SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Denise'

Died September 2020

EXECUTIVE SUMMARY

January 2024

Chair Carol Ellwood-Clarke
Author Sara Wallwork

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 Denise a resident in their area.

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
Denise	Victim	47	White British female
Martin	Offender	44	White British male

1.3 Denise died because of injuries including rib fractures and a collapsed lung which were a significant factor in her catching pneumonia and subsequent death. Martin, her partner was arrested in connection with Denise's death and later released under investigation. The investigation into the circumstances surrounding Denise's death was concluded by the Police and the matter was finalised as 'no further action' as there was insufficient evidence to substantiate any criminal charges.

1.4 Martin died in December 2020, after being found collapsed at home. Martin had suffered multi organ failure because of acute chronic hepatic failure. The investigation into Denise's death was still active at the time of Martin's death.

1.5 Sefton Safer Communities Partnership met on 16 October 2020 and determined the death of Denise 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 Denise and Martin prior to the death were asked to secure their files.

1.6 The first meeting of the DHR panel was held on 15 December 2020. Thereafter five further meetings were held, and a draft report written. All meetings were held online due to restrictions in place because of the Covid-19 pandemic. Denise's family were involved in the review process, having access to the report and attendance at a panel meeting. The overview report was presented to Sefton Safer Communities Partnership Board on 9 September 2021.

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	Chronology	Report
Community Rehabilitation Company (CRC)	✓	✓	
HMP Liverpool			✓
Liverpool University Hospital NHS Foundation Trust (Aintree)	✓	✓	
Merseycare	✓	✓	
Merseyside Police	✓	✓	
North West Ambulance Service (NWAS)	✓	✓	
One Vision Housing			✓
NHS South Sefton Clinical Commissioning Group (CCG)-on behalf of GP services	✓	✓	
Sefton Children's Social Care			✓
Sefton Adult Social Care	✓	✓	
Sefton IDVA service	✓	✓	
Sefton MARAC	✓	✓	
Sefton Women & Children's Aid (SWACA)[1]	✓	✓	

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] https://swaca.com/

3. THE REVIEW PANEL MEMBERS

3.1 The panel members were:

Name	Job Title	Organisation
Kieley Blackborow	Service Manager	Sefton Metropolitan Borough Council: Children's Social Care
Julie Bucknall	Service Manager	Sefton Metropolitan Borough Council: Children's Social Care
Carol Ellwood-Clarke	Review Chair	Independent
Crispin Evans	Interim Safeguarding Lead for Local Division	Merseycare
Trevor Evans	Head of Offender Management Unit	HMP Liverpool
Neil Frackelton	Chief Executive	Sefton Women's & Children's Aid (SWACA)
Rosie Goodwin	Community Director	Merseyside Community Rehabilitation Company
Paul Grounds	Detective Chief Inspector	Merseyside Police
Susan Hewitt	Safeguarding Practitioner	North West Ambulance Service NHS Trust
Bev Hyland	Detective Chief Inspector	Merseyside Police
Jennifer Kavanagh	Liverpool & Sefton Women's Interchange Manager	Community Rehabilitation Company
Dr Bryony Kendall	Named GP Safeguarding Adults	NHS South Sefton Clinical Commissioning Group
Julie Luscombe	Advanced Practitioner	Sefton Metropolitan Borough Council Adult Social Care
Janette Maxwell	Locality Team Manager DA Strategic Lead IDVA/MARAC	Sefton Metropolitan Borough Council: Communities
Rachel McCarthy		HMP Liverpool
Laura Parr	Detective Inspector	Merseyside Police
Natalie Hendry-Torrance	Designated Adult Safeguarding Manager	NHS South Sefton Clinical Commissioning Group

Debbie Ward	Assistant Director	Liverpool University Hospital NHS Foundation Trust (Aintree)
Sara Wallwork	Review Author	Independent

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

4 CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair, Carol Ellwood-Clarke was supported in the review by Sara Wallwork. Both are independent practitioners who between them have served over 60 years in British policing, with additional expertise in safeguarding and vulnerability. They were the authors of the report and judged by the chair of SSCP to have the experience necessary to conduct an independent and thorough enquiry.

4.2 Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews, domestic homicide reviews and have completed the Home Office online training for undertaking DHR's.

5 TERMS OF REFERENCE

5.1 These were set as:

The purpose of a DHR is to:[2]

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.

N.B. This DHR is not a review in accordance with the requirements of NHS Serious Incident Framework[3].

Specific Terms

1. How effectively were disclosures or indicators of domestic abuse addressed? What was the response?

2. What services did your agency offer to the victim and perpetrator and were they accessible, appropriate, and sympathetic to their needs. Were there any barriers in your agency that might have stopped engaging with help for the domestic abuse?

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

[3] https://improvement.nhs.uk/resources/serious-incident-framework/

3. What knowledge did your agency have that indicated Martin might be a perpetrator of domestic abuse against Denise and what was the response? Did that knowledge identify and controlling or coercive behaviour by the perpetrator?

4. What risk assessments did your agency undertake for the subjects of the review; what was the outcome and if you provided services, were they fit for purpose?

5. When and in what way were practitioner's sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

6. How many MARACs[4] were convened on this case? Did the MARAC provide support/reassurance for agencies working with Denise in relation to the risk of domestic abuse? Did all partners actively participate, were there any barriers to the process?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Denise and Martin?

8. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Denise and Martin, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.

9. Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were these followed in this case? Has the review identified any gaps in these policies and procedures?

10. How did your agency gather the wishes and feelings of the subjects of the review in relation to the services that were provided or being offered?

11. What learning has emerged for your agency?

[4] MARAC- Multi agency risk assessment conference.

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 Safer Sefton Communities Partnership?

Timescale

5.2 The review covers the period from 1 September 2018 (prior to the start of the relationship with Martin) until September 2020.

6. SUMMARY CHRONOLOGY

6.1 Denise

6.1.1 Denise was an only child and was described by her mother as a good daughter with a lovely personality. Denise was close to her mother and she would contact her daily. Denise also had a close relationship with her female cousin. Denise was a mother to two children who had not lived with her for several years.

