SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Charles'

Died Spring 2019

EXECUTIVE SUMMARY

FOR PUBLICATION

April 2021

Chair and Author Paul Cheeseman

Supported by Carol Ellwood-Clarke QPM

CONTENTS

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Sefton Safer Communities Partnership [the statutory Crime and Disorder Partnership] in reviewing the homicide of Charles a resident in their area. The DHR panel extend their condolences to Charles' wife on her loss and for the consequences to her of this tragic event.

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

Name	Relationship	Age	Ethnicity
Charles	Victim	90	White British
Thomas	Perpetrator	20	White British
Janette	Wife of Victim	59	White British
Anna	Daughter of Janette	31	White British
Sarah	Girlfriend of Thomas	21	White British
Address 1	Home of Charles, Janette and Thomas	Scene of assault	

1.3 Charles died in hospital sometime after he sustained injuries as a result of an assault by Thomas. This assault occurred on a Sunday in early spring 2019, when Charles and Janette returned from church and asked Thomas for some money. There was an argument and Thomas punched his father to the body and face.

1.4 Thomas was initially arrested and convicted of assault upon his father. Before Thomas was sentenced Charles died. Thomas was then charged with the manslaughter of his father and was sentenced to a term of 3 years and 4 months imprisonment.

1.5 Sefton Safer Communities Partnership met on 28 September 2019 and determined the manslaughter of Charles met the criteria for a domestic homicide review [DHR]. The Home Office were informed, and an independent domestic homicide review was commissioned. All agencies that potentially had contact with Charles and Thomas prior to the homicide were asked to secure their files. The first meeting of the DHR panel was held on 29 November 2019. Thereafter two further meetings were held and a draft report written before work on the review was delayed because of the Covid19 crisis.

The panel resumed work in July 2020 with a further meeting on line before concluding its work with the presentation of the overview report to Sefton Safer Communities Partnership Board on 10 September 2020.

2. CONTRIBUTORS TO THE REVIEW

2.1 The table below shows the agencies that contributed to the review and the material they were able to supply.

Agency	IMR[1]	Chronology	Report
Merseyside Police	Yes	Yes	
GP Surgery	Yes	Yes	
North West Boroughs Health Care NHS Foundation Trust	Yes	Yes	
Aintree University Hospital NHS Foundation Trust			Yes
Sefton Adult Social Care	Yes	Yes	
Merseyside Fire & Rescue Service			Yes
OVH Association			Yes
Sefton Women and Children's Aid [SWACA]			Yes

2.2 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

[1] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review which includes a chronology.

3. THE REVIEW PANEL MEMBERS

3.1 The panel members were:

Review Panel Members		
Name	**Job Title**	**Organisation**
Steve Bentley	Detective Sergeant	Merseyside Police
Paul Cheeseman	Chair	Independent
Carol Ellwood-Clarke QPM	Support to Chair	Independent
Neil Frackelton	Chief Executive	Sefton Women's and Children's Aid [SWACA]
Natalie Hendry-Torrance	Designated Safeguarding Adult Manager	South Sefton CCG and Southport and Formby CCG.
Neil Jones	Detective Constable	Merseyside Police
Angela Lacy	Head of Safeguarding	Merseycare NHS Foundation Trust
Janette Maxwell	Localities Team Manager	Sefton Council
Lynn McNiven	Detective Sergeant Public Protection Unit	Merseyside Police

3.2 The panel met four times[2] and the review chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny.

[2] The final panel meeting was conducted remotely using Microsoft Teams as face to face contact was not possible because of Government restrictions.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 Paul Cheeseman was appointed as the Independent Chair and Author. He was supported by Carol Ellwood-Clarke QPM. Both are independent practitioners who have chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adult Reviews. Neither has been employed by any of the agencies involved with this review nor are they connected to Sefton Safer Communities Partnership Communities Board who judged they had the necessary experience, skills and independence to undertake the review.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 These were set as:

The purpose of a DHR is to:[3]

a) 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;

b) 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;

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

d) 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;

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

f) Highlight good practice.

