OVERVIEW REPORT INTO

THE DEATH OF Eystna Blunnie

ON 27 June 2012

Report produced by Jackie Sully on behalf of the

Safer Harlow Partnership

23 October 2013

(Updated 14 January 2014, 26 March and 30 June 2014)

TABLE OF CONTENTS

EXECUTIVE SUMMARY

1; Introduction;

This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected death of Eystna Blunnie in Harlow, Essex on 27 June 2012. During the early hours of 27 June 2012, Essex Police and ambulance services were called to Howard Way in Harlow, following a report that a female was lying in the road having apparently been run over.

Enquiries eventually revealed the female to be Eystna Blunnie, who was nine months pregnant and just days away from giving birth. Eystna Blunnie had sustained a serious assault having gone out to meet the perpetrator TM in the early hours of the morning, and later died of massive head injuries inflicted during the assault.

In Feb 2013 TM was found guilty of the murder of Eystna Blunnie, and of child destruction. He was sentenced to life imprisonment, with a minimum term of 27 years.

2; The Review Process;

This summary outlines the process undertaken by the Harlow Domestic Homicide Review Panel in reviewing the death of Eystna Blunnie.

On 27 June 2012 Essex Police notified the Chair of the Safer Harlow Partnership of the death of Eystna Blunnie as the circumstances of the death fitted the Home Office criteria for the establishment of a Domestic Homicide Review. The Review was conducted in accordance with the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews 2011.

The Home Office was informed of the intention to conduct a DHR on 9 July 2012 and the first panel met on 2 October 2012.

The process has been completed and a report was submitted to the Home Office in October 2013.

The first meeting of the panel included all agencies who had potentially been engaged with Eystna Blunnie or TM. Further panel meetings were held in January, March, and June 2013. Agencies initially contacted and asked to supply any known information to the review were:

- Essex County Council Schools, Children and Families
- Essex County Council Safeguarding Children's Board
- National Probation Service
- Essex Police

- Central Essex Community Services
- NHS North Essex
- Anglian Community Enterprise
- NHS South Essex
- N E London NHS Foundation Trust
- Colchester Hospital University NHS Foundation Trust
- Mid Essex Hospital Services NHS Trust
- Princess Alexandra Hospital
- Basildon and Thurrock University NHS Foundation Trust
- North Essex Partnership NHS Foundation Trust
- South Essex Partnership University NHS Foundation Trust
- East of England Ambulance Services NHS Trust
- CAFCASS
- Essex County Council Adults health and community wellbeing
- Essex County Council DAAT
- Harlow College
- Braintree District Council
- Basildon Borough Council
- Brentwood District Council
- Castlepoint District Council
- Chelmsford City Council
- Colchester Borough Council
- Epping Forest District Council
- Harlow District Council
- Maldon District Council
- Rochford District Council
- Tendring District Council
- Uttlesford District Council
- Thurrock Council
- Southend-on-Sea Borough Council
- Safer Places
- Victim Support
- Essex Change
- Essex County Council Youth Offending Service
- West Essex CDAT
- Southend University Hospitals NHS Trust
- Nuffield House Surgery
- The Hamilton Practice

From the information initially requested and from those agencies who responded, 9 agencies had significant records of contact with the victim and/or the perpetrator prior to her death. Subsequently the following organisations were requested to submit a full IMR (Independent Management Review):

- Princess Alexandra Hospital
- North Essex Partnership Foundation Trust (NEPFT)
- Essex Police
- Nuffield House Practice
- The Hamilton Practice
- Harlow Council Housing Department
- Essex County Council Safeguarding Board
- Essex County Council Children's Social Care
- Essex Probation

Agencies were asked to give chronological accounts of their contact with the victim prior to her death and the same request was made to agencies re contact with the perpetrator.

In accordance with the Terms of Reference, the review has covered the period of Eystna Blunnie and TM's known relationship in detail. Organisations were further requested to include any other information outside of this timeframe, which was or could be relevant to the review.

Within the individual reports some of the accounts have more significance than others, and some span a greater time period and have a greater involvement with the victim or the perpetrator.

Agencies reported as to whether internal procedures relating to adult safeguarding and specifically domestic abuse were in place and were implemented. Each agency was further requested to draw their own conclusions from the IMR process and the internal responses to their dealings with Eystna Blunnie and TM, to highlight any good practise, and/or to make their own recommendations as to what they have learned from the process and how things could or should have been done differently.

During the panel meetings and the subsequent review of the IMRs it became clear that more information was required regarding the decision made by the CPS not to prosecute TM in April 2012. A request was therefore made to the CPS at the beginning of May 2013, and a chronology was submitted in September 2013.

The victim had a number of contacts with individual agencies prior to her death and whilst there were a number of separate concerns relating to domestic abuse, there was no single agency with an overview of what was an escalating and dangerous situation, and consequently there was no formal referral made. Eystna Blunnie continued to deny that there was anything untoward going on between her and TM and that the relationship with TM was finished even though he was the father of her unborn child. Eystna Blunnie was not known to Safer Places (the Harlow women's refuge) in the context of her relationship with TM, though Essex Police have a number of domestic abuse incidents relating to the volatile relationship between Eystna Blunnie and TM.

The full Overview Report contains many recommendations and it is envisaged that the Harlow Domestic Abuse Forum will be pro-active in monitoring progress against the targets, and driving the agenda forward. They will also take the lead in further negotiating some of the more detailed inter agency requirements in order to ensure that local domestic abuse services are as client centred, effective and responsive as they can be.

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

OVERVIEW OF AGENCY INVOLVEMENT WITH Eystna Blunnie (victim) and TM (perpetrator);

Scope of the review;

Eystna Blunnie was in an on/off relationship with TM for approximately eighteen months before her death, though for the final six months, both stated that the relationship was over. By this time however, Eystna Blunnie was pregnant with TM's child.

The DHR panel agreed that the period to be covered by this review should be from January 2010 until June 2012 which is the approximate time period covering Eystna Blunnie's relationship with the perpetrator, until the date when Eystna Blunnie was tragically murdered. Agencies were also requested to include any other significant incidents prior to this date that would or could have relevance for the review.

A summary of the individual agency contact with the victim Eystna Blunnie, and the perpetrator TM, is detailed within the first section of each organisational report. This information is taken from the IMRs and includes any other relevant details within the chronology of events. This section is followed by a summary of policy, procedure and individual practice. The final section of each agency review contains the author of the Overview Report's observations and analysis of the relevant issues identified within the context of each separate agency's involvement with Eystna Blunnie and TM.

1; Princess Alexandra Hospital (PAH);

1.1; Agency involvement relating to Eystna Blunnie

1.1.1; The IMR author identified from hospital notes, that Eystna Blunnie had a long history of abdominal pain and had several episodes of both consultation and care with PAH prior to her pregnancy.
1.1.2; There were more episodes of care than usual during the pregnancy, sixteen in total. It was noted that some were routine appointments; five were self-referred with abdominal pain, and that four out of the five were in the early hours of the morning.
1.1.3; It is recorded that Eystna Blunnie was asked several times about her safety, but at all times the issues of concern raised were minimized or denied.
1.1.4; There were no disclosures noted at any stage of the recorded appointments and interviews.
1.1.5; The electronic maternity record does include an opportunity to include a safeguarding alert.

1.1.6; In early February 2012 Eystna Blunnie reported to her midwife at a routine anti-natal appointment that she had split from her partner (TM) and that he had taken her maternity notes. PAH issued a duplicate set of notes to Eystna Blunnie.
1.1.7; Following an appointment where TM attended with Eystna Blunnie on 23/03/12, an incident took place on the labour ward. It was recorded that "TM appeared to be intoxicated". Several members of staff were concerned as they were both arguing loudly. Eystna Blunnie was asked if she had any concerns for her safety and she responded by saying that she "felt safe with him around, but didn't like him when he was drunk". Eystna Blunnie was offered admission at this time but declined. This incident was escalated to the safeguarding team and to the community midwife.
1.1.8; The community midwife attempted to contact Eystna Blunnie by making a home visit to her parent's house, but this was unsuccessful. A formal referral was made to the IRT (Initial Response Team within Essex Social Services), but they stated that as there was no evidence of physical violence the referral should be declined. This decision was qualified by stating that it was an inappropriate referral for the IRT team at that time.
1.1.9; Eystna Blunnie attended another anti-natal appointment with her mother in early April 2012. The midwife challenged Eystna Blunnie's safety but was informed that Eystna Blunnie was now at home with her parents. Eystna Blunnie's mother informed the midwife that TM had a history of violence. Eystna Blunnie was advised to call the police if TM tried to make contact.
1.1.10; After a violent incident between Eystna Blunnie and TM in April 2012, PAH received the relevant DV/1 form from the police. The incident took place at TM's home and he was subsequently graded as high risk. Eystna Blunnie again had the opportunity to disclose any episodes of domestic abuse, but informed the community midwife that she was safe at her parent's home.
1.1.11; However, following this incident, the midwife was concerned about Eystna Blunnie's ability to protect herself and her unborn child and made a referral to Children's Social Care, according to the PAH internal procedures.
1.1.12; In early May the April incident was discussed at the Multi Agency Risk Assessment Conference (MARAC). At the ante-natal appointment two days later, when Eystna Blunnie was questioned about the incident, Eystna Blunnie stated that she had definitely split from TM and he would have no involvement with the baby.
1.1.13; The referral to IRT was pursued by the midwife in mid May, and the option of an injunction regarding TM was discussed. IRT decided that no further action was required at this stage and advised the midwives to monitor any contact between Eystna Blunnie and TM.
1.1.14; Towards the end of May Eystna Blunnie was still telling the midwives that she had no contact with TM and "felt safe" at her parent's home.
1.1.15; All other appointments with the midwives including two home visits note that Eystna Blunnie was doing well and seemed relaxed.

1.2; Agency involvement relating to TM

1.2.1; TM had five recorded attendances to the Accident and Emergency (A&E) dept. of the local hospital, two following an assault (though it is not clear whether TM was the victim or the perpetrator on these occasions), one visit was as a result of self-harm, one as a result of alcohol and ecstasy abuse, and one was due to a football injury.

1.2.2; It should be noted that the A&E records for TM could not be found at the time of the IMR completion.
1.2.3; There was however a record on file that TM was subject to a MARAC meeting and a multi-agency discussion in April 2012.

1.3; Analysis of internal procedures and good practice

1.3.1; PAH has a named midwife for safeguarding, however, it is not clear who assumes this role during any periods of leave, or how continuity of care is ensured if patients see different midwives at each visit. There is a specific safeguarding adult's policy, but this has taken a long time to be signed off at the appropriate level, and implementation is hampered until this action is completed.
1.3.2; It is the named midwife who takes part in the MARAC process.
1.3.3; Safeguarding adults training is part of the induction process within the hospital. Currently 47 out of 160 people are trained, and there are yearly training updates. This training is mandatory and attendance recorded and audited for compliance. This affords outcomes to be continuously reviewed and improved, and allows lessons learned to be shared across the internal teams.
1.3.4; There was specific domestic abuse training in January 2012.
1.3.5; The Daisy project, which is a joint pilot project between the PAH maternity department and Safer Places, has been very successful. It is run as part of the women's health programme and there are ambitions to roll the project out to the A&E department. This expansion however will be funding dependent.

