DOMESTIC HOMICIDE OVERVIEW REPORT

EXECUTIVE SUMMARY

INTO THE DEATH OF

Carly

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Safer Bristol Partnership and South Gloucestershire Safer & Stronger Communities Strategic Partnership

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CONTENTS

1. INTRODUCTION

This Domestic Homicide Review has considered agencies' contact and involvement with Carly (a pseudonym) in the Bristol and South Gloucestershire area prior to her death. It has looked at Carly's life in detail from January 2006. As Carly was just 21 years old at the time of her death and was a Looked after Child from the age of 14, the review has also taken a longer view of Carly's life, beginning with her school records in 2003. The review has also considered aspects of Carly's life with her husband Tom (also a pseudonym).

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Additionally, in some cases, DHRs are conducted where there is evidence of domestic abuse but the victim died of as a result of suicide, unknown causes, an accident, or as in this case, is recorded as an open verdict.

The Safer Bristol Partnership was notified of Carly's death in August 2013. After having discussions with the Bristol DHR Advisory Group, the Safer Bristol Partnership Chair concluded that the case should be subject to a Domestic Homicide Review on the 17th October 2013. This was decided because domestic abuse issues were evident.

As Carly had lived in South Gloucestershire for the majority of her life, but her death occurred in Bristol, a meeting between the Community Safety partnership Chairs in both Bristol and South Gloucestershire was convened. It was agreed that a joint review between Bristol City Council and South Gloucestershire Councils would be commissioned. The Home Office was informed of this decision on 15th November 2013.

2. THE REVIEW PROCESS

This summary outlines the process undertaken by the Domestic Homicide Review Panel.

The review used information and facts gathered from Individual Management Reviews (IMRs) requested from relevant organisations and agencies.

IMRs were received from:

Youth Offending Service
Bristol Clinical Commissioning Group
Avon and Wiltshire Mental Health Trust
Assistant Director, Supported Housing, Knightstone Housing
North Bristol NHS Trust.

South Gloucestershire Social Care, Department for Children, Adults and Health.
Somerset and Avon Constabulary
1625 Independent People
Carly's School
University Hospitals Bristol NHS Foundation Trust

Information was also received from:

- The Senior Investigating Officer (SIO) investigating Carly's death
- The post mortem report
- A Video made by Carly with 1625 *Independent People*
- Press articles about the case
- Discussions during Review Panel meetings.

In addition, the following family and friends have been approached by various means to contribute to this DHR:

Tom (Carly's husband)

Tom's parents

Carly's mother

Carly's friend

Carly and Tom's neighbour

Unfortunately, despite significant efforts, the author was unable to successfully contact any of these individuals.

Other sources of information:

Panel Chair's Interview with Dom Wood 16*25 Independent People* on 10/03/14

1625 *Independent People* worker, interviewed by Dom Wood (1625IP)

Video made by *1625 Independent People*

Post mortem examination report by Dr H White

IMR writer interviews with Carly's Adolescent Support Worker

3. TERMS OF REFERENCE (as identified at the beginning of the Review)

3.1 Purpose:

The purpose[1] of a Domestic Homicide Review is to:

- 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 victims

[1] Paragraph 7 of the Home Office Revised Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, 2013

- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-agency working.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

The DHR Independent Chair will ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

3.2 Overview and Accountability:

The Home Office was informed of the decisions to undertake a joint Domestic Homicide Review on the 15th November 2013. The Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

The Coroner's Inquest was held and concluded in January 2014.

This Domestic Homicide Review, which was conducted within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, was to be carried out in a thorough, accurate and meticulous manner.

3.3 Scope of the Domestic Homicide Review:

This Domestic Homicide Review considered:

An overview of each agency's involvement between **22nd January 2006 and August 2013**, following Carly's death at her home in Bristol. Relevant details of her husband Tom, and their relationship as far as it could be ascertained, were also reviewed.

This included details of any relevant events and an account of Carly's school records from **September 2003** for the duration of her time in education. The Review has also considered:

- Whether there was any previous history of abusive behaviour towards the deceased, and whether this was known to any agencies.
- Whether family, friends or colleagues wanted to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour to the deceased, prior to the death.
- Whether, in relation to the family members, were there any barriers experienced in reporting abuse.
- Could improvement in any of the following have led to a different outcome for Carly considering:

a) Communication and information sharing between services

b) Information sharing between services with regard to the safeguarding of children and adults
c) Communication within services
d) Communication to the general public and non-specialist services about available specialist services

- Whether the work undertaken by agencies in this case was consistent with:

a) Organisational and professional standards
b) Organisations' domestic abuse and safeguarding policies, procedures and protocols

- The response of the relevant agencies to any referrals relating to Carly concerning domestic abuse or other significant harm from 22/1/2006, and any relevant earlier records. It has sought to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas were 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 the deceased.
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 Carly.
e) Whether appropriate information sharing and handover occurred when Carly moved from South Gloucestershire to Bristol.

- Whether thresholds for intervention were appropriately calibrated and applied correctly, in this case.
- Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.
- Whether the impact of organisational change over the period covered by the review had been communicated well enough between partnership agencies and whether that impacted in any way on agencies' ability to respond effectively.
- Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse and safeguarding processes and/or services.
- The review has considered any relevant protected characteristics as outlined by the Equalities Act 2010.
- The review has considered any other information that was found to be relevant.

4. KEY ISSUES

Carly lived in a flat in Bristol, with her husband, Tom. They had been married for about six months. According to the police investigation, on an evening in early August 2013, they had a row which resulted in Tom putting some possessions in a bag and leaving the flat. Earlier that evening they had been to a local pub together and on arrival back at their flat Tom says he noticed dog faeces in the living room which had led to an argument. He says he had previously threatened to leave, but on this occasion had packed his bags and walked out of the flat.

The police reported that Tom says after a while sitting at the bus stop he decided to go back to the flat, but could not gain entry as he had left his keys inside and when he could not get Carly to answer the door, so he climbed back in through a window. Once inside he found Carly face down in the bath, pulled her out, started CPR and then called an ambulance which arrived at 23.47. Despite their best efforts Carly was declared dead about 45 minutes later at 00.38 hours.

A post mortem was held the next day by Dr H White and found that the cause of death was drowning. The pathologist noted there were '*a number of cuts and abrasions on her left arm typical of self–infliction*' and that '*Blood samples submitted for toxicological examination contained ethanol at a concentration of 184 milligrams per 100 millilitres, just over two and a quarter times the United Kingdom drink driving limit. There were also therapeutic concentrations of tamazapam and zopiclone*'.

