REDCAR AND CLEVELAND
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW
incorporating a
LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

'Elizabeth'

Died – Winter 2019

EXECUTIVE SUMMARY

FINAL VERSION

October 2021

Chair and Author — Carol Ellwood QPM
Independent support to Chair — Ged McManus

CONTENTS

1. THE REVIEW PROCESS

1.1 This report is a combined domestic homicide review and local children safeguarding practice review, which examines how agencies responded to, and supported, Elizabeth, and her children, residents of Redcar, prior to Elizabeth's death in the winter of 2019.

1.2 The following pseudonyms have been used in this review for the victim, perpetrator and victim's children in order to protect their identities.

Name	Relationship	Age	Ethnicity
Elizabeth	Victim	34	White British female
John	Perpetrator	27	White British male
Grace	Daughter of victim	Secondary school age	White British female
Hope	Daughter of victim	Secondary school age	White British female
Leighton	Son of victim	Primary school age	White British male
Stewart	Son of victim	Primary school age	White British male
Charles	Son of victim and perpetrator	Pre-school age	White British male
Harmony	Daughter of victim and perpetrator	Pre-school age	White British female

1.3 Elizabeth had been in a relationship with John for approximately two years. Elizabeth was found deceased at her home address. John was arrested and charged with the murder of Elizabeth and remanded into custody. Legal arrangements were made for the care and custody of Elizabeth's children.

1.4 On 14 January 2020 John was found deceased in his prison cell. John had hung himself. An inquest into Elizabeth's death determined that she had been unlawfully killed by John.

1.5 Redcar and Cleveland Community Safety Partnership held a scoping meeting on 29 January 2020 and determined the death of Elizabeth met the criteria for a domestic homicide review [DHR]. The Home Office were informed, and an independent domestic homicide review was commissioned.

1.6 On 25 February 2020 at a meeting held by South Tees Safeguarding Children Partnership (STSCP) discussed the case and a recommendation was made that the case met the criteria for a local child safeguarding practice review [LCSPR] in accordance with Working Together 2018. It was agreed that the two processes would be combined, to avoid duplication, and ensure that any identified learning was considered within both review processes. All agencies that potentially had contact with Elizabeth, John and the children, were asked to secure their files.

1.7 At the beginning of 2020 Redcar and Cleveland Borough Council were subjected to a cyber attack which impacted accessibility to relevant files and computer systems. This was followed by the Covid-19 pandemic. These two events impacted the commencement of the review.

1.8 The first meeting of the DHR panel was held in October 2020. The first meeting of the DHR panel determined the period the review would cover. The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce independent management reviews. The DHR panel met six times.

1.9 The review was presented to Redcar and Cleveland Community Safety Partnership and South Tees Safeguarding Children Partnership on 7 October 2021 and concluded on 19 October 2021 when it was sent to the Home Office.

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[1]	Chronology	Report
Alliance Psychological Services			✓
Cleveland Police	✓	✓	
Holmes House			✓
Housing Benefits Team			✓
National Probation Service – Cleveland Area	✓	✓	
Redcar & Cleveland Borough Council - Children's Social Care	✓	✓	
Redcar & Cleveland Borough Council – Early Help	✓	✓	
Redcar & Cleveland Borough Council – School Inclusion	✓	✓	
Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service	✓	✓	
Route 2	✓	✓	
South Tees Hospital NHS Foundation Trust			✓
Tees, Esk and Wear Valleys NHS Foundation Trust	✓	✓	✓
Tees Valley Clinical Commissioning Group	✓	✓	
Thirteen Housing Group Ltd	✓	✓	

2.2 The following agencies were written to as part of the scoping process for the review, but held no information –

1. Foundations
2. Change Grow Live
3. MIND

[1] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

4. We Are With You[2]
5. Lifeline

2.3 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

[2] https://www.wearewithyou.org.uk/services/redcar-and-cleveland/

3. THE REVIEW PANEL MEMBERS

3.1 The panel members were:

Review Panel Members		
Name	**Job Title**	**Organisation**
Karen Agar	Associate Director of Nursing (Safeguarding)	Tees Esk and Wear Valleys NHS Foundation Trust
Gary Besterfield	Service Manager	We are With You
Karen Bowers[3]	Service Manager	Redcar & Cleveland Borough Council, Adult Social Care
John Bye	Named GP for Safeguarding Children	Tees Valley Clinical Commissioning Group
Mandy Cockfield	Service Manager	Redcar & Cleveland Borough Council, Adult Social Care
June Craven	Safeguarding Officer for Schools	Redcar & Cleveland Borough Council
Gordon Bentley[4]	Senior Adult Safeguarding Officer	Tees Valley Clinical Commissioning Group
Jayne Bulmer	Service Manager	Redcar & Cleveland Borough Council, Children's Social Care
Kate Dawson	Health Visiting and School Nursing Lead Nurse	Redcar & Cleveland Borough Council, School Nursing
Jayne Downes	Detective Chief Inspector	Cleveland Police
Carol Ellwood-Clarke	Chair and Author	Independent
Patricia Fenby	Detective Inspector	Cleveland Police
Emma Geldart	Project Manager	Foundation
Jay Hosie	Service Lead – Community Safety & Compliance	Redcar & Cleveland Borough Council
Claire Mahoney	Assistant Director Education and Skills	Redcar & Cleveland Borough Council
Julie McDowell	Inclusion Lead	Redcar & Cleveland Borough Council, School Inclusion

[3] Attended first panel meeting.
[4] Replaced Alison Peevor after third panel meeting.

