Executive Summary

Domestic Homicide Review

Name: Claire

Died: April 2018

Author: Mark Wilkie
Chair: Ged McManus
Date: 8 February 2019

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1 The Review Process

1.1 This summary outlines the process undertaken by the Warrington Community Safety Partnership domestic homicide review panel in reviewing the homicide of Claire, who was a resident in their area.

1.2 The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:

Name	Who	Age	Ethnicity
Claire	Victim	40	White British
John	Perpetrator	55	White British

1.3 Criminal proceedings were completed on 16 October 2018. The perpetrator was found guilty of murder and was given a life sentence with a minimum tariff of 19 years.

1.4 The process began with the chair of the Warrington Community Safety partnership who informed members on 19 April 2018, that the circumstances met the criteria for a Domestic Homicide Review. The Home Office were informed on 10 May 2018. All agencies that potentially had contact with Claire and John prior to the point of death were contacted and asked to confirm whether they had been involved with them.

2 Contributors to the review

CONTRIBUTORS TO THE REVIEW / AGENCIES SUBMITTING INDEPENDENT MANAGEMENT REVIEWS (IMRs)

Agency	**Contribution**
Cheshire Constabulary	IMR
Warrington Care Commissioning Group (CCG)	IMR
Torus	IMR
Refuge	IMR
Change Grow Live known in Warrington as Pathways	IMR
Adult Social Care	IMR
HMP Altcourse	IMR
National Probation Service	Chronology
Cheshire and Greater Manchester Community	IMR

Rehabilitation Company	
RATI (Room at The Inn) Project	Short report
Homeless Team	Short report
Warrington & Halton Hospital NHS Trust	IMR
North West Boroughs Healthcare NHS Foundation Trust	IMR

A number of service providers in the Warrington area are mentioned in this report. The official title of that provider is not necessarily the one used by local people or staff in that provider or by other agencies. The local terminology is used in the report. Below is a list of those providers, the name they are commonly known by and their official title.

RATI	Room at the Inn (RATI) is the name of a night shelter which provides emergency bed and breakfast drop-in accommodation. It is open between 9pm and 8am daily and the building consists of 10 unisex pods in the main room (each pod is separated by a curtain), two lounge areas, kitchen, bathroom, offices and a small outside area. The facility was originally set up by the YMCA in December 2010 and is now managed by the Y project, a Charitable Incorporated Organisation (Charity No. 1176629), registered on 11 January 2018. The Y project also includes a co- located day time support facility which was previously operated from a separate building by the YMCA. The day service is open in the morning and then again in the afternoon and provides activities, information and support for up to 50 people.
Pathways	Pathways to Recovery is the local term for Change Grow Live (CGL) which deliver alcohol and drug services for adults.
Refuge	Refuge provides Independent Domestic Violence Advocates (IDVAs) to support anyone in Warrington who is experiencing domestic violence.
Warrington Hospital	Warrington Hospital is part of Warrington and Halton Hospitals NHS Foundation Trust.
New Leaf	New Leaf is a local project funded by the European Social Fund and the National Lottery aimed at getting people nearer to or back into work. Each client gets 1-2-1 support from an allocated mentor who assists in finding training opportunities. Budgeting and building confidence.

Torus	Torus is a housing group in the North West of England that provides housing and services for the Warrington area.
Golden Gates Housing Trust (GGHT)	Golden Gates were established in 2010 when they took over Warrington Borough Council's social housing stock. They now work in partnership with Torus.
Housing Plus	Housing Plus is a Warrington Borough Council service delivering homelessness and housing services, including services for rough sleepers.
North West Boroughs Healthcare NHS Foundation Trust	Provide mental health services to the local community.