6.1.2 Denise's family were aware of her struggle with alcohol and had supported her when she went on detox programmes. Denise's family felt that her struggles with alcohol were linked to her father being an alcoholic and her mother stated that Denise started to drink heavily in her early thirties. Denise's family believed that she was lonely and stayed in the relationship with Martin due to not wanting to be on her own.

6.2 Background to Martin

6.2.1 Martin has a son with a previous partner with whom he had regular contact. Martin was known to have alcohol dependency issues and engaged with alcohol support services. Martin was unemployed.

6.2.2 Martin has previous convictions which date back to 1990 for violence, theft and three offences of driving under the influence of alcohol, the most recent in April 2019, for which he received a suspended sentence and a disqualification from driving. Martin has no convictions for domestic abuse prior to his relationship with Denise.

6.2.3 Merseyside Police have numerous records of domestic incidents with Martin as the perpetrator against Denise. Denise was referred to MARAC twice as a high-risk victim of domestic abuse. Martin was arrested several times for assaulting Denise. In September 2019, Martin was convicted for an assault on Denise and he received eighteen weeks suspended sentence for one year. In December 2019 Martin was issued with a DVPO against Denise which he breached and received fourteen days imprisonment. The other assaults resulted in no further action being taken against Martin.

6.3 Denise and Martin's relationship

6.3.1 Denise and Martin went to the same school and met up again as adults, via social media. Martin was described by Denise's family as having a negative

influence on her. Martin would regularly bring alcohol to Denise's flat and stay with her, encouraging her to drink.

6.3.2 There were regular arguments between Denise and Martin and the relationship was described by Denise's family as very 'on and off'. Denise's family stated that Martin did not like Denise speaking to other people. Denise's cousin told the report Author that she had suggested the two of them went on holiday together, so that Denise could have a break from Martin and the drinking; this had been the cause of an argument that was reported to the Police. The family stated that looking back they now recognised that Martin's behaviour was controlling and resulted in Denise being isolated from her family.

6.4 Key events

6.4.1 The panel found agencies held some information about Denise which pre-dated the terms of reference. Denise had been a victim of domestic abuse in her previous relationships. During many of these incidents Denise was physically assaulted.

6.4.2 From 2010 Children's Social Care (CSC) were involved with Denise and her children due to Denise's alcohol use, mental health, and domestic abuse. This involvement resulted in the children being subject of a child protection plan. In 2014 the court granted a Child Arrangement Order in favour of the children residing with their father.

6.4.3 In August 2016 Denise was referred to the Brain Injury Rehabilitation Centre in relation to her alcohol consumption. Denise engaged on a community detox programme later that year.

6.4.4 In 2017 Denise was referred to the Early Intervention Programme (EIP) for support around her alcohol misuse. Later that year Denise self-referred for detox.

6.4.5 In 2018 Denise was involved with Phoenix Futures[5] and in July Denise was admitted to the Hope Centre and spent ten days in detox. Denise initially engaged with Ambition Sefton; by August Denise had relapsed.

Events within the timescale of the review

6.4.6 In September 2018, Martin was arrested for driving with excess alcohol and received a suspended sentence, an Alcohol Treatment Requirement (ATR)

[5] https://www.phoenix-futures.org.uk/

and fifteen days rehabilitation activity (RAR) CRC oversaw these requirements. Martin fully complied and attended all twelve sessions. Martin was referred to Access Sefton[6] for additional support.

6.4.7 On 11 November the first domestic abuse incident between Denise and Martin was reported to the Police. Denise wanted Martin to be removed from her house. Denise and Martin had both been drinking.

6.4.8 On 15 November Denise was taken to hospital by ambulance. It was noted she had bruising to her lower lip. Denise made no disclosures of domestic abuse. Denise was referred to Ambition Sefton and she engaged with the service until February 2020.

6.4.9 On 9 December Denise called 999 and reported that Martin had assaulted her and her dog. Denise did not support a prosecution.

6.4.10 On 19 December, Denise called the Police and reported an argument with Martin. Police attended Denise's house. Denise and Martin were intoxicated. Martin was removed from the house by Police.

6.4.11 On 20 February Denise called the Police after an argument with Martin. Denise and Martin appeared to be under the influence of alcohol. Referrals were made to SWACA and alcohol services. SWACA made several attempts to contact Denise but were unsuccessful.

6.4.12 On 4 April Denise contacted the Police and reported she had been assaulted by Martin. Denise did not support a prosecution. No further action was taken. Attempts by SWACA were unsuccessful and the case was closed.

6.4.13 Martin's final ATR session was on 24 April and thereafter his compliance with MCRC became more problematic.

6.4.14 0n 4 June Police responded to a report of assault and disturbance at Denise's address. The Police received a second call in relation to this assault from Denise's GP practice. Martin was arrested. Denise did not remember what had happened and did not support a prosecution. The matter was finalised by the Police as 'no further action.'

6.4.15 On 6 July Denise was assaulted by Martin, resulting in bruising to her chest, eye and face. Both Denise and Martin were under the influence of alcohol. Martin was arrested for the assault, charged with Section 39

[6] Access Sefton provides NHS talking therapies services to people experiencing a wide range of common mild-to-moderate mental health conditions, including depression, anxiety, and stress.

Assault[7] and was remanded in custody. The case was referred to MARAC and referrals were made to Independent Domestic Violence Advocate (IDVA), Adult Social Care and alcohol services. Martin was released on bail with conditions. Denise withdrew her support for the prosecution and the matter against Martin did not proceed. SWACA were unsuccessful in their attempts to contact Denise and the case was closed.

6.4.16 On 20 August Denise reported to the Police that Martin was in breach of his bail conditions. Martin was arrested for breach of bail and released from court with the same bail conditions.

6.4.17 On 7 September Martin was arrested for breach of bail and assaulting Denise. Martin received a fourteen-day custodial sentence. Martin was released from court having served time remanded in custody. MCRC completed a risk review and Martin's risk level was raised to medium risk of serious harm.

