board for comment / sign off 02/10/17. 2. Once signed off share protocol at managers meeting.	31/10/2017 Managers Meeting 15/11/2017	1.Protocol taken to DACT Steering Board for comment / sign off 02/10/17. 2. Shared protocol at managers meeting 15 Nov 17. Protocol now in place. Audit on providers practise will be undertaken in 2019.

	Dorset basis.					
17. Treatment providers commissioned by the DACT / PHD in Bournemouth to have agency specific Domestic Abuse Policies in place that are understood by the workforce.	Bourne mouth specific, with a view to offering the audit templat e to Poole and Dorset.	1. Create audit template. 2. Carry out audit.	Bournemou th DACT (SS) (LF)		31/10/2017	Completed. 31/10/2017
18. Review of the Treatment System involvement with MARAC so a pathway can be developed.	Bourne mouth specific, with a view to sharing good practice with Poole and Dorset.	1. Meet with MARAC Chair and CSP Officer. 2. Develop a pathway.	Bournemou th DACT (KW) (SS)	MARAC process meeting held on 11/01/2017 1. Protocol and pathway taken to DACT Steering Board for comment / sign off 02/10/17.	31/03/2017 Managers Meeting 15/11/2017	MARAC process meeting held on 11/01/2017 1.Protocol and pathway taken to DACT Steering Board for comment / sign off 02/10/17. 2. Shared protocol at managers meeting 15 Nov 17. Protocol now in place. Audit on providers practise will be undertaken in 2019. 3. DACT representative now on MARAC Steering Group. Services now have MARAC champions
19. Improve record keeping	Bourne mouth	1. Share the findings from this IMR with Service Managers.	Bournemou th DACT	HALO 'editorial' group review of current risk guidance and	31/01/2018	IMR has been shared with

practice in the following areas: **Notes need to contain more detail,** **Notes need to evidence why decisions are made or not, and why appointments are cancelled,** **Standards of notes need improving.** **When working with couples, information relevant to both parties must go on both of the parties' case notes.**	specific, with a view to sharing good practice with Poole and Dorset.	2. Request services to audit record keeping quality. 3. Make sure services adopt HALO changes around record keeping within event history. 4. Produce handbook for workers.	(SS) (LF) (MR)	risk forms. Discussions taking place. Adoption of the 'prompts' when record keeping on HALO.		Managers 15 Nov 2018. DHR findings have been shared with Staff at Mandatory Training Jan/Feb 2018. Newsletter produced identifying findings from DHR spring 2018 Adoption of the 'prompts' when record keeping on HALO has been discussed. Still outstanding on Record Keeping Guidance
20. Review service provider safeguarding meeting processes: **Use of safeguarding sub intervention on HALO.** **Process for recording**	Bourne mouth specific, with a view to sharing good practice with Poole and	1. Create audit template. 2. Carry out audit. 3. Shadow BEAT safeguarding meeting.	Bournemou th DACT (SS) (LF)	Shadowing of BEAT safeguarding meeting review taken place and report with actions written.	31/10/2017	Shadowing of BEAT safeguarding meeting review taken place and report with actions written Safeguarding intervention review undertaken 2017 Annual workforce review highlighted safeguarding training Completed 2018

information on to HALO from safeguarding meetings. Competency standards of Safeguarding Leads.	Dorset.					
21. Drug and Alcohol Statutory Social Work Team to keep records on HALO when joint working BEAT clients.	Local - Bourne mouth specific	Liaise with Senior Social Work colleagues	Bournemou th DACT (KW) (CS)	Meetings held	31/03/2017 No agreement as of yet.	Meetings held. No agreement yet.
22. Ensure allowance for provision for pets is known to the workforce.	Local - Bourne mouth specific	1. Incorporate information into the detox and residential rehabilitation protocol. 2. Incorporate information into adult social care Care Management Manual.	Bournemou th DACT (SS) (KW) Bournemou th Borough Council (HH)		31/10/2017	Update of policy completed 2017
23. Synopsis of Learning to be Developed and shared with DHC to detail the learning from the DHR	Local	1. Safeguarding Adult Lead to share learning with Service Managers to disseminate through teams, to include repeated themes from other Dorset DHR's 2. SA lead to add synopsis of learning to safeguarding learning pages on staff intranet	DHC – Safeguarding adults lead		March 2018	Awaiting publication before synopsis presented to wider partners. Synopsis of learning will be shared by CSP. It will be uploaded onto intranet and shared directly with service managers for teams involved with the case. Safeguarding lead shared synopsis of learning at