3 The review panel members

3.1	**Member**	**Organisation**
	Ged McManus	Independent Chair
	Mark Wilkie	Independent Author
	Julie Ryder	Warrington CCG
	Susan Wallace	Cheshire Constabulary
	Paula Underwood	Torus
	Rosie Lyden	Safeguarding Adult and Children Board
	Steve Cullen	Citizens Advice Bureau
	Jackie Hodgkinson	North West Boroughs Healthcare NHS Foundation Trust
	Wendy Turner	Warrington & Halton Hospital NHS Trust
	Theresa Whitfield	Warrington Borough Council, Community Safety Partnership
	Margret Macklin	Quality Assurance and Adult Safeguarding Warrington Borough

	Council
Mari Edwards	Refuge
Cathy Fitzgerald	Substance Misuse and Commissioning Development Public Health Warrington Borough Council
Cheryl Holdbrook	RATI
Jenny Archer-Power	Cheshire and Greater Manchester Community Rehabilitation Company (CGMC CRC)
Wendy Teague	Warrington Borough Council
Ann Woods	Housing
Alan Warburton	HMP Altcourse
Sally Starkey	Women's Aid
Jessica Smith	Pathways to Recovery
John Davidson	National Probation Service
Maria Guidera	Domestic Abuse Co-ordinator Warrington Borough Council

3.2 The panel met five times and the review chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

4 Chair and Author of the overview report

Ged McManus was appointed as the Independent Chair in July 2018. He is an independent practitioner who has chaired and written previous DHRs, and Safeguarding Adult Reviews. He is currently an Independent Chair of a Safeguarding Adult Board in the north of England. He was assisted by Mark Wilkie the report writer who is another independent practitioner. Neither of them has previously worked for any agency involved in this review.

5 Terms of Reference

5.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

[Multi Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

Timeframe under Review

The DHR covers the period 16 February to the date of Claire's murder in April 2018.

Case Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour[1] did your agency have that could have identified Claire as a victim of domestic abuse and what was your response?

2. How did your agency assess the level of risk faced by the victim from the perpetrator and which risk assessment model did you use?

[1] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

3. What services did your agency provide for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?
4. What care and support needs did your agency identify for the victim and perpetrator and what action was taken?

5. What information did your agency have to suggest that the victim or perpetrator may have been experiencing or at risk of abuse or neglect? Were any opportunities missed to make a safeguarding adult alert/referral?

6. How did your agency ascertain the wishes and feelings of the victim about her victimisation and were her views taken into account when providing services or support?

7. What did your agency do to establish the reasons for the perpetrator's abusive behaviour and how did it address them?

8. Was there sufficient focus on reducing the impact of the perpetrator's abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

9. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?

10. How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies that needed it?

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

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

13. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?

14. Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

15. What knowledge did family, friends and employers have that the victim was in an abusive relationship and did they know what to do with that knowledge?

16. Were there any examples of notable good practice?

6 Summary chronology

6.1 Claire and John

6.1.1 John and Claire met during 2016, in Warrington town centre. Both had alcohol and mental health issues and were lonely.

6.1.2 On 30 September 2017, John was arrested for assaulting Claire and possession of an offensive weapon (knife). He was bailed to allow for further evidence to be gathered. The bail conditions were (i) John not to have any contact by whatever means with Claire and (ii) for John not to enter the street where Claire lived. Claire was informed of his release and bail conditions.

6.1.3 This charge and bail conditions set off a catalogue of incidents where by John was further arrested for repeated breach of the bail conditions. Only one of these being directly in relation to Claire. Other breaches did not involve contact with Claire, for example failing to attend and sign at the police station. This culminated on 2 January 2018, when John was arrested for breach of bail and was placed before the court where he was remanded to custody.

6.1.4 On 6 November 2017, Claire self-presented at Warrington Hospital A&E Department complaining of pain to her ribs. The hospital Adult Safeguarding team got involved when Claire disclosed she had been assaulted by her partner (the police were aware of this incident). Claire disclosed more information to health professionals than she had to police. As a result of this a request for a MARAC was made to Cheshire Constabulary.

6.1.5 The MARAC took place on 6 December 2017 the MARAC shared information between agencies and set 5 actions

6.1.6 On 19 February 2018, John appeared at NCMC for offences of Possession of a bladed article (knife) and assault (both dated 30 September 2017 and in relation to Claire). He was sentenced without reports to 6 months imprisonment for the knife possession and 5 months imprisonment concurrent for the offence of assault. A Magistrates Court Restraining Order against John was granted on this date, the purpose of which was to protect Claire

from further conduct which amounted to harassment or would cause fear of violence. This restraining order specified that John was (i) not to contact directly or indirectly Claire and (ii) not to enter the street where Claire lived. The order was in place until 18th February 2019.