Ged McManus	Support to Chair and Author	Independent
Janice McNay	Head of Governance & Compliance	Thirteen Housing Group Ltd
Amy Meadows	Support Officer - Neighbourhoods and Customer Services	Redcar & Cleveland Borough Council
Rachel Paterson	Prevention Team Leader	Redcar & Cleveland Borough Council, Early Help
Alison Peevor	Head of Quality and Adult Safeguarding	Tees Valley Clinical Commissioning Group
Rosana Roy	Senior Probation Officer	National Probation Service – Cleveland Area
Susan Taylor	Named Midwife/Nurse Safeguarding Children.	South Tees Hospitals NHS Foundation Trust
Gary Watson	Partnership Manager	South Tees Safeguarding Children Partnership

3.2 The Chair of the Redcar and Cleveland Community Safety Partnership was satisfied that the Panel Chair and author were independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report. Panel members had not previously been involved with the subjects or line management of those who had.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors.

4.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHR's and other safeguarding reviews. Carol retired from Humberside Police in 2017 after thirty years during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017 she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[5].

4.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not within Redcar and Cleveland area). He served for over thirty years in South and West Yorkshire Police. Prior to leaving the police service in 2016 he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

4.4 Between them they have undertaken over sixty of 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.

4.5 Neither practitioner has worked for any agency providing information to the review.

[5] https://safelives.org.uk/

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The purpose of a DHR is to:

- 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;
- 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 inform national and local policies and procedures as appropriate;
- 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;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016][6] Section 2 Paragraph 7

5.2 Local Child Safeguarding Practice Review

The LCSPR will be conducted in accordance with the requirements set out in:

- The Children Act 2004[7] as amended by the Children and Social Work Act 2017[8]
- Working Together 2018
- Tees multi-agency Children's Safeguarding Policy and Procedures

5.3 Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[9] did your agency identify for Elizabeth?

[6] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

[7] https://www.legislation.gov.uk/ukpga/2004/31/contents
[8] https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted
[9] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

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

3. How did your agency assess the level of risk faced by Elizabeth and her children from John, which risk assessment model did you use and what was your agency's response to the identified at risk?

4. What services did your agency provide for the subjects of this review; were they timely, proportionate and of an acceptable level in relation to the identified levels of risk?

5. In the context of the family arrangements, what consideration did your agency give to any mental health issues or substance misuse in the couples' relationship when identifying, assessing and managing risks around domestic abuse, including domestic abuse in previous relationships?

6. In the context of the family arrangements, what did your agency do to safeguard any children exposed to domestic abuse?

7. How did your agency capture the voice of the children, including their wishes and feelings in relation to their lived experiences? Did your agency experience any barriers in gathering this information?

8. What was your agencies' response to the lived experiences of the children? Did that include an understanding of how their lived experiences impacted on their emotional and physical development?

9. Were the victim, perpetrator and children informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

10. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?

11. How effective was your agency's supervision and management arrangements for practitioners involved with the family. Did managers have effective oversight of the case?

12. Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies?

13. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of this review?

14. Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

15. What knowledge did family, friends and employers have that Elizabeth was in an abusive relationship and did they know what to do with that knowledge?

16. Were there any examples of outstanding or innovative practice?

17. What learning did your agency identify in this case.

6. SUMMARY CHRONOLOGY

6.1 Elizabeth

6.1.1 Elizabeth was an outgoing child, who was popular at school with lots of friends. Elizabeth left school with some qualifications. Elizabeth has two brothers and had a close relationship with her older brother. At the age of 18 Elizabeth had her first child and was married. This relationship was described as violent and ended soon after the birth of her eldest child. At the age of 20yrs Elizabeth moved out of the area to work. Elizabeth's eldest child went to live with her Father.

6.1.2 In 2006 Elizabeth returned to the Redcar area and began working in a canteen at a local factory. After about a year Elizabeth stopped work as she was pregnant with her second child.

6.1.3 Elizabeth was described as a loving Mother to her six children, who always wanted to do the best for her family and children. Elizabeth's Mother stated that Elizabeth often chose the wrong type of partners and always seemed to be attracted to the 'bad boys'.

6.2 John

6.2.1 John was born and raised in Cleveland. His parents separated when he was six years old. John's Mother re-married and John told professionals that his relationship with his stepfather and siblings was generally positive.

6.2.2 John's behaviour throughout his early teenage years caused extensive problems within the family home. John was known to the Police. At the age of fifteen John was expelled from school and he went to live with his Grandparents. From the age of 18 years John spent time in prison, returning to live with his Grandparents on release.

6.2.3 John had a long history of alcohol and illicit drug use from the age of 12. John told professionals that there was a family history of schizophrenia in two of his paternal cousins, both diagnosed under the age of 20, and a history of depression on the maternal side of his family. John has a child from a previous relationship with whom he has no contact.

6.3 Elizabeth and John's relationship

6.3.1 Elizabeth and John relationship began in 2018, although information in agency records indicate that they knew each other prior to this time. Elizabeth's Mother told the Chair that Elizabeth was aware of John's past offending behaviour and that Elizabeth had told her that 'she could be the one to change him'. Elizabeth's Mother told the Chair that she was aware

of abuse within their relationship and described incidents of controlling behaviour and physical abuse.

6.4 The children

6.4.1 Elizabeth was the Mother to six children, five of whom lived with her. John was the Father to the two youngest children. Elizabeth's eldest child visited the family home frequently. The children of school age attended schools within the local area. Towards the end of 2019, Stewart had been assessed by CAMHS following a referral regarding concerns of his behaviour.