1.4; Issues for further consideration

1.4.1; There is no information regarding how the role of named safeguarding midwife is covered in the absence of the current post holder. This is not a role that should be subject to availability and steps should be taken to ensure that there is access to a named safeguarding person at all times, particularly when the Daisy project is implemented within the A&E dept.
1.4.2; It is of concern that when a referral is made to CSC following a serious concern, there is no formal feedback mechanism for the individual midwife, or to the maternity dept. directly.
1.4.3; It is of further concern that referrals and/or any escalation of issues, only make reference to physical or violent abuse, whereas it is well documented that controlling and coercive behaviour as well as emotional abuse, are often part of the pattern of perpetrator behaviours.
1.4.4; The safeguarding adults policy should be ratified and implemented as a matter of urgency.
1.4.5; Adult safeguarding training should ensure that everyone who comes into contact with the public at any level, has been suitably trained and is aware of the escalation routes for identified concerns.

2; NEPFT (North Essex Partnership NHS Foundation Trust);

2.1; The following section of the report relates to TM only;

There is no history of involvement with, or reference to Eystna Blunnie in any NEPFT records, with the exception of noting that she was present at a Mental Health Act assessment with TM on 15/03/12.

2.1.1; The scope of this IMR goes back further than the dates agreed, as it was recognised that much of the information held by NEPFT in relation to TM has relevance to this review.

2.1.2; The Trust had the first contact with TM when he was eight years old, and he was seen by child and adolescent psychiatric services, following a referral by his then GP. He was assessed after parental concerns regarding behavioural issues, anxiety and hearing voices. At that time the diagnosis was that he did not have a psychotic illness, and was only offered additional support at school, where things did improve. He did not attend follow up appointments and the case was closed in July 1997.

2.1.3; TM had seven subsequent episodes of care with mental health and substance misuse services, and was actually discharged on 31/05/12.

2.1.4; NEPFT has a note on file that there was a domestic abuse disclosure made in 2007 by a previous partner of TM's in order that future partners could be made aware and "protected".

2.1.5; An earlier Multi Agency Public Protection Arrangements (MAPPA) report sent to NEPFT states that TM has a history of violent offending against intimate partners, and that he fails to understand the impact of his actions.

2.1.6; It was further noted that TM also fails to take responsibility for his actions and blames everyone else for what has occurred.

2.1.7; As far back as 2009 there were notes on TM's record of a referral due to fits of uncontrollable rage and heavy drinking. It was recorded that one way of coping with these outbursts was by punching the walls. TM also stated that he was worried about harming his own family at this time. Further appointments to work through these issues were offered, but TM failed to attend any of them. His GP was later informed that the case was closed.

2.1.8; It is understood that there is a prescriptive internal process to be instigated when patients do not attend planned appointments, but there is no evidence that this process was followed by NEPFT, and TM was discharged into the care of his GP. There was no real communication between the two NHS organisations regarding this transfer of care.

2.1.9; In 2010, TM's father contacted ADAS (Alcohol and Drugs Advisory Service) regarding TM's mental state. Mr. M senior stated that TM was drinking 23 cans of beer per day and that his violence was escalating. The family did not know what to do and felt particularly vulnerable.

2.1.10; ADAS made a referral to CMHT (Community Mental health Team) who undertook a full assessment of TM in March 2010. His "low mood" was attributed to alcohol abuse. TM stated that he was easily irritated and could react violently to very insignificant issues. He also disclosed that he did bare knuckle fights for money. TM had already completed a prison sentence at this time, and during the assessment, he admitted that he had been sentenced to prison for nine months for ABH (actual bodily harm). He also stated that he was released on license but was recalled to prison when he committed an act of criminal damage. It should be noted that he made no reference to domestic abuse or violence to intimate partners in either of these disclosures.

2.1.11; A further assessment was completed at the end of March 2010 where TM admitted that he had been abusing alcohol for four years, drinking approximately 85 units per day, and was also using cocaine 1 to 3 times per week. This was the first time that drug use had been brought into the conversation. He was assessed as "at risk" of harm to himself and to others, due to his previous history of violence and continued street fighting. This was further exacerbated when he was under the influence of alcohol.
2.1.12; TM was referred back to ADAS as he was not prepared to take part in any programmes that required him to stop drinking completely. He stated that he was prepared to cut his drinking down to weekends **only**, but not to stop altogether.
2.1.13; In July of the same year TM was temporarily detained in Shannon House under Section 136 of the Mental Health Act. He was heavily under the influence of alcohol. It was recorded that he had been fighting with his brother and smashed some glasses, using some of the broken glass to cut his neck, though he denied that this was self-harm. He was released the next day when he was sober with recommendations to contact ADAS or CDAT again. TM failed to follow this up.
2.1.14; Another referral was made to NEPFT in November 2010 by TM's GP, but after another failure to attend and having established no contact; the case was once again closed.
2.1.15; TM was discharged from mental health services in late December 2010, and did not appear again until 14 March 2012. TM was taken to A&E by his parents, under the influence of alcohol and ecstasy, and was allegedly threatening to kill himself. He was sectioned, assessed, but released the next day, as there was no underlying mental disorder diagnosed. It was suggested once again that TM contact ADAS or CDAT. TM stated during this episode that his relationship (with Eystna Blunnie) had ended 10 weeks previously and she was 6.5 months pregnant, but he was unsure if the child was his. This was the first reference to Eystna Blunnie.
2.1.16; In May 2012 TM's GP made another urgent referral to NEPFT after stating that TM had attended A&E the previous week, and that he had cut his own wrists. There is no record of a follow up assessment being undertaken from this referral. It was noted that when TM was treated for the surgical aspect of his self-harm, he was too intoxicated for a full mental health assessment to be undertaken.
2.1.17; In June 2012 after his arrest, TM was visited by a social worker within Chelmsford Magistrates Court where he stated that he and Eystna Blunnie had been together for a year and that she was expecting his child. This was the first recorded acknowledgement that Eystna Blunnie's child was his.

2.2; Analysis of internal procedures and good practice

2. 2.1; There is a lack of information as to the robustness of the internal procedures regarding domestic abuse identification and the formal referral processes. It is stated that the domestic abuse policy is contained within the adult safeguarding policy, and that staff members have undertaken DASH (domestic, sexual and honour based abuse) training, but there is no indication of how many staff have completed this training, and how often training needs are reviewed or refreshed.

2.2.2; There are a number of quotes made from research papers within the IMR, all of which are referenced directly from the NEPFT safeguarding policy. This evidence highlights the following in relation to domestic abuse;

- Pregnancy can be a time when violence intensifies. (Mezey 1997)
- Previous domestic violence is the most effective indicator of further domestic violence. (Walby and Myhill, 2000)
- Perpetrators who have used or threatened to use a weapon are more likely to be violent again. (Sonkin, Martin and Walker, 1985)
- Strangulation is a common method of killing in domestic homicides, and needs to be recorded for purposes of risk assessment. (Richards, 2003)
- **Ending an abusive relationship is strongly linked to partner homicide. (Websdale, 1999; Regan et al, 2007)**

2.3; Issues for further consideration;

2.3.1; There is disconnect within the referral and appointment follow up processes regarding high risk service users. Whilst it has been stated that there is an existing protocol regarding clients who do not attend appointments, particularly those who have had an urgent referral into NEPFT, there is no evidence as to how this is implemented or how it works in practice.

2.3.2; As it is widely accepted that general practice is the main point of contact for health services, there is an urgent need to maintain an up to date holistic record of what is happening within each patient's care pathway. Closer engagement and communication with GPs is therefore an essential aspect of managing the overall health and risk of each patient. With the number of different communication channels available to practitioners today, it is unclear why communication methods are restricted to letters stating only that the case is to be closed, especially where the original referral was classified as requiring urgent attention.

2.3.3; Communication to TM's GP and to NEPFT from HM Prison Chelmsford which related to other mental health interventions undertaken whilst TM was in prison, was neither particularly helpful nor timely but should have formed another essential aspect of keeping his overall patient record up to date.

2.3.4;It is unclear why NEPFT did not have desktop or internet access to MARAC and MAPPA reports, as this is an essential source of information to the assessment process.

2.3.5; There was no assessment offered or made to TM's family, though they identified on several occasions that they did not know what to do next and were frightened of TM. In order to understand the overall client picture, it is imperative that the carer's perspective and experience is taken into account. This is a valuable contribution to the overall assessment of health management and risk, to themselves, to the family in general, and to the wider public.

2.3.6; Whilst children's safeguarding training is mandatory for everyone working within a child centred environment, this is not the case with adult safeguarding training. This disparity means that there is a very different approach taken to the time given, and overall content of the training, and significantly, who the training is offered to. There must be a different approach taken to this in order to ensure organizational awareness

and consistency of approach. Domestic abuse should form a specific and explicit element of the adult safeguarding training for anyone involved in a front line capacity.

3; NHS North Essex, Nuffield House Practice

3.1; The following section relates to Eystna Blunnie only, who was a patient at the practice from 2001.

3.1.1; There are twenty-one visits recorded in the stated timeframe for the IMR. Thirteen visits were to a GP, 6 visits were to a GP registrar, and there were 2 visits made to the practice nurse.

3.1.2; These visits record knee pain, shoulder pain, ear nose and throat problems, as well as gynaecological issues. Notes indicate many appointments logged as DNA (did not attend). There is no disclosure of domestic abuse recorded on file.

3.1.3; Eystna Blunnie's pregnancy was confirmed on 1 December 2011 at her first midwive's appointment. At a subsequent PAH maternity appointment she replied "no" to the question which asks about domestic abuse. This statement is logged on Eystna Blunnie's maternity notes.

3.1.4; Eystna Blunnie was treated for a urinary tract infection in February 2012, and during this appointment she disclosed that she had been the victim of domestic abuse.

3.1.5; In March 2012 the practice received a significant event form which stated that Eystna Blunnie was no longer in a relationship with TM, who had apparently told people via "Facebook" and via friends that he was not the father of Eystna Blunnie's unborn child. It further stated that Eystna Blunnie has family support but made no reference to domestic violence per se.

3.1.6; On 11 April 2012, Eystna Blunnie attended the practice with her mother and stated that she had been assaulted. She had suffered a head butt, scratches and bruises, and she had reported the attack to the police, but they were not taking it any further due to a lack of evidence.

3.1.7; The practice also received a notice from the community midwife requesting a home visit. It stated that Eystna Blunnie's partner had been with her in the PAH maternity unit and that they were both arguing loudly. The partner (TM) smelled strongly of alcohol and had threatened violence. A home visit was attempted but there was no answer at the home address. The IRT were contacted but this was not followed up and there was no further action taken.

3.1.9; Records later noted that Eystna Blunnie had moved out of a previous address and back in with her parents and "felt safe".

3.1.10; Eystna Blunnie's final recorded GP appointment was on 20 June 2012.

3.2; Analysis of internal procedures and good practice;

3.2.1; There is an internal practice protocol for recording domestic abuse incidents, and information handbooks are available in the practice library. There is a named GP lead for children's safeguarding, but they are not specifically trained in adult safeguarding. There is no suitably trained administrative lead.

