

# Domestic Homicide Review – Adult A

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## Multi- Agency Action Plan

20<sup>th</sup> July 2015

This Multi-Agency Action plan seeks to address the recommendations made by the Review Panel as set out in the Overview Report. All actions are agreed at a senior level by the agencies involved and were signed off by the Community Safety Partnership on 1<sup>st</sup> April 2014. During the review extensive consultation was carried with the family via their advocates, AAFDA. Recommendation 7 in particular recognises the views of Adult D. Progress of the Action Plan will be monitored by Be Safe Community Safety Partnership

## Domestic Homicide Review Multi-Agency Action Plan in respect of Adult A

### Recommendation 1

**That the narrow single agency focus which impeded efforts to safeguard Adult A is comprehensively challenged. When the Bolton Domestic Abuse Strategy is revised it should set out in the clearest possible terms expectations that colleagues are expected to take a holistic approach, work effectively together and share information so that risks are accurately assessed and professionally managed.**

Key Actions	Evidence	Key Outcomes	RAG
<p><b>Action 1</b> The re-drafted Bolton Domestic Abuse Strategy is suitably worded to set out these expectations and is submitted to the Community Safety Partnership for approval.</p>	<p>Bolton Domestic Abuse Strategy.</p> <p>On-going commitment to specific work streams of the Domestic Abuse and Violence Strategy and continued partner engagement</p>	<p>No agency working with, or providing a service to a victim and perpetrator of domestic abuse, or their children, adopts a single agency approach and always considers which agency or agencies they need to work in partnership with, or share information with, and keeps the need to work with partners, and share information with partners, under continuous review.</p>	

### Recommendation 2

**That the range of single agency plans to improve information sharing are monitored by Bolton Community Safety Partnership to ensure that information sharing necessary to safeguard the victims and potential victims of domestic abuse is as effective as possible. In order to fulfil this recommendation the Community Safety Partnership should consider focussed audit activity.**

Key Actions	Evidence	Key Outcomes	RAG
<p><b>Action 1</b> Once completed, all single agency action plans are submitted to Bolton Community Safety Partnership for scrutiny. All actions which directly relate to, or have a bearing on, information sharing are particularly scrutinised so that the Partnership can obtain assurance that all information sharing failures identified by this Domestic Homicide Review have been fully addressed.</p>	<p>Completed single agency action plans.</p> <p>Outcome of audit work and remedial action undertaken</p> <p>Description of audit process adopted by partner agencies.</p>	<p>Timely, appropriate and verifiable information sharing by partner agencies in order to safeguard the victims and potential victims of domestic abuse</p>	

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<p><b>Action 2</b> The Community Safety Partnership should consider requesting partner organisations to audit key information sharing processes to ensure that the processes are robust, well understood and complied with by staff and that it is challenging and searching.</p>			
<p><b>Recommendation 3</b> That Bolton Community Safety Partnership assures itself that the possibility of the individual failings identified in this Domestic Homicide Review being repeated in the future is reduced as far as possible by monitoring the implementation of single agency action plans. Where system failings are apparent, the Partnership gains assurance that systems have been put in place, or existing systems strengthened, to prevent a recurrence of the failings identified by this Review.</p>			
Key Actions	Evidence	Key Outcomes	RAG
<p><b>Action 1</b> Once completed, all single agency action plans are submitted to Bolton Community Safety Partnership for scrutiny. All actions which directly relate to, or have a bearing on individual or system failings within partner organisations are particularly scrutinised so that the Partnership can obtain assurance that all individual or system failings within partner organisations identified by this Domestic Homicide Review have been comprehensively addressed.</p>	<p>Completed single agency action plans.</p> <p>Reports describing new or strengthened systems as required by the Community Safety Partnership.</p> <p>Audits of new or strengthened systems which include findings and any remedial action necessitated by the audit.</p> <p>Description of audit process adopted by partner agency.</p>	<p>Partner agencies have robust systems in place which have been designed or redesigned to prevent the individual failings identified by this Domestic Homicide Review.</p>	

