Keeping Swindon Safe

Executive Summary of the Overview Report

Into the death of Tara (pseudonym)

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A Tribute to Tara by her sons

"There is so much in our hearts that we could say about our Mum, but nothing can properly reflect on what a special person she was, what she meant to us or how much we miss her.

She was a loving, caring family person, yes she loved her horses and she would spend many an hour with them but she always would have time for her family. Nothing was too much trouble for her where family or friends were concerned.

Her death has devastated the family and torn our lives apart. We hope no other woman has to die like our mother and no family has to suffer such a loss as ours.

Domestic abuse is like a cancer which gets worse and worse if it is not dealt with early. We hope this Review into our Mum's death, helps victims of domestic abuse have the courage and confidence to seek help and that organisations respond to those victims positively and firmly. "

Domestic Homicide Review Panel

David Warren QPM, Home Office Accredited Independent Chair

Avon and Wiltshire Mental Health Partnership NHS Trust

NHS, England

National Probation Service

SEQOL

Swindon Community Safety Partnership

Swindon Borough Council

Swindon Clinical Commissioning Group

Swindon Women's Aid

Wiltshire Police

Section One: Introduction

1. This Domestic Homicide Review examines the circumstances surrounding the death of Tara (pseudonym), who was 48 years of age and lived in Swindon

1.1. The circumstances of Tara's death are:

1.1.1. On 21st March 2014 Tara and her husband Jonathan (pseudonym) were, in their 4x4 motor car, travelling south on the M1 motorway in Leicestershire. Jonathan, who was driving the vehicle, swerved off the motorway and crashed his car into a tree. Both Jonathan and Tara sustained serious injuries and were taken to hospital. Tara died in hospital two days later as a result of her injuries. Jonathan was later arrested and charged with her murder.

1.1.2. Jonathan's criminal trial was delayed during his physical recovery in hospital and to await psychiatric reports into his mental health. He was later found guilty of Tara's murder and was ordered to serve at least 17 years in prison. His defence team has lodged an Appeal against both conviction and sentence.

Section Two: The Review Process

2.1. This summary outlines the process undertaken by the Swindon Domestic Homicide Review Panel in reviewing the death of Tara.

2.2. After seeking advice from the Home Office, a decision to undertake a Domestic Homicide Review was taken by the Chair of the Swindon Community Safety Partnership on 24th June 2014 and the Home Office informed on 25th June 2014.

2.3. The process began on the 9th July 2014, with an initial Review Panel meeting of all agencies that potentially had contact with the victim Tara or perpetrator Jonathan prior to the point of Tara's death on the 23rd March 2014 and it was concluded on the 16th July 2015.

2.4. One of Tara's sons was contacted at the commencement of the Review and confirmed that the family wanted him to be the family link with the Review and that he wished to assist the Review. He provided a pseudonym to be used for his mother and gave written consent for the Review to access her medical records. Jonathan's solicitor was informed of the Review. She later informed the Review Chair that her client did not wish to engage with the Domestic Homicide Review.

2.5. At the conclusion of the Review, both the victim's and the perpetrator's families were offered the opportunity to read the Overview Report and were invited to attend the final meeting of the Domestic Homicide Review Panel. There was no response from the perpetrator's family; however nine members of the victim's family took the opportunity to read the Overview Report and Chronology and to attend the final DHR Panel meeting on 16th July 2015.

2.6. The agencies participating in the Review are:-

- Avon & Somerset Constabulary
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Boots.
- Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Ltd
- Capita Insurance & Benefits Services
- Church of England Bristol Diocese
- CP Counselling (Confidential Professional Counselling)
- Crime Reduction Initiative (Drug and Alcohol Service)
- Driver and Vehicle Standards Agency
- Great Western Hospitals NHS Foundation Trust
- Hometruths, Domestic Abuse Service
- Leicestershire Constabulary
- National Probation Service
- NHS England
- North Yorkshire Police
- Optum
- Safer Gloucester
- SEQOL
- Swindon Borough Council Housing
- Swindon Clinical Commissioning Group

• Swindon Community Safety Team
• Swindon Women's Aid
• Westfield Health
• Wiltshire Police

2.7. The agencies were asked to give chronological accounts of their contacts with the victim and/or perpetrator prior to the homicide. All relevant documentation was secured. Where organisations had no involvement, or insignificant involvement, they informed the Review accordingly.