						"Think Family "meeting in Sept 2018. 15/10/18 the business managers from the CSP's, SAB and LSCB are looking at methodology to share learning themes and identify the learning transfer.
24. DHC staff to be supported with the application of the MARM process for people who self-neglect of do not engage with services	Local	1. Multi-agency workshops on how to use MARM have been provided to staff across Dorset	DCC, DHC and CCG	Workshops have been provided. DCC and CCG to scope if further workshops are required for nominees who were unable to attend last cohort.	December 2017	Workshops have been provided. DCC and CCG to scope if further workshops are required for nominees who were unable to attend last cohort
25. Ensure that the requirements of the Mental Capacity Act 2005 are embedded in practice across all agencies, including the appropriate use of advocacy.	Local	1. Pilot template to record capacity has been disseminated to CMHT's 2. A caseload review management tool is used CMHT's to self-assess Compliance. 3. MCA training is mandatory for clinical staff	DHC – Service managers	All actions are now in place and are being embedded into practice	Complete	1. Pilot template to record capacity has been disseminated to CMHT's 2. A caseload review management tool is used CMHT's to self-assess Compliance. 3. MCA training is mandatory for clinical staff. All actions are now in place and are being embedded into practice. DHC worked collaboratively with DCC to run a series of x 4 workshops covering this

						topic at the MCA Conference in March 2018. These workshops attracted a high level of delegates on a multi-agency basis including staff from DHC. DHC working group are developing a guidance in the use of MCA and best interest decision making to include templates for each process and good and poor practice examples. Staff MCA training is monitored by the learning and development team. Compliance is reported quarterly to the Joint Safeguarding Group and is included in the Safeguarding Adults quarterly reports to the Executive Quality and Clinical Risk Group and Dorset CCG.
26. Review process to ensure	Local	1.1 Learning covered at team meetings.	Housing & Customer	Confirmation received from managers and recorded when	1.1 End of October	1.1 Learning covered at team meetings. = Confirmation

all staff check all records within Locata when dealing with enquiries.		1.2 Access rights for staff be checked. 1.3 Quality/Performance of customer contact monitored through supervision.	Bournemouth Borough Council	covered in team meetings. Supervision template. All clients are assisted by staff who are fully informed through using all available systems to inform the service delivered.	2017 1.2 End of October 2017 1.3 This is day to day practice	received from managers and recorded when covered in team meetings. 1.2 Access rights for staff be checked. = Supervision template 1.3 Quality/Performance of customer contact monitored through supervision. = All clients are assisted by staff who are fully informed through using all available systems to inform the service delivered.
27. Record keeping training to be introduced to the staff training matrix to ensure accurate and appropriate recording takes place.	Local	2.1 Record Keeping Policy to be written and rolled out to all staff. 2.2 Initial training to be organised for all staff and maintained through the training matrix.	Housing & Customer Bournemouth Borough Council	Adult Social Care training accessed and new policy in line with social care policy. Records can be relied upon to be clear, factual, evidence based and beyond interpretation.	2.1 End of November 2017 2.2 End of March 2018	2.1 Record Keeping Policy to be written and rolled out to all staff. = Adult Social Care training accessed and new policy in line with social care policy. 2.2 Initial training to be organised for all staff and maintained through the training matrix. = Records can be relied upon to be clear, factual, evidence based and beyond interpretation.
28. Process for	Local	3.1 Floating support information	Strategic	Housing Officers have good	3.1, 3.2 and	3.1 Floating support