6.5 Information known prior to the start of the review.

6.5.1 Elizabeth and her children were known to Children's Social Care from 2013. There were no assessments from the first contacts, with Early Help services being identified as the most appropriate. Concerns were linked to domestic abuse, alcohol misuse and Elizabeth's mental health. In July 2015, a Section 47 enquiry was undertaken by Children's Social Care due to sexual abuse of Hope by a family member. This resulted in a criminal investigation and conviction.

6.5.2 Since 2014 Elizabeth was known to Mental Health Services. It was documented that Elizabeth had taken an overdose at the age of 18, with one of the factors being that she was in a 'violent' relationship. Elizabeth described a 'difficult childhood' with adverse early childhood experiences which appeared to have impacted on her abilities around attachment and adjustment. During contact with services Elizabeth described how 'she often goes for the wrong type' describing relationships that were abusive and controlling.

6.5.3 At the age of 13 John was referred to CAMHS[10] due to aggressive behaviour towards his younger sibling. He was diagnosed with conduct disorder. In 2010, John was assessed by Early Intervention Psychosis (EIP) team. The outcome was that his psychotic symptoms were as a result of drug induced psychosis. John admitted to using illicit substances and alcohol which exacerbated his mental health symptoms. John's engagement with Mental Health Services was poor.

6.5.4 John's criminal behaviour included offences of anti-social behaviour, criminal damage, and violence. In 2010, at the age of 18, John assaulted his Mother, for which he received a custodial sentence. In January 2015 John was sentenced to 30 months imprisonment for an offence of

[10] Child and Mental Health Services

wounding (Section 20 Offences Against the Person Act 1861) on his partner.

6.6 Events within the timeframe of the review

2015

6.6.1 On 21 December, John was released from prison on Home Detention Curfew. The following day, John was issued with his first warning by his Offender Manager, having breached the non-contact licence condition of his licence. An OASYs risk assessment completed upon release assessed John as being high risk to his ex-partner. Five days after his release the Police attended a fight between John and his brother. John's brother did not co-operate with the investigation and no further action was taken.

2016

6.6.2 On 7 January John informed his Offender Manager that he had been intimate with Elizabeth, but he had no intention of seeing her again. This is the first recorded contact of Elizabeth and John together. Six days later, John was recalled to prison. In April, John commenced RESOLVE (non-intimate violence programme) to address his offending behaviour. John completed the programme in June.

6.6.3 Throughout 2016, Elizabeth had contact with her GP and Mental Health Services. Elizabeth's engagement with Mental Health Services was inconsistent; however, there was evidence that Elizabeth had undertaken some work around self-esteem, cognitive behaviour therapy. Children's Social Care were involved with Elizabeth and her children, and a referral was made to Sure Start to provide support and services. In addition, referrals were made for Stewart due to concerns raised around his behaviour.

6.6.4 In October, Elizabeth moved into accommodation provided by Thirteen Housing Group Ltd. Elizabeth was still living in this house at the time of her death.

2017

6.6.5 In January, John was released from prison. During contact with his Offender Manager John stated that whilst in prison he had received letters from Elizabeth who had also visited him on a few occasions. John told the Offender Manager that Elizabeth was not aware of his release and that he

had no intentions of contacting her. A Spousal Assault Risk Assessment (SARA)[11] was completed. Enquiries were made regarding John's accessibility to domestic abuse programmes, with John eventually being referred to Route 2, which he commenced in February. John's licence conditions ended in March, and he was no longer under the supervision of Probation. John failed to attend any further appointments with Route2 after the end of his licence.

6.6.6 In June, Grace disclosed abuse by a family member. This matter was investigated by Children's Social Care and the Police. The offender was subsequently charged with criminal offences. Towards the latter part of the year, and early 2018, the Police received several reports that Grace had gone missing from her home. (Grace lived with her Father). Missing persons policies and procedures were followed, and Grace was seen by professionals and referred to Children's Social Care and Vulnerable, Exploited, Missing, Trafficked (VEMT)[12].

6.6.7 In October Elizabeth contacted the Police and reported a serious crime from when she was a child. The offender was a family member. Elizabeth did not provide the Police with details of the offence and after the initial contact she stated that she did not wish at that time to progress the complaint due the stress it may cause. Elizabeth was currently pregnant. The offender was not made aware of the complaint.

6.6.8 On 22 December, Grace disclosed that during a visit to her Mother's house, (Elizabeth) there had been a strong smell of cannabis. Grace expressed concerns for her younger siblings. Present at the house was John, who was described as Elizabeth's partner. The school completed a SAFER[13] referral to Children's Social Care. Advice and Information was given to Elizabeth.

6.6.9 At the end of December John was seen by his GP, he was accompanied by a female who he referred to as his 'Girlfriend'. There are no details as to who this female was. John reported anxiety and increased paranoid

[11] The Spousal Assault Risk Assessment Guide (SARA) helps criminal justice professionals predict the likelihood of domestic violence by screening for risk factors in individuals who are suspected of, or who are being treated for spousal abuse.
[12] https://www.middlesbrough.gov.uk/children-families-and-safeguarding/safeguarding-children/vulnerable-exploited-missing-trafficked-vemt

[13] https://www.teescpp.org.uk/contact/redcar-cleveland
SAFER - SITUATION, ASSESSMENT, FAMILY, EXPECTED RESPONSE, RECORDING)

thoughts and was referred to Mental Health Services. John failed to attend arranged appointments.