6.4.18 By mid-September the IDVA service had received seven referrals. There had been eleven incidents of domestic abuse within a twelve-month period. The IDVA service was unsuccessful in their attempts to contact Denise.

6.4.19 On 16 October Police received a third-party report of a naked female in the foyer of the flats where Denise lived. Denise was found and reported that Martin had manhandled her out of the premises after she had refused to have sex with him.

6.4.20 On 1 November NWAS contacted the Police after they received a call from Denise. Denise stated she had thrown a mug at Martin causing a minor cut to his neck. Denise and Martin were under the influence of alcohol. Martin was removed from Denise's address.

6.4.21 On 28 November Denise reported to the Police that she had been assaulted by Martin. Martin was arrested for the assault, interviewed and he denied assault. Denise was reluctant to support a prosecution and provided a retraction statement. Martin was not charged with the assault. Martin was issued with a Domestic Violence Protection Notice (DVPN)[8] and a referral was made to MARAC. The IDVA services contacted Denise. Denise did not want to engage with the service.

[7] https://www.legislation.gov.uk/ukpga/1988/33/section/39

[8] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

6.4.22 On 3 December during an appointment with MCRC, Martin minimised his offending behaviour. Martin was reluctant to engage in the domestic abuse perpetrator programme and there was no statutory requirement for him to attend.

6.4.23 On 10 December Denise reported that she had been assaulted by Martin and subsequently denied calling the Police. Two days later Police and NWAS responded to an incident at Denise's home where she had sustained a broken wrist. Martin was arrested for assault and breaching the DVPO after CCTV footage captured Martin in the lobby of Denise's home.

6.4.24 Three days later, Denise made a 999 call to Police, the call was abandoned. Martin was heard shouting in the background and he was arrested for the assault on 10 December and for breaches of the DVPO. Denise was reluctant to make a complaint of assault. Martin was charged with both breaches and received two weeks custodial sentence. A referral was made to MARAC and IDVA.

6.4.25 On 16 December Martin arrived at HMP Liverpool. Martin was informed that a DVPO was in place and that he was not allowed contact with Denise.

6.4.26 The MARAC was heard on 19 December.

6.4.27 Martin was released from custody on 20 December. The DVPO expired on 30 December.

Events during 2020

6.4.28 During January Martin continued to engage with CRC and agreed to a referral to a domestic abuse perpetrator programme.

6.4.29 In February, Denise reported to the Police that Martin had threatened to snap her dog's neck. The Police scheduled an appointment to see Denise. The appointment was not kept and Denise was not seen

6.4.30 By February, Denise's engagement with alcohol support services fluctuated. Martin was seen by his allocated CRC case worker for the first time.

6.4.31 Between July and August Denise attended hospital four times. On 7 July Denise called 999, reporting she had been assaulted four days earlier by a neighbour. Denise was transported to hospital and was confirmed as having a pneumothorax (collapsed lung). A Section[9] notice was sent to Adult Social Care and information was also received by the hospital social work and safeguarding teams. The referral highlighted Denise's

[9] Care Act 2014, Section 2 requires an NHS body to notify social services of a patient's likely need for community care services after discharge

vulnerabilities and risk of significant harm due to physical abuse, excessive alcohol intake and being subject of MARAC. Denise was discharged without contact being made.

6.4.32 On 19 July Denise was admitted to hospital with symptoms linked to her recent trauma. Denise self-discharged against medical advice. Two days later Denise called the Police and reported an argument with Martin during which Martin had pushed her against a chair, banging her previous injury. Denise did not complain of an assault. Martin left the premises. A referral was made to MARAC. IDVA services attempted to contact Denise but were unsuccessful.

6.4.33 On 24 July Denise made a complaint to the Police that Martin had sent text messages and made calls threatening to burn her mother's house down. Denise made a complaint about the previous incident on 21 July. Martin was arrested for assault and malicious communications. The investigation was active at the time of Denise's death.

6.4.34 On 5 August Denise was admitted to hospital due to difficulty breathing.

6.4.35 The following day the MARAC was held. Agencies known to be actively involved with Denise at that time, were One Vision Housing and Ambition Sefton. Denise's GP was actively engaged with her at the time of the MARAC however this was not known to the MARAC coordinator. CRC were still involved with Martin.

6.4.36 A VPRF1[10] was completed and risk assessments determined at every incident attended by the Police.

[10] Vulnerable Person Referral Form used by Merseyside Police

7. KEY ISSUES ARISING FROM THE REVIEW

7.1 Denise had engaged with support offered from professionals in relation to alcohol dependency and this fluctuated over time. Professionals attempting to offer support to Denise in relation to domestic abuse were unsuccessful in contacting her. Denise's additional vulnerabilities made her situation more complex and challenging for professionals responding to her needs.

7.2 The review panel identified opportunities for closer multi-agency working including consideration of having a lead professional or key worker to coordinate activity. Further multi-agency working could have been enhanced in supporting Denise with her decision making to withdraw support for a criminal prosecution and in determining who was best placed to support her.

7.3 The review panel identified incidents where professionals did not demonstrate professional curiosity and information was not shared amongst professionals involved in the case. This included the attendance of some agencies at MARAC, and information not being shared, which resulted in decisions being made without all relevant facts having been considered.

7.4 There was an acceptance amongst professionals that the information provided by Martin was accurate and robust challenge and probing of information should have been considered to accurately understand the risk he presented to Denise.

8. CONCLUSIONS

8.1. Denise died weeks after an altercation with a neighbour and a separate domestic incident, where Martin had pushed Denise against a chair. Martin was arrested in connection with Denise's death and released under investigation. Martin died before the criminal investigation concluded.

8.2 Denise had a long history of alcohol misuse and dependency and was known to alcohol services. Denise had accessed several support services and inpatient detoxification. After each domestic abuse incident Denise was offered specialist domestic abuse support by IDVA and SWACA services. When contact was made with Denise, she declined the services. Denise was also offered specialist support for her alcohol dependency. The review identified the importance of combined support for victims of domestic abuse who have additional complexities and needs and developing methods to engage more effectively with those victims.