3.3.2; Whilst there was a great deal of awareness regarding children's safeguarding, there appears to be a lack of awareness regarding the different responsibilities and training required for adult safeguarding.

3.3.3; The only training relating to adult safeguarding is stated as being delivered at a half day GP shut down event. There is no record as to whether this training covered any aspect of domestic abuse training, or whether domestic abuse was recognised as a specific topic within the adult safeguarding agenda and which requires additional specialist training and specific internal protocols.

3.3; Issues for further consideration;

3.3.1; Internal communication and specific training regarding domestic abuse and adult safeguarding appears to be an issue which needs addressing within general practice.
3.3.2; General practice is currently outside the MARAC process there needs to be consideration given as to how important information can be shared and cascaded within GP practices.
3.3.3; All staff need to be aware of the requirements of an integrated adult safeguarding policy and the associated procedures.
3.3.4; Midwives should be invited to attend the practice primary care meetings.
3.3.5; Significant event forms or domestic abuse incident reports should also go to the primary care meetings, so that the information can be shared, and any required response can be planned systematically and owned by all practice staff, including GPs.
3.3.5; Safeguarding adults training should be delivered across the whole practice immediately. This training should incorporate domestic abuse as an integral aspect of the adult safeguarding procedure, and ensure that the information given allows staff at all levels to understand their role, and where to take concerns or information relating to domestic abuse disclosures or concerns.
3.3.6; GPs need an effective but simple to use “toolkit” for adult safeguarding, and in particular domestic abuse. Developing a few trigger questions and having an easy to process, follow up procedure, would assist in the cascading of internal knowledge and confidence, as well as the overall assurance process.

4; NHS North Essex, The Hamilton Practice

4.1; The following section relates to TM only, who has been a patient at the practice since birth.

4.1.1; There are five recorded appointments with the Hamilton Practice GPs during the specified time frame but the IMR author has included other relevant or significant consultations as requested.
4.1.2; The Practice does have a “flag” system for violent patients or those who have been involved in domestic abuse. TM did have a flag on his records, and this WAS related to violence. However the reference was made to the likelihood of self-harm rather than as a perpetrator of violent behaviours to others.
4.1.3; TM visited the practice on 29-10-09 as he was worried about his own mental health. He reported having fits of rage, and that he was worried about causing harm to his family. It was noted that he had a long history of self-harm and of heavy alcohol use.
4.1.4; A referral to CMHT was made but not marked as urgent, and a return appointment to the GP was recommended.

4.1.5; TM did not attend the CMHT assessment nor did he go back to the GP. CMHT copied the practice into the letters sent to TM following the non attendance, and which were sent as further attempts to make contact. Having received no response at all the case was closed.
4.1.6; In March 2010 notes record that a referral was made from ADAS for TM to attend CDAT, but again TM did not attend.
4.1.7; In July 2010, TM was sectioned into the care of NEPFT for "cutting his neck in a public place". An assessment was completed at that time but the conclusion reached was that the cause of TM's problems was alcohol abuse and that he did not have any underlying mental health issues. He was left to self-refer to ADAS following this episode as he had failed to attend the previously booked CDAT appointment.
4.1.8; In October 2010 TM attended the practice with his mother, and was still reporting issues with anger management. Minor depression was identified and medication prescribed. Further support and psychotherapy were both offered. Another referral was made to CMHT, and on this occasion it was classed as urgent. A further referral was made to CDAT from this GP consultation, as TM had failed to attend ADAS. TM did not attend any of the referral appointments and both agencies had no success in making contact with TM.
4.1.9; Following TM's prison sentence there are notes on his file relating to a discharge summary sent to the GP after TM's release. This summary makes reference to TM's mental health issues whilst in prison. There is also a note on file in relation to the anti-psychotic medication prescribed which is generally only used in secondary care, and is not usually prescribed within general practice/primary care.
4.1.10;The practice notes indicates another referral to NEPFT in November 2010 which TM did not attend, and there was an additional "did not attend" note regarding a referral to the fracture clinic at the local hospital.
4.1.11; In December 2011 the practice received a DV1 alert from Essex Police which indicated that TM was a victim in a domestic violence incident. The police assessment of risk was classed as standard and the practice accepted this classification
4.1.12; On 14-03-12 TM's practice notes record a visit to A&E, due to excess alcohol, drugs and depression. TM's parents had called an ambulance and TM was detained under the Mental Health Act. An in-patient assessment was completed during this time, and this again indicated that alcohol was the primary factor in TM's on going mental health problems. At this assessment TM disclosed that his "ex" girlfriend was pregnant and that he wasn't sure that the child was his.
4.1.13; In May 2012 there was a further GP consultation regarding low mood, self-harm and alcohol dependence. Information regarding support agencies as well as CDAT was given to TM, and yet another urgent referral was made to CMHT.
4.1.14; The CMHT assessment concluded once again that TM had no underlying MH issues and that the cause of TM's problems was his excessive and habitual alcohol consumption. CMHT sent another referral off to CDAT and to ADAS, but noted that TM was poorly motivated to address these issues and to take responsibility for himself and for his actions.
4.1.15; In July 2012 the practice received a notification from the Mid Essex Criminal Justice Mental Health Team (part of NEPFT) that TM had undergone a mental health

assessment whilst in the custody of the court. This occurred following TM's arrest for Eystna Blunnie's murder.

4.2; Analysis of internal procedures and good practice;

4.2.1; Like Nuffield House, The Hamilton practice was very well informed regarding its responsibilities regarding children's safeguarding, but there is a marked contrast in the approach to adult safeguarding. Whilst children's safeguarding training is mandatory, there is no compulsion to ensure that staff are trained to the same level of expertise in the subject of vulnerable adults. There was no evidence or reference to an internal adult safeguarding policy, but there is a policy for "flagging" vulnerable patients.
4.2.2; It was stated that two nurses and a member of the administrative staff attended an adult safeguarding event which did include domestic abuse. The practice is also familiar with the local SET (Southend, Essex, and Thurrock) safeguarding procedures.
4.2.3; The practice are aware of and do receive the DV/1 alerts from the police. However without a clear internal policy and procedure in place it is unclear how the classification of risk is assessed from a practice perspective, or how risk assessments are discussed and where necessary, challenged.

4.3; Issues for further consideration;

4.3.1; There appears to be a mismatch within inter-agency communication and interpretation as to a timescale for response and follow up when a referral is marked urgent.
4.3.2; It is unclear as to whether there are varying degrees of "urgency" attached to a referral but one must assume that when you are dealing with someone with a history of self-harm, violence to others, and domestic abuse, this must be at the upper end of urgency.
4.3.3; The fact that TM had a long history of "revolving" referrals does not seem to have made any difference to the importance of getting TM into the system and keeping him there, whilst his issues or at least some of them were addressed.
4.3.4; It is factual that unless a person is sectioned under the Mental Health Act, they cannot be detained against their will. However someone who is continuously presenting with the same on-going issues to NHS generalist services, as well as to specialist Mental Health Services seems to be able to bypass the system by not attending any referral appointments or follow up consultations. A lack of timely interagency information, as well as no formal intervention process, enables this to continue.
4.3.5; Every practice should have a named adult safeguarding lead that is supported by other internal staff, who are also appropriately trained. All practice personnel should be familiar and confident with the internal safeguarding policy and procedures. All available adult safeguarding training should also include specific components designated to domestic abuse.
4.3.6; A simple risk assessment toolkit should be developed to assist with the identification and management of patient risk from all perspectives.

5; Harlow Council Housing Department

5.1; The following section relates to Eystna Blunnie only;

5.1.1; Eystna Blunnie was on the register for housing with HDC (Harlow District Council) from April 2009, and was in fairly regular contact with the Housing Options team within the department to discuss her housing needs. At times she presented to the department as homeless and requested temporary accommodation.
5.1.2; Eystna Blunnie first registered for housing in April 2009 and was registered at that time as a sole applicant.
5.1.3; In February 2010, the status of the application was changed to joint names as AD (the then partner of Eystna Blunnie) was added to the registration.
5.1.4; On 31 May 2011 Eystna Blunnie presented as single and homeless, having been "thrown out" of home. The case file noted that Eystna Blunnie was offered "advice and assistance". A subsequent application to NACRO supported housing, and the local Harlow foyer was declined. It is not clear whether NACRO declined the referral or whether Eystna Blunnie refused this option.
5.1.5; On 10 December 2011 Eystna Blunnie informed the housing dept. that she was pregnant and her file was updated accordingly.
5.1.6; On 9 Feb 2012 Eystna Blunnie presented as a homeless emergency as she had been forced to leave her partner's parents' property, where she had been staying.
5.1.7; Eystna Blunnie disclosed the assault by TM (in April 2012) to her housing case worker, and stated that Essex Police were conducting an investigation. She declined a place in a safe house or a refuge at that time as she did not want to move out of the Harlow area. She said that she was no longer in contact with TM. Eystna Blunnie was booked into temporary accommodation for the weekend on 5 April 2012.
5.1.8; In May 2012 Eystna Blunnie contacted the housing dept. again to state that she was still homeless and sleeping with friends. HDC made a call to Eystna Blunnie and left a message for her to call back, but there is no record of the call being returned.
5.1.9; The IMR states that an offer of accommodation was made on 22 June 2012.

5.2; Analysis of internal procedures and good practice;

5.2.1; The IMR author notes that HDC has "effective" policies and procedures in place for dealing with concerns and reports of domestic abuse, though it is not stated how these are linked into the adult safeguarding or domestic abuse agenda.
5.2.2; Staff are trained in domestic abuse awareness, and the internal IT system allows housing department staff to share information, and to make referrals to other agencies where appropriate, and where they have the client's permission. Alternatively, information regarding external agencies who offer advice and support can be passed on to the applicant directly, and they can make an approach themselves.
5.2.3; In this instance following the assault in April 2012, the Housing Dept. did not take any further action themselves. When they contacted Essex Police, they were informed that Eystna Blunnie's allegations were being "looked into".

5.3; Issues for further consideration;

5.3.1; Whilst there are no substantive issues or recommendations regarding the HDC housing dept. involvement with Eystna Blunnie, one observation is how individual agencies can be "assured" or receive relevant feedback, if or when they are informed that another agency is dealing with or "looking into" a domestic abuse situation.

5.3.2; As it was recognized that Eystna Blunnie was in enough danger to make the offer of "safe" accommodation outside the area, was it enough to accept that Essex Police were investigating Eystna Blunnie's allegations against TM?

6; Essex County Council (ECC), Safeguarding Essex;

6.1; This IMR is quite restricted in its scope and content due to the limited contact with both Eystna Blunnie and TM.
6.1.1; The report notes that Eystna Blunnie was known to ECC briefly in 2007, when there was an issue with neighbours at the parental home.
6.1.2; There are several contacts noted with regard to TM.
6.1.3; In 2010 the IMR report records TM's detention under the Mental Health Act after he cut his neck in a public place. It further states that TM was known to Shannon House, which is a unit for people who are compulsorily detained and who require treatment in secure conditions during an acutely disturbed phase of serious mental disorder.
6.1.4;The report also records a call from TM's father on 15-03-12 saying that TM was missing and that he was talking about killing himself. Later that evening, It was further recorded that Shannon House was made aware that TM was in Princess Alexandra Hospital with a very high alcohol level, and had also been taking ecstasy. A full mental health assessment could not be undertaken at this time due to TM's intoxicated state, but once the influence of the drink and drugs had dissipated he was released. The out of hour's doctor then referred the matter to the CMHT.
6.1.5; There are no other interactions or contacts recorded within this IMR, and therefore it is not appropriate to comment on the internal policy and procedures regarding adult safeguarding or specifically domestic abuse. For the same reasons there are no recommendations relating to this department within ECC.