2018

6.6.10 In February, John reported anxiety to his GP and a referral was made to Mental Health Services. Subsequent appointments were made, which were not attended. It was not until 15 June 2018 that John attended as appointment with Mental Health Services when he was accompanied by Elizabeth. John described fluctuating mood and 'hearing whispering' linked to stress reaction. An assessment concluded that John's symptoms were linked to stress and he was discharged back to his GP. On hearing the outcome, John became angry and left the assessment room having shouted expletives at the clinician. There was no further contact with Mental Health Services.

2019

6.6.11 In March, the school spoke to Elizabeth and John after Stewart had been observed to be over emotional. Elizabeth and John reported that Stewart was upset and finding it difficult that their relationship had ended. The learning mentor and class teacher provided support to Stewart through the PSHE[14] curriculum. Later that month, John and Elizabeth were seen together and described as being in a relationship during appointments with a GP and Health Visitor.

6.6.12 During April, Elizabeth and John engaged with the school in seeking support for Stewart due to his behaviour, which included talk of death and suicide and threats of violence towards other. Stewart had seen a GP and had been referred to CAMHS. Whilst waiting for the CAMHS appointment, Stewart attended nine 1:1 support sessions with the school learning mentor. Stewart attended CAMHS on 15 November 2019.

6.6.13 On 20 May, the school made a SAFER referral to Children's Social Care after Stewart disclosed that John had been fighting with an Uncle. Elizabeth told professionals that Stewart had overheard a conversation about an historical incident. Three days later, Elizabeth saw her GP and reported that she felt she was suffering with post-natal depression. It was agreed for contact to be made with the Health Visitor and for a review in

[14] PSHE stands for Personal, Social, Health and Economic education.

two weeks' time. The incident was not received in South Tees Multi Agency Children's Hub (MACH)[15]until 5 June.

6.6.14 On 30 May, Elizabeth was seen at home by a Health Visitor. This was the only time that Elizabeth had been seen alone without John present. Elizabeth told the Health Visitor that she had been snappy and irritable with John, which had caused a lot of friction between them and that they had had a few days living apart. Elizabeth further stated that John was returning home today, and that the days apart had helped. The family told the Chair that John's Mother paid for him to stay in a caravan with his brother, but following a fight with his brother, John had been asked to leave the campsite. John was collected by his Mother, who returned him to live with Elizabeth.

6.6.15 On 5 June, Children's Social Care Children's received a referral from Stewart's school. Stewart had told his teacher that John had had a fight with his brother. John was drunk and during the incident damage was caused in the home, and they had to leave the house. Elizabeth was asked about the incident and denied that it had happened. At the end of June, the Health Visitor discussed the referral with Elizabeth and John, who claimed that Stewart had overheard a conversation regarding an incident that had happened some time before.

6.6.16 In August Elizabeth self-referred to Mental Health Services and was seen by Alliance Psychological Services. Elizabeth reported low mood and anxiety around a relationship breakdown.

6.6.17 On 23 October, the school made a SAFER referral to Children's Social Care after Stewart disclosed to the learning mentor that 'Daddy had hit mammy, squished her eyes and banged her head on the door'. The disclosure about 'squished eyes' was not recorded on the referral. Elizabeth denied the assault had happened and stated that Stewart struggled with reality and fantasy. The referral was allocated to Early Help, which was then sent to the School Nurse to undertake work with Stewart at Level 2[16].

15 https://www.middlesbrough.gov.uk/sites/default/files/MACH%20BRIEFING%20NOTE%2008.05.19.pdf

16 https://www.teescpp.org.uk/media/1080/r_c_lscb_local_framework_and_protocol_for_the_assessment_of_children_in_need_and_their_families_december_2014.pdf

6.6.18 On 8 November, Elizabeth informed the School Nurse that she had separated from John three weeks earlier. Elizabeth described the relationship as 'amicable', and that John was supporting with childcare. On 15 November Stewart attended an assessment with CAMHS. Elizabeth and John attended the appointment. It was agreed to complete an ADHD[17] screening process and to identify any social and communication difficulties. It was agreed that the clinician would contact MACH to enquire about the SAFER referral that school had made prior to half term and if required to submit another referral, which CAMHS later did. The outcome for the SAFER referral from the MACH, was for a keyworker to be allocated. This did not happen, and the SAFER referral was linked to the existing open case held by the school Nursing Service.

6.6.19 On 19 November, Elizabeth telephoned the School Nurse. During the conversation Elizabeth stated that John was back at home. There were further unsuccessful calls with Elizabeth, and a letter was sent to Elizabeth with an appointment for 2 January 2020.

6.6.20 On 16 December contact was made between the School Nursing Service and Early Help Co-ordinator to discuss the SAFER referrals and case allocation. It was confirmed during this discussion that a keyworker would not be allocated.

6.6.21 On 30 December the Police received a report from a 16 year old female that she had been approached by a male who had been under the influence of alcohol and had asked for contact details via social media. The caller named the person as 'John', and requested the details be recorded for information. It was only confirmed by the victim after the death of Elizabeth that the male was the same John, responsible for Elizabeth's death.

6.6.22 At the end of the year, Police attended Elizabeth's home address and found her deceased. John was arrested away from the scene in the company of the two youngest children. John was charged with Elizabeth's murder. Emergency arrangements were made for the placement of Elizabeth's five younger children. Grace was living with her Father. Subsequent childcare arrangements have been undertaken with Children's Social Care.

