Domestic Homicide Review
Executive Summary Report

REPORT INTO THE DEATH OF PETER 2013

Report produced by Brian Lawson

Date: 25th August 2014

1.1 Background

This Domestic Homicide Review (DHR) examines agency responses and support given to Peter prior to the point of his death in 2013. The review will consider agencies contact and/or involvement with Peter, Kate, child Tom and other relevant family members from January 2010. Prior contact with the individuals prior to January 2010 will be included as relevant to the terms of reference (see later).

1.2 Terms of reference

The following terms of reference were agreed

1.2.1 Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the Panel until the Review Panel agrees what information is to be shared in the final report when published**.**

1.2.2 To review the involvement of each agency, statutory and non-statutory, with Peter, Kate and Tom during their relationship with each other. This part of the review should cover the period from 1st January 2010 to the point of death.

1.2.3 IMR authors should also review agency contact prior to 1st January 2010 with Peter, Kate and Tom. In reviewing contact prior to 2010 authors should include in their chronologies any contact which has a bearing on the purpose of the DHR. In particular authors should include:

- Any history of violence in previous relationships in relation to Peter, Kate and any relevant incidents of violent behaviour.
- Any contact Social Care agencies had in relation to Tom.
- Any relevant history in relation to Peter and Kate in relation to their childhoods and adolescence, including Education and Schools attended and their health.
- Any relevant history in relation to Peter and Kate which include the misuse of substances and alcohol and contact with specialist services in relation to any form of violent conduct.
- Any relevant history in relation to Peter and Kate in relation to mental health issues and contact with mental health services.

1.2.4 The IMR authors should create a chronology in the format provided and submit this to Angela Hartley, Domestic Abuse Coordinator by Monday 24th June 2013. All chronologies will then be shared with the North Yorkshire Police Disclosure Officer, thus ensuring any issues of disclosure are addressed. Whilst preparing the chronology, the authors must not collude in relation to the original source of information, i.e. speak to colleagues or other agencies to clarify any details (as this may result in some witnesses discussing evidence).

1.2.5 In reviewing the records of agency involvement and creating the chronology IMR authors should also make their Review Panel members immediately aware of any issues which require immediate action. This is a requirement of the Home Office Guidance.

1.2.6 IMR authors will meet with the Chair, and the Domestic Abuse Coordinator on the 16th July 2013 to review chronologies, clarify time periods, conclude any disclosure issues and plan for the production of the full IMRs following the conclusion of the Court case.

1.3 Particular Areas of Focus

1.3.1 Focus on the relationship and interactions between Primary Care, Mental Health and Substance Misuse Services in relation to the identification and progression of concerns in relation to Domestic Abuse in general and in relation to “Peter” and “Kate” in particular.

1.3.2 Focus on the implications for current service delivery of any issues of domestic abuse identified in Peter and Kate’s history between the ages of 16 and 18.

1.3.3 Review local practice and wider practice and research into female and male domestic violence to locate the relationship between Peter and Kate in a wider context.

1.3.4 To look at support and intervention with Peter and Kate in relation to domestic abuse.

1.3.5 To consider any issues which may be highlighted in relation to cross agency, cross boundary working or any impact of major changes to organisations.

1.3.6 Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Peter or Kate in contact with their agency.

1.4 Independent Management Review Authors

1.4.1 The following personnel completed Independent Management Reviews on behalf of their organisations as indicated:

Agency	Author Name	Author Title
Cleveland Police	Michael Cane	Detective Inspector
North Yorkshire NHS	Chris Brace	Safeguarding Officer
Compass	Kerry McKay	Assistant Director Compass
Durham and Tees Valley Probation Trust	Helen Morton	Probation Manager
York and North Yorkshire Probation Trust	Paul Kirk	Performance and Quality Manager
Tees, Esk and Wear Valleys NHS Foundation Trust	Arthur Turnbull	Senior Nurse Safeguarding Adults
Redcar and Cleveland Peoples Service	Linda McCalmont	Independent Social Worker
South Tees Hosptitals NHS Foundation Trust	Jo Gamble	Specialist Nurse Safeguarding Children
Summary Report Authors		
North Yorkshire Police	Shaun Page	Detective Inspector
North Yorkshire County Council Children's Social Care	Danielle Johnson	Team Manager Child Protection and Children in Need
York Teaching Hospitals NHS Trust	Claire Ramsay	Safeguarding Adults Specialist Nurse