6.1.7 Details of the restraining order were sent to HMP Altcourse. On receipt a paper copy of the conditions was put in an envelope to be delivered to the Public Protection department. This was never received so the relevant staff were not aware of the restraining order. This enabled John to have contact with Claire. He phoned her on 160 occasions during the 39 days between conviction and release. Claire also attempted to phone him.

6.1.8 On 3 April 2018, John was released from prison. He gave his release address as the RATI project. He failed to attend his meeting with probation on his release.

6.1.9 On 6 April 2018, Probation issue a recall order for John. This information was forwarded to Cheshire Police.

On 10 April 2018, Claire was found dead in her flat. John was arrested on suspicion of her murder.

6.2 **Key events Claire**

6.2.1 In 1995, Claire was subject to an indecent assault in Warrington town centre. A DNA match was later linked to an offender in 2001. This male was arrested and later pleaded guilty. He was sentenced to 3 years imprisonment for the offence against Claire.

6.2.2 In July 2012, Claire presented at Warrington Hospital with a serious non-accidental injury. She had a stab wound to her buttock. Professionals suspected that Claire may be vulnerable to abuse from her partner.

6.2.3 Between 2012 and 2016, Claire was in a relationship with a male who died on 27th February 2016 (date of the start of the terms of reference). This previous relationship came to the attention of Cheshire Constabulary a number of times in relation to intoxication and reports of verbal arguments and damage to property. Claire also called police about her relationship believing it to be psychologically abusive (pre coercive control legislation).

6.2.4 It is believed that the death of her partner was a key event for Claire. They did not live together initially but lived in separate flats in the same block. It is thought that they shared one of these flats for a short time before Claire moved to different accommodation.

6.2.5 Warrington Borough Council Adult Social Care had no contact with Claire during the period under review. Previously between 2012 and 2015 Claire had been referred to New Directions and Mental Health Outreach Services. Both of these engage with adults with 'low level' mental health needs.

6.2.6 Claire attended her GP practice on numerous occasions. This was generally for low level mental health issues and a variety of physical medical problems. The medical care provided by the GP practice was in line with expected practice however relationships and domestic abuse were rarely discussed.

6.2.7 Claire would regularly visit the RATI where she was offered advice and support with regards to the relationship with John, budgeting, her alcohol and mental health issues but Claire would always say that she didn't need any help.

6.2.8 Claire had problems with budgeting. Torus and previously Golden Gates Housing trust had regular contact with her to assist when possible. Claire was in receipt of benefits which changed from time to time. When the amount of benefit dropped this caused her problems as did the transition to Universal Credit. During the time under review Torus had difficulty contacting Claire and getting her to attend appointments.

6.3. Key events John

6.3.1 John was born and lived in Liverpool for the majority of his life. He worked as a plasterer until his alcohol and substance abuse made it untenable.

6.3.2 John's father, who was a successful business man died about 5 years ago, he had many properties which were then sold after his death and divided between John and his siblings. John's money was placed in a trust fund that he could access.

6.3.3 John moved to Warrington in December 2014 to the Salvation Army hostel following a transfer from a Salvation Army hostel in Liverpool. However, he left the hostel in Warrington and returned to the Salvation Army hostel Liverpool between February 2015 and May 2015. Sometime after May 2015 he returned to Warrington. In July 2015 John was admitted to Hollins Park and presented as homeless in October 2015. A homeless investigation identified that he had no local connection to Warrington and Liverpool City Council accepted a full housing duty and offered to provide accommodation. Housing Options offered to provide transport, although John refused to return to Liverpool

6.3.4 In December 2015 John was again admitted to Hollins Park Hospital under section 2 of the Mental Health Act (MHA) with an episode related to poly-substance abuse. Emotionally unstable personality disorder was also written in his discharge letter. He was discharged to the RATI and having been identified as having eligible needs, referred to social services for support with his accommodation and social isolation.

6.3.5 After refusing to return to Liverpool, who offered to provide accommodation, John was homeless whilst in Warrington but spent most of his time at the RATI. He received support from both the day and evening services. Staff were able to talk to John and he would engage to a degree that he would not with other agencies. To help John manage his money they gave him £10 a day spending money from his own fund.