[17] https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

7. CONCLUSION

7.1 It was difficult for the review panel to understand what a typical day in the life of Elizabeth and her children looked like. Whilst some agencies were aware that Elizabeth and John were in a relationship, those agencies were not aware that John was a perpetrator of domestic abuse.

7.2 Elizabeth had been a victim of domestic abuse from previous relationships. At times of significant stress Elizabeth used alcohol as a coping strategy. This along with her mental health and poor home conditions resulted in contact with agencies. When Elizabeth recognised that she needed support, particularly in relation to her mental health, there was evidence that she sought support and was referred into services.

7.3 John was a known perpetrator of domestic abuse. Despite serving a prison sentence and time in the community on licence he did not complete any programme to address his domestic abuse offending.

7.4 Elizabeth and John had been in a relationship for two years, prior to Elizabeth's death. John was the Father of Elizabeth's two younger children. The Police and the National Probation Service were not aware of the relationship and therefore did not have an opportunity to provide Elizabeth with disclosure in relation to the risk that John posed.

7.5 The agencies who did know of the relationship, had some information of concerns that indicated domestic abuse. Professionals were reassured by Elizabeth's explanations which on reflection minimised any concerns of domestic abuse and did not seek to gather further information on John to inform those concerns.

7.6 Elizabeth's family, friends and community were aware of the abuse, but did not report this to professionals for fear of reprisals from John and a belief that the children would be removed from Elizabeth's care. This knowledge included information that Elizabeth was a victim of coercive and controlling behaviour. The panel recognised that raising awareness amongst the community needed to be broader than awareness raising on domestic abuse, with a need for a focus on providing information as to how agencies

respond to concerns, and what can be expected from agencies when concerns have been raised. This also needed to address the sharing of the information to the victim and perpetrator.

7.7 There was a reoccurring theme within this domestic homicide review in relation to the accuracy of recording when safeguarding concerns were raised and professionals utilising their 'professional curiosity' and seeking clarification as opposed to the acceptance of assurances at face value.

7.8 Elizabeth's family contributed to the review and provided information that helped the review panel understand the barriers that are faced by families, friends, and the community in reporting incidents of domestic abuse. The report was seen by Elizabeth's family and the review panel wished to express their appreciation of the contribution that the family made to the review.

8. Multi Agency Learning developed by the DHR panel

8.1 Narrative

Information was held within agency records that identified concerns and evidence of domestic abuse. The full content of this information, including the voice of the child and detailed disclosures was not shared during SAFER referrals and amongst professionals which resulted in the information not being considered during multi-agency discussions around threshold and case allocation.

Learning

Information sharing between agencies must contain explicit language, including the exact disclosure, and voice of the child.

Recommendation 1 applies

8.2 Narrative

Information was disclosed to professionals which identified safeguarding concerns, including domestic abuse, within the relationship and the home environment. When this was raised by professionals, reassurances were given that the information had been misinterpreted and that there were no risks or safeguarding concerns. This view was accepted by professionals, without challenge or further clarification.

Learning

Whilst engagement with families is a fundamental element of establishing a working relationship, professionals need to ensure they are proactive in verify information that has been provided and that they adopt a 'trust but verify' approach when working with families. This includes the accurate recording and verifying of all household members and significant others within a relationship.

Recommendation 2 applies

8.3 Narrative

There were incidents of violence occurring within the wider family that were reported to Professionals. These incidents occurred in the presence of children and were not routinely recognised as domestic abuse. The outcome

was that referrals were not made, which prevented information being shared with other Professionals involved in the case.

Learning

The awareness and implementation of the wider definition of domestic abuse, to include 'other family members' will ensure that information is shared, and professionals are aware of the family dynamics and risks that are present within households.

Recommendation 3 applies

8.4 **Narrative**

People outside the household were aware of domestic abuse and coercive and controlling behaviour. These concerns were not reported due to fear of violence and reprisals, including the belief that children in the household would be removed from the home. This finding is consistent with many other DHRs and Redcar DHR1.

Learning

The panel felt that this illustrated a cultural acceptance of domestic abuse within some neighbourhoods of Redcar and Cleveland and that action was required to address the cultural issue. This may need to go beyond publicity as Redcar and Cleveland Community Safety Partnership already conducts extensive publicity around domestic abuse and should be within the domestic abuse strategy that is a requirement within the Domestic Abuse Act 2021.

Recommendation 4 applies

9 Panel Recommendations

9.1 That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that accurate information, including exact details of disclosures and the voice of the child are being shared between agencies where safeguarding concerns are known.

9.2 That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that professionals are adopting a 'trust but verify' approach when working with families, which includes the accurate recording and verification of all household members and significant others to inform assessment and risk planning.

9.3 That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that professionals are aware of the full extent of the definition of domestic abuse, in terms of 'family members' and are implementing safeguarding policies where incidents of domestic abuse are known.

9.4 That Redcar and Cleveland Community Safety Partnership's Domestic Abuse Strategy details how it will respond to the cultural acceptance of domestic abuse and improve the confidence of victims and witnesses to report abuse.