1.4.2 IMR training was provided on the 8th May 2013 and an overview of Domestic Abuse Services was provided to authors.

1.4.3 Following a review of chronologies on the 5th August 2013, it was decided that full IMR's would not be required from the following agencies:

North Yorkshire Police
Children's Social Care, North Yorkshire
York NHS Foundation Trust

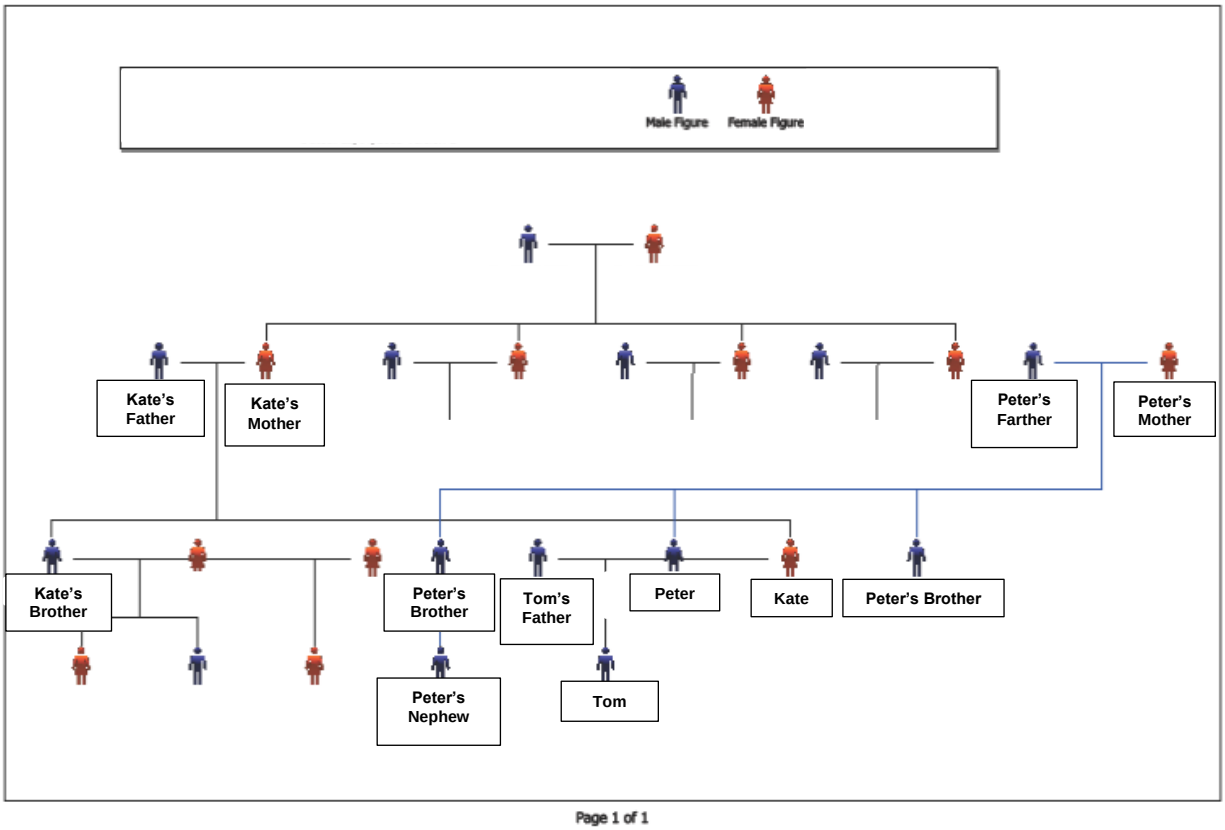
1.5 Subjects of the Review

1.5.1 Following clarification of consents and scope in relation to the terms of reference for the DHR the following individuals were identified as subjects of the review. Kate's consent was dispensed with as being in the Public Interest to do so.

1.5.2 Focus and additional subjects of the review:

Victim(Focus)	"Peter" born 1980
Perpetrator (Subject)	"Kate" born 1990
Child (Subject)	"Tom" born 2006

1.6 Family Genogram: Identifying Key Relationships



1.7 Summary of the contribution of friends and family

1.7.1 The following friends and family were interviewed as part of the Domestic Homicide Review. All interviews were undertaken by the Chair with the

Domestic Abuse Co-Ordinator for Scarborough and Ryedale:

Parents of Peter were seen on four occasions. Firstly to inform them of the review and establish their wishes and feelings, secondly to talk to them in more detail about Peter and to host the friends interview and finally to go through and agree the draft report.