There were no notes found in the flat suggesting Carly had intended to kill herself and at the Inquest in January 2014 the Coroner recorded an Open Verdict. No one else was living at the property and the couple did not have any children. They had been married for a short time, for around six months, since December 2012 although they had lived together prior to this and were currently renting a flat. They had been a couple for about six years.

At the scene of the incident, on the night of her death, ambulance personnel and police officers noticed that the flat had broken glass and crockery on the floor. Tom said there had been an argument earlier but denied any violence had occurred between them, saying the broken items had not been there when he left. In his police interview he stated that they would argue, but he would be the passive one and Carly the aggressor.

A search by Avon and Somerset Constabulary of numerous databases for anything of relevance prior to Carly's death revealed that a 999 call to the police about three weeks before Carly's death. It was what the police describe as an 'inadvertent' or 'silent' 999 call in that the operator can hear events in the background but no-one is speaking directly into the phone. The call taker reported that there were sounds of a disturbance in the background and a female voice was heard to say something about her nose, such as *'…on my nose, look*.' She sounds distressed and is clearly crying. She then says *'You do this to me and then you leave me*'. Later in the conversation a male voice, presumably Tom's, is heard to reply *'Yeah that's why you push me and push me and push me… 'til I hurt you*'.

When the call taker subsequently called the number back Tom gave a false name and address so that when police officers were dispatched to try to find the flat they were unable to do so. The call is not recorded as a Domestic Abuse Incident, which will be discussed later in this report.

Another set of significant facts, in addition to those related by the police, is that a few weeks prior to Carly's death she had suffered the bereavement of a man she regarded as a father figure. As a result of this incident and on-going mental health issues, she was referred to the Bristol Intensive Team (BIT) by her GP. She had an assessment meeting with a mental health professional on 24th July 2013. A report of that meeting concluded that Carly was struggling to cope with the recent death of the man she regarded as a father figure, and would 'get ideas about wanting to harm herself or end her life'.

Carly's GP reported that she came to the surgery in distress talking about the death of her father figure, three days before. Carly was saying she was unable to eat and the GP noted 'obvious grief with a strong underlying risk'. The GP made a note to say she will '*Refer to the Crisis Team this morning as urgent, patient consents, review three days*.' The GP then added, '*Carly will be safe from deliberate self-harm as husband is staying with her all the time*.' Later she noted that Carly's phone is not receiving calls, so she called Tom's phone, and Carly asked her to pass his number to the crisis team. Three days later Carly is seen again by the GP who noted she is still distressed and not eating, and prescribes some anti-anxiety and sedative medication.

The GP then wrote that Carly attended the surgery alone but Tom is '*watching her like a hawk*' and he is '*stopping her from deliberate self –harm*'. There was some problem with the mental health team and the GP reaching Carly on her mobile and she had missed a couple of appointments. Carly was still losing weight, and her notes say '*self –harmed when husband went to the toilet, husband will look after her medications*.'

A few days later Carly died as a result of drowning in her bath and the Coroner recorded an open verdict.

5. LESSONS TO BE LEARNT FROM CARLY'S DEATH

This has been a challenging review from which to draw conclusions and make recommendations. In cases where a homicide occurs, a perpetrator can be viewed as having caused the death and situations leading to that event can be analysed and evaluated. Where a suicide or accident occurs, there are causal events that can be viewed with hindsight and potential lessons learnt. With an open verdict, as in Carly's case, it is difficult to get to the absolute 'cause' of the death and therefore to look at contributing factors, as there is obviously some doubt as to what has happened.

5.1 There is evidence however that Carly lost her life in circumstances that involved disclosures of domestic abuse, which is why this review was commissioned. Throughout the review the panel has kept this in mind when discussing the following questions:

- If the police had registered the ‘silent’ 999 call as a ‘Domestic’ and obtained a correct address, might Carly have had access to services and other options that might have prevented the train of events occurring?
- If the mental health services she accessed not been so focussed on her recent bereavement and identified her wider (possibly domestic) issues, would the outcome been different?
- Had Carly’s GP been aware that Tom was viewed as an abuser and controller by some people but a protective influence by others, would that have been useful information to pass to the other professionals involved with Carly?
- If disclosures made to the voluntary and statutory agencies been followed up or communicated, could other avenues of potential help have been opened up for Carly?
- Were all the pieces of Carly’s life as a care leaver put together at any point? In other words what seems to be a chaotic, troubled young life, lived at the edge in many senses, seen by anyone as a total picture?

5.2 The following section outlines lessons to be learnt, or identified as having been learnt, by individual agencies and organisations.

Avon and Somerset Police

In the Review Panel’s opinion it is unfortunate that Carly came to their attention on numerous occasions needing their protection, but it was not always clear that information was shared with children’s social care. It was also unfortunate that the incident of the ‘silent’ 999 call was not correctly recorded as a domestic incident, and therefore not subsequently referred to the specialist Domestic Abuse Team.

Since the time when these incidents took place the police have made significant changes to how they manage these areas of business. Specialist staff within safeguarding and coordination units (SCUs) risk assess all Domestic Abuse, child abuse and high risk missing person incidents, information sharing and joint action planning with partners. These SCU’s are currently the subject of a further development into Multi-Agency Safeguarding Hubs which will take further steps towards improving our information sharing. Similarly developments are underway to modernise the flow of information between social services and the Police in Bristol by phasing out the use of Fax machines in favour of secure email.

‘Safe and well’ checks now form part of everyday business and this is a process supported by missing person coordinators who intervene in repeat or high risk cases. Recent developments include the use of the Sexual Exploitation Risk Assessment Framework as an aid to professional judgement when sexual exploitation is suspected.

Youth Offending Service

In the Review Panel’s opinion, the Youth Offending Service had a limited role to play in protecting Carly in the short time she was on a referral order to them. It is important that opportunities are not missed when young people are compelled to attend sessions with a service, as agreed by a Referral Panel, unlike some other

agencies that were involved. There was a sense from the notes that information was shared with Social Care, as the key workers on this case, including alerting them to concerns over involvement with a young person known to the service who they considered may be potentially aggressive. Services, relationships, and self-esteem were discussed with Carly as a vulnerable young person and it is important that such discussions are proactive. After any disclosure of abuse a risk assessment must always be conducted and appropriate referrals made.