Specific Terms

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

[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

2. What risk assessments did your agency undertake for Charles or Thomas; what was the outcome and if you provided services were they fit for purpose? Did Charles have any known vulnerabilities and was he in receipt of any services or support for these?

3. What was your agency's knowledge of any barriers faced by Charles that might have prevented him reporting domestic violence and abuse and what did it do to overcome them?

4. What knowledge did your agency have of Charles' and Thomas' physical and mental health needs and what services did you provide? Was Thomas living with Asperger syndrome or any other diagnosed condition?

5. What knowledge or concerns did the victim's family, friends, colleagues and wider community have about Charles' victimisation and did they know what to do with it?

6. What knowledge did your agency have that indicated Thomas might be a perpetrator of domestic violence and abuse and what was the response, including any referrals to a Multi-Agency Risk Assessment Conference [MARAC]?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Charles and Thomas? Were they members of any faith communities and if so does that community have any information that may be of relevance to the DHR?

8. Was debt, finance, alcohol or substance misuse an issue that was a relevant factor in relation to this DHR?

9. Did your agency follow its domestic violence and abuse policy and procedures, and the multi-agency ones?

10. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Charles and Thomas, or on your agency's ability to work effectively with other agencies?

11. What learning has emerged for your agency?

12. Are there any examples of outstanding or innovative practice arising from this case?

13. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Sefton Community Safety Partnership?

Timescale

5.2 The review covers the period from 6 April 2017 to a day in Spring 2019 when Charles died. The start date approximated to the date of Charles' registration with his most recent GP practice.

6. EQUALITY AND DIVERSITY

6.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

6.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if—

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[4].

6.3 Charles and Thomas were born in the United Kingdom and their ethnicity is White British. There is nothing within Charles' family background or medical history to indicate he lacked capacity to understand either the spoken or written word. There was some concern within the family shortly before Charles' manslaughter that he might be displaying the early signs of a condition such as dementia. However, there is nothing in his medical records to substantiate this. In all other respects, Charles appears to have been ambulant and fit and well for a man of his age. Consequently, Charles could not be said to be living with a disability within the meaning of this Act.

6.4 Thomas had a diagnosis of Asperger's Syndrome which was made when he was a child and for which he received specialist services at Alder Hey Children's hospital. While this condition remained with him, he was discharged from specialist services when he reached adulthood and there is no evidence in medical records that he received any further treatment for

[4] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

this condition. When Thomas was examined by a clinical psychologist instructed by his defence they concluded the correct diagnosis for Thomas was that he suffered from Autism Spectrum Disorder[5]. Therefore Thomas has a disability as defined by the Act. Further information about his condition is included later in this report. The review did not find any evidence Thomas was faced with barriers to accessing services because of this. However [see paragraph 12.20] there is some evidence that Thomas' disability impacted upon his employment opportunities.

6.5 Given Charles was 90 at the time of his manslaughter, consideration was given as to whether he might have faced barriers in relation to accessing services. Thomas was much younger at 20 years of age. The panel did not find any examples that indicated either Charles or Thomas was discriminated against because of their age or faced barriers or difficulties to accessing services because of age.

6.6 Charles was a devout Catholic and spoke openly about his faith. Similarly the review looked carefully to see if Charles faced barriers to accessing service or suffered any discrimination because of his faith. The review found no evidence this was the case. However, the review did find evidence that Charles behaviour towards others was sometimes intolerant and appeared to be influenced by his own religious beliefs. These occasions are highlighted within the report.

6.7 The review established that both Charles and Thomas were heterosexual males. The review found no evidence to indicate they suffered discrimination nor barriers to accessing services because of their sex or sexual orientation.

6.8 The review did find that debt, poverty and securing employment were a significant feature of the life of this family. While socioeconomic characteristics are not specific defined within the Equality Act 2010, these factors undoubtedly placed strains on relationships within the family.