6.3.6 During the period under review John had two different Social Workers who had been unable to establish a relationship with him. At times he had had been challenging to Social Worker 1 and he had refused to engage with her on some occasions prior to the review period, although she had obtained some personal history from him. He was assessed as having care and support needs, having been at risk of self-neglect and social isolation. The main aim was to try and support him to address his accommodation needs through coordinating enquiries on his behalf and offering advice and support to RATI as this was the agency he would engage with. Partly as a result of John declining involvement with social services, he was only seen once during this time frame.

6.3.7 John came to the attention of Cheshire Constabulary 14 times between 15 July 2016 and 13 July 2017. These incidents did not involve Claire. He was arrested on 8 occasions.

6.3.8 John was released from HMP Altcourse on 3 April 2018. Part of the release process involved CGMCRC completing a release plan which included residing at the RATI and meeting with his CGMCRC case manager on release.

7 Key issues arising from the review

1. Claire had been in abusive relationships for several years.
2. During the time that John was in Warrington he was always homeless.

3. John had no regard for authority and would not engage with agencies.

4. Cheshire Constabulary failed to arrest John after he was recalled to prison.

5. HMP Altcourse failed to ensure that the terms of the restraining order placed upon John were complied with.

6. The MARAC process was ineffective.

7. Information was not shared between agencies and the third sector (RATI).

8. Professionals need to be able to share information on difficult cases where clients are challenging to engage.

8 Conclusions

8.1 Claire and John met in 2016, in Warrington town centre. John had moved from another area and was homeless. The focal point for their early relationship was the art classes run at the Nora Street community Centre. Both had alcohol and mental health issues. As time went by John spent time at Claire's flat. This relationship was mostly unknown to Agencies; however, John was frequently involved with the Police for drunkenness and public order offences. He was arrested on several occasions. Claire's family were not aware of this relationship until after her death. Staff at the RATI were aware of the relationship between the couple but not the domestic abuse. They did attempt to give the couple advice and assistance whilst recognising that Claire and John had the capacity to make their own decisions. Claire was offered support services, for example housing, but then did not keep to appointments. John engaged with staff at the RATI but would not engage with Adult Social care.

8.2 There were occasions when Claire presented to her GP with injuries. There was inconsistency of approach with regards to asking about domestic abuse and if it was disclosed opportunities to further explore were missed. There is evidence to support the fact that Claire suffered domestic abuse in all three of her adult relationships. This was over a period of 20 years and does not appear to have been part of a holistic approach to Claire's care. Consideration could be given to commissioning the IRIS[2] model locally to raise awareness of the issues surrounding domestic abuse and how to refer women to IDVAs.

[2] Identification & Referral to Improve Safety

8.3 Claire was referred to MARAC following a referral from Warrington Hospital. The staff involved in this referral correctly identified that Claire was a high-risk victim and acted in accordance with established protocols. This is good evidence that domestic abuse training is embedded in practice in the Warrington and Halton Hospitals NHS Foundation Trust.

8.4 The MARAC meeting that heard Claire and John's case identified Refuge (IDVA) as the nominated lead professional for communication with Claire. The MARAC's purpose is to share information amongst agencies and then formulate an action plan to keep the victim safe. In this case key information was not available to the meeting because there was no input from RATI. Five actions were identified but not all of these were completed and there was no follow up to ensure that the actions were finalised.

8.5 Safelives[3] have produced videos to help with understanding the MARAC process. It explains that the MARAC co-ordinator is the unsung hero and essential to the efficient running of the process.
https://youtu.be/Dp9H5SBOKIg

8.6 There were different perceptions as to whether or not a VPA was a referral; Police thought that it was, Pathways thought that it was not. This confusion meant that Claire was not contacted by Pathways.

8.7 The actions generated by the MARAC meeting were not wholly realistic, for example the panel heard that the action accepted at the meeting by the Pathways representative for Pathways to contact Claire was against their policy and should not have been accepted. This is said to be due to an inexperienced member of staff attending the meeting. Overall the MARAC process was ineffective in this case.

8.8 A series of workshops had been held to review MARAC processes prior to October 2017, and a final draft of a revised MARAC protocol had been sent to relevant agencies on 27 October 2017. The panel reflected that elements of that revised protocol had not been embedded at the time of the MARAC meeting which considered Claire and John's case.