Avon and Wiltshire Mental Health Partnership Trust

The Review Panel considered the risk assessment process at length and came to the conclusion that Carly had been treated professionally and in a timely manner. Areas of learning were identified however; Carly received a letter from the South Bristol Recovery Team which the Panel did consider to be written in a rather 'clinical' way, rather lacking in empathy. The organisation has also recognised that 'handing over' responsibilities to another agency may not lead to action, and that young people may not follow up advice to contact services that could help. Furthermore, care professionals viewed Tom as a 'protective factor', but the Panel debated whether he was aware of this status, and whether he should have been made aware.

A number of recommendations have been raised regarding record keeping – including timely recording on electronic record (RiO), recording of assessments and RiO training for staff were made through the internal AWP process and have all been put into action and completed.

Children's Social Care

As a Care Leaver, Carly was eligible for support until her 21st birthday, and this support was provided via her Pathway Plan. The Pathway Plan should be pivotal to the process whereby young people map out their future, articulate their aspirations and identify interim goals along the way to achieve their ambitions. Workers should ensure that the plan is owned by the young person, and is able to respond to their changing needs and ambitions. It should look ahead at least as far as the young person's 21st birthday and will be in place beyond that where the person is in a programme of education or training which takes them past that age. This is in line with the current legislative framework Children's Act 1989 Guidance and Regulations including the Care Leavers (England) Regulations 2010 (Volume 3: Planning Transition to Adulthood for Care Leavers).

Between May 2008, and May 2009, Carly's Pathway Plans were in place, but it was the IMR author's view that her voice was noticeably missing. Furthermore, the Plans seemed to be largely reactive to emerging issues and crises; little analysis of Carly's difficulties and past trauma was evident. Current practice remains that care leavers beyond the age of 18 do not have independently chaired reviews of their Pathway plans - the statutory responsibilities of the Independent Reviewing Officer end at 18. Further pathway plan reviews remain the responsibility of the care leavers' team.

The legislation was implemented on April 1, 2011, whilst Carly was still an 'eligible child' (An eligible child is defined in paragraph 19B of Schedule 2 to the 1989 Children's Act and in regulation 40 of the Care Planning Regulations, is a looked after child aged 16 or 17, who has been looked after for a total of at least 13 weeks which

began after s/he reached the age of 14 and ends after s/he reaches the age of 16). At the point at which Carly left foster care but continued to receive support she became a 'relevant child', defined in section 23A (2) of the 1989 Act, as a child who is not looked after, aged 16 or 17 and was, before s/he last ceased to be looked after, an eligible child.

The duties of the Local Authority are outlined in the legislative framework which underpins the principles for young people making the transition from care to independence. In Section 4.10 of the legislation it is acknowledged that support to a young person must be balanced, and 'may need to experience failure and a learning experience first'. As such the final year of pathway planning needs to be carefully focused on identifying the areas of need that may require support from adult community services. Had Carly been offered such an assessment this could have identified levels of need and vulnerability that, whilst not meeting the statutory requirements of adult care eligibility, may have prompted further support from the voluntary sector, and may have empowered Carly to give voice to her own definition of need.

The Pathway Plan, and critically the assessment which informs it, needs to be an accurate record of the views of the young person. This does not seem to be the case with Carly. In some cases there may be a tension between the wishes of the young person for privacy, and their right to decline support. It would seem that the most appropriate way to protect against a potential situation where, for instance, the Local Authority want to refer to Adult Care and the young person declines, is to ensure that the relationship between the young person and their worker is positive and that there is a clear line of risk and assessment feeding into the Pathway Plan, so that a young person does not approach the ending of their service with a surprise referral to another service. The Local Authority must also be proportionate in its actions, considering the legislative framework of the Human Rights Act and at all times aim to act as a "reasonable" parent.

For Carly the pathway planning process involved several agencies both statutory and voluntary, but it did not include an assessment of risk that specifically focused on her needs as a survivor of abuse in a relationship that was thought to at least have the potential to be abusive. This could have resulted in a referral to services in Bristol (the Unitary Authority that she was "ordinarily resident" under the 1948 National Assistance Act) provided that an assessment had concluded that Carly met the eligibility criteria for Adult Social Care. Whilst there was no referral made and I believe that this is the right decision as Carly would not have satisfied the criteria for adult services, the process of reaching this view should have been discussed and recorded in the Pathway Plans, and as such provided both an acknowledgement of Carly's needs and an analysis of the assessment that reached that conclusion. It should also include early discussions with Adult Services if, once aged 16, it becomes an area of discussion.

One of the most crucial issues is that Carly made disclosures of abuse at various times throughout her life to Children's Social Care, including from the very beginning of their involvement. She disclosed sexual abuse in the home, made allegations of physical abuse against family members, and at various points in her adolescence and early adulthood.

Carly's School

The Panel felt that the school staff had been very caring and had tried on numerous occasions to engage with Carly's parents. The IMR identifies their lack of documented self-harm prevention procedures.

Bristol Clinical Commissioning Group on behalf of Primary Care (GP's surgery)

It might have been pertinent to ask whether domestic abuse was any part of the myriad of problems Carly was facing. The Panel had concerns about the use of Carly's husband's phone to contact her as there may be controlling aspects to a care giver's relationship. The surgery is an IRIS practice, the GP took responsibility, but for patients with complex needs and mental health issues, identifying domestic abuse whilst recognising the abuser/carer nexus is challenging.

So although the surgery was an IRIS practice it seems that the issue of domestic abuse was never broached or suspected. Given that Carly's GP was seeing her regularly, and she was in distress and having mental health issues, asking if 'everything is OK at home?' could have been one of the questions asked. In addition, Tom was said to have issues with drink, drugs and anger, perhaps a referral to an IRIS advocate might have been appropriate in this case.

1625 Independent People

In the Review Panel's opinion, there is a clear training need, as people working for support services should be aware that calling the police is not the only option to support an individual experiencing domestic abuse.

A support service should offer 'support' and not simply befriend, but be willing to challenge and guide young people, not just give them options. In the review panel's opinion, this service demonstrated an unwillingness to have difficult conversations with their service users, for fear of them disengaging from support. The DHR identified a reluctance to challenge, especially in relation to difficult subject areas such as abuse/unhealthy relationships and this should be rectified. Cultural change may be needed, as workers are there to support people like Carly and need to understand that this is their core purpose and not to befriend.

Again there were multiple disclosures of abuse and controlling behaviour, but no domestic abuse risk assessment was ever conducted with Carly. The panel believe that organisational policy and practice must change to ensure that any disclosure of this nature from a young person is responded to appropriately, including conducting a risk assessment and making appropriate referrals.

As a commissioned service, there is also a responsibility on the commissioning authority to ensure that appropriate policies, and training in relation to safeguarding, including domestic abuse, is a requirement of the contract.