7; Essex County Council (ECC) Children's Social Care

7.1; Both Eystna Blunnie and TM were known to CSC as children. TM was referred in 2004 after a domestic incident between his parents. A complaint was made regarding Eystna Blunnie in 2007, due to a neighbour dispute, where the allegation was that Eystna Blunnie was "out of parental control".
7.1.1; There are incidents of domestic abuse against a previous partner recorded in 2008 re TM. The file notes state that there were two previous incidents with other intimate partners, but there was no detail recorded and no follow up from CSC.
7.1.2; In 2009 TMs file notes a conviction of assault and possession of an offensive weapon, and he was subsequently subject to MAPPA
7.1.3; In 2010 records show that TM was held under the Mental Health Act due to self-harm.
7.1.4; There is another domestic abuse incident recorded in 2011 where TM is logged as the victim and Eystna Blunnie as the perpetrator. Following this incident there are further two incidents noted on 6-12-11, and 7-12-11 where Eystna Blunnie was noted as the victim. There were no risks identified re the pregnancy, which was known at this

time. However file notes state later that if there were any further incidents, a pre-birth assessment should be carried out.
7.1.5; The file states that during the eight months Eystna Blunnie was with TM they split up a total of ten times, but even when Eystna Blunnie was pregnant the risk of harm was only assessed as medium.
7.1.6; Another incident occurred on 10-04-12 and was reported by Eystna Blunnie on 12-04-12. Eystna Blunnie stated that TM had tried to strangle her, and also threatened to kill her, which he had allegedly done before in front of his friends. Notes detail that TM's mother and father had come into the room to stop TM during this violent assault.
7.1.7; CSC took no further action following this incident as they decided that there was no role for them at that point. The IRT gave Eystna Blunnie advice about seeking an injunction
7.1.8; Notes from the midwife following this incident state that Eystna Blunnie is still meeting up with TM and putting herself in danger. A senior practitioner with the IRT rang the midwife to seek clarification regarding the relationship between Eystna Blunnie and TM and whether Eystna Blunnie was engaging with ante-natal care. A message was left as there was no reply, and following no subsequent call back, the senior practitioner rang again and spoke to the duty midwife, who confirmed that she was still concerned about the continued risk of violence. Notes record that the duty midwife stated that "if she (Eystna Blunnie) is still seeing him (TM) and is still being beaten up we need to do something" CSC agreed to call Eystna Blunnie's mother to assess the situation further.
7.1.9; On 1 May 2012, CSC phoned Eystna Blunnie's father and explained the role of the IRT. Eystna Blunnie's father was clear that Eystna Blunnie was no longer with TM and she was receiving support from him and Eystna Blunnie's mother. They agreed that they would help her as long as she stayed away from TM. Eystna Blunnie's father stated that he had "had a go at TM" and been arrested for it. He further stated that Eystna Blunnie was staying with friends as well as at the parental home while she was waiting to be housed by the local council. The phone number for the IRT and the police was left with Eystna Blunnie's father with the advice to call them if he had any concerns, which Eystna Blunnie's father agreed to do. He also agreed to also pass the same message on to Eystna Blunnie.
7.1.10; The agreement within CSC at this point was that there should be no further action by any of their staff.
7.1.11; On 8 June the duty midwife contacted CSC again with concerns that Eystna Blunnie was still in contact with TM, but it was noted that this was based on hearsay rather than factual evidence.
7.1.12; The senior practitioner within CSC made 3 attempts to contact Eystna Blunnie on 8, 11, and 13 June, with no response, and it was decided at this point that the case should be closed.

7.2; Analysis of internal procedures and good practice;

7.2.1; In this case the IMR author makes several references to the "toxic trio" of drugs, alcohol, and mental ill health, and how this increases the risk of domestic violence fourteen fold. Evidence confirms that the risk of escalation in relation to the number of

domestic abuse incidents is also increased during pregnancy. This fact is corroborated within the NEPFT IMR.
7.2.2; Prior to 2009 the IMR author notes that all case records were held on a different system (SWIFT) to the one currently in use. Swift was almost entirely paper based whereas the new system is electronic, apart from documents which cannot be uploaded on to the system and which are still kept in a paper file.
7.2.3; The system now in use is the Protocol version of the Integrated Children's System (ICS).
7.2.4; Adult mental health records are held on a system known as Carebase, which is inaccessible to the IRT, but the emergency duty team (EDS) can view the information. As a consequence, staff members working with the separate IT systems would not have access to all the records or known information (NEPFT also use Carebase but would not have access to the other IT systems).
7.2.5; MAPPA records are held on yet another separate system which is held within the Quality Assurance dept. within CSC, and not accessible to all practitioners.
7.2.6; CSC use four internal documents used to assess a referral, or to judge assessment criteria;

- The Guidance for Threshold of Need and Intervention (Jan 2011)
- Southend, Essex and Thurrock child protection procedures (SET procedures)
- Domestic Abuse; a directory of services for Essex (May 2011)
- DV INDICATORS (prompts) written by the IRT managers for internal use by their staff

7.2.7; The IMR report also makes reference to quotes from research papers which are very similar to the evidence base used by NEPFT, and which highlight the dramatic increase in the prevalence of domestic abuse during pregnancy, particularly where it has been present before.
7.2.8; All staff involved in this case are experienced team managers who have been DASH trained.

7.3; Issues for further consideration;

7.3.1; During the course of the CSC investigations, checks were not made with the MAPPA co-ordinator, nor with adult mental health services, regarding TM. This should be routine in cases where domestic abuse has been identified and where a MAPPA discussion has taken place.
7.3.2; Information provided by Shannon House did not make any link between TM and Eystna Blunnie's unborn baby and therefore no note was made on the file.
7.3.3; Once the "toxic trio" of mental ill health, alcohol and drug abuse is identified within any case, but particularly where domestic abuse has been identified, an information sharing protocol should be set up. This would enable all agencies involved in the case, to have access to ALL relevant information.

8; Essex Probation

8.1; Essex Probation was involved in the supervision of TM between October 2007 and August 2009.

8.1.1; There are previous cautions for violent and abusive behaviour which included male assaults in 2007, and a clear pattern of abusive behaviour towards intimate partners is also logged at this time.
8.1.2; The IMR records that TM was sentenced to a twelve month supervision order on 18-10-2007, and in addition had to complete 100 hours of unpaid work. The sentence was imposed for the offence of common assault against his former partner. The sentence plan contained objectives relating to partner abuse and on-going liaison with the police. In the course of the IMR the author concluded that the assessment of "medium risk" was appropriate at this time.
8.1.3; On 05-05-2008 TM was sentenced to eighteen months in prison for domestic abuse against another former partner. He served nine months in prison and was the released on license on 15-01-09. The period of license was due to run until 14-08-09. There were no additional conditions attached to TM's early release and he was therefore subject to standard license release conditions, which are common to all post custodial licences. The pre-sentence report indicated that TM was unsuitable for a domestic violence programme as he did not accept responsibility for the offence. When TM was released on license there was not enough time left under supervision to complete a domestic abuse programme, though some of the preparatory work was completed with him. TM's probationary supervision was re-allocated to a band 3 Offender Manager two months after his release and meetings were reduced from weekly to monthly.
8.1.4; In April 2004 TM disclosed to his probation officer, that he had started another relationship, which should have triggered a contact to the police liaison unit
8.1.5; On 02-06-09 TM was recalled to prison for a fixed term 28 day recall. This was caused by an offence of criminal damage and another incident of domestic abuse outside his former girlfriend's house.
8.1.6; Whilst he was in prison TM complained of hearing voices and was prescribed anti-psychotic medication. Essex Probation does not have a formal record of this, but the GP records confirm that this was the case.
8.1.7; On release, time constraints resulting from the limited licence period meant that TM was not referred to the Criminal Justice Mental Health team.
8.1.8; TM's risk was re-assessed as high following the recall to prison, and he was required to have weekly meetings with his Probation Officer, where it was noted that he was still apportioning blame to others for his violent behaviour.
8.1.9; The MAPPA referral re TM which was discussed on 29-07-09 did not continue as the probation licence was about to end, and the case was subsequently closed. Following this, Essex Probation had no further contact with TM.
8.1.10; There was no contact between Essex Probation and Eystna Blunnie as the victim of the domestic assaults at any time. This is standard practice as contact with victims is made via the Victims Contact Unit or Women's Safety Workers.

8.2; **Analysis of internal procedures and good practice;**

8.2.1;The IMR author states that practices have changed considerably with Essex Probation over the review period, and also that Essex Probation have had no contact with TM for over three years.

8.2.2; The Probation Officer with whom TM had the most contact, has now left the service so it was difficult to follow up on some of the records.
8.2.3; Record keeping over the period covered within the IMR report, consisted of a mixture of paper and electronic records, and the IMR author highlights the challenges that this presents.
8.2.4; It is recognized that Essex Probation acted swiftly and decisively when TM breached the terms of the license which had originally permitted his early release from prison
8.2.5; One of the Probation officers who had been assigned to manage TM had not had specific domestic abuse training. However, it is stated that the training policy has changed since this period.

8.3; Issues for further consideration;

8.3.1; It is noted that at one point TM's supervision was re-allocated to a less senior Probation Officer, with less frequent supervisory meetings required. This decision is questionable given the lack of responsibility issues that remained, and the persistent nature of the offences. It should be compulsory if or when cases are transferred internally they are assigned to the appropriate officer level, in order that any planned intervention work can continue.
8.3.2; There were no additional conditions attached to TM's early release on license even though there was already a recorded pattern of violent behaviour towards intimate partners.
8.3.3; There was no increase in supervision or monitoring when TM told his probation officer that he had started a new relationship.

9; Essex Police

9.1; Criminal record checks on TM highlight the following;
2 x Offences against the person (2007-2009)
1 x Firearms/shotguns/offensive weapons (2008)
2 x Offences against property (2009)
1 x Public order offence (2009)
Remands and cautions;
2 x Offences against the person (2004 and 2006)
TM's file also highlights self-harm as a warning signal
9.1.1; During the period of review records note that there was a 999 emergency call on 29 January 2010. The call was made by TM's brother who reported that TM was being verbally abusive and aggressive towards their parents. He reminded the police of TM's alleged past violence. When officers attended they were told that TM had an alcohol problem and he was agitated because TM's father had taken the alcohol away from him. The family wanted TM removed from the premises but he refused to go. Even when the police were there TM refused to go, and the officers noted that although there was no actual violence on that occasion TM had been previously assessed as a "high risk perpetrator" of domestic abuse, and that in the past he had used a knife to threaten an ex-partner. TM was arrested to prevent a breach of the peace but was later released without charge. A DV1 was completed and the risk assessed as standard.