Kate and Kates mother were interviewed.

A close friend of Peter's and the family were also interviewed. A further friend who originally agreed to be interviewed felt unable to go through with it on the day.

1.7.2 These interviews provided us with additional information in relation to:

The kind of person Peter was in life.
An understanding of Kate's background and life experience.
A clearer understanding of the nature of the relationship between them.
An understanding of the impact on the families.

2 A Summary of Agency involvement and key timeframes for agency involvement in relation to the review

2.1 Peter

Peter had significant involvement with the Criminal Justice System from an early age. He also had significant involvement with Health Services in relation to his drug addiction, mental health and suicide attempts. There is some evidence that he was successfully managing the extent of his addiction to heroin.

2.2 Kate

Kate had significant involvement with Primary Care and General Practice as well as a large number of referrals to mental health services. Kate also had contact with the Criminal Justice system.

2.3 Tom

There was involvement with Children's Social Care in relation to the Residence Order and two safeguarding concerns.

2.4 Engagement with Domestic Abuse Services

Cleveland Police undertook a number of Domestic Abuse Assessments in relation to Kate and Peter following call outs. These were assessed and follow up support offered which was not taken up. Kate's mother was also offered support following the incident with Kate which she did not follow up. A number

of referrals for domestic abuse were suggested by agencies but none were followed up by the individuals themselves.

2.5 Key timeframes in relation to agency involvement.

2.5.1 There are five key timeframes in relation to agency involvement with Peter and Kate:

- Involvement prior to January 2010 deemed as relevant in the terms of reference.
- Involvement between January and December 2010.
- July 2011 to October 2011.
- April 2012 to December 2012.
- New Years Eve 2013 to the point of death.

2.5.2 Involvement prior to 2010:

There is relevant information from Police, Health, Probation and Children's Social Care which provides relevant background information in relation to the terms of reference and key areas of focus. This work establishes that issues of substance misuse, mental health and social exclusion were part of Peter and Kate's experience from an early age. Peter had a longstanding engagement with the Criminal Justice System. Kate had a history of violence in her intimate relationships.

2.5.3 January to December 2010:

There is relevant information from a range of agencies which covers the start of the relationship, suicide attempts and domestic abuse incidents and joint offending. This period also covers the application for and granting of a residence order for Tom, an incident of violence between Kate and her mother and the investigation of a safeguarding incident.

2.5.4 July 2011 – October 2011

There is relevant information from and engagement with Health, Police and Probation Services. The couple separate in the summer. There is a flurry of domestic abuse calls to the house in October of this year, including a significant assault on Kate by Peter.

2.5.5 April 2012 to December 2012

There is relevant information from and engagement with Probation, Compass and Health Services. Peter in custody until March 2012. There is an incident with a dart board in April and an injury to Kate in May. The couple move in

September 2012. Kate overdoses in November 2012 and Peter is distressed at the same time about Kate sleeping with someone else.

2.5.6 New Year's Eve 2013 to the point of death

There is a further change of address at the end of January. Probation, Health and Compass all involved over this time with the couple.

2.6 Impact of ethnicity and culture

All IMR authors covered these issues in their individual reports and these were quality assured for this content. The issues are only referred to in the summaries which follow where they had an identified impact on service delivery and or outcomes.

3 Findings in relation to the terms of reference

3.1 Information sharing and confidentiality.

Confidentiality boundaries were respected during the criminal trial phase and the sharing of information as part of the DHR process has been good.

3.2 Review of agency involvement between January 2010 and the point of death.

Agencies have all been able to review their contact over this period of time and submits draft IMRs to timescale.

3.3 Agency review of relevant contact prior to January 2010.

Agencies have been able to review contacts prior to this time and provide the following helpful additional information:

- Examples of violence in Kate's previous relationship with Tom's father.
- Some prior contact with Children's Social Care in relation to Kate's family.
- Some similarities between Peter and Kate in relation to their schooling and pre-existing issues in relation to substance misuse, mental health and offending.