Merlin Housing

The Review Panel thought that as a care leaver, Carly needed more support, for example, to help find alternative accommodation as part of a couple or to help her to independently manage housing as a sole occupier. Domestic abuse training did not seem to be a mandatory requirement for all support staff within the organisation. The Panel thought that Carly's support plan needed to be robust, well rounded, and not just concerned with housing issues. It does not appear that this was the case, and no reason seems to have been offered as to why it was not completed.

North Bristol NHS Trust

Emergency Department (ED) and Community Child Health

In terms of her disclosures to health workers, Carly's problems do not seem to have been followed up by anyone and she was advised to make appointments with various agencies, such as her GP, but it is left to her, and perhaps more active intervention could have helped. The Panel felt there should be training across the workforce which should be on-going and mandatory, using screening questions from the young people's CAADA-DASH toolkit. Social situations should be checked more thoroughly at A and E, especially where a Looked After Child is involved. For example, Carly attended the Accident and Emergency Department five times between February and November 2009 and some of these were around self-harm and anger issues.

Knightstone Housing

It may seem strange that almost all of the other agencies were aware of domestic abuse at some level or another and yet Knightstone, with its close and fairly long term association with Carly and Tom, do not seem to have been aware of any such issues. The Review Panel does not doubt the veracity of this assertion, but wonder why questions were not posed at any stage of the tenancy, during the discussions and support around the financial problems the couple were experiencing, whether this might lead to potential for abuse, especially given the reference to anger issues.

6. RECOMMENDATIONS

6.1 Cross agency recommendations (multi agency)

From the various agencies responses considered for this Review it is clear that disclosures of domestic abuse were made to numerous people on different occasions. These disclosures were not followed up in many cases and risk assessments were not carried out.

RECOMMENDATION

- Where disclosures of domestic abuse are made an appropriate risk assessment should be carried out

From the evidence gathered by this review it seems that some health professionals and some voluntary agencies are unsure about asking about and following up disclosures of domestic abuse.

RECOMMENDATION

- On-going domestic abuse awareness training should be mandatory. This should cover asking about issues of domestic abuse and knowing what to do about disclosures for all statutory and commissioned agencies and organisations.

Cross-agency recommendations South Gloucestershire:

- To embed the CAADA DASH RIC for Young People within all safeguarding practices across all agencies, in a way which will ensure professionals and practitioners use this as a tool to ensure appropriate support, safety planning and onward referrals are considered where a young person discloses domestic abuse.
- Raise awareness of the CAADA DASH RIC for Young People by incorporating into all MARAC and DASH training programmes.
- Ensure that all contracts for commissioned services include adequate and appropriate training requirements that will ensure frontline practitioners are adequately trained, and understand the principles of safeguarding; and their responsibilities where Domestic Abuse is identified.

Cross-agency recommendations Bristol:

- To embed the CAADA DASH RIC for Young People within all safeguarding practices across all agencies, in a way which will ensure professionals and practitioners use this as a tool to ensure appropriate support, safety planning and onward referrals are considered where a young person discloses domestic abuse.
- Raise awareness of the CAADA DASH RIC for Young People by incorporating into all MARAC and DASH training programmes.
- Ensure that all contracts for commissioned services include adequate and appropriate training requirements that will ensure frontline practitioners are adequately trained, and understand the principles of safeguarding; and their responsibilities where Domestic Abuse is identified.

6.2 Individual Service Specific Recommendations:

Avon and Somerset Police

RECOMMENDATIONS

- Share the findings of this DHR with all 999 call takers so that they are aware of the significance of recording incidents as ‘domestic’ where the circumstances suggest that may be the case.

- Where the circumstances surrounding a silent 999 call suggest that the situation may be domestic abuse, to err on the side of caution and record the incident as domestic abuse.
- To continue with developments relating to information sharing in relation to vulnerable people

Youth Offending Service

RECOMMENDATIONS

- to review policies and protocols in relation to disclosures of domestic violence and abuse, and ensure that all staff receive appropriate training**.**

Avon and Wiltshire Mental Health Partnership Trust

RECOMMENDATIONS

- a specific question regarding domestic abuse should be considered as part of the assessment process
- review the template for letters sent to services users following assessment to ensure the format and contents are empathetic. To consider adding a foot note apologising for any potential factual inaccuracies and requesting that the service user contacts the author to amend these.
- To ensure that staff involve families and significant others in considering the role they might have in helping to manage and/or mitigate risks.

Children's Social Care

RECOMMENDATIONS

- Pathway Plans should be carried out to make sure the young person's voice is always heard. They should be completed with young person and where possible signed by the young person and the supervisor responsible for overseeing the support worker.
- Given that young people often lack the skills to make good choices on their own, care leavers should be provided with mentoring services where this is assessed as needed.
- Disruption Meetings exploring the reasons for placement breakdown and identifying learning and actions required to prevent future breakdowns in a child/young person's care arrangements must be held.
- Pathway Plans must be focussed on the future, aspirational and led by the young person and reflects their changing needs and ambitions.
- South Gloucestershire council should consider the viability of having Path way Plan reviews Independently chaired, post 18 years of age.

- Where a care leaver is an adult but is known to be in an abusive or vulnerable situation a risk assessment should always be undertaken and completed with that young person.
- As a pro-active corporate parent, where there are known risks to a young person's welfare or safety, steps to obtain consent for sharing information with key agencies and partners should be explored prior to case closure, Where consent is declined this should be clearly recorded and advice obtained as to whether threshold is met for dispensing with consent.

Actions by all agencies having contact with child/young people

- Any allegations or disclosures of abuse by a young person under 18yrs of age must be managed in accordance with the requirements of Working Together to Safeguard Children 2013.
- The views of the child /young person must be sought and clearly recorded as should information from them enabling workers to understand the child/young person's experience of daily life.

Carly's School

RECOMMENDATIONS

- The School's self-harm support procedures should be reviewed.
- Renewed attempts should be made to find innovative ways to engage with families such as Carly's.

Bristol Clinical Commissioning Group on behalf of Primary Care (GP's surgery)

RECOMMENDATIONS

- The surgery should consider additional training around patients with complex needs, and recognising the carer/abuser tension.
- To recommend that IRIS training emphasize the challenges of balancing protective and potential abusive factors in patients who have mental health issues or complex health needs, particularly those who require a significant amount of care from family members or people with whom they are in an intimate relationship.
- To recommend that the surgery checks that their IRIS training includes refresher training at three yearly intervals following the initial training package.