9.1.2; On 20 May 2011 police were called to a fight in an alleyway between TM, his brother and a third male. TM and his brother were arrested for assault causing actual bodily harm. Whilst in custody both the M brothers claimed that the fight was in self-defence as the third male had attempted to attack them with an iron bar. Both were placed on police bail whilst the case was reviewed by the CPS. Having failed to identify any independent witnesses, the CPS decided to take no further action, as there was not a realistic chance of conviction.
9.1.3; At 6am on 17 Nov 2011, TM called the police to report that his ex-partner was blocking his entry into his parents' home. A poor telephone line meant that the full facts of the complaint could not be heard, but shouting could be heard in the background. Police attended the scene but ascertained that there had been a verbal argument only and that no offence had been were committed. TM stated that he wanted Eystna Blunnie out of the property, and to diffuse the situation police transported Eystna Blunnie to the police station in order that she could contact friends and sort out alternative accommodation. A DV/1 was completed and subsequent checks revealed that there were no previous incidents recorded between them, but each were the subject of previous incidents logged separately. The risk was assessed as standard at this time.
9.1.4; There was a further incident on 23 November 2011 when TM made a 999 call to the police following alleged threats from Eystna Blunnie's father, who was coming over to TM's house to assault him. Mr B was arrested and served with a first stage harassment warning. A DV/1 was completed and the risk assessed as standard.
9.1.5; Another 999 call was received from TM on 02-12-11 complaining that Eystna Blunnie was "kicking off" and had become uncontrollable. He told the police that Eystna Blunnie was living at his house as she had been kicked out of her parent's home. He also told officers that Eystna Blunnie was pregnant but he wasn't sure that the baby was his. By the time the police got to the house Eystna Blunnie had left and once again the risk was assessed as standard.
9.1.6; On 05-12-11 police received a call from Eystna Blunnie's brother who reported that Eystna Blunnie had been assaulted two days earlier by her partner TM. It was alleged that TM had verbally abused her then "chucked" her on to the sofa. Eystna Blunnie's brother also alleged that TM had been emotionally abusing her. Having checked and discovered the previous domestic abuse history, police officers went to the house and spoke to Eystna Blunnie. She gave a different account saying that she had provoked TM by getting into his face and swearing at him. TM had grabbed her by the arms and pushed her down on to the sofa. Eystna Blunnie stated that she did not want any police involvement. She further stated that she did not consider herself to be a victim, and would not testify if the police decided to prosecute TM. Officers then interviewed TM who confirmed that he had grabbed hold of her to calm her down. He also stated that Eystna Blunnie was 8 weeks pregnant. No further action was taken and the risk assessment given at this point was medium. This risk assessment was endorsed by the Domestic Abuse Safeguarding Team (DAST) trained inspector. It was noted at this time that there were additional concerns to TM's violence, specifically his controlling behaviour, and the fact that Eystna Blunnie was now 8 weeks pregnant.
9.1.7; Eystna Blunnie attended the police station on 10-04-12 to report that TM had assaulted her on the previous day. The incident happened in TM's room within his

parents' house. He had grabbed her around the neck and then attempted to punch her. The assault was halted by TM's parents who had come into the room after hearing screams. At this point TM told his parents that he was going to "stab her and kill her". Eystna Blunnie told officers that she had been in a relationship with TM from May to December in 2011, but had since split up. They had met on 8 April 2012 as arranged to discuss their relationship and the baby, though TM did not believe that the baby was his. Eystna Blunnie was seven months pregnant at this time.

9.1.8; The injuries from this attack were described as relatively minor, and consisted of a scratch and reddening to her neck and bruising with reddening to her nose. Eystna Blunnie reported that she thought he was going to kill her, as he had threatened to kill her previously and had also attempted to choke her on a previous occasion.

9.1.9; Checks were made on the domestic history of both Eystna Blunnie and TM, and once TM was identified as a previous perpetrator of domestic abuse, police officers were sent to his home address where he was arrested for assault causing actual bodily harm.

9.1.10; Eystna Blunnie stated that was going back to her parents' house, but this was to be a temporary measure as they had "fallen out" the previous year, over her relationship with TM.

9.1.11; TM gave a different account to what had happened when he was in custody. He said that Eystna Blunnie had contacted him saying that she was homeless. He had met up with her and taken her belongings back to his parents' house, but once there she had become argumentative. They had several arguments during the course of the evening and into the early hours of the morning when she was shouting very loudly at him. According to TM this is when his parents had come into the room to find them both sitting on the floor. TM stated that Eystna Blunnie had stayed at the house until 2pm the next day and then left without speaking to him. TM's mother stated that she had checked Eystna Blunnie over following the argument and there were no injuries. All of TM's family supported his account of what had occurred and his mother made a written statement to that effect. TM's brother informed the police that he had heard Eystna Blunnie telling TM "if you leave me I will get you nicked" .

9.1.12; A referral was made to the CPS, but internal lawyers decided that as there was insufficient evidence to secure a conviction and therefore no further action was made. Officers completed another DV/1 and this time the risk was reassessed and increased to high.

9.1.13; Notes report that officers made several attempts to obtain accommodation for Eystna Blunnie at refuges and other suitable premises but these were declined as were the offers of transport to take her to the new accommodation. Eystna Blunnie stated that she was afraid of TM but she didn't want to leave the local area as she had friends there.

9.1.14; The incident and subject were referred to the next MARAC meeting. Eystna Blunnie was informed of the MARAC process and of the referral, but police notes suggest that the only thing she wanted from the system was permanent accommodation.

9.1.15; At the MARAC meeting on 8 May 2012 the incident between Eystna Blunnie and TM was discussed and minuted. TM was risk assessed as high following his previous

domestic abuse incidents and prosecutions, which had involved previous partners. However there was no formal record of these logged.
9.1.16; Within the maternity section of the MARAC notes, the incident which took place on 28 March 2012 within the PAH maternity dept., was recorded. Eystna Blunnie had attended with stomach pains, and TM had gone with her. TM appeared drunk and possibly under the influence of drugs.
9.1.17; Maternity staff were concerned enough to refer the matter to Social Care on April 25th, but as there was no evidence of physical violence the matter was not referred to the police. Later notes also highlight the concerns of the maternity staff regarding Eystna Blunnie's safety, as "she is still going back to the perpetrator"
9.1.18; There was an incident involving TM on 13 June 2012, where it is alleged that TM was attacked by another male who hit him over the head with a bottle. This incident was reported by a third party and following this the police made contact with TM, who was totally uncooperative. This lead the police to note that this was potentially a non-event reported by TM himself as an attention seeking exercise which he had been known to do before. Police do not think that this incident had anything to do with TM's situation with Eystna Blunnie.
9.1.19; The final record logs the incident of 27 June 2012, which was the incident that lead to Eystna Blunnie's murder. Eystna Blunnie died of massive head injuries sustained from a serious assault, after having gone out in the early hours of the morning to meet TM. Her unborn child also failed to survive.
9.1.20; TM was arrested and though he denied any involvement, further enquiries revealed that he had admitted the offences to his family. TM was subsequently charged with murder and child destruction.

9.2; Analysis of internal procedures and good practice;

9.2.1; Essex Police updated their Domestic Abuse policy and all associated procedures following two domestic homicides in 2011.
9.2.2; Currently they deal with circa 32,000 incidents of reported domestic abuse incidents every year, approximately 88 per day. These figures have increased from 10,000 a year five years ago.
9.2.3; The change of internal policy initiated a Domestic Abuse Intelligence Team within the Force Control Room. Once a domestic abuse incident has been reported, officers within this team are responsible for researching police databases to update attending officers regarding past or on-going calls to the relevant address or involving known persons.
9.2.4; In 2012, a Central Referral Unit for domestic abuse incident reporting was established. This was to provide one central point of contact, and to ensure accurate recording, grading and research into domestic abuse
9.2.5; Information regarding domestic abuse incidents from the DV/1 forms are logged promptly onto the internal database. The form DV/1 is completed when a victim advises police that they are being stalked, harassed or threatened.
9.2.6; All police officers and contact staff undertake DASH training.
9.2.7; Police use three categories of risk assessment, **Standard, Medium or High.**
Standard-Indications based on the evidence available at the time, do not indicate the likelihood of the perpetrator causing serious harm. These cases are handled by the

Central Referral Unit, who ensures that all details are accurately recorded. Standard risk cases are updated every six days and reviewed every fourteen days.
Medium- A Domestic Abuse Safeguarding Officer (DASO) will make any necessary referrals to partner agencies, and sends a letter to victims offering them support. At times this could also include a phone call to the victim. Medium risk cases are updated every four days and reviewed every seven days.
High-A high risk case is referred to the relevant Domestic Abuse Safeguarding Team (DAST) office for case management. The victim is contacted by phone and if there is no contact made, officers will be dispatched to the address to check on the victim's welfare. High risk cases are updated every twenty four hours and are reviewed every forty eight hours.

9.3; Issues for further consideration;

9.3.1; There appears to be inconsistency in the risk assessment processes, that were applied to TM and his offences during the course if this review.
9.3.2; One example was following the incident on 17 November 2011, when TM made a 999 call to police at 6am. Eystna Blunnie was said to be blocking his entry to the home. Police attended within ten minutes and eventually Eystna Blunnie was transported to the police station in order to diffuse the situation and to allow Eystna Blunnie to sort out alternative accommodation. TM was noted on previous police records as being "high risk" and of being a "very high risk perpetrator" due to alcohol and violence. Even though TM was noted as being in a drunken condition at 6am this incident was classed as standard.
9.3.3; Essex Police notifications highlight the risk to the victim but not to the child or unborn child, and this does not give any other agency the full risk potential.

10; Crown Prosecution Service (CPS) Essex

10.1; An IMR was requested from the CPS at the beginning of May 2013, when the DHR panel decided that there was a need for further examination into the decision not to prosecute TM following the assault on Eystna Blunnie in April 2012.
10.2; After much chasing and follow up, what was received in Sept 2013 was in the format of a chronology rather than a full IMR, but as it included information on the April 2012 decision, as well as subsequent policy and practice changes, the Chair of the panel decided to accept the submission in order to avoid any further delay in the overall review process.
10.3; The chronology states that that TM has two "incidents" recorded on file between 2004-2006, and both involve Essex Police. These offences were dealt with by means of a police caution and reprimand. The earliest that the CPS was involved with TM in terms of a court prosecution was 2007.
10.4; The first prosecution was in Oct 2007 when TM was charged with common assault by battery, on his then partner. This charge and outcome is covered in more depth within the Essex Police and Essex Probation IMR.
10.5; A second prosecution took place in August 2008 at Chelmsford Crown Court when again TM was convicted of common assault and possession of a pointed blade. This is covered in more depth within the Essex Police and Essex Probation IMR.