9.5 All single agency recommendations are shown at 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 all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that accurate information, including exact details of disclosures and the voice of the child are being shared between agencies where safeguarding concerns are known.	Local	RC CSP task the newly formed DAP to commit to improving awareness and practice across the partnership	RC Domestic Abuse Partnership	DAP conducts an audit or partner agency to confirm that suitable and sufficient training, awareness& instruction has been carried out with all front line staff to ensure understanding and compliance DAP conducts an audit of partner agencies to ensure that robust supervision of front line staff encourages/challenges information sharing of disclosures	July 2022	

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**
					DA Strategic Lead presents findings of audits back to RC CSP		
2	That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that professionals are adopting a 'trust but verify' approach when working with families, which includes the accurate recording and verification of all household members and significant others to inform assessment and risk planning.	Local	RC CSP task the newly formed DAP to commit to improving awareness and practice across the partnership	RC Domestic Abuse Partnership	DAP conducts an audit or partner agency to confirm that suitable and sufficient training, awareness& instruction has been carried out with all front line staff to ensure understanding and compliance DAP conducts an audit of partner agencies to ensure that robusts supervision of front line staff encourages & challenges information sharing of disclosures DAP Strategic Lead presents findings of audits back to RC CSP	July 2022	

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**
3	That all agencies provide evidence to Redcar and Cleveland Community Safety Partnership that professionals are aware of the full extent of the definition of domestic abuse, in terms of 'family members' and are implementing safeguarding policies where incidents of domestic abuse are known.	Local	RC CSP task the newly formed DAP to commit to improving awareness and practice across the partnership	RC Domestic Abuse Partnership	DAP conducts an audit or partner agency to confirm that suitable and sufficient training, awareness& instruction has been carried out with all front line staff to ensure understanding and compliance DAP conducts an audit of partner agencies to ensure that robust supervision of front line staff encourages/challenges information sharing of disclosures DAP Strategic Lead presents findings of audits back to RC CSP	July 2022	
4	That Redcar and Cleveland Community	Local	RC DA Lead to complete	RCBC	Draft Strategy consultation	30 Nov 21	

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**
	Safety Partnership's Domestic Abuse Strategy details how it will respond to the cultural acceptance of domestic abuse and improve the confidence of victims and witnesses to report abuse.		DA Strategy inclusive of commitment to challenging cultural acceptance and improve community awareness to improve reporting.		Finalise & launch Strategy All partner agencies to be working to new DA Strategy	January 2022 June 2022	

National Probation Service – Cleveland Area						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	NPS Cleveland to take part in the roll out of pilot work on polygraph testing for Domestic Abuse cases when Covid restrictions allow.	Polygraph testing for Domestic Abuse offenders	This has been delayed somewhat by Covid but staff briefings about the new polygraph for Domestic Abuse are starting May 2021	To assist Offender Managers with risk management plans for Domestic Abuse offenders	Ann Powell	**3 year Pilot started in May'21 and ongoing**

National Probation Service – Cleveland Area						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
2	NPS to encourage Offender Managers to use professional curiosity and always liaise with each other when there is a link between Service Users and to undertake joint risk management plans and ensure that these are recorded accordingly.	Briefings, workshops and reminders to be provided reminding colleagues of the importance of Liaison between Offender Managers. Joint risk management plans	First quarter of 2021 - Quality Development Officers have completed professional development workshops with NPS staff including on the theme of professional curiosity May 2021 - Written briefings about professional curiosity shared with staff as back up to training – for discussion in team meetings	To ensure joint risk management plans when there are links between offenders and that the liaison between Offender Managers is recorded accordingly.	Ann Powell	Immediately and ongoing
3	NPS to encourage Offender Managers to use an investigative approach and to make relevant safeguarding referrals following home	Briefings, workshops and reminders to be provided reminding		Offender Managers to make safeguarding referrals following home visits or whenever there is information of children attending a house where a	Ann Powell	Immediately and ongoing

National Probation Service – Cleveland Area						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	visits or whenever there is information of children attending a house where a domestic abuse perpetrator resides.	Offender Managers to make safeguarding checks and / or referrals whenever there is information of children attending a house where a domestic abuse perpetrator resides.		domestic abuse perpetrator resides		

Redcar & Cleveland Borough Council - Children's Social Care						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	LCS must be reviewed for all adults detailed in referrals	MACH to detail within outcome of contact/ referral that information	Evidence of consideration to the information held by social care in all outcomes for referrals		D Harrison	With immediate effect.

Redcar & Cleveland Borough Council - Children's Social Care						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		held by the service has been reviewed and considered				