2.8. Of the twenty five agencies contacted about this Review, twelve responded that they had had no contact with the victim or perpetrator. A further one organisation declined to provide the Review with information relating to their counselling of the perpetrator. Two organisations, Avon and Somerset Constabulary and Safer Gloucester, provided good practice guidance documents to be used by the DHR. Her Majesty's Inspector of Constabulary (HMIC) were consulted and agreed to implement a Review recommendation.

2.9. Nine agencies completed either an Independent Management Review (IMR) or a report with information indicating some level of involvement with either Tara or Jonathan.

2.10. The facts obtained from the IMRs, reports and from the family are summarised as follows:

2.10.1. Tara and Jonathan met in 2011 and after living together for a few months, married in September 2012. Both had previously been married and each had two children from previous relationships. They lived in a house which had been owned outright by Tara. Just prior to their marriage she put Jonathan's name on the house deeds to enable them to obtain a mortgage to complete renovation work to the property. (Later, Tara worried about Jonathan being a joint owner of the house, as he told her she would get nothing if she left him. She sought advice from Optum, a support and counselling service for Boots employees).

2.10.2. Tara had been the victim of domestic abuse from a previous partner in 2010. She contacted the police on one occasion and consequently finished the relationship with that individual.

2.10.3. Jonathan was described by his first wife as controlling during his first marriage and whilst he assaulted his wife on five occasions the police were never notified. She recalled that on one occasion she went with Jonathan to speak to a Church of England vicar about their family problems. The vicar could not recall any suggestion of domestic abuse being discussed at that meeting.

2.10.4. A number of Tara's family and friends informed the Review that Tara told them that Jonathan was regularly violent towards her. She twice saw her GP about the assaults and on a further occasion saw the GP with Jonathan for joint counselling.

2.10.5. Jonathan visited his GP on several occasions, complaining he had a high sex drive and that his relationship with his wife was strained at times as he was quite controlling. He also referred himself to LIFT Psychology Service for counselling and for an anger management course.

2.10.6. On 11th March 2014 Tara made her only complaint to the Police about an assault by Jonathan. They attended and although Jonathan was not arrested, he admitted that offence and one previous assault. Later the same day they went to CP Counselling for Couple counselling. CP counselling is a professional counselling service for couple counselling, individual counselling and psychosexual therapy. When Tara told the therapist about the domestic abuse and showed her the extent of her injuries the session was stopped and they were offered individual counselling.

2.10.7. On 15th March 2014 Tara and Jonathan, went on a "make or break" holiday to a cottage in Yorkshire with the intention of staying until 22nd March. At 9.30am on 21st March 2014 Tara dialled 999 on her mobile, but the call did not connect as there was no signal. Shortly afterwards, Jonathan told the owner of the cottage they were staying in, that they would be leaving early as they had had a "big bust up".
They left shortly afterwards.

2.10.8. During the journey back Tara sent text messages to her son and sister. She told her son "…he is driving and volatile. I need him arrested when we get back but do not want to wind him up."

2.10.9. A summary of the incident itself is set out in paragraph 1.1.1.of this report.

2.10.10. The Pathologist's report revealed the cause of Tara's death as being "due to ischaemia to her large intestine, which was consistent with the injuries consequent upon the impact with the seat belt causing injuries to the abdominal contents." The pathologist's opinion is that this ischaemia is a direct consequence of the road traffic collision and that this collision is the underlying cause of death.

Section Three: Terms of Reference

3.1. **The purpose of the Domestic Homicide Review is to:**

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

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

- Identify clearly what 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 victims and their children through improved intra and inter-agency working.

3.2**. Overview and Accountability:**

3.2.1. The decision for Swindon to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Swindon Community Safety Partnership on the 24th June 2014 and the Home Office informed on 25th June 2014.