10.6; There was a final prosecution before 2012, which involved TM causing criminal damage and once again using threatening behaviour to an intimate partner.
10.7; There was an incident reported to police in Dec 2011, alleging that TM had grabbed Eystna Blunnie by the arms causing reddening, but there was no further action taken and the case was not referred to the CPS. Essex Police have a statement from Eystna Blunnie on file, stating that "I do not believe I'm a victim of crime and do not support a prosecution in this matter. I do not want TM arrested and will not attend court."
10.8; Regarding the incident in April 2012, where TM assaulted Eystna Blunnie by squeezing her throat until she could not breathe, and issuing threats that he would "kill her", a request for charging advice was made to the CPS by Essex Police on 9 April 2012. TM was arrested and in police custody when the file was passed over to the CPS for further action, on 11 April.
10.9; A decision not to prosecute TM was made by the CPS citing insufficient evidence to meet the evidential standard required in accordance with the Code for Crown Prosecutors. This decision has now been recognised by the CPS as being the wrong decision.

10.2; Analysis of internal procedures and good practice;

10.2.1; Given that the submission from the CPS has taken the form of a chronology, there is no analysis of internal procedures or statement as to whether those procedures were followed.
10.2.2; Given the above there is no means of analysing or highlighting good practice or challenging the robustness of internal mechanisms for dealing with adult safeguarding issues or specifically domestic abuse.

10.3; Issues for further consideration;

10.3.1; The CPS report does highlight what has occurred to date, following the order to review the decision made not to prosecute TM, following the April 2012 incident. The review order was made by the judge at Eystna Blunnie's murder trial.
10.3.2; The chronology makes reference to the fact that whilst the prosecution assessment was underway, additional enquiries were being requested by the CPS to Essex Police. However police responses were sent to a different lawyer, something which highlights internal inconsistencies in the interpretation of the evidential standard required.

11. Summary of responses to the specific Terms of Reference;

11.1; Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
11.1.1; All agencies responded that they were sensitive to the needs of both the victim and the perpetrator. However this ambition can only be delivered when agencies have

access to the bigger picture and all of the relevant information, and this was not the case within this review.
11.1.2; Whilst all agencies referred to adult safeguarding training, there was a huge variation in the time given and the depth of the training undertaken. Primary health in particular, had a very different approach to adult safeguarding when compared to children's safeguarding. In these examples there was no indication that even if a domestic abuse situation was identified, health practitioners and front line staff would be confident as to what to do next, or where to refer. It is not enough to have a named person who has undertaken adult safeguarding training, when a majority of front line staff have none, and if there is no internal mechanism for the cascading of the training or for information sharing.
11.1.3; Whilst it would not be appropriate for all staff to be trained to DASH level, the whole topic of adult safeguarding, with an integral specific reference to domestic abuse, needs to be communicated in a pro-active way within all organizations.
11.1.4; Insensitivity was highlighted by the family of Eystna Blunnie in relation to her housing requirements and assessments. It was stated that the majority of interactions with Eystna Blunnie were conducted via phone calls and messages (this is not substantiated within the HC Housing dept. IMR). The question was raised as to whether face to face contact enabled a better approach to a vulnerable person, particularly in a case where domestic abuse has been identified.
11.1.5; There is no reference to the level of training or understanding of domestic abuse situations by the CPS.

11.2; Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/ perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim, or perpetrator, subject to a MARAC?
11.2.1; All agencies made reference to having policies and procedures for adult safeguarding, though not all related specifically to domestic abuse. Not all agencies had staff trained to the appropriate level to be confident in dealing with an adult safeguarding or to a domestic abuse situation. Policies need to be reviewed and updated on a regular basis to reflect best practice regarding training and information share, particularly where there is multi agency involvement.
11.2.2; It is not clear as to whether agencies regularly undertook their own risk assessments once a domestic abuse situation was identified. All information given within the IMRs seemed to point to an acceptance of the police classification of risk. Again it is unclear as to whether there is any environment where agencies, other than the police, discuss and/or challenge the risk classification given and adopt a different approach for their own internal purposes.
11.2.3; Risks are classified around the perpetrator and victim, but do not refer to any children within a household or to an unborn child.

11.2.4; TM was subject to MARAC in the past, and the incident in April 2012 was referred to the relevant MARAC meeting. However the outcome of this meeting and any agreed actions are less clear and not included within the minutes of the meeting.
11.2.5; Information re TM was held by the MAPPA coordinator but this was not always accessible because of incompatible IT systems. Reference to MAPPA information and/or the coordinator needs to be programmed into investigations as an automatic line of enquiry, especially when concerns regarding adult or child safety are raised.

11.3; Did the agency comply with domestic abuse protocols agreed with other agencies, including any information-sharing protocols?
11.3.1; As previously stated, all agencies received the DV/1 notifications from the police and took part in the MARAC meetings, with the exception of primary care who are not currently included in the MARAC process.
11.3.2; The police information was accepted and treated as a reliable source, with most agencies flagging the information as appropriate within their own systems. There is no evidence of individual agencies discussing the information disclosed within the DV/1 within their internal meetings, or adopting an agency specific approach to the issues raised by re-classifying the degree of risk from their own organisational perspective.

11.4; What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
11.4.1; The key points within this case could be perceived to be different for individual agencies, though most would refer to the two major incidents of domestic abuse where Eystna Blunnie was the victim. Following these incidents and the escalation of the police risk assessment from standard to medium and eventually to high/very high, there is some evidence of a different approach to Eystna Blunnie, within housing for example where her allocation of points was increased to reflect the urgency of the situation.
11.4.2; However knowing that there is a strong evidence base which highlights an escalation of violence during pregnancy within an already abusive relationship, it is not unreasonable to expect that this would be a trigger point for a further risk assessment, particularly in this case when Eystna Blunnie disclosed that she was pregnant.
11.4.3; A further trigger point with regard to TM, was when the health and social care agencies made the connection between the “toxic trio” of alcohol, drugs and mental ill health in relation to TM’s violence and aggressive behaviour. However having noted the connection there is no evidence of a more pro-active approach to TM’s health or care management.
11.4.4; The CPS have acknowledged formally that their decision not to prosecute TM in April 2012 was wrong, and that he should have gone to court for both assault charges and also for a possible restraining order to keep him away from Eystna Blunnie.

11.5; Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered, or provided, or relevant enquiries made in the light of the assessments, given what was known or should have been known at the time?

11.5.1; Agencies responded to the risks identified as appropriate to the specifics of their individual policies. Therefore the fact that many of the policies were not robust enough to deal specifically with a domestic abuse situation should be factored into each of the individual responses. In the absence of one lead agency co-ordinating or overseeing the responses, it is difficult to have anything other than different expectations
11.5.2; Maternity services were alert to the presenting issues and had policies for escalation, but these were not followed up, and there was no prescribed review process to ensure all routes of enquiry were concluded appropriately.
11.5.3; There are examples of Eystna Blunnie being offered access to safer accommodation and support services, but these were declined. Explanations were given for the refusals and these are covered within the summary and the resume of the discussions with Eystna Blunnie's parents.
11.5.4; It was noted within the police IMR that Eystna Blunnie would not cooperate with them in terms of supporting a prosecution of TM after the first incident where she was the victim.
11.5.5; TM was offered a great number of routes and opportunities to access support services, but these were all made leaving TM to take the initiative. This continued throughout the time period under review, whilst it was known that TM was leading a chaotic lifestyle and had multiple substance dependencies, and mental ill health.

11.6; When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of the options/choices to make informed decisions? Were they signposted to other agencies?
11.6.1; There are clear reports of Eystna Blunnie being given advice and information regarding the choices she had to get away from TM, and also to access support services for victims of domestic abuse. These were declined, but this is covered more within the summary and recommendations.
11.6.2; TM was offered numerous referrals to alcohol and drug advisory services, which he did not take up. TM stated that he did not want to give up drink altogether, just to reduce consumption to weekends only. He was offered support within mental health services, and offered additional therapeutic services via external agencies, all of which were declined or not attended when direct referrals were made.

11.7; Was anything known about the perpetrator? For example, were they being managed under MAPPA?
11.7.1; TM was discussed at a meeting under the MAPPA arrangements in July 2009 when he was released from prison. As there were no on-going supervision arrangements, it was decided that there were no other suitable management arrangements available.
11.7.2; TM was again discussed at a MARAC meeting, following the incident in April 2012 but the outcome of that meeting is unclear. There was a note within the minutes that there was a need to check the referral from the maternity dept., with the result noting that Eystna Blunnie's unborn child was referred to CSC on Wed 25 April 2012.

11.8; Had the victim disclosed to anyone and if so, was the response appropriate?

11.8.1; Eystna Blunnie was given every possible opportunity to disclose domestic abuse to the midwives during the numerous ante-natal appointments whilst she was pregnant, but declined to do so. She stated at each time of questioning that she was safe at home.

11.8.2; However Eystna Blunnie did report the assaults to the police after the two separate incidents. After the first incident she refused to cooperate with the police, and after the second incident, the CPS decided that there was not enough independent evidence to secure a conviction. A decision which they have now conceded was wrong.

11.8.3; Eystna Blunnie disclosed to housing services that she was a victim of domestic abuse, and her status on the housing register was upgraded accordingly. An offer of temporary accommodation and a "safe" property in Cambridge was turned down. Housing services record that support services were offered but it is unclear what the offers and advice consisted of.

11.9; Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?

11.9.1; There were no issues noted regarding the ethnic, cultural, linguistic or religious identity of Eystna Blunnie and TM, or their respective families. There were no disabilities noted, but both Eystna Blunnie and TM were recorded as vulnerable at different times. Eystna Blunnie was classified as vulnerable because she was in an abusive relationship, pregnant and at times homeless, and TM was recorded as vulnerable due to his self-harm and alcohol abuse.

11.9.2; Both Eystna Blunnie and TM were classified as "White British" and both came from families where there were 2 parents who lived together. Both Eystna Blunnie and TM had siblings. Eystna Blunnie had been living at home with her parents until her relationship with TM, when she moved into TM's home, together with TM's parents and his brother.

11.10; Were senior managers or other agencies and professionals involved at the appropriate points?

11.10.1; All agencies reported that this case was escalated to the appropriate level of management, who each had oversight of their own internal processes. However the CPS did not address this issue in their report.

11.11; Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

11.11.1; This is not the only domestic homicide to be reviewed in this area. There are no connections identified between the cases.

11.11.2; Lessons from each case and recommendations are collated and fall within the responsibility of the local Domestic Abuse Forum. There are common issues and recommendations within each of the cases reviewed.

11.11.3; Essex has formed its own DHR panel involving the Chairs and support officers within the CSPs. This panel has reviewed issues and challenges, as well as good practice within all of the Essex DHRs.
11.11.4; The local review panel meetings were very open and frank in their discussions and offered representatives the opportunity to raise issues of concern, and to explore other lines of enquiry. There was one request for further information and following this discussion a request was sent to the CPS. The panel were also able to review the national Home Office summary of lessons learned and common themes emerging from recent DHRs.

11.12; Are there ways of working effectively that could be passed on to other organisations or individuals?
11.12.1; In terms of effective working, there is the very real challenge of inter-agency communication and information share. This will be covered within the recommendations.
11.12.2; All agencies have their own ways of working and organisational "norms", but unfortunately they are all quite different. IT systems within the same agency are sometimes incompatible and this adds further to the challenge of key workers having access to the bigger picture in order to make informed choices about any timely referral or intervention.

11.13; Are there lessons to be learned from this case relating to the way in which agencies work to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
11.13.1; Lessons to be learned from the review will be covered within the recommendations.