8.3 The review identified that alcohol featured in every incident of domestic abuse that was reported. Denise experienced domestic abuse perpetrated by Martin which manifested in physical assaults, assault on Denise's dog and verbal threats. Denise's case was referred to MARAC on two occasions as her situation was assessed as high risk.

8.4 During the summer of 2020, Denise experienced several incidents of domestic abuse perpetrated by Martin which manifested in physical assault and threats to burn Denise's mothers house down. Denise told the Police that she felt a sense of misguided acceptance of her situation and normalised the domestic abuse.

8.5 The learning from the review has been captured into the relevant recommendations which will be progressed through Sefton Safer Communities Partnership. The DHR Author has maintained regular contact with Denise's mother and cousin who have contributed to the review process throughout and provided valuable and relevant information to assist the DHR panel.

8.6 The DHR panel are grateful for the family's contribution and acknowledged their views during their attendance at a panel meeting in July 2021. It was evident that the family were unaware of the extent of the domestic abuse being perpetrated by Martin towards Denise and shared with the Panel that had they known, they felt they may have been able to provide more support

for Denise. Denise's family asked relevant questions of the Panel, listened to the learning identified and were appreciative of the review.

9. LEARNING

9.1 The DHR panel identified the following learning. Each point is preceded by a narrative which seeks to set the context within which the learning sits. Where learning leads to an action a cross reference is included within the header.

Learning 1 [Panel recommendation 1 & 2]
Narrative
The MARAC process identified Denise as a high-risk victim of domestic abuse. In Denise's case, agencies attempted contact with her but were unsuccessful in securing engagement and providing support. Whilst the MARAC meeting invited the appropriate agencies to the meetings, attendance was not consistent and written reports were submitted as an alternative to attending. This did not allow for those agencies to actively contribute to the discussions and decision making. Agencies were not consistent in the 'flagging' of their internal systems to identify Denise as a high-risk MARAC case. In Denise's case additional support via alternative pathways such as the MARAM could have been considered. A full review of the MARAC will explore the areas identified from this DHR.
Lesson
MARAC relies on the sharing of all available information, active contribution to discussions and decision making. Commitment to the MARAC process provides a robust framework for meetings, ensuring structure and accountability is maintained in the process and ensures effective information sharing and communication.

Learning 2 [Panel recommendation 3]
Narrative
People who are experiencing domestic abuse and seeking help during times of crisis, need to know what options are available and be encouraged to accept support. Denise was additionally vulnerable due to her alcohol dependency and this impacted on her engagement with agencies. Face to face contact is vital with professionals with the specialist skills for complex cases. In Denise's case specifically when considering withdrawing from the criminal justice process, she should have been supported and understand options available.
Lesson

A specialist role such as a key worker or 'complex IDVA' would provide the necessary support to victims. By having a multi-agency approach to the process of withdrawal of support for a criminal prosecution, others as well as specialist police officers can ensure that elements of coercion or duress can be properly assessed and maximum support provided to victims.

Learning 3 [Panel recommendation 4 & 7]
Narrative
Professionals need to ensure that when engaging with individuals, they consider the wider context and proactively seek out information to identify domestic abuse and have clear information sharing pathways to enable effective multi-agency working and avoid working in silos. Closer agency integration on a day-to-day basis would support this
Lesson
Embedded and effective information sharing pathways, will support professionals in gaining a better insight to an individual's situation. This will help identify who can provide the best support to victims of domestic abuse. Ongoing multi-agency information sharing and closer integration will prevent working in isolation and ensure information is current.

Learning 4 [Panel recommendation 5]
Narrative
Perpetrators of domestic abuse can develop skills to manipulate professionals. When dealing with perpetrators all agencies need to ensure that their staff look beyond compliance and consider controlling and coercive behaviours.
Lesson
All agencies to remind staff of controlling and coercive behaviour towards professionals and refresh awareness training as appropriate.

Learning 5 [Panel recommendation 6]
Narrative
Professionals need to consider the impact of alcohol dependency, in relation to the Mental Capacity Act 2005, when responding to individuals in domestic abuse situations and determine whether their decision making is impacted by alcohol. In a high-risk case, a best interest decision made on behalf of the victim may be appropriate.
Lesson

By considering the impact of alcohol and decision making, in the context of high-risk domestic abuse cases, professionals can properly assess and support victims.

9.2 Agencies learning

9.2.1 Adult Social Care

- To ensure social workers have case discussion with Hospital Team Manager when wards visits are required
- Review of the safeguarding process and revised process in place since August 2020. Joint process to be drafted between ASC and LHFT. For existing process in place, a Standard Operating Procedure is required with a review in 6 months
- MARAC cases, outcomes to be shared and entered onto systems.

9.2.2 Children's Social care

- Consider reasons for excessive alcohol use and emotional wellbeing, offering further support rather than withdrawing services when reported domestic abuse incidents ceased or relationships ended.

9.2.3 General Practice

- Increased awareness of domestic abuse in primary care. Training for GP's and revision of policy
- Increased recording of domestic abuse in primary care

9.2.4 IDVA

- Service changes and staff sickness resulted in delays when dealing with new referrals.
- Victims of domestic abuse with complex needs makes it more difficult for IDVA engagement /support.
- Wider systems review of complex cases to be considered. Innovative solutions.

9.2.5 Liverpool University NHS Foundation Trust (Aintree)

- Use of routine enquires in relation to domestic abuse and staff to be competent and confident to action responses.
- Professional curiosity is often lacking. Need to probe further into the potential causes of domestic abuse

- Revisit the purpose of MARAC both in attendance and follow up of actions. Current training and its effectiveness.
- A review of the current Domestic Abuse Policy.

9.2.6 MARAC

- Importance of attendance at MARAC meetings and active participation.
- Understanding partner agencies limitations /decreasing resources.
- Review managing complex cases at MARAC and consider more innovative ways of working.

9.2.7 Merseycare

- Reinforcement professional curiosity and understanding domestic abuse.
- Ambition Sefton staff, refresher training on professional curiosity and domestic abuse.