8.9 John entered HMP Altcourse on 5 January 2018 as a remand prisoner with no restraining order in place. He was remanded for assaulting Claire. He attempted to phone Claire on 54 occasions before he was convicted on 19 February 2018. Prior to being remanded into custody Claire was afforded the protection of bail conditions however once remanded the conditions no longer applied. The guidelines set out in the National Offender Management Service

[3] SafeLives is a UK-wide charity dedicated to ending domestic abuse

Public Protection Manual 2016 Chapter 6 refer to tackling witness intimidation by remand prisoners. This should be read in conjunction with PSI 46/2011, Prisoner communication services. PSI 46/2011, Tackling witness intimidation by remand prisoner, and PSI 4/2016, The interception of communications in prisons and security measures. Essentially this sets out a process that can protect witnesses from intimidation. If bail has been refused and one of the reasons was because there were substantial grounds to believe that the perpetrator would interfere with witnesses and that interference constitutes intimidation, then the Police can submit this to CPS on the MG6 which would be forwarded to the prison via the PER. The prison governor can then take appropriate steps to mitigate the risk whilst the defendant is on remand. The numbers of such requests per year would suggest that this is not being utilised in domestic abuse cases. The panel discussed this and were of the opinion that the continual communication to Claire from John was a form of coercion and control which could be construed as an act of intimidation.

8.10 HMP Altcourse received John as a convicted prisoner on 19 February 2018, as a result of his conviction at NCMC for assaulting Claire and being in possession of a knife. Accompanying him was a 12-month restraining order issued by the Magistrates preventing John from having any contact with Claire. HMP Altcourse did not appear to follow the guidelines set out in the National Offender Management Service Public Protection Manual 2016. He should have been managed under Harassment Public Protection Measures which would have ensured his communications were managed and monitored. After his conviction he attempted to phone Claire on 160 occasions. Most of the calls did not connect. He also wrote several letters to her. The system failed Claire.

8.11 Cheshire Constabulary failed to arrest John after he was recalled to prison. Their internal processes did not identify the resources that may have been able to arrest John in a timely manner but instead followed their rigid command and control processes.

8.12 RATI knew Claire and John better than any other agency and could have assisted other agencies with engagement, particularly with John. It is also apparent that they did not have access to relevant information that could have kept Claire safe. For example, they were not aware of the MARAC. This was also the case when John was released from prison, they were told by other users of their service that John had been seen in the town centre.

8.13 When John was released from HMP Altcourse he gave his CGMCRC case manger the RATI as his release address. RATI do not and would not have held a bed for John. It operates on a need's basis and not like a bookable bed

and breakfast. This should have been identified and mitigated by CGMCRC.

9 Lessons to be learned

9.1 Narrative

With the full benefit of hindsight Claire's family can now see that Claire may have been the victim of domestic abuse for a number of years before her death.

Learning 1

There is a continuing need to raise awareness of domestic abuse and healthy relationships within the community.

9.2 Narrative

A MARAC was held to discuss the relationship between Claire and John after it had been identified that Claire was suffering domestic abuse. This was ineffective and did not contribute to keeping Claire safe.

Learning 2

Agencies must take a greater degree of responsibility to complete actions than there was in this case. This would have been achieved by better coordination and governance. Agencies need to mainstream work on MARAC cases and ensure that if key members of staff are unavailable then MARAC related work is appropriately allocated to other staff.

9.3 Narrative

There was confusion during the MARAC meeting and after about whether or not a VPA was a referral and hence could the victim be contacted. The Police believed that it was but the Pathways service were not of the same view.

Learning 3

Staff need to be aware of their agency's respective information sharing protocols and if unsure seek clarification at the earliest opportunity.

9.4 Narrative

There are 2 examples in this case where new guidance has been issued to

agency/agencies at crucial times. The MARAC guidance workshops and the NOMS Public Protection manual 2016, (Issued November 2017). Neither of these appears to have been effective in this case.

Learning 4

Agencies should have in place a methodology to check and ensure that any new policy is embedded within the respective agencies practice.

9.5 **Narrative**

There were several occasions where information was either not shared or sought which could have assisted in making Claire safer. RATI were not informed about John ‘s release, nor were their staff asked to contribute to the MARAC

Learning 5

Third sector organisations make a valuable contribution to keeping potentially vulnerable people safe. Policies and working practices need to be established which recognise and encourage third sector contributions.