3.2.2. The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. As there are criminal proceedings pending relating to this homicide, a decision had been made to adjourn the Review until the completion of the trial.

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

3.3. **The Domestic Homicide Review will consider:**

3.3.1. Each agency's involvement with Tara, (48 years of age at time of her death, of Swindon, Wiltshire) and Jonathan, (50 years of age at date of incident, of Swindon, Wiltshire); between 1st January 2012 and the 23rd March 2014, together with any contacts relevant to domestic abuse, violence or mental health issues prior to that period

3.3.2. Whether there was any previous history of abusive behaviour towards the deceased or to any previous partner of Jonathan's and whether these incidents were known to any agencies?

3.3.3. Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide?

3.3.4. Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

3.3.5. Whether the alleged perpetrator has any previous history of mental health concerns known to any agency?

3.3.6. Could improvement in any of the following have led to a different outcome for Tara:

(a) Communication and information sharing between services?

(b) Information sharing between services with regard to the safeguarding of adults and children?

(c) Communication within services?

(d) Communication to the general public and non-specialist services about available specialist services?

3.3.7. Whether the work undertaken by services in this case is consistent with each organisation's:

(a) Professional standards?

(b) Domestic Abuse policy, procedures and protocols?

3.3.8. The response of the relevant agencies to any referrals relating to Tara concerning domestic abuse or other significant harm from 1st January 2012, or any other incident relevant to violence or domestic abuse relating to Jonathan prior to that date. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

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

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

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

(d) The quality of any risk assessments undertaken by each agency in respect of Tara, or Jonathan**.**

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

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

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

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

3.3.13. The review will consider any other information that is found to be relevant.

Section Four: Key Issues

4.1. The DHR provided an opportunity to analyse the information obtained from agencies, from Tara's and from Jonathan's families, friends, colleagues, neighbours and from parallel reviews/inspections

4.2. The Review considered whether any of the nine protected characteristics of the Equality Act influenced decisions made by organisations in their contacts with either Tara or Jonathan. The Review Panel is satisfied that there is no evidence that any of these characteristics adversely affected the quality of responses provided by agencies. There was however evidence of sexist behaviour by Jonathan towards both Tara and his first wife when they did not wish to comply with his sexual demands.

4.3. The Review Panel considers the key issues in this Review to be;

- Jonathan being a repeat perpetrator of domestic abuse.

- Jonathan's first wife never reported the domestic abuse she suffered to the police, therefore when Tara made a Domestic Violence Disclosure Scheme request to the Wiltshire Police, there were no records about Jonathan's past behaviour.

- Tara being a repeat victim of domestic abuse.

- Tara disclosing Jonathan's physical violence, to a wide circle of friends and family but not seeking help from local domestic abuse support services and only once contacting the police.

- Tara remaining with Jonathan, initially because she loved him and believed he was seeking help for his high sex drive and controlling behaviour, then later as she felt trapped, after he told her she would get nothing if she left him.

- The response of Wiltshire Police when Tara made a 999 call on 11th March 2014, after Jonathan had assaulted her. Jonathan was interviewed and admitted both assaults but was not arrested. This appeared to be contrary to the Wiltshire Police's policy of taking positive action when dealing with perpetrators of domestic abuse.

Section Five: Effective Practice/Lessons to be learnt (*summarised from section 15 of the Overview Report***)**

5.1. The following agencies that had contacts with Tara and Jonathan have identified effective practice or lessons they have learnt during the Review.

5.2. **Avon and Wiltshire Mental Health Partnership NHS Trust**

5.2.1. The service has reviewed its policies and has considered:

- If the anger management course Jonathan attended, should include specific reference to domestic abuse.

- If staff could have asked more probing questions about domestic abuse.

5.2.2. The internal review acknowledged that Lift's contact was solely with Jonathan and he never made any disclosure of domestic abuse, nor did the service have any reason to suspect that domestic abuse had taken place. If there had been any indication of domestic abuse, the service expected that the protocol would have ensured that it was dealt with positively, including if considered appropriate disclosing such information to the police. All staff have been trained in safeguarding procedures including domestic abuse.