9.2.8 Merseyside Community Rehabilitation Company

- The importance of timely and accurate information sharing- by the Court
- Line management oversight of domestic abuse cases and allocation to experienced staff.
- Training events in the assessment and management of risk of harm.
- Professional curiosity, new staff development of this skill via training/ action learning.
- Improvement of intelligence sharing with the Police , particularly for breaches of civil orders e.g. DVPOs.
- Sustained focus on the criminogenic needs associated with domestic abuse.
- Safeguarding checks should be repeated during the life of the order/licence. It is not sufficient to accept that a case is closed with Children's Services without ongoing liaison, particularly following a significant event. This has been a feature of previous HMIP inspection reports and forms part of an HMIP action plan which will be reported on in due course.

9.2.9 Merseyside Police

- Raising awareness of strangulation in domestic abuse cases.
- Improvement of intelligence sharing with NPS in relation to domestic abuse incidents with individuals subject of ongoing probation supervision.

10. RECOMMENDATIONS

10.1 Panel and Agency Recommendations

10.1.1 The recommendations are set out in Appendix A.

Appendix A

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	That Sefton Safer Communities Partnership review the MARAC protocol in terms of agency attendance, involvement, flags and pathways to other multi-agency meetings such as the MARAM.	local	MARAC Steering group to review MARAC operating protocol MARAC Steering Group regularly review performance information	MARAC steering group	Review of protocol is completed and approved by Steering Group Performance information is shared and discussed on a quarterly basis	April 2022 Ongoing basis	Complete July 2022 Update sent out to MARAC partners July 2022 Complete - ongoing activity MARAC performance information, including agency attendance and involvement is discussed at every MARAC Steering Group meeting; any issues are

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**
			Review of pathways and links between MARAC and MARAM for DA cases with other complex needs, outcomes to be used to refresh procedures to be shared across agencies		Review of multi-agency pathways completed	April 2022	escalated via group chair and /or MARAC Chair to the relevant agency Complete January 2024. Complex Lives is a standing item of the MARAC Steering Group as part of the review of performance information. This work continues to be fed back in the Merseyside wide DHR learning group looking at key themes, one of which is complex needs and context with MARAC. Since the

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**
							completion of this report, Mersey Care have established a Complex Lives Multi-Disciplinary Team (MDT) covering south Sefton, with a North MDT in development to start Feb/March 2024. In addition to this, a new multi-agency DA Perpetrator Group is being established starting Feb 2024 focusing on high repeat/high harm cases, using Police and MARAC data. This will be

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**
							governed by MARAC and overseen by the MARAC Steering Group. These new forums provide additional multi agency pathways for complex cases, therefore original action no longer needed.
2	That all agencies review their internal processes for documenting and flagging victims/perpetrators who have been referred and discussed at MARAC, including how these flags are reviewed	Local	Updated MARAC protocol – which includes updates on flagging files – is shared with all MARAC members agencies Outcomes of Nov 2020 Questionnaire on flagging and	MARAC Steering Group	Updated protocol completed and circulated Review of information collected from	April 2022 April 2024	Completed July 2022 At Jan 2024. Long term issues with capacity within this team has meant

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**
	and removed, taking cognisance of the Human Rights.		tagging sent to MARAC agencies to be reviewed and followed up		agencies completed. Outcomes shared with MARAC Steering Group		this work has been delayed It is part of the MARAC Steering Group's work programme
3	That Sefton Safer Communities Partnership and the Domestic Abuse Partnership Board review the support 'offer' to complex cases victims of domestic abuse and maximise the opportunities with the 'complex IDVA' /key support worker roles.	Local	Share outcomes and learning from the Complex Needs audit with the DA Board and other relevant multi-agency partnerships and the DA Needs Assessment	Sefton DA Partnership Board	Complex Needs audit outcomes shared with MARAC Steering Group DA Partnership Board Learning from the Complex Needs IDVA is shared with Merseyside Strategic Domestic Violence and Abuse group to feed into regional DA work	January 2022	Complete Audit of MARAC complex cases 20-21 completed Oct 21, outcomes shared with MARAC steering group Nov 2021, further audit completed Feb 23, shared with MARAC steering group. Now a standing item within performance reporting.

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**
					Complex needs learning is included in the Domestic Abuse Needs Assessment to inform the DA Strategy refresh		New funding secured for Sefton IDVA team for a new Complex Needs IDVA role, post in place January 2022 This role will continue to support the learning and development of DA complex needs work. Progress report presented at DA Board May 2022 Provision and gaps around complex needs captured with the DA Needs Assessment

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**
							completed Aug 2022. Complex needs are a priority area in Sefton's DA Strategy 2023-28
4	That all agencies provide Sefton Safer Communities Partnership with assurance and evidence that information sharing pathways have been embedded and that sharing of updates continue throughout interventions to prevent working in isolation.	Local	DA Board to request key agencies in Sefton provide information on their information sharing protocols and pathways regarding domestic abuse and safeguarding and how these are built into practice and information is made available to staff	Revised to be DA Partnership Board	Agencies submit information requested	April 2024	This has been incorporated within the wider DA Partnership Board work and is being progressed as part of the DA Strategy action plan sub group activities.