3.4 Submission of chronologies

- These were submitted to agreed timescales.

4. Findings in relation to the particular areas of focus

4.1 Relationships and interactions between Primary Care, Mental Health and Substance Misuse Services in relation to identifying and taking forward concerns about Domestic Abuse:

- The IMR summaries indicate that Agencies were generally aware of the contact Peter and Kate had with others but that these were rarely followed up in a coherent or consistent way. This was to the detriment of service delivery and on occasion also exposed Tom to risk as there was little awareness that Peter should not be having unsupervised contact with Tom.
- The communications between mental health services, primary care and Probation seem to be particularly inconsistent given some of the levels of concern, the number of referrals, and the lack of engagement. It would seem that a local case conference could have done a lot for Kate both to focus interventions and to improve information sharing and the management of risk.

4.2 Implications for current service delivery of any issues of domestic abuse identified in Peter or Kate's history between the ages of 16 and 18.

- One incidence is disclosed in relation to domestic abuse which would have resulted in a risk assessment taking place.
- In hindsight further assessment should have taken place in relation to Kate's sexual relationship at 15 with an older male(Tom's father).

4.3 Review local practice, wider practice and research into female on male domestic abuse to locate the relationship between Kate and Peter in a wider context.

- We have undertaken a brief audit of local MARAC referrals and some desktop research. These findings are discussed later in part 4.4 of this section and compared with the CAADA analysis. There is a wider local and research context within which to assess the relationship between Kate and Peter.

4.4 To look at support and intervention with Peter and Kate in relation to domestic abuse.

- Cleveland Police responded to every notified incident, made relevant assessments and offered appropriate follow up. This should be seen as an example of good practice.
- Other agencies also noticed and acted on concerns whilst others missed some opportunities to raise the issue which they picked up in their internal recommendations.
- Both Peter and Kate disclosed domestic abuse. In Peter's case this was disclosed to Probation early in his relationship with Kate. It was not picked up on at that point and was not included in subsequent assessments with the consequences which are identified in the relevant summary report. Kate was seen as a victim of domestic abuse by Cleveland Police and she called them out several times in that capacity. However she was never willing to progress a complaint and did not accept offers to engage with support services.
- None of the attempts made to engage with victims with support services were successful.
- Nobody characterised Kate as a domestic abuse perpetrator.

4.5 Consider any issues to be highlighted in relation to cross agency, cross boundary working or any impact of major changes to organisations.

- The level of co-operation between the agencies involved with this review has been an example of good practice given the tensions that can often exist when such reviews cover living arrangements in two geographical areas.
- This is a time of major structural and service change for the Probation Service, of changes to governance arrangements for the Police with the new Police and Crime Commissioners and for commissioning arrangements for health which may impact on the provision of services in the future. We have

learned during the review that Kate and Peter's situation is not uncommon for agencies to be dealing with on a routine basis.

4.6 Agencies without contact with Peter or Kate developing an understanding of their circumstances and how changes in policy or procedures could assist the response to such circumstances.

- A number of agencies with a peripheral involvement in the lives of Kate and Peter (such that no formal IMR was required) have stayed involved and engaged with the process. This has been to think about current and future provision as well as to build understanding, experience, skills and capacity in relation to their agencies future involvement in any other DHRs.

5. Lessons learned in relation to the wider purpose of a DHR in relation to the more general provision of services and the level of training around domestic abuse

5.1 The challenge of working effectively in a multi agency way with other agencies and families experiencing domestic abuse where the situation is volatile and chaotic is challenging. This is particularly the case where there are pre-existing concerns in relation to mental health, substance misuse and offending. It remains a challenge in the current context of policy change, budget reductions and new commissioning arrangements to be clear about how to effectively work together.

How can agencies effectively assess support and sustainability intervene into situations such as Kate and Peter's? Situations such as these generate enormous costs for a range of Public Services and wider concerns for the communities in which they live. The Government's Troubled Families initiative is designed to provide assertive and intensive support to such situations. It may be that Kate and Peter and situations similar to them would not currently meet the criteria for this initiative.

5.2 Finding a way of the agencies working for more routinely together around this cohort of people may be a way of helpfully building on some of the good individual examples in this case in relation to communication between GP's, Mental Health, Probation and Specialist Substance Misuse Services. The concept of multi-agency co-ordination meetings for such a cohort should be considered.