1625 Independent People
RECOMMENDATIONS

- Training should be carried out with all staff around how to respond to disclosures of domestic violence and it should be a compulsory part of 1625 Independent People's on-going programme of staff development.
- This recommendation for training should extend to all services contracted to the council who support young people - using the young people's CAADA DASH risk assessment tool should be routine in these organisations.
- As a commissioned service, the contract should include an expectation that robust domestic abuse policies are in place, and training regarding safeguarding, including domestic abuse is implemented.
- 16-25 to support and encourage their staff to challenge young people in relation to unhealthy relationships, and to emphasise their role as a support organisation.

Merlin Housing

RECOMMENDATIONS

- Risk assessments and robust support plans should always be in place. If they are not completed there should be some written explanations as to why not.
- There should be better engagement with clients and more detailed record keeping.

North Bristol NHS Trust

Emergency Department (ED) and Community Child Health

RECOMMENDATIONS

- Domestic Abuse training in ED should be reviewed to ensure that the contents include a focus on the vulnerabilities of young people, particularly young people who are Looked After or are care leavers under 21years and include the use of the Young Peoples CAADA-DASH toolkit

- The process and forms for review health assessments for Looked After Children must be reviewed to ensure a holistic assessment is undertaken.

- Following Looked After Children health assessments robust care plan must be formulated which include active intervention when risks such as excessive drinking, drug use, concerning sexual behaviour and relationships are identified and this must include a process to ensure follow up of any onward referrals.

- All professionals must use the Young People's CAADA-DASH toolkit in cases where a Looked after Child is identified as being in a potentially abusive relationship. They should also consider asking the sort of questions a parent would be asking if a young person was in a potentially coercive relationship.

Knightstone Housing

RECOMMENDATIONS

Risk assessments and robust support plans for tenants should always be in place. If they are not in place there should be some written explanations as to why they have not been carried out.

7. CONCLUSIONS

Carly had a difficult adolescence and young adulthood, and despite being talented, had missed opportunities. Her records show she was a competent horsewoman, athlete, dancer and actor. Carly's performance in a video which she made with 1625 Independent People, shows her to be a vibrant, lively and sensitive person, skilled in front of the camera. Her voiceover is about being saved from a life on the streets, saying:

> ***'Homelessness – you never know what's going to come around the corner,***
> ***They said other things were wrong- go with someone else.***
> ***Vulnerable, invisible, self-harm, dreams,***
> ***I always felt that my life was dark'***

The final words she spoke on the video are somewhat prophetic:

> ***'It would kill me. I know, it would kill me if I went back on the street now….'***

It is difficult to reconcile that happy and engaging young woman, from the video and from her wedding photographs just six months before her death, with the sad, lonely and tragic final hours. She clearly loved Tom and was proud and happy about her marriage. As outside observers however, and with the benefit of hindsight, this DHR has revealed that there were tensions surrounding their relationship, physical and mental abuse were evident and violence was recorded. The tensions might be regarded as almost expected, given the difficult circumstances in which Carly and Tom found themselves. It seems that there were manipulative and controlling aspects to the relationship on both sides although Carly would seem to be the more vulnerable partner. 'Coercive control' is one of the current ways to describe couple relationships where the controlled person – normally the woman – seems complicit in her abuse. She will defend he abuser, claiming he is helping or supporting her, sometimes without realising that she has lost the power to make her own decisions. As Evan Stark (2007) has argued in his extensive text on intimate partner violence, our general focus on physical violence is only part of a pattern of coercive control. In fact, it is part of a pattern which defines the relationship and the pattern is much more destructive and debilitating (Johnson, 2014, p. 46).

From the evidence the Panel has considered Carly's relationship with Tom seems to be abusive at times and potentially violent. The DHR Panel members listened to a recording of the 'silent' 999 call where crockery is crashing and people are shouting and she is heard to say he has hurt her nose. They seem to be arguing about the flat being untidy. In the final sentence we hear him say that she 'always does this and makes him hurt her'.

Despite this evidence, the review cannot ascertain if Carly was the subject of coercive control because in the days before her death she describes Tom as 'her rock'. The panel heard Carly crying hysterically at the idea of Tom leaving her on the 'silent' 999 call. It may be the case that on the evening of her death in her eyes he had carried out his threat and she may have wished to die. Alternatively she may have accidently gone too far in a cry for help suicide attempt. Sadly, we cannot ask her. If we take this alternative view, that in fact Carly was having overwhelming mental health problems, underdiagnosed for various reasons, such as the masking of her underlying issues by her grieving symptoms, and she was feeling suicidal, with Tom as her protector from harming herself, should he have been informed of his status?

The Review Panel considered the AWP's risk assessment process at length and came to the conclusion that Carly had been treated professionally and in a timely manner. She had received a letter from the South Bristol Recovery Team which the Panel requested, and on reflection, did seem to be written in a rather 'clinical' way, rather lacking in empathy. The care professionals viewed Tom as a 'protective factor', but the Panel debated whether he was aware of this status, and if not, had he been informed whether this would have meant he would have stayed with her or used it as a tool in situations of potential domestic abuse.

Recent research on disclosure of domestic violence in mental health settings has suggested that their service users are more likely to suffer domestic violence, but 'were reported to give little consideration to the role of domestic violence in precipitating or exacerbating mental illness' (Trevillion et al 2014: 430).It is not clear if Carly's mental health and the abusive situation she found herself in were ever connected. The 'seriousness' of Carly's threats to kill herself cannot be viewed with the benefit of hindsight. The BIT (mental health team) assessed Carly and decided she was 'medium risk' of self-harm and was not in need of further intervention, other than via her GP and bereavement services counselling. According to her GP's notes Carly was unhappy with the letter she received regarding her diagnosis as 'just grieving' but this does not mean that professionals who assessed her were mistaken, despite what happened afterwards, any more than the police were responsible for not designating the silent call as a domestic abuse situation. In essence, there were lessons to be learnt but no-one can be certain that any particular intervention could have saved Carly, or someone in her place.