[5] The way in which Asperger's Syndrome is classified has changed since Thomas was discharged from specialist services. Asperger's Syndrome is now considered to be a form of Autism.

7. SUMMARY CHRONOLOGY

7.1 Charles

7.1.1 There was little background information available to the panel with which to build a picture of Charles' life before he met Janette. He is believed to have been born in Bootle and had a brother and a sister, both of whom predeceased him. His first wife pre-deceased him before he met Janette. There were no children from that marriage.

7.1.2 Charles was a devout Roman Catholic and it was through the church that he met Janette. She had been married before and had one child Anna. The couple married when Charles was then in his late sixties and Janette in her late thirties. Janette gave birth to Thomas who was Charles only child.

7.1.3 There were concerns within Janette's family about the relationship. Janette suffered from mental illness [Bipolar Disorder-a condition characterised by extreme mood swings]. It was felt that, because of Janette's illness, she was a very vulnerable person. One of Janette's family described Charles as a bully and said he was controlling. Other family members describe a similar picture as did members of the community who knew Charles well.

7.1.4 Because of Covid19 restrictions and her illness, it was not possible for the panel to speak personally to Janette[6]. In an interview she gave to the police following Charles manslaughter she said there had been both good times and bad times. She acknowledged Charles had a quick temper however she said he was also good hearted and could be generous.

7.1.5 Financial poverty appeared to be a significant aspect of Charles and Janette's life. Anna said there was debt in the family and this was aggravated when Janette's personal independent payment [PIP] and employment support allowance [ESA] were cut. Charles was said to have called at neighbours' houses on occasions asking for money, either saying they had no food in the house or that Janette needed cigarettes. The parish priest told the panel

[6] Anna was the family representative who met with the panel Chair and provided liaison between the panel her mother and Thomas.

Charles had asked all sorts of people in the parish for money, including the priest himself.

7.2 Background to Thomas

7.2.1 Thomas was born when Charles was 70 years of age and Janette 38 years of age. Anna said her mother did not cope well because of her illness and Charles did not know how to be a father because of his age. Thomas had development needs as a child including anger management issues. He was educated in main stream schools in the Sefton area and left when he was 16 years of age with no qualifications.

7.2.2 Because of learning difficulties Thomas struggled to gain and retain employment, mainly holding jobs with zero hours contracts. At the time of the homicide Thomas was in a relationship with Sarah who lived with her parents in the Liverpool area. At the time of Charles homicide, Sarah was pregnant and gave birth to their daughter during June 2019.

7.3 Charles and Thomas' Relationship

7.3.1 Anna told the panel Thomas had an unhappy childhood. She said Charles had a short temper and often hit Thomas. She said he was brought up in an environment with violence and was able to give examples of Charles behaviour towards Thomas. This included Charles throwing one of Thomas' favourite toys against a wall and breaking it.

7.3.2 Members of the community also provided testimony about the relationship between Thomas and Charles. They described Charles as often shouting at his son. One person heard Charles threaten Thomas when he was a young adult and say, 'I will put my fist in your face'. Another saw Charles swear at his son and slap him to the side of this head telling him to get home, and that he wanted money.

7.3.3 Janette provided a different perspective and said the relationship between Charles and Thomas was "on and off" although she accepted it was rocky. However, she said there had been good times between them and gave examples of their mutual interest in football. Janette said Thomas was a good son. She said she did not blame Thomas for Charles' manslaughter.

7.3.4 Because he died before Anna's allegations were reported the police did not have an opportunity to ask Charles about them. The panel feel it is important to balance that information, when considering what Anna says about Charles, and to recognise that, irrespective of what allegations may have been made about him, he remains the victim of a domestic homicide and the focus of this review.

7.4 Key Events

7.4.1 The panel found agencies held some information about the family which pre-dated the terms of reference. During 2003 there were concerns about Thomas' development as a result of Janette's illness. In 2004 and 2005 Merseyside Police attended two reports of domestic incidents at the family home. These were reported to be connected to Janette's illness.