The Castle/North Bay multi agency initiative
An example of this work locally in Scarborough is the Castle/North Bay multi agency initiative which was newly formed in October 2013. The Castle/North Bay joint prevention and enforcement team is a multi-agency initiative which aims to provide effective integrated working between agencies and the community and to develop joint solutions to identified issues. The team is already identifying cases in the community that have previously not been

known to agencies. The initiative has a vision of working together to create a safer, stronger and desirable local community by:

- Building better relationships with residents and increasing community capacity to identify and work in partnership to resolve issues
- Improving the physical environment
- Keeping people safe and reducing anti social behaviour and crime

Core agencies located in the building include:

Scarborough Borough Council; North Yorkshire Police; North Yorkshire Fire and Rescue Service; Ambulance Service; Yorkshire Coast Homes; Cambridge Centre
(local drug and alcohol agency);Foundation Housing (work with high risk offenders); Domestic Abuse Services; Domestic Violence Coordinator.

Agencies attending for team briefings include:

Designated CP nurse; Designated CP Midwife; local School; Educational Social Worker

5.3 One of the core functions of a Domestic Homicide Review is to seek to directly address then needs of victims and families to understand what has happened and what learning and re-enforcement of positive practice and interventions can be done as part of coming to terms with what has happened. The timing and process of engaging family members in the DHR process and the impact on them should not be under estimated. We are undertaking this work at a time when their grief is still raw and when they maybe going through first time losses in relation to Christmas, Birthdays and other significant family dates. The trial was a traumatic and difficult time for both families, but particularly for Peter's. We should also note the significant impact this incident has had on two of the children in the family - Peter's nephew and Kate's son.

6 Agency Recommendations

6.1 South Tees Hospitals NHS Foundation Trust

Finding	Recommendation	Required action / evidence	By Whom	To be completed by when
1. Lessons learnt from IMR.	Share the lessons learnt and the findings of the IMR within the organisation.	Present the lessons learnt and findings from the IMR to the Trust Board via Risk and Assurance Committee and the Child Protection and Looked After Children Governance Group. Include appropriately anonymised information on this IMR on the Trust intranet.	Helen Smithies (Lead Nurse) and Joanne Gamble (IMR Author). Jane Parkes, Safeguarding Trainer.	December 2013
2. There was no documentation to evidence support offered or information provided to Peter as a victim of domestic abuse when he	Findings of the IMR are shared with Safeguarding Trainers within South Tees Hospitals NHS Foundation Trust	Present the lessons learnt and findings to the Safeguarding Children Team Trainers and Adult Safeguarding Specialist Nurse to include in current training	Joanne Gamble (IMR Author)	November 2013

attended the Urgent Care Centre				
3. There was no documentation to evidence support offered or information provided to Peter as a victim of domestic abuse when he attended the Urgent Care Centre.	A baseline audit is to be undertaken in A&E to determine staff responses to injuries that may be a result of domestic abuse.	An audit of records is to be undertaken to determine if staff in A&E or Urgent Care Centres assess for domestic abuse in patients who attend for minor injuries as a result of physical harm. Parameters of audit will be defined as part of the process. It will consider that there is documented evidence of effective enquiry and risk assessment for adults and children in relation to the injury and the context in which it occurred[1].	Susan Liles - Named Nurse Safeguarding Children (Audit Lead for Safeguarding)	March 2014

6.2 Redcar and Cleveland Council Peoples Services

Finding	Recommendation	Required action / evidence	By Whom	To be completed by when
1.	Tom's case file to be updated to reflect all known family members so that all significant family members and any associated risks are known and visible on the database to Children's Services.	All known information regarding Tom's birth father to be entered on the Protocol system.	Service Manager, Children and Families Social Work	31st December 2013
2.	Introduction of process to clearly record management decision making regarding care planning for the child on the electronic file.	Operational Managers to work collectively to produce an appropriate tool consistent with the Protocol system Quality Assurance Manager to carry out a subsequent check to determine compliance and report findings to the Children and Families Management Team.	Head of Children's Services Quality Assurance Manager	31st December 2013 1st April 2014
3.	Ensure that the new single assessment process due to be implemented within Redcar and Cleveland	Protocol Version 9 to be implemented and all Social Workers and Team Managers to be trained on its use.	Head of Children's Services	31st December 2013