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<p><b>Action 2</b> The Community Safety Partnership should scrutinise any existing systems which have been strengthened, or new systems put in place, to gain assurance that such systems are robust enough to prevent a recurrence of the failings identified in this Domestic Homicide Review.</p>			
<p><b>Recommendation 4</b> That Bolton Community Safety Partnership write to the Home Office to propose an analysis of the Domestic Homicide Reviews completed so far in an effort to identify the reasons why a number of domestic homicide cases are unknown to the MARAC process. This analysis could then be used to further develop and enhance the MARAC process.</p>			
<p><b>Key Actions</b> Notwithstanding the recently published Home Office analysis of common themes emerging from Domestic Homicide Reviews, the Community Safety Partnership should write to the Home Office to propose further analysis to try and understand why a number of cases subject to Domestic Homicide Review were unknown to the MARAC process including the case of Adult A.</p>	<p><b>Evidence</b> Letter to Home Office together with any substantive response.  Any action taken locally or nationally to further develop or enhance the MARAC process as a result of the analysis.</p>	<p><b>Key Outcomes</b> A MARAC process which is highly effective at identifying and responding to the cases which carry the highest risk to victims and their families.</p>	<b>RAG</b>
<p><b>Recommendation 5</b> That the procedure by which cases are referred to the MARAC process is reviewed to ensure that cases are not overlooked because they do not obviously fit the criteria and that the scope for referring cases on the grounds of professional judgement is reinforced.</p>			
<p><b>Key Actions</b> The Community Safety Partnership commissions the MARAC Steering Group to review the process by which cases are referred to MARAC to ensure that the process is sufficiently flexible to include cases which might not obviously meet the criteria for referral but carry a level of risk which nonetheless merits referral.</p>	<p><b>Evidence</b> MARAC Steering Group Action Plan  Completed CAADA Assessment</p>	<p><b>Key Outcomes</b> A MARAC process which is highly effective at identifying and responding to the cases which carry the highest risk to victims and their families.</p>	<b>RAG</b>

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### **Recommendation 6**

**That Greater Manchester Probation Trust review its use of RAMA in cases where high risk offenders will be released at sentence expiry date, and to put a further stage in the process where a RAMA should take place a few weeks prior to release to ensure that a risk management plan is in place, agreed by all agencies.**

Key Actions	Evidence	Key Outcomes
The Community Safety Partnership request the Greater Manchester Probation Trust to review the RAMA process in respect of cases in which high risk offenders will be released at sentence expiry date and that the Trust consider making a pre-release RAMA mandatory in such cases.	Greater Manchester Probation Trust report setting out the review of the RAMA process.  Amended RAMA policy and arrangements for disseminating that policy internally and externally.	In cases in which a high risk offender is being released at sentence expiry date, a pre-release RAMA is always held.

### **Recommendation 7**

**That multi-agency and single agency domestic violence training is informed by this case. In particular, the issues raised in paragraphs 8.61 (contrasting decisions in respect of Adult A and Adult F), 9.8 (“forensic curiosity”) and 9.9 (the obscuring of Adult A’s status as a victim) should be addressed in such training.**

Key Actions	Evidence	Key Outcomes
The Community Safety Partnership commissions multi-agency and single-agency domestic violence training which highlights the lessons identified by this case.	Multi-agency and single-agency training plans.  Report providing information about delivery, partner agency engagement and impact of training.	Multi-agency and single-agency domestic violence training which is informed by the lessons identified by this and other domestic homicide reviews and which is regularly refreshed as relevant reviews are published or disseminated.

### **Recommendation 8**

**That Bolton Community Safety Partnership work with partners to improve the planning and co-ordination of work carried out across a range of agencies to challenge the behaviour of violent and aggressive offenders.**

Key Actions	Evidence	Key Outcomes
The Community Rehabilitation Company will review its DV programmes delivered to offenders on Community Orders and Licences.	Terms of reference for the review.  The review report. Any action plan resulting from the review.	Work to challenge the behaviour of violent and aggressive offenders is well planned and co-ordinated and the range of agencies involved work together in a consistent and mutually reinforcing way.

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### **Recommendation 9**

**That Bolton Community Safety Partnership ensure that all staff who have roles in safeguarding the victim of domestic violence are able to readily access information about the range of refuge provision available.**

<b>Key Actions</b>	<b>Evidence</b>	<b>Key Outcomes</b>
<p><b><u>Action 1</u></b> Bolton Community Safety Partnership identifies the full range of refuge provision which could realistically be available to Bolton domestic violence victims and their families.</p>	<p>User friendly information about refuge provision is readily available via a wide range of communication methods.</p>	<p>That all staff involved in safeguarding the victims of domestic violence have easy access to up to date information about refuge provision</p>
<p><b><u>Action 2</u></b> The Partnership ensures that this information is made readily available to all relevant staff and that there is a system in place for keeping this information up to date.</p>		