11.14; How accessible were the services for the victim and perpetrator?
11.14.1; Accessibility of services does not appear to have been a problem within this case. At the opposite end of the spectrum, the challenge was to get TM, and to a lesser extent Eystna Blunnie, to engage with services, and to attend pre-arranged meetings and consultations.

11.15; To what degree could the homicide have been accurately predicted and prevented?
11.15.1; Given all the information provided, and once it has been considered in its entirety, there appears to be every likelihood that the abuse would have continued whilst TM and Eystna Blunnie were in contact, as patterns of abusive behaviour had already been clearly established. However in taking all of the submissions into account, there is no evidence based way that the homicide itself could have been accurately predicted, though threats to kill had been made previously.
11.15.2; However given TM's previous record of domestic abuse with intimate partners, and the known researched evidence regarding the likely escalation of violence within

pregnancy. Therefore a more collaborative inter agency approach could have enabled practitioners to review the circumstances of this case and have a clearer picture of the overall risk to Eystna Blunnie as the clearly identified victim of TM's aggression and violent behaviour.
11.15.3; The decision not to prosecute TM in April 2012 did not send out the correct message to TM regarding his threats to kill Eystna Blunnie especially given his previous violent record with intimate partners. There is no evidence that a restraining order would have been made, or indeed that it would have been adhered to, but the message would have been much clearer to all agencies (including the police) about what would have happened if the order was breeched. However if TM had been remanded in custody there could have been a completely different outcome.

11.16; What action was taken by Children's Social Care following the report of the incident in the Maternity Ward at Princess Alexandra Hospital?
11.16.1; How the referral to CSC from the PAH maternity ward was followed up is covered within the CSC analysis of involvement.

11.17; How were TM's mental health issues communicated between his GP and the Community Mental Health team?
11.17.1; The issue of inter-agency communication is of concern across the whole review. If GP's within primary care are expected to be the custodians of all health information it is imperative that they receive accurate and timely information about the referrals that have been made and any non-attendances in order that the planned interventions can be reviewed in a pro-active way.

11.18; Following the incident on 10 April 2012, why did the Crown Prosecution Service take no further action?
11.18.1; The account of why there was no prosecution of TM following the incident with Eystna Blunnie in April 2012 is recorded within the review of the Essex Police involvement, and also partially covered within the CPS report.
11.18.2; A separate IMR was requested from the CPS at the beginning of May 2013, and a chronology of involvement was received in September 2013. The report also records that the decision not to prosecute TM in April 2012 was wrong.

12; Final Summary;
12.1; TM was known to many statutory agencies for a number of years. Each acknowledged that he had an on-going dependency with alcohol, abused drugs, and suffered mental ill health as a result of both. His violent rages and abusive behaviour were also attributed to alcohol addiction, but TM made it very clear that he had no desire to stop completely, just to cut his drinking down to weekends
12.2; There were several organisational responses to the issues which manifested themselves as a result of the alcohol dependency. It was noted that TM was likely to self-harm and have uncontrollable fits of rage. However TM himself stated clearly on several occasions that he was fearful that he would harm someone as a result of these rages, especially his own family.

12.3; Violence was playing an increasing role in TM's life by the time he started a relationship with Eystna Blunnie, and he had already established a pattern of abusive behaviour with intimate partners, and acquired a criminal record as a result of it.
12.4; Given TM's previous history, it is not surprising that it did not take too long for him to repeat his violent and controlling behaviour towards Eystna Blunnie. Their relationship was shaped by erratic and violent outbursts, which at times involved police intervention. Eystna Blunnie stated at the maternity department that she "did not like him (TM) when he was drunk".
12.5; Once the first violent incident against Eystna Blunnie was recorded, and it was noted shortly afterwards that she was pregnant, evidence suggests that it would be difficult to expect anything other than a further deterioration of the relationship, particularly as he regularly disputed paternity. Again the midwives comment to CSC that "we must do something" in relation to the on-going danger that Eystna Blunnie was placing herself (and her unborn child) in by remaining in contact with TM, is testimony to the fact that several organisations were concerned, but there was no coordinated or shared interventions made.
12.6; There are many references within the IMRs to a desire to "do something", but all result in aborted actions which are attributed to a lack of "physical" evidence. This is presumed to mean no evidence of violence or actual assault. However domestic abuse research recognises that controlling and coercive behaviour and counter allegations/accusations are part of the "suite" of perpetrator behaviours. It is further recognised that denial is also a common response by a victim who is in a violent and controlling relationship.
12.7; Adult safeguarding training and awareness is very much the poor relation in comparison to children's safeguarding, even though statistically there are more "significant events" involving adults. Whilst children's safeguarding is mandatory, adult safeguarding is discretionary, and the individual agency approach to the adult agenda is quite disparate and largely unregulated. This is particularly apparent within primary care, where more and better training is an essential component of raising the profile of domestic abuse. This could offer much better response options to victims or potential victims.
12.8; Inter agency communication and information sharing is still not flexible or responsive enough to afford any agency a better overview of a damaging or abusive relationship. Therefore, every agency, whilst expressing determination to make a positive impact on Eystna Blunnie's situation, only had a limited view of what was actually happening. IT systems that are incompatible do not help to encourage information sharing, and the Data Protection Act is frequently used as an inhibitor to what is an essential component of a shared agenda.
12.9; A simple toolkit of appropriate questions for agencies to use in face to face situations would assist in the approach to a domestic abuse situation and would ensure some consistency of approach. This would benefit a primary care setting in particular but could be of use to all front line practitioners.

13; Involvement with the family of Eystna Blunnie

13.1; During the course of the review the panel Chair had the opportunity to meet and interview Eystna Blunnie's family and to discuss their issues and concerns regarding the review process, and to ascertain their thoughts on how the process could be improved. The family are being advised and supported by AAFDA (Advocacy After Fatal Domestic Abuse) and a representative of the organisation was present during the interview.
The following summarises the questions which formed the basis of the discussion;

1. **Tell me about Eystna.**
2. **What would you like us to know about her life?**
3. **What would you like us to know about the relationship between Eystna and the perpetrator?**
4. **Were there any good times in their relationship?**
5. **Do you know who Eystna turned to for help, if anyone, when she had suffered abuse?**
6. **Did Eystna try to talk to you or anyone else about the abuse she suffered?**
7. **Were you aware of the abuse? When/how did you become aware?**
8. **What kind of support might have been helpful to Eystna in order to stay safe?**
9. **Is there anything else you would like us to know about Eystna's life?**
10. **What message would you give to other families who are experiencing violence?**
11. **How would you like Eystna to be remembered?**

13.2 The family were concerned to ensure that their own experiences were used to help others, and where possible, to prevent anyone else having to go through their nightmare.
13.3; They remembered Eystna as a happy bubbly girl who was always willing to help others particularly when she was younger. She had lots of friends and was a homely girl, who liked to look nice and was careful about her appearance.
13.4; Eystna changed after she met TM and her parents were upset at the changes, none of which were for the better.
13.5; When she was living with TM and his family she was difficult to get in touch with, would not communicate, and became indifferent about her appearance. The family were also concerned about the type of company she was mixing with as TM had some "unsavoury" friends. They were aware of the alcohol and drug issues TM had and whilst being sure that Eystna would not go down that route, they knew that drink and drugs were an everyday part of TM's life.
13.6; The family have a number of concerns, some of which fall within the scope of this review and some do not. The concerns raised that do not form part of the main review have been included as simple but effective pointers to making the treatment of abused women more effective.
13.7; *For example a request to the local job centre to change a "signing on" time in order that Eystna didn't come face to face with TM or his friends was declined for no reason other than, "it couldn't be done".

13.8; *Mrs B also stated that Eystna did not see the same midwife twice, and therefore it is difficult to establish a relationship or trust when there is no continuity of care.
*These statements are not verified with the individual agencies named. It should be further noted that the DWP were not part of this review process.
13.9; Their major concern was that Eystna's unborn child, (who was given the names Rose Louise Blunnie) appears to have been "airbrushed" out of the review process. As baby Rose Louise was not born, there was no birth certificate issued, and as she was not stillborn, there was no stillbirth certificate issued. However TM was charged with child destruction, thus acknowledging within the criminal justice system at least, that there was a child involved in these tragic events as well as the murder of their daughter.
13.10; The family had the opportunity to express their wishes regarding the way their daughter and her baby, should be remembered. Their wish was that the final report should not be anonymised, and should make reference to Eystna and baby Rose Louise by name. They also expressed the wish that their daughter should be remembered as the person she was and not the person she had become under the influence and control of TM.
13.11; Any homicide is devastating for the family of the victim, but in this case Eystna's family lost two family members in horrific circumstances, something that will take a very long time, if ever, to come to terms with.
13;12; The DHR panel Chair is aware that the Chief Crown Prosecution Officer has visited the family on 2 occasions. The first visit was to acknowledge that the decision not to prosecute TM in April 2012 was deemed to be wrong following her review of the process. The subsequent visit was to inform them of the steps the CPS have taken to improve internal practices and procedures. These specific improvements have been implemented in order that internal decision making regarding domestic abuse incidents can be more victim aware, and open to external scrutiny by specially established panels.

14; Second interview with the family of Eystna Blunnie

14.1; The Chair of the DHR panel was able to meet with the family of Eystna Blunnie a second time following the completion of the Overview Report. The same representative from AAFDA was present to offer advocacy and support to the family.
14.2; Whilst the family were in general agreement with the content of the report they were keen to qualify some of the statements and to add a different viewpoint as to how some events had been recorded.
14.3; Eystna Blunnie's parents stated that for the first six months that she went to live with TM they had no contact with her at all and had to use friends and acquaintances to find out where she was living. When Eystna Blunnie's mother finally found out she was living with TM in his parent's home she went to visit and couldn't believe the change in Eystna's appearance. Eystna had lost a lot of weight (dropping several dress sizes) had sores on her face and was very nervous. TM was shouting for Eystna "to get rid of her" referring to Eystna Blunnie's mother and the general impression was that she was completely under his control. When Eystna Blunnie eventually resumed a relationship with her parents she confided that she had not been "allowed" to have contact with them, and had to abide by lots of "rules". She was not allowed to have a bath, nor to flush the toilet at night whilst living with TM in his parent's house. She also had needed

to arrange for her benefit payment to be paid directly into TM's bank account. They were amazed that no other agency had picked up on the changes in Eystna Blunnie and been alerted to the fact that things weren't right.
14.4; Eystna Blunnie's parents disputed the account of Eystna's interaction with the HDC Housing Services and stated that many attempts to make contact with her allocated case worker were unsuccessful and this was during "normal" office hours. They produced a copy of a letter that had been sent to the local MP in response to his enquiry as to Eystna's housing status, which stated quite clearly that Eystna Blunnie was housed in temporary accommodation, and this had never been the case. They were concerned that the statements relating to offers of temporary housing or a safe house which were recorded as declined did not reflect a true account of what actually happened. An offer of temporary accommodation was refused due to the hostel housing some of TM's "dubious" friends. The offer of the safe house in the Cambridge area was stated as being available within a 2 hour "window" meaning that Eystna Blunnie would have had to present to the address within 2 hours. With no money and no transport this was an impossible task. In addition Eystna Blunnie was required to attend an important ante-natal appointment the next day, which was linked to calming a midwife concern re her unborn child.
14.5; They corrected the statement that the CPS had been to visit them, which had been stated within the CPS report, and confirmed that they had been invited to the CPS offices in Chelmsford on 2 occasions, but they had to make their own way there.
They also requested the addition of 2 additional recommendations before the report was submitted to the Home Office. These relate to a formal acknowledgement regarding the status of Eystna Blunnie's unborn child, and the inability of a government agency to respond to a request for a change in an appointment time to avoid a confrontation with a domestic abuse perpetrator. These recommendations are recorded in 13.10.4 and 13.10.5.