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Clear referral form for Freedom and single route for referrals all documented through the children's services system	Discussion to be held with MACH Manager about routing all Freedom referrals through the front door Exploration of using existing Family Hubs, Early Help or SAFER referral form	All referrals are made using the Families Together referral form. This referral form is in the signs of safety format and asks for detailed evidence of past harm and current risk. Referrals are made to the Families Together Email which are screened by Cath	There is a clear audit trail within the children's services system to demonstrate who referred, who screened the referral and what the outcome of the referral was. This will also aid future decision making should further referrals be received about the children in the family. This is now achieved. Julie Topley has now left the service so approved referrals now go direct to the Programme facilitator	Cath Prest/Julie Topley (Project Development Officer) Cath Prest/Julie Topley	28.02.21 21/10/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		for Freedom referrals and decision about a single referral form and how it will be processed through the EHM system	Prest to ensure there has been an EHM or C&F Assessment. Cath also requests the referrer complete additional information if past harm is not detailed enough. Appropriate referrals are authorised and sent on to the Julie Topley for allocation to a Freedom Programme Facilitator. All referral forms are uploaded into the documents folder on protocol (if Social Care referral) or EHM (if Early Help referral)	to arrange planning meeting and home visit. The referrer is responsible for uploading the referral to Protocol/EHM		21/10/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			There is now a clear evidence trail of referrals being received, screened, authorised, allocated and uploaded to the child's electronic file.	The Freedom Programme Facilitator ensures that a planning meeting takes place with referrer. The planning meeting is uploaded onto the child's electronic file	Freedom Programme Facilitator (Mandy Knights/Sue Porter or Ali Hatfield	21/10/21
2	All referrals for Freedom to be supported by an EHA or CIN Assessment so facilitators understand the whole family's needs	The Parenting Coordinator to reject any referrals without an EHA or CIN/CP assessment and encourage referrers to complete an EHA so the family's	All referrals are screened by Cath Prest (Resource Team Manager). If referral is not supported by an EHA or C&F Assessment they are not authorised for Freedom Programme provided by Cath's service. In these cases the referrer is signposted to	All women who attend the Freedom course have a whole family lead practitioner who is coordinating their plan and has worked with them to set goals and desired behavioural changes	Cath Prest (Resource Team Manager)	28.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		needs are understood, prior to determining if Freedom is the right provision for them	independent organisations who will accept referrals from other agencies, or self-referrals. Once the allocated worker is assigned a family they will make contact with the referrer to arrange a planning meeting. Referral form is checked and updated if necessary and desired outcomes are agreed as part of the Families Together Plan. This plan is also uploaded onto the child's electronic file (Protocol or EHM)	The Freedom Programme Facilitator ensures that a planning meeting takes place with referrer. The planning meeting is uploaded onto the child's electronic file.	Freedom Programme Facilitator (Mandy Knights/Sue Porter or Ali Hatfield	21/10/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
3	Evidence of the past harm to predict future risk to be evident at point of referral	Use of Harm Matrix as part of referral and decision making on screening it	We have been unable to implement the Harm Matrix as part of the referral form as this is a barrier to many referrers. However, Cath Prest screens all referrals, ensuring that there is clear evidence of past harm detailed in the referral form. Referral Forms are returned for additional information if past harm is not evident. At allocation the referral form is sent to the Freedom Programme Facilitator so that	A more robust assessment of risk is in place for all women attending Freedom. Women and children are kept safe from harm.	Cath Prest/Julie Topley	28.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			she has all information relating to past harm. Following allocation a planning meeting is held between the referrer and the Freedom Programme Facilitator. The information on referral is checked and there is a plan produced with clear outcomes which is uploaded onto the child's electronic file.			
4	Ensure robust information sharing between facilitators and the lead practitioner (Social Worker or Early Help worker)	Joint supervision to be explored between Freedom	It has not been possible to implement joint supervision between the referrer and the	The Lead practitioner has more meaningful relationships with victims and the freedom facilitator, to ensure a shared approach to	Julie Topley Rachel Paterson Jayne Bulmer	15.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		facilitator and the lead practitioner. Routine recording of case notes by facilitators on either EHM or LCS but not limited to simply noting attendance or otherwise.	facilitator due to time constraints. However, we have developed a new recording template for each session of the freedom Programme (sample template attached). This recording template has been streamlined across the Freedom Programme delivery and includes a reflective analysis during debrief sessions. De-brief sessions are held between Julie Topley and the Freedom Programme facilitators in the	achieving outcomes and goals	Debbie Harrison Julie Topley/Freedom Programme facilitators Julie Topley/Freedom Programme facilitators	15.02.21 15/02/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			form of a group supervision and discussion. After every session of Freedom Programme the facilitator completes a detailed analysis of engagement, risk and highlights any areas of concern (as per attached template). These are uploaded to the child's electronic file within 7 days. This generates an alert for the referrer inviting them to read the recording and use in their ongoing assessment and		Freedom Programme Facilitator (Mandy Knights/Sue Porter or Ali Hatfield)	21/10/21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			interventions with the family. If immediate concerns are identified the Freedom Programme Facilitator will contact the referrer the same day. If not available, the team manager will be contacted to discuss and share information.			
5	Facilitator to develop a safety network and safety plan for children with the women attending the programme in conjunction with the Lead Practitioner	Freedom Facilitators work more closely with the lead practitioner and family in developing the safety plan, e.g. by	At the planning meeting between the referrer and the facilitator safety plans are discussed and agreed. The referrer may also arrange a Family Network Meeting	A more robust plan for managing risk within the family is evident and understood by all involved including the Freedom Facilitator. Women and children are kept safe from harm.	Julie Topley Jayne Bulmer Debbie Harrison Rachel Paterson	15.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		attending the Family Network meeting	to agree a safety plan with the family and identify support from wider family and friends. Once the planning meeting has been held the facilitator will contact the woman referred to discuss the Families Together plan and objectives. They will advise and support the woman to attend (virtually at present) ensuring she is attending from a place of safety and confidentiality and has access to the			

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			internet and Teams.			
6	Group supervision to be embedded in the Freedom Programme	Start using group supervision within the Freedom programme and record this on EHM/LCS.	The new recording template has been streamlined across the Freedom Programme delivery and includes a reflective analysis of risk, concerns and progress and these are further discussed with facilitators during debrief sessions. Group supervisions are held every 3 months with all Facilitators, chaired by Julie Topley. These are recorded under the Signs of Safety Group supervision log and via survey	More robust management oversight is evident of the Freedom programme and women's cases	Cath Prest Julie Topley	28.02.21 15.02.21

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			monkey specific to group supervision. Any concerns highlighted in group supervision will be shared with the referrer.			
7	Programme Coordinator for Freedom to sit on and report to MARAC	Programme Coordinator to be invited to MARAC	Cath Prest has emailed the MARAC coordinator requesting inclusion in the meetings. Following attendance Cath Prest will feedback to Freedom Programme facilitators any concerns or changes in risk for them to take appropriate action to address this.	Regular information sharing takes place with MARAC as appropriate and women are flagged on appropriate systems	MARAC Chair Julie Topley	