5.2.3. As a result of this case the service managers reviewed the policy of not pre-screening clients or asking them probing questions, but concluded that to do so might inhibit people with mental health worries from entering the service and could impact negatively on the service's suicide prevention work.

5.3. **Church of England**

5.3.1. When Jonathan's marriage to his first wife was breaking down, he asked her to go with him to discuss their problems with a Church of England vicar whom he knew. Whilst the vicar remembered the meeting, he could not recall anything that was said which would have indicated that domestic abuse had taken place. Nevertheless it was acknowledged by the Church of England that the Church's domestic abuse guidance, "Responding to Domestic Abuse. Guidelines for those with pastoral responsibilities" was published in 2006 and needs to be updated.

5.3.2. The Church recognises that there needs to be closer links with local Community Safety Partnerships, so that those with pastoral responsibilities have a better awareness of the specialist support services available locally for domestic abuse victims and perpetrators.

5.4. **NHS England**

5.4.1. The review of the records and interview with Tara and Jonathan's GP established that care was consistent with Good Medical Practice guidelines up to 3rd October 2013. Both Tara and Jonathan's consultations involved an adequate assessment and referral to other practitioners or other agencies where appropriate.

5.4.2. The consultation with Tara on 27 December 2013 was not consistent with guidelines. The frequency of the abuse was such that the GP should have discussed the case with the Safeguarding Lead in the Practice and perhaps anonymously with a specialist

domestic abuse support service or the police for further advice on how to manage this disclosure.

5.4.3. The consultations with Jonathan on 3rd January, 7th and 10th February 2013 were appropriate and consistent with good medical practice.

5.4.4. The consultation with Tara on 11 February 2014 was not consistent with guidelines. This was an opportunity for further exploration of the reported physical abuse and to discuss further support in seeking assistance.

5.4.5. The joint consultation with both Tara and Jonathan on 17th February 2014 was not consistent with guidelines; there were safety issues which would have been better addressed by taking specialist advice.

5.5. **Optum (Support and Counselling Service for Boots Employees)**

5.5.1. The Optum Report author confirmed that an internal review was undertaken which found that there were instances of good practice, i.e.:

a) The specialist legal/financial advisor encouraged Tara to speak to a telephone counsellor although she insisted she only wanted financial/legal advice relating to the ownership of her home.

b) The telephone counsellor was correct to assess Tara's safety and discuss a safety plan which included calling the police and Women's Aid.

c) However the telephone counsellor responded to Tara's own judgement of her safety and failed to "red flag" the case for risk.

5.6. **Wiltshire Police**

5.6.1. Analysis of the contemporaneous notes taken from Jonathan highlighted a number of concerns regarding the quality of the initial investigation. It also raised questions as to how appropriate the taking of contemporaneous notes were from a suspect of domestic assault so soon after it was reported, and whether or not this method of dealing with the suspect complied with Wiltshire Police's positive action policy on dealing with cases of Domestic abuse.

5.6.2. At the time of the incident there was no policy in place for dealing with contemporaneous note interviews.

5.6.3. The lack of any clear guidance or training also had an impact on the resultant supervision of this case with operational sergeants unable to effectively benchmark due to the absence of training or policy to support and guide them through clear identified processes.

5.6.4**.** There is a clear lack of guidance in respect of submission of summons files. This is particularly concerning in respect of domestic abuse cases whereby the requirement to deal quickly and effectively with the perpetrator is of paramount importance.

5.4.5. The absence of policy and formal training for staff has resulted in differing interpretations of the time frames associated with the submission of report files for summons.

5.4.6. This review has highlighted that there is no current method of prioritising a summons file for domestic abuse and as a consequence are afforded no greater priority than other offences**.**

5.6.7. It is not the first time that the Domestic Abuse, Stalking and Honour Based Violence (DASH) checklist for identifying and assessing risk; risk assessment process has raised issues for Wiltshire Police. The lack of recording accurate information as well as poor interpretation of the DASH question set by the attending officers the incident is a cause for concern.