	Children and Families Services routinely includes genograms and significant family details in order to improve the quality of assessments.	The Quality Assurance Manager to carry out a subsequent check to determine compliance and report findings to the Children and Families Management Team.	Quality Assurance Manager	1st April 2014

6.3 Durham Tees Valley Probation Trust

Finding	Recommendation	Required action / evidence	By Whom	To be completed by when
1	To review and re-issue guidance regarding the completion of SARA and use of domestic abuse checks in relevant cases.	Actions / responsible persons and dates for completion will be decided once the report has been accepted by the DH Review Board. The DTVPT Executive Team will assign roles appropriately and feedback to the Board.		
1	Significant information linked to risk of harm to be included in the review of assessments and informed by liaison with Social Care where children are identified as potentially at risk.			
2	To review training needs of practitioners, particularly newly appointed staff or those transferred into OMU functions.			
3	To review the risk of harm communication			

	document used when cases are transitioned to CSS and circulate this among the Trust.			
1 and 4	To review the general guidance for information exchange and case review protocols between OM's upon case transfer.			
4	No action required			
5	No action required			
6	No action required			
7	The provision of Mental Health Services for offenders and other vulnerable groups in Middlesbrough is currently subject to a wide partnership review led by the CEO of the Council. The Director of Offender Services is a member of the strategic review group and will update the DH Board on progress.			
8	The possibility of increased risks to service delivery as a			

	consequence of the 'Rehabilitation Revolution' have been repeatedly raised with the Justice Minister. The structures and management of the new services (National Probation Service and Community Rehabilitation Companies) are not yet clear enough to enable a recommendation to be made.			

6.4 Tees, Esk and Wear Valley NHS Foundation Trust

Finding	Recommendation	Required action / evidence	By Whom	To be completed by when
2.All teams need to maintain accurate records	All staff to be reminded of professional and employment duty to maintain accurate records and comply with Trust record keeping policy and procedures.	2a) Team managers to implement briefing sessions regarding record keeping guidelines for their teams. 2b) Team managers to ensure records reviews are incorporated into management supervision. 2c) Trust wide communication to be made following the annual record keeping audit.	2a) Locality manager 2b) Locality manager 2c) Louise Eastham, Head of IG and Clinical Records	By January 31st 2014 From December 1st 2013 By March 31st 2014
3. There should be a mechanism within the Trust to identify people who have multiple referrals but fail to engage with services	The Trust should identify a system to identify individuals who repeatedly do not engage to see how to engage them in services.	3. To include system development for recurrent DNA into the revised risk management procedures currently being developed.	3. Lesley Mawson , Associate Director of Nursing and Governance	By June 30th 2014
4.Following discharge	Teams should be	4. Team managers to		

from services the GP should be notified in a timely manner	comply with the discharge guidelines that give clear instructions of timescales for communications re discharges.	implement audit of discharges from service over a three month period and use feedback to educate teams regarding compliance with discharge guidelines.		

6.5 Cleveland Police

Finding	Recommendation	Required action / evidence	By Whom	To be completed by when
1. Insufficient scrutiny in some instances by a first line supervisor	Endorsement by Patrol Sergeant of correct action and risk level in ALL cases of domestic abuse	Move to computerised submission of all domestic abuse incidents direct from the scene.	DI Mike Cane	1.11.13
2. More effective management of multiple repeat domestic violence incidents that fall below the high risk MARAC level	(a) Identification of such repeat standard and medium risk cases by Vulnerability Unit (b) Joint proactive work on identified cases by Neighbourhood Police Teams and support services	Identification of cases and action plans by each relevant Local Authority	DCI Steve Jermy	1.12.13

6.6 NHS Yorkshire and Humber

Finding	Recommendation	Required action / evidence	By Whom	To be completed by when
1.	That all GPs undertake Domestic Violence Training	Each GP as part of their re-validation to undertake an assessment of their knowledge base. For each GP to demonstrate competence.	NHS England Local Area Team	
2.	Where appropriate GP practices assess the potential risk of domestic violence where clinically indicated.	Identify a clinically useful actuarial tool for assessing violence risk, to be used with identified patient groups.	NHS England	31 January 2014
3.	Practices in East Cleveland and North Yorkshire to review communication protocols with Mental Health Services in those areas.	Health and social care agencies to plan a review strategy and identify a lead organisation for this purpose	NHS England /	