9.6 **Narrative**

It has been noted in the review that there have been occasions when Claire attended appointments with her GP practice. She was invariably seen by different doctors and there were differing approaches to discussions about domestic abuse and any subsequent referrals.

Learning 6

It is important that health professionals have a consistent approach in supporting victims of Domestic Abuse. The panel heard that Warrington Borough Council Families and Wellbeing Directorate have provided domestic abuse to health care professionals. This is a positive as the referral to MARAC by hospital staff indicates. Since then training has been provided for 140 GPs and practice nurses. The panel reflected that it is important that all agencies are fully engaged with domestic abuse training.

9.7 **Narrative**

Services were unable to keep Claire or John engaged and the panel heard that John was aggressive and intimidating towards a social worker. There was little visibility of the couple or their relationship across the partnership until 6 December 2017.

Learning 7

Professionals need to be able to share information on difficult cases where clients are challenging to engage. A partnership approach to these clients has an enhanced chance of success as opposed to a single agency approach. The panel felt that this would be the most effective way of engaging challenging clients to offer them support and thereby reduce risk.

10 Recommendations from the review

10.1 **Recommendation one**

Warrington Community Safety Partnership to raise the profile of domestic abuse services within the Borough with emphasis on raising awareness of where to get advice and access to help and support.

10.2 **Recommendation two**

Warrington Community Safety Partnership should put in place processes by which it can gain assurance that.

1. MARAC actions are meaningful and contribute to the safety of the victim.
2. Agencies are held to account for the delivery of agreed actions.
3. Effective MARAC co-ordination arrangements are in place.

10.3 **Recommendation three**

Warrington Community Safety Partnership should seek assurance from it's constituent agencies and the commissioners of Pathways that the purpose and status of a VPA is consistently understood across the partnership.

10.4 **Recommendation four**

Warrington Community Safety Partnership should seek assurance from its constituent partners and third sector agencies that they commission that an appropriate mechanism is in place to ensure that domestic abuse and safeguarding policies are embedded in practice.

10.5 **Recommendation five**

Warrington Community Safety Partnership should seek written assurance from HMP Altcourse that the failure in internal communications which led to John's restraining order not being recorded and his subsequent ability to communicate with Claire in breach of the restraining order has been effectively resolved.

10.6 **Recommendation six**

Warrington Community Safety Partnership should seek assurance from its constituent partners that there are no inappropriate barriers to sharing information with the third sector partners.

10.7 **Recommendation seven**

Warrington Community Safety Partnership should seek assurances from all agencies and commissioned third sector agencies that they are fully engaged in local domestic abuse training.

10.8 **Recommendation eight**

Warrington Community Safety Partnership and Warrington Safeguarding Adult Board should consider the feasibility of developing a coordinated case management/information sharing approach to the care of high intensity service users, who for whatever reason engage in risky behaviours that are not captured by other safeguarding processes. The two boards are best placed to collaborate and facilitate discussion around this with a view to agreeing and implementing a multi-agency protocol.

10.9 **Recommendation nine**

Torus New Leaf

When clients are being assessed for the 1-2-1 mentor scheme this assessment should include asking questions about domestic abuse as well as safeguarding issues.

10.10 **Warrington CCG**

Ensure that staff at GP practices understand the indicators of possible domestic abuse and how to ask about domestic abuse in a sensitive way and manage any disclosures made. Consideration should be given to commissioning the IRIS[4] model locally to raise awareness of the issues surrounding domestic abuse and how to refer women to IDVAs.

10.11 **Warrington and Halton Hospitals NHS Foundation Trust**

Staff should receive targeted domestic abuse training with a focus on

[4] Identification & Referral to Improve Safety

recognising controlling and coercive behaviour.

10.12 **Warrington and Halton Hospitals NHS Foundation Trust**
Targeted DASH completion and assessment training should be provided with a focus on enabling staff in recognising domestic abuse situations; they should be equipped with the knowledge of how to escalate situations in which there is danger even when the victim does not know/realise danger is present, or does not consent to receiving support in high risk situations.

10.13 **Warrington and Halton Hospitals NHS Foundation Trust**
Staff should be made aware of their statutory and professional obligations and reminded of their professional responsibilities with regard to documentation and record keeping.