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**
			Review of the information collected				
5	That Sefton Safer Communities Partnership provides a learning document which captures the learning on this case and highlights the tactics and traits of perpetrators of domestic abuse, in relation to coercion and control, including their engagement with professionals.	Local	Overarching learning and recommendations shared with Sefton Safer Communities Partnership DHR case study and 7-minute briefing produced	Council DA lead/ DA Partnership Board	Presentation at Community Safety Partnership Information resources produced/updated and shared across multi-agency partnerships	August 2021 April 2024	Completed August 2021 At January 2024. This has been incorporated within the wider DA Partnership Board work and a review of all Sefton DHR learning to ensure repeat learning & key themes are being identified and addressed and appropriate

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**
							resources are available across the partnership
6	That all agencies consider how to ensure their staff take cognisance of the Mental Capacity Act 2005 and the proactive opportunities available to support domestic abuse victims with additional alcohol dependency, considering a best interest decision if appropriate.	Local	Sub group established by the DA Board in conjunction with the Adults Safeguarding Board to consider how to take this forward	Domestic Abuse Partnership Board	Sub group established and meeting Terms of reference agreed for what will be reviewed a	April 2022	At April 2023. This has been incorporated within the wider DA Partnership Board work and will be progressed as part of the refreshed DA Strategy 2023-28 and action plan. Revised timescale of July 2023

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**
7	That Merseyside Police & the Probation Service provide Sefton Safer Communities Partnership with assurances that the newly developed Information Sharing Agreement is effectively embedded	Local	Evidence of implementation provided by Probation and Merseyside Police Update report provided to the DA Partnership Board on the implementation of the ISA and progress to date	Probation/ Merseyside Police	Progress updates provided Report(s) presented to DA Partnership Board	January 2022	Updates in Probation/police action plans

Adult Social Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Joint process to be agreed between Adult Social Care and Aintree Hospital	Standard Operating Procedure to be developed.	Julie Luscombe ASC in conjunction with LUFHT	Feedback from Manager Sefton Safeguarding Team, Manager Aintree	December 2021 Processes around safeguarding alerts are consistently applied in	Complete Update January 2024 A Standard Operating Procedure has been in place since

Adult Social Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
	regarding Safeguarding Alerts	Review in 6 months		Safeguarding Team, Team Manager Hospital Social work team Copy of the Process	relation to concerns about domestic abuse. Improved multi-agency approach Improved outcomes for victims of domestic abuse by ensuring their safeguarding is considered and acted upon in a consistent way	September 2021. It is regularly reviewed to ensure that it remains fit for purpose. Closer working relationships between ASC Safeguarding and Hospital teams and LUFT safeguarding staff is well established to ensure coordinated support to individuals at risk of abuse.

General Practice						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Increased awareness of domestic abuse in primary care	Development and updates of policies on domestic abuse affecting primary care staff.	Named GP for Safeguarding adults	Policies written and updated by the index surgeries Training materials	31 August 2021 Embedding of domestic abuse recognized as a reason for staff absence.	Action completed September 2021 Victim's practice is reviewing and updating the existing policy.

General Practice						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
		Delivery of training to GPs and staff in collaboration with SWACA		created: PowerPoint presentation, minutes of planning meetings	Appropriate safeguarding and signposting Increased referrals from primary care	Perpetrator's practice is liaising with their parent company to ensure a policy is developed. Planning meetings have taken place with SWACA and a learning event in September 2021
2	Increased recording of domestic abuse in primary care	Review of maternal post-natal check template on GP computer system	Named GP for safeguarding adults	Audit of template usage within index surgeries	31 October 2021	Audit completed October 2021 A national clinical coding group has been established by the Named GP Safeguarding in Sefton. There will be a national recommendation for one single code for Domestic Abuse in primary care records. This work is ongoing

General Practice						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						and will have national significance.

IDVA						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Review IDVA team policies and procedures to ensure that they are up to date and reflect current working practices	Review current IDVA policies and procedures	IDVA Manager	Revised policy and procedure	31 August 2021 Clear understanding for IDVA staff and linked partner agencies of procedures for managing IDVA referrals, less opportunity to miss things out	Completed 31 August 2021 Specific IDVA admin support and management in place
2	Audit of IDVA complex cases to better understand the challenges with engaging and supporting these individuals and feed the outcomes into wider strategic discussions on	Dip sample of cases with the additional needs of substance misuse and/or significant mental health issues	IDVA Manager	Completed audit	30 September 2021 Better understanding of the challenges facing victims of domestic abuse with complex needs in engaging with support services to help influence future commissioning of needs led services	Completed October 2021 Additional funding secured for a new Complex Needs IDVA role, in post January 2022

IDVA						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
	complex domestic abuse cases					

Liverpool University NHS Foundation Trust (Aintree Hospital)						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	To embed routine enquiry to ensure every 1st contact counts.	To review and update safeguarding adult level 2 and level 3 training to ensure routine enquiry for domestic abuse is incorporated Development of 7 min briefing to provide relevant and supportive information to all staff who are currently complaint with training to ensure they	Ann Marie Cresham, Safeguarding Matron	New training packages which will include relevant information to support staff to undertake routine enquiry Minutes of Safeguarding and Vulnerable People Group to show 7 min briefing has been disseminated through divisions. Minutes from ward /	End of September 2021 Increased awareness that every 1st contact will count and routine enquiry will occur.	Complete September 2021 Training package was reviewed to include specific DV training, 7 min briefing – Routine Enquiry produced and shared

Liverpool University NHS Foundation Trust (Aintree Hospital)						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
		receive information		department safety & governance meetings to show discussion relating to 7 min briefing.		
2	To improve knowledge of professional curiosity across all staff groups.	To review and update safeguarding level 2 and 3 training to ensure professional curiosity is explained in sufficient detail with examples to improve staff confidence with application in practice Development of 7 min briefing to provide relevant and supportive	Ann Marie Cresham, Safeguarding Matron	New training package which will include relevant information to support staff to understand the importance of professional curiosity Minutes of Safeguarding and Vulnerable People Group to show 7 min briefing has been disseminated through divisions.	End of September 2021 Increased awareness of professional curiosity in relation to individuals who may be at risk of domestic abuse and other safeguarding risks	Completed September 2021 7 minute briefing – Professional Curiosity produced and shared

Liverpool University NHS Foundation Trust (Aintree Hospital)						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
		information to all staff who are currently complaint with training to ensure they receive information		Minutes from ward / department safety & governance meetings to show discussion relating to 7 min briefing		
3	To review LUFHTs participation and process associated with all Local MARAC meetings (Sefton / Liverpool / Knowsley)	To review current working practice in relation to attendance at local MARAC meetings. To review internal process for reviewing feedback from MARAC and how this is acted upon within Trust.	Deborah Ward, Associate Director Nursing – Safeguarding	Identification of Trust wide process to ensure appropriate attendance at MARAC meetings. Identification of Trust wide process to ensure MARAC feedback is actioned and when appropriate added to patient hospital record.	End of September 2021 Robust Trust process is implemented relating to regular attendance at MARAC Actions are identified and acted on appropriately	Completed December 2023 MARAC meetings are attended when LUFHT have been the referrer. An alert is routinely placed on the patients record when identified through the MARAC research, which is ongoing.