Redcar & Cleveland Borough Council – Early Help						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
8	Domestic abuse training for all staff	Team managers to ensure all staff have up to date Domestic abuse training	Tracey Hill has met Louise Walker to discuss a training strategy for improving capacity and quality of provision.	All staff at early help and social care level are able to recognise and respond appropriately to signs of domestic abuse	Louise Walker Cath Prest Tracey Hill	30.06.21

Redcar & Cleveland Borough Council – School Inclusion						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Schools should consider sharing the decision to submit a SAFER referral to schools of siblings.	To promote schools to consider sharing the decision to submit a SAFER referral to schools of siblings.	Referral training workshops	Improve information sharing to further develop a culture of vigilance to safeguard children and young people.	June Craven	15/07/21 Ongoing throughout future training workshops

Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	To revise the safeguarding supervision practice guidance to include trigger points to seek supervision	Safeguarding Lead to revise the supervision guidelines to incorporate trigger points whereby staff are expected to seek supervision		When a victim of domestic abuse enters a new relationship safeguarding supervision will occur to determine assessment and analysis of new relationship. When a staff member is having difficulty screening for DA, safeguarding supervision will be sought to determine next steps and analyse any risk factors.	Safeguarding Lead Nurse	End of Jan 2021
2	That all health visiting and school nursing staff utilise every opportunity to screen for domestic violence. Claire's Law Disclosures are utilised when necessary, information is sought routinely regarding significant males in the child's life and all staff	The Safeguarding Lead Nurse will develop a new practice guidance on how staff work with families where there is a history of		There will be a significant increase in the screening for domestic abuse and rescreening will take place routinely. Staff will use a written screening tool where necessary and when staff have difficulty completing DA screening they will seek safeguarding	Safeguarding Lead Nurse	End of Jan 2021

Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	utilise every opportunity to explore parental/caregiver's relationships.	violence, this will include standardising when/if to apply for Claire's Law Disclosures; assessment of males, when and how to screen for domestic abuse and when and how to explore adult relationships.		supervision and also explore other means to see the individual on their own. Staff will gather more information about significant males which in turn will enable an effective risk analysis. Staff will routinely explore adult relationships in the hope that any indictors of domestic abuse are exposed.		
3	All staff will be familiar with the national learnings from safeguarding practice reviews where domestic abuse was a feature	Domestic Abuse prompt sheet will be printed and laminated to A5 diary size. It will act as an aide		Staff learn from safeguarding practice review recommendations	Safeguarding Lead Nurse	End of Jan 2021

Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		memoire for all staff in how to recognise and assess domestic violence				
4	All of the Health Visiting and School Nursing workforce are aware of the new and revised practice guidance and that assurance is gained that the guidance is being followed.	Mandatory training will be provided to all staff inclusive of students. This training will be based on learnings from this and other recent safeguarding practice reviews in addition to introducing the new practice guidance. It will also form	Dates have been published for staff to book on to training throughout Feb 2021	That all staff follow the new and revised practice guidance	Safeguarding Lead Nurse	March 2021

Redcar & Cleveland Borough Council – School Nursing & Health Visiting Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		part of the safeguarding induction of new staff. There will also be an audit of records to ensure that the guidance is being adhered to.	Commencing Aug 2021			Sept 2021

Tees Valley Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	In additional to the GP safeguarding lead, practices will be advised to nominate administrative safeguarding lead that will support the GP safeguarding lead.	Share best practice with GP practices to: a. Practices to appoint administrative safeguarding lead.	This has been standard advice from the CCG since 2016. It will be reminded to practice representatives at the next CCG GP	Safeguarding practice will be embedded within all roles with the GP practice	TBC	June 2021

Tees Valley Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		b. GP & administrative lead to hold regular sharing information meetings and cascade key information to all GP practice staff	training session in June 2021			
2	Practices will be advised that their audit policies should include a specific safeguarding record keeping audit to review if safeguarding concerns have been identified, recorded and acted upon and / or review the quality of safeguarding referrals	Share best practice with GP practices to: a. Include safeguarding record keeping audit within GP practice audit policy. b. Provide evidence of lessons learnt and appropriate	This has been standard advice from the CCG since 2016. It will be reminded to practice representatives at the next CCG GP training session in June 2021	Practices are able to demonstrate review of records and appropriate actions related to safeguarding correspondence and practices.	TBC	September 2021

Tees Valley Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		actions to address any gaps in practice.				
3	General Practices will be advised to implement a Child Not Brought (CNB) Policy.	CCG to disseminate a best practice CNB policy.	CCG to disseminate a best practice CNB policy.	Practices are able to demonstrate compliance with the follow up of any child that has not been brought to an appointment.	Dr John Bye	March 2021
4	General Practices are routinely invited to contribute to statutory safeguarding meetings (including Strategy Meetings) and included in the distribution list	The CCG safeguarding team will work with the Local Authority to ensure there is a consistent and robust process in place.	Work around communication and information sharing between GPs and Social Care was started in 2019 and is subject to on-going review and quality improvement work.	GP's are able to demonstrate participation in the statutory safeguarding meetings.	TBC	June 2021
5	The CCG will continue to deliver locality specific safeguarding training for practices which emphasises the	CCG will continue to provide an annual safeguarding	This work continues to be delivered on a quarterly basis.	GP practices are able to demonstrate continued safeguarding practice learning for all appropriate staff.	TBC	March 2021

Tees Valley Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	importance of 'Think Family' and the use of professional curiosity.	training programme.				