7.4.2 It was reported Thomas had witnessed violence and aggression in the family home and he was made the subject of a child protection plan. Sefton Women's and Children's Aid [SWACA][7] provided support to Thomas and the family and this continued through to March 2006 when it was reported there was no longer any violence at home. Thomas continued to receive support from the Learning Disabilities Team. He was also under the care of a specialist at Alder Hey Children's NHS Foundation Trust community paediatric clinic for Asperger's Syndrome. He was discharged from that service when $16^{1/2}$ years of age.

7.4.3 In August 2018 Charles reportedly threatened a neighbour with a letter knife after Janette had asked the neighbour's elderly mother for money. The neighbour described Charles as having a bad attitude. The police were called and the neighbour asked them to speak to Charles as she did not wish him to be prosecuted.

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[7] SWACA's dedicated team help women, young people and children survive the impact of Domestic Violence and Abuse by giving free practical and emotional support. Their services are offered regardless of Age, Disability, Sexuality, Race or Religion. Support can be given by phone, in person, in school, in the workplace, in Children's Centres or in our Centre. www.swaca.com

7.4.4 A few days later the housing association [landlord of address one] received a report that Janette and Charles were screaming and shouting at each other. A neighbourhood officer visited the address and Janette explained they had argued over money and that it would not happen again.

7.4.5 Later that month Merseyside Police received an emergency call reporting banging and shouting from address 1. On attending the police found an argument had occurred during a birthday party for Charles. Thomas had reacted adversely to a conversation about people working. There were no injuries and the police correctly recorded the matter as a domestic incident and graded it as bronze[8]. Charles was recorded as the victim and sent a letter with contact details for support agencies.

7.4.6 On 28 September 2018 Charles attended a walk-in centre with a cut to his arm which he said had been caused on a coffee table. He was also noted to have bruising to his forearm. The wound was treated and he was discharged.

7.4.7 On 26 October 2018 Charles and Janette visited the same walk-in centre and reported that Charles had been assaulted by Thomas who had been drinking and was angry, due to the internet having been cut off. Staff were also told that Thomas had assaulted Charles before. He was treated for a laceration to the left side of his head and staff from the centre correctly referred the matter to Sefton Council Adult Social Care Dept [ASC]. They also notified Charles' GP surgery of the incident and the surgery recorded this on Charles' record.

7.4.8 A member of the ASC team made a telephone call to address 1 and spoke to Janette. She said the internet was now back on, so things had calmed down and were OK. ASC therefore closed the case as requiring no further action.

7.4.9 On 25th March 2019 Janette rang Charles' GP surgery for a consultation. She said a fight had taken place the previous day over money. Thomas had struck Charles who sustained a black eye and a nose bleed. As a result of the call the GP visited Charles at home. The GP examined Charles and found no sign of a fracture to the orbital bones and no bruising to the chest wall at that time.

[8]Merseyside Police grade domestic incidents according to their nature and the type of follow up response required using bronze, silver and gold.

He was advised to take pain relief. The following day the GP surgery made a referral about the matter to adult safeguarding.

7.4.10 On 27 March 2019 police officers attended address 1 as a result of a call from a concerned member of the community who said Charles was injured and struggling to breathe. He was admitted to hospital for treatment and Thomas was arrested on suspicion of assaulting him. Charles told the police Thomas became angry because he and Janette had asked him for £10.00. Charles said Thomas punched him at least three times to his face and also once to his left side near his stomach. Charles said Thomas had been angry with him before and had hit him three times previously.

7.4.11 Thomas was charged with assault. Before the court sentenced him, Charles died. A post mortem found Charles had facial injuries including fractures of the cheek bone, upper jaw and ribs. These injuries were due to the assault on 24 March 2019. The cause of his manslaughter was recorded as:-

1a Bronchopneumonia.

b Blunt chest trauma and facial trauma.

Death was due to the consequences of the assault.