Liverpool University NHS Foundation Trust (Aintree Hospital)						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
				To ensure patient flag/alert relating to MARAC attendance is evidenced on patient hospital record		

MARAC						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Reiterate through the wider-partnership the responsibilities of the core agencies to commit to attending all MARAC meetings and actively participate within case discussions as well as offering actions were appropriate	Email sent out to MARAC partners from MARAC Coordinator. Periodic reminders given by Chair at MARAC meeting about the importance of consistent agency	MARAC Coordinator and MARAC Steering Group Chair	Emails sent to partner agencies Record of agency attendance at meetings Information shared with MARAC partners about the DHR findings	April 2021 Agency commitment to attending MARAC meetings is clearly understood Consistent attendance by agencies at MARAC meetings Increase in range of actions offered by agencies	Completed 30 April 2021 Agency attendance at meetings good overall. Importance of agency attendance & participation is regularly highlighted at MARAC meetings by the MARAC Chair, it is also reviewed by MARAC Steering Group on an ongoing

MARAC						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
		attendance and involvement MARAC operating protocol is re circulated to agencies as part of yearly review – includes a section on agency attendance and engagement				basis as part of data discussions. Any issues with attendance are escalated to the relevant agency. Actions offered by agencies is being looked at within the MARAC performance management framework.
2	Review with partner agencies how decreases in resources have impacted on their services and establish what actions they are now able to offer through MARAC	Questionnaire devised to be sent out to all MARAC partner agencies 1:1 discussion with organisations after questionnaire completed	MARAC Coordinator	Questionnaire and email sent to partners Questionnaire outcomes 1:1 discussion outcome	September 2021 Clear understanding of the range of resources available to MARAC across the partnership Identification in barriers/gaps to feed into wider review of MARAC complex cases	Revised timescale of April 2024 Ongoing –Review of current agency resources is part of MARAC steering group work programme

MARAC						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
3	To review how complex cases are dealt with through MARAC, ensuring the local Sefton context is linked into wider Merseyside wide discussions about the same issues and also into Sefton's strategic work on domestic abuse.	MARAC complex case audit conducted with partners, overseen by MARAC Steering group Review how complex cases identified within MARAC are dealt through the MARAC process, with consideration given to agency resources, service provision available, commissioned contracts and cross over with other areas of managing complex needs	Locality Team Manager/Service Manager	Completion of MARAC complex cases audit Outcome of review with MARAC partner agencies to understand impact of reduced resources and actions currently available to MARAC Minutes from Merseyside meetings Overall review report completed to outline findings and recommendations for managing	31 March 2022 Better understanding of the challenges facing victims and perpetrators of domestic abuse with complex needs in engaging with support services There is a focused and needs led multi-agency response to high-risk complex domestic abuse cases. Support services better able to respond to victims and perpetrators of domestic abuse	Initial audit of complex cases heard at MARAC in 2020-21 completed October 2021, outcomes fed into MARAC Steering group and DA Partnership & Merseyside's DA strategic group. Further audit completed Feb 23 and discussed at MARAC Steering Group Feb 23. Ongoing work also linked to Sefton's DA Board and Merseyside DHR learning group which feeds into Merseyside Strategic Domestic Violence & Abuse Group. Complex Needs IDVA continuing to collect

MARAC						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
		Involvement in Merseyside MARAC discussions about complex cases		complex domestic abuse cases.		frontline evidence on themes and key challenges around victims with complex needs. New Multi-Agency DA Perp Group being established Feb 24 to look at highest risk/harm perpetrators, closely linked to complex lives work Review with MARAC partners agencies re: resources still to take place.

Mersey Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Re-enforced learning around Professional	Refresher training session for Ambition	Crispin Evans, Interim	Copy of slides used	01 July 21	Ambition Sefton services transferred to Change Grow Live

Mersey Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
	curiosity and domestic abuse.	Sefton on Professional Curiosity	Safeguarding Lead for Local Division		Increased awareness of domestic abuse and confidence of staff	in April 2022 as the provider for substance misuse support in Sefton. Mersey Care run modular training which supports the bigger, mandatory, Safeguarding packages which are required to be Intercollegiate framework compliant. The modular sessions include Professional Curiosity and Domestic Abuse. These are run by the safeguarding team and are open Trust wide to enable a greater mix of professionals/disciplin

Mersey Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						es to learn collectively The Trust launched a single point of access within the organisation for safeguarding advice in Oct 22 which is called the Safeguarding Duty Hub. Data from the hub can now evidence the ongoing professional curiosity from staff. Data sets can be broken down into divisions and teams for onward reporting and oversight. A presentation of this data has bee shared with the Safeguarding Adult Board in Sefton. The duty data highlighted that domestic abuse

Mersey Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						across Children's and Adults services is the primary concern shared by staff with the safeguarding leads. As a result of this we have established "safeguarding links" in each operational team and have run a targeted conference for the links on Dom Abuse. Future plans include a relaunch of Routine Enquiry in the "How Safe Do You Feel" campaign.