people moving on from supported into council stock to include the Housing Officer and floating support worker making contact to establish relationship and ensure joint engagement with new tenant.		to be noted on Locata and sent to Lettings Team by SP Hub. 3.2 Lettings Team to make relevant Housing officer aware and note information on Northgate and EDRMS. 3.3 Housing Officer to contact floating support and hold a joint meeting with new tenants.	Housing and Housing Landlord Bournemouth Borough Council	knowledge of their areas and stock and maintain key contacts such as local PCSO's and call upon additional services such as the Financial Inclusion service, CMHT's. The client receives an effective and consistent service from all agencies involved and any needs, risks or changes identified are shared and action taken.	3.3 with immediate effect.	information to be noted on Locata and sent to Lettings Team by SP Hub. 3.2 Lettings Team to make relevant Housing officer aware and note = Housing Officers have good knowledge of their areas and stock and maintain key contacts such as local PCSO's and call upon additional services such as the Financial Inclusion service, CMHT's.
29. Review the process of key information from Locata being transferred to Northgate and EDRMS at the start of a tenancy to provide background knowledge for Housing Officers	Local	4.1 Housing Options staff to notify Lettings team of pertinent needs and risk information on Locata. 4.2 Lettings Team to transfer information to Northgate and EDRMS and make the relevant Housing Officer aware.	Strategic Housing and Housing Landlord Bournemouth Borough Council	Key staff have access to both Locata, Northgate and EDRMS. The client receives an effective and consistent service from all agencies involved and any needs, risks or changes identified are shared and action taken.	4.1 and 4.2 with immediate effect	4.1 Housing Options staff to notify Lettings team of pertinent needs and risk information on Locata. = Key staff have access to both Locata, Northgate and EDRMS. 4.2 Lettings Team to transfer information to Northgate and EDRMS and make the relevant Housing Officer aware. = The client receives an effective and consistent service from all agencies involved and any needs, risks or changes identified are shared and action taken.
30. Review the	Local	5.1 Review assessment process	Housing	Rent Vulnerability Assessment	5.1 End of	5.1 Review assessment

Rent Vulnerability Assessment which now takes place for people moving into a tenancy, to ensure it instigates the appropriate action for people who are at risk of falling into rent arrears.		and initiate any appropriate changes.	Landlord Bournemouth Borough Council	introduced previously to identify those at risk at the start of a tenancy. Potential risks are identified early and services/support put in place to mitigate these risks.	March 2018	process and initiate any appropriate changes. = Rent Vulnerability Assessment introduced previously to identify those at risk at the start of a tenancy. Potential risks are identified early and services/support put in place to mitigate these risks.
31. Staff are to be reminded of the importance of recording and to keep all agencies updated of non-engagement and signs of deterioration or withdrawal.	Local	6.1 Learning covered at team meetings. 6.2 Record keeping training to be rolled out. 6.3 Quality/Performance of customer contact monitored through supervision.	Housing & Customer Bournemouth Borough Council	Confirmation received from managers and recorded when covered in team meetings. Process change made from previous SCR learning to notify all agencies where there is non-engagement in Housing services or closure of a case. The client receives an effective and consistent service from all agencies involved and any needs, risks or changes identified are shared and action taken	6.1 End of November 2017 6.2 End of March 2018 6.3 This is day to day practice	6.1 Learning covered at team meetings. = Confirmation received from managers and recorded when covered in team meetings. 6.2 Record keeping training to be rolled out. = Process change made from previous SCR learning to notify all agencies where there is non-engagement in Housing services or closure of a case. The client receives an effective and consistent service from all agencies involved and any needs, risks or 6.3 Quality/Performance of customer contact monitored through supervision.