7.4.12 Thomas was charged with the manslaughter of Charles. Prior to sentencing he was examined by a clinical psychologist and diagnosed as suffering from autism spectrum disorder [rather than Asperger's Syndrome]. The media reported the sentencing judge told Thomas that, despite being on the autism spectrum, he must have appreciated he should not have repeatedly punched his elderly dad in the face and had intended or been reckless whether harm was caused and consequently only an immediate prison sentence was justified[9]. The panel feel it is important to recognise that the sentencing judge's comments do not allude to Charles' behaviour contributing to his homicide.

[9] https://planetradio.co.uk/city/local/news/

8. FINDINGS

8.1 The panel were clear Charles is the victim in this case. However, in trying to understand what happened it is not possible to avoid the fact Charles was also a perpetrator of verbal and physical abuse towards Thomas. His life, as described by Anna, was terrible. From his early years he also witnessed domestic abuse.

8.2 Why Charles behaved in the way he did is unclear. On the one hand he appeared to be a devout man and yet on the other hand there were aspects of his behaviour that were incongruent; for example he was intolerant of people who did not worship, castigated an unmarried mother, threatened a neighbour with a knife and generally had a reputation as a bully and an unpleasant man.

8.3 The psychology report into Thomas, used during the sentencing hearing, disclosed he developed psychological difficulties that left him vulnerable to mental health issues. The report found Thomas learnt from Charles in his early years that, the way he solved problems or reacted to others that annoyed him, was to be aggressive and violent.

8.4 The panel were concerned as to why some people in the community, who saw what Charles did to Thomas, did not report what they saw. There may be many reasons why that did not happen. Anna made a powerful comment that it was normal in the community where the family lived for boys to fight with their fathers. It may be that such behaviour might have become normalised.

8.5 Although Charles and Thomas remained largely unseen to agencies, there were some opportunities to engage with them before the final and fatal event. This included the visit by the housing association and the police in August 2018. The panel found the response of both agencies was appropriate.

8.6 When Charles visited the walk-in centre on 26 October 2018 staff correctly made a safeguarding referral. However, they did not appear to recognise this was also domestic abuse and did not complete a risk assessment. Similarly when ASC received and triaged the referral from the walk-in centre they did not treat the matter as domestic abuse either. There were clear indicators from what Janette said, that indicators associated with domestic violence and abuse were present, including misuse of alcohol by Thomas and debt within the family. The panel felt some agencies do not recognise that domestic abuse

does not always present within the context of intimate male and female relationships.

8.7 Similarly, while the GP also made an adult safeguarding referral as a result of their visit to see Charles on 25 March 2019, they did not appear to recognise this was also a case of domestic abuse. More importantly the GP, like ASC, did not realise there was a need for more immediate action to be taken to protect Charles from further harm [Thomas was still in the house] and to report what was a serious offence to the police. They only became aware two days later when an anonymous caller reported the matter.

9. LEARNING

Lesson 1 [Panel recommendation 2 and 6]
Narrative
Thomas had a troubled childhood. His mother suffered from mental illness and this in turn led to Thomas witnessing domestic abuse within the household. There were concerns about the impact of this behaviour upon Thomas who was made the subject of a child protection plan. Although his mother's mental health settled, as a couple Charles and Janette appeared to struggle as parents. There is evidence from many people, including his sister, that Thomas continued to be exposed to violent, coercive and controlling behaviour at the hands of Charles throughout the remainder of his childhood and into his early adult years.
Lesson
Children that are raised in households in which they are exposed to domestic abuse may in turn have some of those behaviours embedded and/or normalised within their own behaviour.

Lesson 2 [Panel recommendation 3 and 6]
Narrative
Debt and financial issues were a significant feature for the whole family in this case. Both Charles and Janette had difficulties in managing their finances. Janette suffered financially when her benefits were reduced. Because of her mental illness she was not able to work. Charles and Janette turned to informal means of support such as asking for loans from members of their local community and from their church. Thomas faced financial challenges as well. His autism spectrum disorder meant that he had difficulty finding and remaining in employment. What little money he had he was trying to save towards supporting his unborn child. When Charles started to ask Thomas for money this was a significant factor that led to Thomas then assaulting his father.
Lesson
There are well documented links within previous cases of intimate domestic homicide and debt and financial issues. Very often perpetrators will use financial and economic abuse as a means of exercising coercive and controlling behaviour on their victims. While that is not the case here, the manslaughter of Charles demonstrates that debt and financial issues can also be factors within familial domestic abuse and homicide.