5.6.8. There should have been a reassessment of the risk when the Control Room Operator received further information from the victim regarding her injuries. This should also have been recorded on the Public Protection Referral Form (PPD1)**.**

5.6.9. The case has highlighted a significant variance and understanding of the process required in the completion of PPD1 and the duties of supervisors in checking and endorsing the investigations.

5.6.10. When the two officers were interviewed as part of the misconduct investigation it became apparent that neither officer felt comfortable in offering meaningful safeguarding advice to Tara, other than simply advising her to dial 999. This has been found to be an issue with DASH risk assessments that are deemed as standard risk, as these do not attract any input from the Domestic Abuse Investigation Team.

5.6.11. The supervision in this case was inadequate and the investigating officer was not questioned as to why an arrest had not been made, or why a rationale for not arresting Jonathan was not recorded on the PPD1. The supervisor did not recognise that the file contained significant anomalies and deficiencies. Furthermore the supervisor did not ensure that a CPS charging decision was sought in a timely manner.

Section Six Conclusions (*summarised from section 16 of the Overview Report***)**

6.1 In reaching their conclusions the Review Panel has focused on the following questions:

6.2. **Have the agencies involved in the DHR used the opportunity to review their contacts with Tara and Jonathan in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?**

6.2.1. The Review Panel is satisfied that the Individual Management Review reports have been thorough, open and questioning from the view point of Tara and Jonathan.

The organisations have used their participation in the review to identify and address lessons learnt from their contacts with Jonathan and Tara in line with the Terms of Reference (ToR).

6.3. **Will the actions they take improve the safety of domestic abuse victims in Swindon in the future?**

6.3.1. The Review Panel believes that the agreed recommendations address the needs identified from the lessons learnt. The Panel also recognises that the Swindon Community Safety Partnership and the individual agencies represented on the Review have comprehensive domestic abuse strategies and polices in place which are being improved by the recommendations made in this Review. Provided those recommendations, strategies and policies are fully and promptly implemented, they will improve the safety of domestic abuse victims in Swindon in the future. The Panel notes that the Church of England is in the process of updating its domestic abuse policy and when it is complete will undertake to share it with other denominations.

6.4. **Was Tara's death predictable?**

6.4.1. There were signs that Jonathan might react negatively and aggressively when he understood that Tara was determined to leave him. However no organisation or individual was in possession of all of the available information, prior to the incident, to recognise the warning signals.

6.4.2. **The Review Panel therefore concludes that no individual or agency taking part in this Domestic Homicide Review had sufficient knowledge to have reasonably predicted Tara's death**.

6.5. **Could Tara's death have been prevented?**

6.5.1. The Review Panel acknowledges that on the basis of the outcome of the criminal trial and the Judge's comments the one person who could have prevented Tara's death was Jonathan.

6.5.2. Nevertheless having considered all of the information provided to the Review, the Panel is of the opinion that there were decisions made which if they had been different may have prevented Tara's death at that time:

- Tara's decision to put Jonathan's name onto the deeds of her house was a factor in her staying with him. Jonathan later used this to his advantage to threaten her that if she left him she would have nothing. She decided to give him one more chance and go on the "make or break" holiday to Yorkshire with him; despite advice from her sister and a friend not to go.

- If the Police had arrested Jonathan on 11th March 2014, four days prior to the holiday, would they have still gone? In theory they could have gone on the holiday, as Jonathan, who had no previous convictions, would undoubtedly have been granted bail, either at the police station or by the Court. However in practice it is probable that bail would have been granted with conditions attached. Those conditions may have included a direction to stay away from Tara or the house until after the case was heard. Jonathan's arrest would also have triggered an Independent Domestic Violence Advisor (IDVA) contact with Tara. The Panel accepts that Tara may not have wanted to engage with the IDVA as she had declined to contact specialist support services previously, but an IDVA would have been able to offer her support and advice about her rights and informed her of the various help available to her. **It is clear that whilst it would be speculative to suggest that had the police officers arrested Jonathan that may have saved Tara, there is no doubt that the officers and their supervisors failed her.**