10.14 **Pathways to recovery (Change, Grow, Live)**
Pathways to identify two additional staff members as MARAC deputies who will receive the local induction to MARAC, including shadowing a MARAC session, and training from the lead Pathways MARAC representative on record keeping.

10.15 **Warrington Borough Council Adult Social Care**
WBC Adult Social Care to undertake an audit of cases to confirm the effectiveness of recent strength-based approach training including the use of and clarity around service user outcomes.

10.16 **Warrington Borough Council Adult Social Care**
WBC Adult Social Care to ensure the integration of the Skills for Care Knowledge and Skills Statement for Practise Supervisors within its supervision policies and procedures.

10.17 **Warrington Borough Council Adult Social Care**
WBC Adult Social Care to ensure that supervisors review each case when there is a transfer between case managers to maintain direction and focus.

10.18 **Warrington Borough Council Adult Social Care**
WBC Adult Social Care to raise awareness of the use of multi-agency frameworks to escalate and share risks in relation to capacitated adults, including the lessons identified in the recent Safeguarding Adults Board audit.

10.19 **Cheshire and Greater Manchester Community Rehabilitation Company (CGM CRC)**
CGM CRC to improve the knowledge, understanding and effective use of Through the Gate (TTG) guidance and procedures for relevant staff.

10.20 **Cheshire and Greater Manchester Community Rehabilitation Company (CGM CRC)**
CGM CRC to deliver SARA3 training across the organisation and across all operational grades of staff.

10.21 **Cheshire and Greater Manchester Community Rehabilitation Company (CGM CRC)**
CGM CRC to develop and embed Quality Assurance and continuous improvement in relation to EMO arrangement.

10.22 **Cheshire Constabulary**
To review policies and procedures in relation to dealing with prisoner recall orders.

10.23 **Cheshire Constabulary**
Cheshire Constabulary to raise awareness amongst officers of the importance of submitting a VPA in cases of breaches of bail when the bail conditions have been imposed as a result of a domestic incident.

10.24 **Cheshire Constabulary**
Cheshire Constabulary to consider making use of the current legislation around the harassment and intimidation of witnesses when a remand is sought for the perpetrator of domestic abuse.

Appendix A

Warrington Community Safety Partnership

No	Recommendation	Lead Agency / Officer	Date of Completion & Outcome
1	Warrington Community Safety Partnership to raise the profile of domestic abuse services within the Borough with emphasis on raising awareness of where to get advice and access to help and support.	WCSP PW / AA (MB)	CSP Reviewed Action – Closed 29 August 2019
2	Warrington Community Safety Partnership should put in place processes by which it can gain assurance that. 1. MARAC actions are meaningful and contribute to the safety of the victim. 2. Agencies are held to account for the delivery of agreed actions. 3. Effective MARAC co- ordination arrangements are in place	WCSP PW / AA (MB)	CSP Reviewed Action – Closed 29 August 2019
3	Warrington Community Safety Partnership should seek assurance from its constituent agencies and the commissioners of Pathways that the purpose and status of a VPA is consistently understood across the partnership	WCSP CF	CSP Reviewed Action – Closed 14 November 2019
4	Warrington Community Safety Partnership should seek assurance from its constituent partners that an appropriate mechanism is in place to ensure that domestic abuse and safeguarding policies are embedded in practice.	WCSP PW / AA (MB)	CSP Reviewed Action – Closed 29 August 2019

No	Recommendation	Lead Agency	Date of Completion & Outcome
5	Warrington Community Safety Partnership should seek assurance from constituent partners that there are no inappropriate barriers to sharing information with third sector partners.	WCSP	CSP Reviewed Action – Closed 14 November 2019
6	The Home Office should seek assurance from HMPPS that in all prisons in England and Wales the guidance given in the NOMS Protecting Public Manual 2016; is complied with in relation to the restriction of communications by prisoners who have a Court restraining order in place when they enter custody.	Home Office	CSP Reviewed Action - Closed 14 November 2019
7	Warrington Community Safety Partnership should seek assurances from all agencies and commissioned third sector agencies that they are fully engaged in local domestic abuse training.	WCSP PW/AA (MB)	CSP Reviewed Action - Closed 29 August 2019
8	Warrington Community Safety Partnership and Warrington Safeguarding Adult Board should consider the feasibility of developing a coordinated case management/information sharing approach to the care of high intensity service users, who for whatever reason engage in risky behaviours that are not captured by other safeguarding processes. The two boards are best placed to collaborate and facilitate discussion around this with a view to agreeing and implementing a multi-agency protocol.	WCSP MM to lead on group to explore	CSP Reviewed Action - Closed 14 November 2019