6.7 York and North Yorkshire Probation Trust

Finding	Recommendation	Required action / evidence	By Whom	To be completed by when
1. A home visit was not undertaken when the risk level was lowered during the OASys review.	A home visit should be undertaken in all cases where there are child safeguarding or domestic violence concerns when the risk level in these areas are lowered.	Review and update home visit guidance. Communicate this to all practitioners.	Jo Atkin/Paul Kirk	31/1/14
2. There was insufficient communication with the GP about Kate's mental health issues.	Where a case has mental health difficulties and there are domestic violence concerns the OM should liaise with the GP to exchange, verify and share information.	Supervising OM to be made aware of the need to communicate more effectively with GPs	Line Manager	31/1/14
3. A full OASys risk analysis was not completed when it was reviewed as an exemption was sought and granted.	In order to provide a defensible decision the risk of harm level should only be lowered if a full risk analysis is completed. It is not defensible to lower the risk level when an exemption has been sought.	Guidance in the Practice Framework Toolkit to be updated. All staff to be informed of this through a Trust wide communication.	Paul Kirk	31/1/14
4. The correct child safeguarding and	The OMs line manager review all her cases to	Line manager to complete case checks.	OMs Line Manager.	21/1/14.

Domestic Violence flags were not entered on the case management system by the OM.	check they are accurate.			
5. Police checks were not completed when the OM reviewed the OASys assessment.	Police checks should be made in all domestic violence cases when reviewing OASys.	Review and update guidance in Practice Framework. Communicate action to all staff through OASys flyer.	Paul Kirk	31/1/14
6. There was insufficient detail in the risk analysis in respect to child safeguarding concerns and domestic violence.	Specific details concerning behaviour that is of concern in respect to risk issues should be included in the risk of harm assessment.	New risk guidance to be issued and workshops covering this conducted with Practitioners.	This has recently been completed.	Complete
7. No review OASys was completed in either case when there was a significant change in circumstances.	OM3s Line Manager to complete a review of all her cases to ensure review have taken place.	Line Manager to complete a review.	Line Manager.	31/1/14.

6.8 Compass

Finding	Recommendation	Required action / evidence	By Whom	To be completed by when
1. Requesting previous file not applied consistently.	Reiterate policy with team. Agree internal pathway. JWA with Redcar and services most likely to transfer clients.	Team meeting minutes. Pathway distributed implemented. JWA written, distributed & implemented.	T/L T/L & Team Manager	Nov 2013 Nov 2013 Jan 2014
2. Lack of system to check assessments.	Assessment checks to be put in place. Supervision to include 2 different clients a month presenting as stable.	Process agreed. Team meeting minutes. Supervision notes and case file entry by supervisor	T/L & Team T/L & Team	Nov 2014 Nov 2013
3. Lack of exploration of partners substance use & mental health.	Workshop with staff. Discussed as part of supervision & team meeting.	Minutes. Supervision & Team meeting minutes. Assessments & case notes.	T/L & Team	Dec 2013
4. Limited detail of case notes.	Ensure all staff have attended Compass documentation training. Workshop with staff.	Training Records. Minutes.	Manager T/L	Nov 2013 Nov 2013

	Template examples given.	Supervision records.	T/L	Nov 2013
5. Information sharing opportunity with partners not taken.	Reiterate policy with Team.	Team meeting minutes. Case notes. Supervision.	T/L & Team	Nov 2013
6. Safeguarding risk assessment based on self reporting.	Reiterate policy with Team. Ensure all Staff are up to date with LSCB training.	Team meeting minutes. Training records.	T/L & Team Manager	Nov 2013 Nov 2013
7. Lack of evidence of follow up.	Reiterate policy with Team. Share DHR with staff.	Team meeting minutes. DHR & Team meeting minutes.	T/L Manager & Team	Nov 2013 Jan 2014
8. Violence was not explored as part of the relationship.	Workshop with Staff. Ensure staff are up to date with MARAC, MAPPA & DV training. Share DHR with staff.	Team meeting minutes. Training Records. DHR & Team meeting minutes.	T/L Manager Manager & Team	Nov 2013 Nov 2013 Jan 2014
9. Encourage Family engagement.	Review policy. Workshop with staff. Ensure staff attend working with concerned others.	Policy	Recovery Lead T/L	Jan 2014 April 2014