REFERENCES

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Stark, E. (2007) *Coercive Control: The Entrapment of Women in Personal Life*. (New York: Oxford university Press)

Trevillion,K., Hughes, B., Feder, G., Borschmann, R., Oram.,S. and Howard, L.M. (2014) Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis. *Review of Psychiatry,* 26(4): 430–444

Appendix 1

Glossary

Abbreviation	Explanation
ACPO	Association of Chief Police Officers
ASW	Adolescent Support Worker
AWP	Avon and Wiltshire Mental Health Partnership Trust
BCCG	Bristol Clinical Commissioning Group
BIT	Bristol Intensive Team
CAADA	Co-ordinated Action Against Domestic Abuse
CAADA DASH	Co-ordinated Action Against Domestic Abuse- Domestic Abuse Stalking and Harassment and Honour based violence
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CYPD	Children and Young People's Directorate
DHR	Domestic Homicide Review
IMR	Individual Management Review
IRIS	Identification and Referral to Improve Safety
LAC	Looked After Child(ren)
MARAC	Multi Agency Risk Assessment Conference
PCLS	Primary Care Liaison Service
PTSD	Post-Traumatic Stress Disorder
RiO	Electronic Patient record System

SCU	Safeguarding and Coordination Unit (Police)
SIO	Senior Investigating Officer

Appendix 3: Action plan						
Recommendation	**Scope of recommendation i.e. local/ regional/national**	**Action to take**	**Lead agency/SPOC**	**Key milestones achieved in enacting recommendation**	**Target date**	**Date of completion and outcome**
CROSS AGENCY ACTIONS: SOUTH GLOUCESTERSHIRE AND BRISTOL						
Where disclosures of domestic abuse are made an appropriate risk assessment should be carried out	South Gloucestershire and Bristol	1625: Make sure staff are briefed in risk assessment and supported by DA lead (Dawn Taylor) prior to training. South Glos PADA to agree a briefing note for circulation to all agencies hi-lighting the findings of recent DHRs to raise the awareness of Domestic Abuse and the importance of conducting risk assessment All agencies to agree mechanisms for raising awareness and implement	Bristol Domestic and Sexual Abuse Strategy Group South Gloucestershire Partnership Against Domestic Abuse	1625: Staff briefed & Training completed by all staff Police: All reports of domestic abuse are risk assessed using the DASH RIC, which was the case at the time of the incident.	1625: 1st May 15 1st October 15 June 15 Sept 15	Complete Oct 2015 Complete Oct 2015
On-going domestic abuse awareness training should be mandatory. This should cover asking about issues of	South Gloucestershire and Bristol	1625: Training planned and booked	Bristol Domestic and Sexual Abuse Strategy Group	1625: Training planned with BAVA All staff trained Police: DV/A training is already mandatory for all staff. Frontline staff have had training about	1625: 1st May 15 1st October 15	

domestic abuse and knowing what to do about disclosures for all statutory and commissioned agencies and organisations.		South Glos PADA to request Managers from all Agencies conduct a review of safeguarding training requirements, to include domestic abuse to ensure any mandatory requirements are current and up to date.	South Gloucestershire Partnership Against Domestic Abuse	vulnerable factors over the last phase of training 14/15	Sept 15	
To embed the CAADA DASH RIC for Young People within all safeguarding practices across all agencies, in a way which will ensure professionals and practitioners use this as a tool to ensure appropriate support, safety planning and onward referrals are considered where a young person discloses domestic abuse.	South Gloucestershire and Bristol	1625: Done via training South Glos PADA to request all Agencies include the CAADA DASH RIC for young people in to all existing safeguarding Policies and procedures. All South Glos Agencies to review and amend policies and procedures	Bristol Domestic and Sexual Abuse Strategy Group South Gloucestershire Partnership Against Domestic Abuse	1625: Training completed Police: Avon & Somerset Constabulary conduct a DASH RIC for all disclosures for domestic abuse, in line with the Home Office definition of DV/A.	1625: 1st October 15 May 15 Sept 15	Complete Oct 2015
Raise awareness of the CAADA DASH RIC for Young People by incorporating into all MARAC and DASH training programmes.	South Gloucestershire and Bristol	1625: Done via training South Glos to review MARAC/DASH Training to	Bristol Domestic and Sexual Abuse Strategy Group South Gloucestershire	1625: Training completed	1625: 1st October 15 June 15	Complete Oct 2015

		incorporate into all future training programmes.	Partnership Against Domestic Abuse			
Ensure that all contracts for commissioned services include adequate and appropriate training requirements that will ensure frontline practitioners are adequately trained, and understand the principles of safeguarding; and their responsibilities where Domestic Abuse is identified.	South Gloucestershire and Bristol	South Glos PADA to request agencies review existing contract arrangements ensuring contracts and agreements for commissioned services include reference to domestic abuse and training requirements; and Contract Managers are aware of their responsibilities in relation to review meetings	Bristol Domestic and Sexual Abuse Strategy Group South Gloucestershire Partnership Against Domestic Abuse	S.Glos & Bristol: This has been actioned corporately and all safeguarding clauses in contracts will now include domestic abuse specifically.	June 15	S.Glos: Complete 30/04/2015 Bristol: Complete March 2015
INDIVIDUAL SERVICE SPECIFIC RECOMMENDATIONS						
AVON AND SOMERSET CONSTABULARY						
Share the findings of this DHR with all 999 call takers so that they are aware of the significance of recording incidents as 'domestic' where the circumstances suggest that may be the case.	Avon and Somerset		Avon and Somerset Constabulary	Police: Agreed & Completed Training updated Continuous improvement framework introduced including organisational learning which covers learning from DHRs	Completed mid 2014	Complete 2014
Where the circumstances surrounding a silent	Avon and Somerset		Avon and Somerset Constabulary	Police: Training updated and delivered to staff. The training re-iterates to all call takers the need	Completed mid 2014	Complete 2014

999 call suggest that the situation may be domestic abuse, to err on the side of caution and record the incident as domestic abuse.				to classify a call as D/A where there is any feeling/consideration that it may be such and the reasons for doing so.		
To continue with developments relating to information sharing in relation to vulnerable people	Avon and Somerset		Avon and Somerset Constabulary	Police: We have dedicated Safeguarding Coordination Units who ensure all relevant information is shared with Social Services in a timely and dynamic manner. This is a fundamental part of our daily business in protecting vulnerable people and communities. Currently actively working with partners across Avon and Somerset to develop Multi Agency Safeguarding Hubs		Bristol: New partnership information sharing arrangements rolled out as part of Target Operating Model 2015
SOUTH GLOUCESTERSHIRE AND BRISTOL YOUTH OFFENDING SERVICE						
Youth Offending Service to review policies and protocols in relation to disclosures of domestic violence and abuse, and ensure that all staff receive appropriate training.	South Gloucestershire and Bristol	1. Review of policies and protocols in relation to domestic violence and abuse disclosure and update as needed in light of this review. 2. Review training in relation to domestic violence and abuse. 3. Ensure all staff training up to date and recorded.	South Gloucestershire and Bristol Youth Offending Service	1. Policies and protocols reviewed and updated 2. All staff training records indicate training is completed and up to date.	March 2016	South Gloucestershire completed South Gloucestershire completed and ongoing with any

						staff changes Bristol: ongoing
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP TRUST						
Review whether domestic abuse should be considered as a specific question as part of the assessment process	South Gloucestershire and Bristol	Actions are currently being agreed by the Board	Avon and Wiltshire Mental Health Partnership Trust			
Review the template for letters sent to services users following assessment to ensure the format and contents are empathetic. To consider adding a foot note apologising for any potential factual inaccuracies and requesting that the service user contacts the author to amend these.	South Gloucestershire and Bristol	Actions are currently being agreed by the Board	Avon and Wiltshire Mental Health Partnership Trust			
To ensure that staff involve families and significant others in considering the role they might have in helping to manage and/or mitigate risks	South Gloucestershire and Bristol	Actions are currently being agreed by the Board	Avon and Wiltshire Mental Health Partnership Trust			