No	Recommendation	Lead Agency	Date of Completion & Outcome
9	When clients are being assessed for the 1-2-1 mentor scheme this assessment should include asking questions about domestic abuse as well as safeguarding issues.	Torus	CSP Reviewed Action - Closed 29 August 2019
10	Ensure that staff at GP practices understand the indicators of possible domestic abuse and how to ask about domestic abuse in a sensitive way and manage any disclosures made. Consideration should be given to commissioning the IRIS model locally to raise awareness of the issues surrounding domestic abuse and how to refer women to IDVAs	Warrington CCG	CSP Reviewed Action - Closed 14 November 2019
11	Staff should receive targeted domestic abuse training with a focus on recognising controlling and coercive behaviour.	WHHFT	CSP Reviewed Action - Closed 29 August 2019
12	Targeted DASH completion and assessment training should be provided with a focus on enabling staff in recognising domestic abuse situations; they should be equipped with the knowledge of how to escalate situations in which there is danger even when the victim does not know/realise danger is present, or does not consent to receiving support in high risk situations.	WHHFT	CSP Reviewed Action - Closed 29 August 2019
13	Documentation of conversations between professionals and of plans regarding the DASH process is important. In this instance all details of conversations between professionals were not always recorded	WHHFT	CSP Reviewed Action - Closed 29 August 2019

No	Recommendation	Lead Agency	Date of Completion & Outcome
14	Pathways to identify two additional staff members as MARAC deputies who will receive the local induction to MARAC, including shadowing a MARAC session, and training from the lead Pathways MARAC representative on record keeping.	Pathways CF	CSP Reviewed Action - Closed 29 August 2019
15	WBC Adult Social Care to undertake an audit of cases to confirm the effectiveness of recent strength-based approach training including the use of and clarity around service user outcomes.	WBC ASC MM	CSP Reviewed Action - Closed 29 August 2019
16	WBC Adult Social Care to ensure the integration of the Skills for Care Knowledge and Skills Statement for Practise Supervisors within its supervision policies and procedures.	WBC ASC MM	CSP Reviewed Action - Closed 29 August 2019
17	WBC Adult Social Care to ensure that supervisors review each case when there is a transfer between case managers to maintain direction and focus.	WBC ASC MM	CSP Reviewed Action - Closed 29 August 2019
18	WBC Adult Social Care to raise awareness of the use of multi- agency frameworks to escalate and share risks in relation to capacitated adults, including the lessons identified in the recent Safeguarding Adults Board audit.	WBC ASC MM	CSP Reviewed Action - Closed 29 August 2019
19	CGM CRC to improve the knowledge, understanding and effective use of Through the Gate (TTG) guidance and procedures for relevant staff.	CRC	CSP Reviewed Action - Closed 29 August 2019

No	Recommendation	Lead Agency	Date of Completion & Outcome
20	CGM CRC to deliver SARA3 training across the organisation and across all operational grades of staff.	CRC	CSP Reviewed Action - Closed 29 August 2019
21	CGM CRC to develop and embed Quality Assurance and continuous improvement in relation to EMO arrangement.	CRC	CSP Reviewed Action - Closed 29 August 2019
22	To review policies and procedures in relation to dealing with prisoner recall orders.	CC	CSP Reviewed Action - Closed 29 August 2019
23	Cheshire Constabulary to raise awareness amongst officers of the importance of submitting a VPA in cases of breaches of bail when the bail conditions have been imposed as a result of a domestic incident.	CC	CSP Reviewed Action - Closed 29 August 2019
24	Cheshire Constabulary to consider making use of the current legislation around the harassment and intimidation of witnesses when a remand is sought for the perpetrator of domestic abuse. (Para 17.9)	CC	CSP Reviewed Action - Closed 29 August 2019