Merseyside Community Rehabilitation Company **NB: Action Plan updates provided by Probation Service following national restructure of CRC and Probation services in 2021**						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Allocation of cases should include an element of	New policy on allocation recently	Senior leads MCRC	Review of HMIP action plan.	July 2021	Completed July 2021

Merseyside Community Rehabilitation Company NB: Action Plan updates provided by Probation Service following national restructure of CRC and Probation services in 2021						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
	management oversight to assure correct decision making and re allocation if necessary	implemented. Review required as part of HMIP action plan			Cases are allocated to suitably trained and experienced staff	
2	Risk of harm training is quality assured to confirm professional competence	Quality development officers to have completed this project	Senior leads MCRC	Learning and development data	July 2021 Staff are assessed as competent in managing DA cases assessed as medium risk of harm	Completed July 2021
3	Training in professional curiosity is delivered as part of L&D schedule and ongoing as part of reflective practice discussion	Review of L&D schedule to confirm inclusion of professional curiosity as a key skill.	Senior Leads MCRC	Risk of harm training materials DA training materials Learning & Development schedule	July 2021 Staff have been given opportunities to consider the art of professional curiosity and supported into practice	Completed July 2021 Confirmed section on professional curiosity included in L&D training materials
4	Intelligence sharing between police and probation is improved	Review between Police and Probation	Senior Police and Probation leads Liverpool/Sefton	Progress report to Board	December 2021 Intelligence is shared to improve decision making around DA risk of harm and protection of the public	Complete December 2023 Regional agreement that current ISA, approved nationally by the Chief

Merseyside Community Rehabilitation Company NB: Action Plan updates provided by Probation Service following national restructure of CRC and Probation services in 2021						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						Probation Officer and National Police Chiefs Council, is used. Document provided as evidence. Whilst there have been system and resource developments and improvements over the last 12 months. There is no further progress on moving to a reportable incident process..
5	Offence focused work on licence is improved.	Referral to lead senior resettlement manager for inclusion in resettlement practice development group for action.	Senior lead Sefton	Progress report to Board	Resettlement officers retain a focus on criminogenic need associated with offence.	Completed July 2021

Merseyside Community Rehabilitation Company NB: Action Plan updates provided by Probation Service following national restructure of CRC and Probation services in 2021						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
6	Child/adult safeguarding checks are a feature of case management at times of significant change	Via HMIP action plan	Senior leads MCRC	Outcome of HMIP action plan and future HMIP inspection	Safeguarding practice improved	Completed August 2021 Safeguarding checks are mandated for all new cases, whether the offence is related to safeguarding or DA issues, with the clear instruction that any new information, change in behaviours, or other information warrants a review of the case; this is also set out in the Policy Framework. This has been supported by a briefing from the Partnership Manager to all court and sentence management staff. Continued

Merseyside Community Rehabilitation Company NB: Action Plan updates provided by Probation Service following national restructure of CRC and Probation services in 2021						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						membership of MARAC and MACE. Awaiting next HMIP inspection

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	That the force considers raising awareness among officers and staff of the significance of strangulation as a form of domestic abuse and the current legislation i.e. S21 Offences Against the Person Act 1861, with the aim of ensuring there are no missed opportunities	Delivery of training on this form of Domestic Abuse and the current legislation relating to strangulation. Review of working practices to ensure evidence gathering	Detective Chief Inspector Protecting Vulnerable People	There is a specific question re strangulation on VPRF1 Awareness raising and communications relating to the new offence of non-fatal strangulation completed	May 2021 Awareness of the new offence of non-fatal strangulation (Domestic Abuse Bill 2021)	Completed January 2023 On 29th April 2021 the Domestic Abuse Bill received Royal Assent and became law. The Domestic Abuse Act will provide further protections to the millions of people who experience domestic abuse and strengthen measures to bring perpetrators to justice, as well as transform the support we

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
	to detect this offence.	records the sequence of events correctly, and that photographic and medical evidence of strangulation are obtained whenever possible.				give to victims ensuring they have the protection they deserve. The Act introduces a new offence non-fatal strangulation. Learning re the offence of strangulation: Section 21 Offences against the Person Act 1861: •A person commits the offence if, by any means, they attempt to choke, suffocate, or strangle another with intent to commit an indictable offence. was incorporated into the DA Intensification CPD event. Officers were also made aware of the impending new legislation regarding the new non-fatal strangulation

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						offence scheduled for spring 2022. On the 7th June 2022 section 70 of the Domestic Abuse Act 2021 commenced. The Serious Crime Act 2015 has been amended to introduce two new sections — section 75A and 75B— which create a new specific criminal offence of non-fatal strangulation and suffocation. The new offence applies in England and Wales, where a person intentionally strangles or suffocates another person, including cases where this offence occurs in a domestic abuse context. It covers a range of behaviours, including strangulation, suffocation

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						and other methods used by a person that affect a victim's ability to breathe (such as constriction of airways). The offence also applies where strangulation or suffocation has been committed abroad by a UK national (or a person who is habitually resident in England and Wales) as if the offence had occurred in England and Wales. Communications have been cascaded force wide re this new offence and training provided at recent CPD events. Processes have also been implemented that ensure that NFS criminal investigations are always referred in to and investigated by a

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						Detective within a PVPU department. With regards to identifying risk - With such cases, the MeRIT reflects the severity of the incident reported and this is an academically robust process of identifying risk used for many years across agencies within Merseyside. There is a specific question that asks "Did the perpetrator strangle/attempt to strangle or place hands around the victim's throat" which will be ticked where cases involve strangulation. This tick will be considered when calculating the final risk assessment grade. There is no specific question

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						around suffocation however, there is always the ability to upgrade cases on professional judgement either by police officers or by the risk assessors within the MASH. Training has been disseminated across strand so all officers have received it. The new offence Section 75a is embedded as part of the training criteria so not only do existing officers receive this it is also given to new recruits as part of their initial training.
2	Improvement of intelligence sharing with Police and NPS	Review underway and an automated	Detective Chief Inspector	Progress review ISA produced	December 2021	Complete December 2023 Merseyside Police are still in consultation with

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
	in relation to domestic abuse incidents with individuals subject of ongoing probation supervision.	system is being developed to share information. An Information Sharing Agreement will be produced	Protecting Vulnerable People		Automated ISA approved implemented Intelligence is shared with NPS to improve decision making around DA risk of harm and protection of the public	probation who are developing the ISA but have yet to finalise the reportable incidents implementation. We have been assured as soon as this is complete the ISA will be in a position to be reviewed, agreed and signed off. In the mean time they are using the national ISA as per other force and probation areas.

Please note: the action plan is a live document and subject to change as outcomes are delivered.

End

FOR PUBLICATION DHR 'DENISE' – January 2024