Lesson 3 [Panel recommendation 2, 5 and 6]
Narrative
Charles was the victim of domestic abuse on a number of occasions. On 18 August 2018 Merseyside Police attended address 1 following a call about loud banging and shouting. They identified Charles as the victim of domestic abuse and correctly documented this. On 26 October 2018 Charles presented at the walk-in centre with injuries he said were caused by Thomas. The walk-in centre identified this as a safeguarding adult case and made a referral to ASC. Neither ASC nor the walk-in centre recognised this was also domestic abuse. On 25 March, Charles' GP was told that he had been assaulted by Thomas. The GP made an adult safeguarding referral; however they did not recognise this was also a case of domestic abuse. Neither the walk-in centre, ASC nor the GP completed a risk assessment.
Lesson
Professionals need to understand there are different aspects to domestic abuse and that it does not always present in the context of an intimate relationship between a male and a female. Failure to recognise domestic abuse means opportunities are lost to identify and respond to the risk victims face.

Lesson 4 [Panel recommendation 2 and 6]
Narrative
Thomas was also the victim of domestic abuse at the hands of Charles. This included both verbal and physical abuse. On occasions this took place within the home and sometimes it took place in the street. His behaviour was witnessed by Anna and also by members of the community. Charles was also said to have shouted at Janette on occasions demanding she come home. Some family members said Charles was a bully and that he was controlling. Charles' abusive behaviour towards Thomas was never reported to any agency. The comments made by Anna, that in this community it is common for fathers to fight with their sons, suggest behaviour like this might have become normalised for some members of the community.

Lesson
Family members and 'bystanders' in the community sometimes have valuable knowledge about domestic abuse. They do not repeat that for a variety of reasons. Those factors might include barriers within the community because some behaviours have become normalised. Empowering them to say something and to know where they can share information will improve safety and outcomes for victims.

Lesson 5 [Panel recommendation 2 and 6]
Narrative
On 26 October 2018 Sefton ASC received information via a safeguarding adult referral made by the walk-in centre that Thomas had assaulted Charles. They did not take any steps to ascertain with Charles whether that information could be shared with other agencies including the police. On 25 March 2019 Charles's GP received information that he was the victim of a more serious assault by Thomas. The GP attended to administer treatment and made an adult safeguarding referral. They did not report the assault to the police nor did they take more immediate action to safeguard Charles from further harm by Thomas.
Lesson
Failure to recognise when the serious nature of a crime committed or suspected overrides the confidentiality wishes of a vulnerable person means they may face continuing risk and are not adequately protected from risk.

10. RECOMMENDATIONS

10.1 Panel and Agency Recommendations

10.1.1 The recommendations are set out in Appendix A.

Appendix A

Action Plans

Sefton Council Adult Social Care

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	Reinforce use of the Dash risk assessment tool for all DA referrals	Liaise with IDVA team to present this to team again and include discussion	Minutes of meetings , emails , training materials, new pathway	Increased knowledge across the dept. Ensure that all DA contacts are checked	Janice Lee-Croll	Immediate by email and latterly by Nov 2020
2.	All DV referrals from Call Centre/emails to be screened via safeguarding team members	Currently in place but to be formalized via new Safeguarding business model to ensure appropriate level of resource (staffing) committed to achieve robust practice	New business model pathway devised and shared.	Improved risk assessment at front door and accurate signposting.	Janice Lee-Croll	Target date March 2021
3.	Ensure all team members receive DA training via module	Ensure PLDR (professional learning and development	Supervision/PLDR documentation. Principle Social worker	Increased knowledge base, closer liaison and partnership work	All management team (Safeguarding	March 2021

	on-line and via course attendance at training unit – post covid.	review) process checks completion of this module and related relevant material (supervision by line manager)	– SGA manager to check on progress of protected study time to achieve appropriately trained and knowledgeable staff in the dept.	with DA advocacy services .	Adults) in liaison with Sefton Training unit.	