SOUTH GLOUCESTERSHIRE COUNCIL						
Pathway Plans should be carried out to make sure the young person's voice is always heard. They should be completed with young person and where possible signed by the young person and the supervisor responsible for overseeing the support worker.	South Gloucestershire	Team Mangers only sign off pathway plans when there is clear evidence they contain the views of the young person and have been completed with them. New Pathway plan form to include a signature from the young person	Children, Adults and Health Department	The existing Corporate Parenting Improvement Plan includes this action as a key priority. Some progress has been made but this required practice is not yet consistently achieved and embedded.	Ongoing 30th July 2015	
Given that young people often lack the skills to make good choices on their own, care leavers should be provided with mentoring services where this is assessed as needed.	South Gloucestershire		Children, Adults and Health Department	The Care Leavers strategy 2015-2017 incorporates the action for a Mentor programme (involving university students) to be established and co-ordinated by the NEET and work experience co-ordinator. These posts have been appointed to and commenced in October 2015 . This action will be progressed within the next quarter.		
Disruption Meetings exploring the reasons for placement breakdown and identifying learning and actions required	South Gloucestershire	Disruption meetings consistently occur following placement disruptions to promote learning and improve placement stability.	Children, Adults and Health Department	The existing Corporate Parenting Improvement Plan include this action as a key priority. Placements stability meetings and a disruption meetings policy has been implemented, all disruptions meetings for children in care are	Ongoing	

to prevent future breakdowns in a child/young person's care arrangements must be held.				chaired by the Independent Reviewing manager.		
Pathway Plans must be focussed on the future, aspirational and led by the young person and reflects their changing needs and ambitions.	South Gloucestershire	The Pathway plan proforma needs to be re-designed to reflect the requirements of this recommendation	Children, Adults and Health Department	Consultation and workshops with the Children in Care Council and Care Leavers have been undertaken to commence this work. The pathway plan pro-forma needs to be completed, authorised and implemented.	Ongoing	
South Gloucestershire council should consider the viability of having Pathway Plan reviews Independently chaired, post 18 years of age.	South Gloucestershire	Service Manager for Strategic Safeguarding to consider whether this is a viable possibility for the Quality Assurance Reviewing Unit	Children, Adults and Health Department	Initial discussion has been held between the Corporate Parenting Service Manager and the Strategic Safeguarding Service Manager. Currently the service does not have the capacity for IRO's this fulfil this function as an alternative the team manager and senior social worker from the transition to independence service will chair pathway plan reviews on an annual basis .	30 June 2015	
Where a care leaver is an adult but is known to be in an abusive or vulnerable situation a risk assessment should always be	South Gloucestershire	Corporate Parenting Service Manager to communicate expectation to staff. Risk assessment pro-forma to be updated and disseminated.	Children, Adults and Health Department	Feedback to staff from the outcome of the DHR and key lessons for social care has commenced.	April 2015	

undertaken and completed with that young person.				Expectation that a risk assessment is completed has been communicated to staff group.		
As a pro-active corporate parent, where there are known risks to a young person's welfare or safety, steps to obtain consent for sharing information with key agencies and partners should be explored prior to case closure, Where consent is declined this should be clearly recorded and advice obtained as to whether threshold is met for dispensing with consent.	South Gloucestershire	Procedure for case closure for care leavers to include (where risks remain present) an updated risk assessment and the requirement to obtain consent to disclose key information, refer on to relevant agencies to be updated and implemented.	Children, Adults and Health Department	Expectation that an updated risk assessment prior to case closure and consent to share key information with agencies were risk to a care leavers safety are present has been communicated	30th July 2015	

C&YP SETTINGS						
Any allegations or disclosures of abuse by a young person under 18yrs of age must be managed in accordance with the requirements of Working Together to Safeguard Children 2015.	South Gloucestershire and Bristol	SG position: Dealing with an allegation or disclosure of abuse is part of all single and multi agency training. Any issues with not responding operationally in the correct way will be picked up by the team manager as this is an expectation of ongoing practice. The learning from this DHR should be shared across both Safeguarding Children and Safeguarding Adults Boards.	Cross-Agency; all C&YP Settings	Part of ongoing training and practice.		Bristol & S Glouc: Completed 2015 S Glouc: The DHR will be discussed at the two safeguarding boards in early 2016
The views of the child /young person must be sought and clearly recorded as should information from them enabling workers to understand the child/young person's experience of daily life.	South Gloucestershire and Bristol	SG position: all teams have been provided with a direct work toolbox, online resources and there is an excellent ongoing training programme of communication with children. The voice of the child is a specific question in CP conferences and Lac reviews. It was found to be lacking in SAFs so additional training is now being provided. There is a question in relation to voice of the child in the departmental audit form.	Cross-Agency; all C&YP Settings	Continue to promote and audit the voice of the child and equip workers to obtain this.		Bristol & S Glouc: Completed