- **The Panel acknowledges that policing is unique, in as much as it is the most junior and inexperienced officers who, when policing the streets and respond to 999 calls on a day to day basis, are required to make instant and critical decisions. In Wiltshire the average length of service of front line officers is approximately three years. The Panel therefore believes that it is critical for the maintenance of force standards, the protection of the public and the development of junior officers, that Sergeants and Inspectors provide professional, operational supervision on a daily basis.**

16.5.3. T**he Review Panel welcomes the Wiltshire Police action plan to address these weaknesses and acknowledges the importance of the programme of domestic abuse inspections of police forces in England and Wales currently being conducted by HMIC.**

7. **Section Seven Recommendation**

7.1 National Recommendations

7.1.1. That the Church of England updates the 2006 domestic abuse policy document, “Responding to Domestic Abuse. Guidelines for those with pastoral responsibilities" and publishes its new guidance before June 2016.

7.1.2. That the Church of England’s new guidance should be brought to the attention of those with pastoral responsibilities as promptly and clearly as possible and not later than June 2016.

7.1.3. That the Church of England ensures that all those with pastoral responsibilities receive domestic abuse training by December 2017.

7.1.4. That the Church of England shares its new domestic abuse policy with other Faiths in England and Wales before the end of June 2016.

7.1.5. That Her Majesty’s Inspector of Constabulary includes a focus on the supervision of domestic abuse cases when carrying out its current programme of domestic abuse inspections of police forces in England and Wales. This has already been implemented and will be ongoing during future Police Force inspections.

7.2 **Cross agency recommendations** (*summarised from section 17 of the Overview Report)*

7.2.1. That Swindon Community Safety Partnership links with religious leaders to engage with them in raising awareness of domestic abuse and the availability of specialist domestic abuse support services in Swindon. This will be fully implemented by March 2016.

7.2.2. That Swindon Community Safety Partnership uses good practice material from other areas to update current literature informing the public and general organisations about domestic abuse and what action to take if they become aware of abuse taking place. This will be fully implemented by March 2016.

7.2.3. That Swindon Community Safety Partnership leads partnership agencies in raising public awareness of domestic abuse and the availability and scope of specialist support services in Swindon and adjoining areas. This will be fully implemented by March 2016.

7.2.4. That Swindon Community Safety Partnership agencies appoint Domestic Abuse Champions/Leads to ensure that their organisation’s domestic abuse policies are up to date and implemented positively by all personnel; that staff receive regular appropriate level training and that they are available to provide advice and support if required. This will be fully implemented by March 2016.

7.2.5. That the Swindon Community Safety Partnership, with the support of Woman’s Aid and Wiltshire Police assist with the training of the new domestic abuse champions/lead officers. This will be fully implemented by March 2016.

7.3. **Individual Agency Recommendations**

7.3.1 Avon and Wiltshire Mental Health Partnership NHS Trust. / SEQOL

a) **T**he LIFT Psychology service will reinforce the current safeguarding protocols, including Domestic Violence procedures with the staff team. This has been implemented, and will be ongoing.

b) The LIFT Psychology service had a training session on the 22nd July 2015 which included further specific training on possible indicators of Domestic violence and the need to ask specific questions when indicated. This will be a feature in training new staff on induction.

7.3.2. **CP Counselling (Confidential Professional Counselling)**

a) That the organisation review personnel awareness of the company's domestic abuse policy and knowledge of their responsibilities if they suspect a client may a victim or perpetrator. This was fully implemented with existing staff on 22nd July 2015 and will be part of induction training for any new personnel.

7.3.3. **Optum**

a) A performance review was held with the Telephone Counsellor and their line manager to revisit assessment protocols and the importance of Red Flags. This was completed in April 2015.

b) Assessment protocols and the importance of Red Flags has been revisited in weekly team meetings. Discussion included risk assessment, clarity of note taking and evidence of a clear rationale for all care plans and escalation protocols. This was completed in April 2015.

c) The following activities were conducted not as a result of the Internal Review; however they provide an outline of the company's wider focus to improve clinical quality and governance to safeguard against risk:-

- Training: Two days training was delivered in 2014 to the whole clinical team in Oxford and Dublin. The training focused on risk and risk assessment within the Solution Focused Brief Therapy model used by the company. However, the case helped to highlight the importance of attention to risk and escalation protocols.