Merseyside Police

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	Officers should explore 'financial hardship' as a causative factor in cases of domestic violence and abuse and to signpost to support services such as Citizens Advice Bureau.	Delivery of training – to be included within the rolling program of Protecting Vulnerable People. Information included in newsletters across all Strands within the Force so all officers are made aware. This	Training material Newsletter	Increase in the identification of incidents where financial hardship was a causative factor and signpost to support services.	DCI Bev Hyland	January 2021

		will include first responders				

GP Surgery

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	In situations of domestic violence and abuse, GP Practice staff to directly question whether individuals are at immediate risk of harm and document within the patient records as evidence of assessment of risk	Practice to include in the Practice Learning Time Events. To incorporate within the Practice Safeguarding and Domestic violence and abuse Policy and Procedures	Agenda from the practice Learning Time event Updated Safeguarding Policy and Procedure Agenda CCG's GP Safeguarding leads meeting	Increased assessment of risk as part of safeguarding / domestic violence and abuse incidents	GP Safeguarding Lead Glovers Lane Practice	January 2021

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
		CCG to highlight at the CCGs GP Safeguarding Leads Meeting to disseminate learning across all GP practices				
2.	GP Practice Domestic violence and abuse Policy to be reviewed and updated in line with Home Office domestic violence and abuse guidance (2016), to include local procedures of what to do at a Practice level.	GP Practice Domestic violence and abuse Policy and Procedures to be revised in line with Home Office guidance. GP practice staff are aware of the updated policy and changes to policy	Policy and procedures in place. Policy and procedure have been discussed that the practice protected learning time. Flow chart in place and available for practice staff to follow on 'what to do'	Increased awareness that older people can be at risk of domestic violence and abuse / violence from family members and to take appropriate action.	GP Safeguarding Lead Glovers Lane Practice	January 2021

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
3.	GP Practice Safeguarding Adult Policy to be reviewed and updated in line with Care Act, Care and Support statutory guidance (2014), to include local procedures of what to do at a Practice level.	GP Practice Safeguarding Adult Policy and Procedures to be revised in line with Care Act statutory guidance GP practice staff are aware of the updated policy and changes to policy	Policy and procedures in place. Policy and procedure have been discussed that the practice protected learning time. Flow chart in place and available for practice staff to follow on 'what to do'	Increased awareness of the categories of abuse for adults as per the care act.	GP Safeguarding Lead Glovers Lane Practice	January 2021
4.	Training / Awareness raising to be undertaken at a practice level and across Sefton GP Practice's to ensure that GP practice staff are able to recognise domestic violence and abuse and violence in	To include domestic violence and abuse / violence in older people at the next Practice protected learning time event To include domestic violence and abuse in older people at the	Agenda for the Practice Learning Time Event	Increased awareness that older people can be at risk of domestic violence and abuse from family members	GP Safeguarding Lead Glovers Lane Practice Tracey Forshaw Assistant Chief Nurse South Sefton &	January 2021

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
	all its guises and take appropriate action.	next CCG Practice protected learning time event	Agenda at the CCGs Safeguarding Business Meeting Agenda for the CCGs GP Practice Learning Time Event		Southport and Formby CCG	

North West Boroughs Healthcare NHS Foundation Trust

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	Review of awareness of domestic violence and abuse signs/symptoms and processes with walk-in centre staff.	Audit on staff awareness to understand any gaps.	Audit outcome	Assurance that walk-in centre staff are knowledgeable on domestic violence and abuse signs/symptoms. Identification of any further training needs.	Sarah Shaw - NWBH	April 2020.