SCHOOL						
The School's self-harm support procedures should be reviewed.	South Gloucestershire	Current procedure: Incidents reported via an Olympus Academy Trust safeguarding form • Sent to Student Support Team & safeguarding lead • Followed up with student by Student Support Assistant • First aid are involved if necessary. Counselling offered. • Parents informed • Signposting to other agencies • Students and Parents are directed to helpful leaflets on the website To be reviewed and evaluation of impact completed (term 6 2014 - 15)	School (Response from Dave Baker: Executive headteacher)	• Robust and accurate documentation to outline individual cases and provide detailed information for appropriate parties • Referral to intervention time reduced to ensure maximum impact • Fewer incidents that require ongoing supervision or intervention Reduced number of repeat incidents (students)	July 2015	
Renewed attempts should be made to find innovative ways to engage with families such as Carly's.	South Gloucestershire	Linking up with the family: • Increased capacity in Student Support Team which includes a Family Liaison Officer • Student Support Team Roles and responsibilities subject	School	• Opportunities provided for parents to engage with school via consistent and effective communication. Newsletter, home visits, website, phone calls.	July 2015	

		to review and planning for increased effectiveness • Student Support Team are involved in more Single Assessments too and involve agencies such as Southern Brooks & Family and Intervention and Support Services to get support for parents • Single Assessments to be led by key individual with most positive link with family Parent Forum – for vulnerable students		• Clear roles, defined in Student Support Team for developing links with Parents and Abbeywood Community School. • Single Assessments to be outcome/ time focused in order to achieve positive outcomes and ensure that individuals/ families are given support that is effective and SMART • Parent Forum group to be established for parents of vulnerable students Links with outside agencies that are robust and have a measurable impact		
BRISTOL AND SOUTH GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP						
The surgery should consider additional training around patients with complex needs, and recognising the carer/abuser tension.	Bristol and South Gloucestershire	Safeguarding / Domestic abuse training offered to GPs by the CCG will include a focus on safeguarding adults with complex needs who require additional care	Clinical Commissioning Group		September 2015	
To recommend that IRIS training emphasize the challenges of	Bristol and South Gloucestershire	The Clinical Lead for Domestic Abuse will advise the national IRIS project Clinical Lead of recommendation from DHR and	Clinical Commissioning Group		April 2015	

balancing protective and potential abusive factors in patients who have mental health issues or complex health needs, particularly those who require a significant amount of care from family members or people with whom they are in an intimate relationship.		request that the IRIS training content is revised. Training provided to GPs in S Glos in the future will emphasize this				
To recommend that the IRIS project includes refresher training at three yearly intervals following the initial training package.	Bristol and South Gloucestershire	The Clinical Lead for Domestic Abuse will advise the national IRIS project Clinical Lead of recommendation from DHR and request that the IRIS training schedule be reviewed with a view to including a refresher session. Refresher training provided to GPs in S Glos in the future will emphasize	Clinical Commissioning Group		April 2015	
1625 INDEPENDENT PEOPLE						
Training should be carried out with all staff around how to respond to disclosures of domestic violence and it should be a compulsory part of 1625 Independent People's on-going		Training planned and booked	1625 Independent People	Training planned with BAVA All staff trained	1st May 15 1st October 15	Complete Oct 2015

programme of staff development.						
Training should extend to all services contracted to the council who support young people - using the young people's CAADA DASH risk assessment tool should be routine in these organisations.		Training planned and booked	1625 Independent People	Training planned with BAVA All staff trained	1st May 15 1st October 15	Complete Oct 2015
to support and encourage their staff to challenge young people in relation to unhealthy relationships, and to emphasise their role as a support organisation (something along these lines)		Done via training	1625 Independent People	Training planned with BAVA All staff trained	1st May 15 1st October 15	Complete Oct 2015
MERLIN HOUSING						
Risk assessments and robust support plans should always be in place. If they are not completed there should be some written explanations as to why not.	South Gloucestershire and Bristol	A clear risk assessment and tailored support plan should be in place for residents in supported housing hostels within two weeks of moving in. The support plan should be continually reviewed and updated.	Merlin Housing	Risk assessment procedure reviewed and implemented Support plan procedure reviewed and implemented Updated training completed on both processes with all staff		Complete

		Where support plans are not completed, the reasons should be recorded, such as 'tenant would not engage' etc.				
There should be better engagement with clients and more detailed record keeping.	South Gloucestershire and Bristol	The recording of information should be consistent with general housing management. Basic record keeping rules, such as signing and dating all entries onto a housing file, need to be followed.	Merlin Housing	All information being stored on DMS and Capita housing systems Refresher training for all staff in note keeping		Complete
NORTH BRISTOL NHS TRUST						
Domestic Abuse training in ED should be reviewed to ensure that the contents include a focus on the vulnerabilities of young people, particularly young people who are Looked After or are care leavers under 21years and include the use of the Young Peoples CAADA-DASH toolkit	South Gloucestershire and Bristol	ED team have training delivered in conjunction with the Survive IDVA service. Training to be reviewed to comply with the requirement for LAC children and adult who were previous LAC.	North Bristol NHS Trust	Requirements of DHR forwarded to ED matron, Ward Manager and Band 7 Nurse Child protection and DVA Lead Nurse Review to be conducted and outcome reported to the ED Domestic Abuse Steering Group	May 2015 July 2015	
The process and forms for review health assessments for Looked After Children must be	South Gloucestershire and Bristol	Both LAC Teams to review health assessments.	North Bristol NHS Trust	LAC Named Nurse and Named Doctors to conduct review and to report to Safeguarding Operational Group.	May 2015	

reviewed to ensure a holistic assessment is undertaken.						
Following Looked After Children health assessments robust care plan must be formulated which include active intervention when risks such as excessive drinking, drug use, concerning sexual behaviour and relationships are identified and this must include a process to ensure follow up of any onward referrals.	South Gloucestershire and Bristol	Both LAC Teams to review health assessments.	North Bristol NHS Trust	LAC Named Nurse and Named Doctors to conduct review and put in place a robust care planning arrangement and to report to Safeguarding Operational Group.	June 2015	
All professionals must use the Young People's CAADA-DASH toolkit in cases where a Looked After Child is identified as being in a potentially abusive relationship. They should also consider asking the sort of questions a parent would be asking if a young person was in a	South Gloucestershire and Bristol	LAC teams are reviewing the use of DASH assessment.	North Bristol NHS Trust	LAC Named Nurse and Named Doctors to confirm is DASH assessments are used. Lac Named Doctor to consider the questions used in assessments of LAC patients.	March 2015 March 2015	

potentially coercive relationship.						
KNIGHTSTONE HOUSING						
As part of the provision of housing related support, to routinely request Risk Assessments from other agencies working with residents in order to gain a fuller picture of their circumstances	South Gloucestershire and Bristol	Amend procedures for staff	Knightstone Housing	Procedures amended	April 2015	April 2015
To deliver specialist domestic abuse training to staff to enable them to better identify potential domestic abuse	South Gloucestershire and Bristol	Roll out training delivered by Knightstones Domestic Abuse service to all frontline support staff working in other areas of supported housing as follows: Bristol accommodation, floating support, sheltered and LD South Gloucestershire accommodation, floating support, sheltered & extra care and LD North Somerset LD, sheltered and accommodation Somerset P2i, LD and sheltered	Knightstone Housing	Training developed in partnership with Barnardos and delivered in Somerset services	October 2015	