- Enhanced Monitoring: Implementation of a Telephone Counsellor Tracker. This is used to monitor Telephone Counsellor performance following any complaint or non-conformance.

- Company – Implementation of Risk Register to capture all risk events that result from non-compliances within the organisation. This has been implemented and is ongoing.

7.3.4. **NHS England/Swindon CCG**

a) That Swindon CCG will identify and arrange the training of a GP to be the Safeguarding lead with a special responsibility for domestic abuse. This role will include advising GPs and other medical service providers on what action to take when faced with issues relating to domestic abuse. This will be cascaded by NHS England to CCGs. This was agreed in June 2015 and the post holder will be in place by September 2015.

b) The Swindon CCG website will include a link to Women's Aid to inform medical practitioners about the specialist domestic abuse support services available locally. This was completed in June 2015.

c) When domestic abuse is disclosed to a medical practitioner, the patient's vulnerability and safety should be considered against their autonomy. This has been agreed and fully implemented by June 2015.

d) When domestic abuse is disclosed in a GP consultation, up to date and appropriate information should be available to the individual. This has been agreed with GPs and implemented by June 2015.

e) Leaflets in a locality should be readily accessible on search engines, clearly labelled, in accessible appropriate, supportive language and dated to ensure they are current. This is ongoing and will be completed by September 2015.

f) Each GP Practice in the Swindon area will have a safeguarding lead who will receive specialist domestic abuse training by Woman's Aid. Courses have already commenced and are ongoing.

g) When domestic abuse is disclosed in a GP consultation it should be discussed with the safeguarding lead in the Practice in order to assess the risk and appropriate actions to be taken and services to be offered. All GP Practices in the Swindon area have agreed to implement this recommendation immediately.

h) If a joint consultation for marital disharmony is offered this should only be done if the GP has appropriate qualification in counselling. This must not proceed if there is any suspicion of domestic abuse. This has been communicated to and agreed by all Swindon GP practices.

7.3.5. **Wiltshire Police**

a) With immediate effect the practice of interviewing perpetrators by way of a contemporaneous note interview should cease. If an arrest cannot be justified the perpetrator should be interviewed on tape at a police station under invitation. The domestic abuse policy has now been amended to reflect this. Completed prior to June 2015.

b) Create and circulate a 'best practice document' and policy document for existing operational staff dealing with incidents by way of contemporaneous notes. This has been fully implemented.

c) Establish, agree and circulate procedures regarding the timely submission of report files for summons recommending that in domestic abuse cases this should be within 24hrs, or as soon as practicable, due to the non-availability of CPS for non-custody offences over weekends. This recommendation has been completed, June 2015.

d) Create a policy for the submission of summons files for Wiltshire Police. This must incorporate a process to ensure priority for domestic abuse cases submitted for summons. This recommendation has been completed, June 2015.

e) Amend the current domestic abuse policy to incorporate timescales for the submission of all types of domestic abuse court files. This recommendation has been completed, June 2015.

f) Develop a flow chart process map to reaffirm the requirement to review the DASH risk assessment upon new intelligence and history. Communicate this using e-brief & managers briefing. This will be completed by the end of July 2015.

g) Front line staff and control room staff to be given refresher training regarding safeguarding measures available for victims of domestic abuse. The training to include an understanding of the information required to correctly complete the PPD1, the DASH risk assessment process and review. This training will take place during Autumn 2015.

h) Effective training should be rolled out to supervisors regarding their duties and responsibilities to effectively manage domestic abuse investigations. Specifically, supervisors must satisfy themselves that the DASH risk assessments have been completed accurately and that incidents have been dealt with appropriately. This training will take place during Autumn 2015.

i) The PPD1 should be redesigned to allow for consistency in supervisor endorsement with the support of effective training enabling supervisors to demonstrate due consideration concerning victim safeguarding and risk. This has commenced and will be completed by Autumn 2015.