DHR Panel Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1.	Sefton Safer Communities Partnership revisits the recommendations arising from the deaths of Kathleen and Nathanial and looks for evidence that the recommendations have been embedded in policy and practice.	Local	Review of actions completed in relation to DHRs 4 and 5	Sefton DA Steering Group	Completion of review Outcomes fed back to SSCP	December 2020	
2.	Sefton Safer Communities Partnership improves the response to domestic abuse by ensuring the following areas of policy	Local	Review existing Sefton DHR action plans Review other Merseyside DHR learning	Sefton DA Steering Group	Completion of review Outcomes fed back to SSCP	November 2020 December 2020	

	and practice are effectively applied; a) Professionals recognising when the serious nature of a crime committed or suspected means it should be reported to the police immediately. b) Professionals recognition of domestic abuse and that it does not always present in the context of an intimate relationship between a male and a female and what to do when it is identified. c) The impact and response to the exposure of children to domestic		outcomes and actions		Any further actions resulting from the review are agreed		

	abuse and what might happen when they reach adulthood. d) Increasing family and 'bystander' knowledge of domestic abuse and what they should do with such information for example the promotion of a green cross code.						
3.	Sefton Safer Communities Partnership considers how it can improve the way in which services are provided to victims of domestic abuse who may also face issues of debt by ensuring the links between domestic abuse and debt is recognised by professionals in agencies when delivering services.	Local and regional	Agencies to consider how their own DA training covers the links between debt and abuse and update if required Develop a 7 minute briefing on links between	Sefton DA Steering Group	Feedback to DA steering group from agencies on their review of DA training and inclusion of info on links to debt 7 minute briefing produced and shared across Sefton partnerships	January 2021 October 2020	

			DA and debt as risk indicator	Sefton Council			
	Sefton Safer Communities Partnership considers how multi-agency training on domestic abuse includes abuse/violence in older people.	Local	Agencies to consider how their own DA training includes violence and abuse against older people and also within a family context.	Sefton DA Steering Group	Feedback to DA steering group from agencies on their own DA training.	January 2021	
4.	Sefton Safer Communities Partnership considers how it can improve the way in which services are provided to male victims of domestic abuse by reviewing the need for, and availability of such services.	Local	Incorporated within Sefton's DA Strategy work and Systems review	Sefton DA Steering Group	Multi agency systems review completed	November 2020	
5.	Sefton Adult Social Care should consider reducing the risk of vulnerable adults becoming victims	local	Quarterly updates provided shared with SSCP	Sefton Council: Communities	Adult Social Care /Safeguarding updates	From December 2020	

	of domestic abuse by providing regular progress reports to Sefton Safer Communities Partnership on its work to improve the links between safeguarding adults and domestic abuse.		Continued Communities representation on Sefton's Care Governance group		Agenda/minutes of Sefton's Care Governance Group		
6.	Sefton Safer Communities Partnership ensure the knowledge of professionals in partner agencies is improved about the risks of domestic abuse by sharing the learning from this review, for example through a learning event or a briefing document.	Local and regional	Key lessons and recommendations shared across partnerships Learning case study produced and shared across agencies. Agencies to discuss with workforce		Learning case study produced Agencies report back to Sefton DA Steering group as to how case learning has been shared and any actions implemented as a result Case learning and recommendations shared with Sefton's Adult Safeguarding	September 2020 January 2021 September 2020	

					and Care Governance Group Case learning and recommendations shared with Sefton LSCB, Merseyside Safeguarding Adults Board, other Merseyside CSPs and with Merseyside Strategic Domestic Violence Group	December 2020	
7.	To ensure all agencies that have contributed to this review are held accountable for improving the response to domestic abuse they should all report on their progress with implementing their action plans to Sefton Safer Communities Partnership	Local	Quarterly updates provided shared with SSCP	Sefton Council: Communities	Agency progress updates SSCP Agenda /minutes	Quarterly from December 2020 until actions completed	

End Sefton8 Executive Summary Publication 20210407