15; Recommendations;

15.1; Primary Care Health; to include Nuffield House, and the Hamilton Practice

15.1.1; General Practice should be included in the MARAC process, and elect their own representative who can cascade relevant information to all the practices.

15.1.2; All practices should have a named person for adult safeguarding, and clear polices for escalation of concerns.

15.1.3; Adult safeguarding needs to be given the same priority as children's safeguarding, with all staff undertaking
this training as mandatory. The training needs to extend through the practices to front line and administrative staff.

15.1.4; Individual practices should be encouraged to develop policies that make all staff aware of the issues of domestic abuse

15.1.5; The West Essex Clinical Commissioning Group (CCG) in its safeguarding role, should develop a simple to use toolkit which will enable clinicians and practice staff to ask four or five pertinent questions regarding domestic abuse, and be confident about the pathway for referral if there are concerns.

15.1.6; The WECCG should also develop specific training for GPs regarding domestic abuse, and this training should be repeated on a regular basis.

15.2; Health, PAH;
15.2.1; The PAH adult safeguarding policy should be ratified and implemented immediately.
15.2.2; PAH in partnership with Safer Places, should develop a robust business case for the expansion of The Daisy Project into A&E, and implement as soon as funding can be secured to make it sustainable.
15.2.3; There should be a named adult safeguarding person available at all times, particularly if and when the Daisy Project is extended to A&E.
15.2.4; Adult safeguarding training should continue to be delivered to all personnel as part of the induction process.
15.2.5; Where there are concerns raised, every effort should be made for the patient to have continuity of care and be seen by the same midwife.
15.2.6; Where a referral to CSC or any other agency is made there should be a more formal process for reporting back to the referring agency, thus ensuring appropriate follow up procedures are implemented.

15.3; Health, NEPFT;
15.3.1; Timely information regarding a patient's urgent referral and non-attendance should be communicated back to the referring GP and a pro-active approach to follow up taken.
15.3.2; NEPFT must refer to any information pertinent to MARAC or to a MAPPA co-ordinator involvement, when undertaking patient assessments.
15.3.3; All front line staff should be trained in adult safeguarding, with a specific component covering domestic abuse and/or DASH.
15.3.4; Carers and family members should be included in the assessment process, and have their own separate assessment; especially if like TM's family, they have highlighted that they are living in fear.
15.3.5; Where there is proven evidence or research regarding the likely outcome of an abusive relationship, the trust should develop a clear escalation policy which alerts other statutory services or providers using an information sharing protocol
15.3.6; Children and/or an unborn child identified within an abusive relationship should be flagged as routine, and this process should initiate a referral to CSC.

15.4; Essex County Council-Adult Services
There are no recommendations within this section of the review.

15.5; Essex County Council-Children's Social Care
15.5.1; All investigations should include a check with the MAPPA Coordinator as routine.
15.5.2; Where there is a "toxic trio" of drug abuse, alcohol abuse and mental ill health identified within a referral or subsequent investigation, the information should be flagged on all of the separate IT systems.

15.5.3; All aspects of domestic abuse behaviour should be factored into an evaluation of referral or risk regarding someone who has been identified as a cause for concern. It is too narrow and potentially dangerous to only look for evidence of physical violence, when other behaviours and their associated risks are well researched and documented. There also needs to be more acknowledgements of any risks to an unborn child.

15.6; HDC-Housing Department

15.6.1; The Housing Dept. should continue with face to face interviews with clients presenting themselves as "at risk" whenever possible. However it is noted that there is a telephone response service for all out of hours contact and this does not allow a more personalised approach to anyone presenting as homeless. This is not about the creation of a more efficient service, but would present a more compassionate and responsive service to vulnerable or abused clients.

15.7; Essex Probation;

15.7.1; Internal processes with Essex Probation should be able to flag an alert when an offender with a history of violence and domestic abuse discloses that they have started or are in a new relationship.

15.7.2; When an offender (who has been convicted of domestic abuse or violence) is released from the sentence early and on license, there must be appropriate conditions placed on the terms of the release. These should be related to the original offence and must include the requirement to stay away from previous victims as a minimum.

15.8; Essex Police

15.8.1; Essex Police should amend their approach to risk classification once there is a record of previous incidents of domestic abuse on file. This might include, but not be restricted to, issues of alcohol and or drug abuse.

15.8.2; Where possible information recorded on the DV/1 form should indicate any children or an unborn child who may be at risk together with the victim.

15.8.3; Agencies have requested information about previous incidents of domestic abuse to be included on the DV/1 form, however it is unclear whether this would comply with the law regarding the disclosure of spent convictions. More reference should be made to "the 7 golden rules for information sharing" which have been published by HM Government.

15.9; CPS

15.9.1; The CPS should put a "victims right to review" policy in situ. This would operate when a decision has been taken **not** to authorise a criminal prosecution in a domestic abuse case.

15.9.2; "Violence against women" panels must be set up to review domestic abuse cases which have proceeded into the criminal justice system but have failed to secure a conviction. These panels should make referrals into an Area Casework Committee when they feel a review is required. This committee can then issue appropriate guidance to the lawyers who handle domestic abuse cases.

15.9.3; A victims and witness committee should be set up to operate under the Essex Criminal Justice Board. This needs to be set up as a multi-disciplinary group and can

review any shortcomings and recommendations made by the other panels or committees.

15.10; All Agencies
15.10.1; To raise the value and importance of adult safeguarding training and awareness to that of children's safeguarding, and to ensure that domestic abuse features appropriately within the training.
15.10.2; To develop appropriate information sharing protocols that can override the barriers caused by separate IT systems, and the laws regarding data protection.
15.10.3; All agencies should familiarise themselves with the "7 golden rules of information sharing" as published by HM Government.
15.10.4; Consideration should be given to the status of an unborn child who is delivered within a homicide situation. As Eystna Blunnie's baby was not born there was no birth certificate, and as she was not recorded as a stillbirth there was no certificate to state that either. However the judicial system recognised that there was a child death involved in TM's actions and he was charged with child destruction as well as Eystna Blunnie's murder.
15.10.5; Where a victim of domestic abuse is likely to come across their perpetrator and/or their known associates within a statutory setting, a request to change an appointment time should never be dismissed as "not allowed" or impossible to do. All government agencies have a duty to respond appropriately if domestic abuse concerns are raised.

16; Conclusions

16.1; Crime statistics from 2009/2010 show that domestic abuse accounted for 14% of all reported violent incidents nationally, and that women were the victims in 77% of all cases. It is also recorded that domestic abuse has the highest rate of repeat victimisation of any serious crime with 47% experiencing more than one incident, and 30% more than three.
16.2; This review has examined the relationship between Eystna Blunnie and TM leading up to her death, and the multi-agency responses to the escalating violence perpetuated by TM towards Eystna Blunnie. This was particularly evident during the time when Eystna Blunnie was pregnant.
16.3; The review highlights that developments are required across the breadth of service planning, as well as within organisational governance and integrated IT systems. In addition these developments will need to address workforce issues and training, in order to make a more co-ordinated and responsive service for vulnerable and abused victims.
16.4; It is usual to make reference to a coroner's report within a DHR, but on this occasion an inquest has been opened and adjourned immediately. To date the inquest has not been resumed.
16.5; It is difficult to assess or predict what might have happened, or what outcome a different decision by the CPS would have made, regarding the violent assault in April 2012. Whilst the courts could have issued a restraining order to keep TM away from Eystna Blunnie, there is no guarantee that he would have adhered to it, and also no

guarantee that Eystna Blunnie would have conformed to the requirements of the order and stayed away from TM. However an intended prosecution and a remand in custody would have removed TM from the community and kept him away from Eystna Blunnie which could have altered the situation completely. As Eystna Blunnie was almost at the point of giving birth, emotionally she was even more susceptible to the direct and indirect control that TM exerted over her and a restraining order or a remand in custody might just have given her additional protection for the final few weeks and days of her pregnancy.

16.6; The whole issue of domestic abuse has been rising up the community safety agenda in the last few years, and some agencies, in particular Essex Police, have organised their internal structures and response capabilities to reflect the priority given to the provision of a much better and more responsive service for abused victims. However there remains a level of tolerance within society in general regarding the abuse of an intimate partner, which is not afforded to any other violent crime. Training, awareness raising, and information sharing must continue across the breadth of statutory and voluntary agencies to ensure that these attitudes are challenged and eradicated.

16.7; In acknowledging the many recommendations within this report, it is envisaged that the Harlow Domestic Abuse Forum will be pro-active in driving them forward, and in further negotiating some of the more detailed inter agency requirements in order to ensure that local domestic abuse services are as client centred, effective and responsive as they can be.

APPENDIX 1

TERMS OF REFERENCE, MARCH 2012

INTRODUCTION – decision to hold a review and timescales

This Domestic Homicide Review (DHR) is initiated by the Safer Harlow Partnership (the Community Safety Partnership for Harlow), in response to the death of Eystna Blunnie on 27 June 2012, and is being undertaken in accordance with the requirements of the Domestic Violence, Crime and Victims Act (2004).

The Review will be undertaken following the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Review issued by the Home Office in March 2011.

On 27 June 2012 Essex Police notified the Chair of the Partnership Performance Executive of the Safer Harlow Partnership of the death of Eystna Blunnie. The circumstances of the death fit the Home Office criteria for the establishment of a DHR.

The Home Office was informed of the decision to conduct a DHR on 9 July 2012 and the Domestic Homicide Review Panel ('the Panel') has six months from that date in which to complete the Review.

THE PURPOSE OF THE REVIEW

DHRs are not inquiries into how the victim died or into who is culpable. These are matters for Coroners and criminal courts to determine. Nor are DHRs specifically part of any disciplinary enquiry or process.

The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local, regional and national 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 policies and procedures as appropriate
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

THE SCOPE OF THE REVIEW

The following issues will be considered by each agency's Individual Management Review (IMR) and the Overview Report:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/ perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim, or perpetrator, subject to a MARAC?
- Did the agency comply with domestic abuse protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered, or provided, or relevant enquiries made in the light of the assessments, given what was known or should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of the options/choices to make informed decisions? Were they signposted to other agencies?
- Was anything known about the perpetrator? For example, were they being managed under MAPPA?
- Had the victim disclosed to anyone and if so, was the response appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training,

management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?

Additional issues of particular concern in this case are likely to be identified and will also require analysis within each relevant agency's IMR and the Overview Report. These include, but are not restricted to:

- What action was taken by Children's Social Care following the report of the incident in the Maternity Ward at Princess Alexandra Hospital?
- How were TM's mental health issues communicated between his GP and the Community Mental Health team?

- Following the incident on 10 April 2012 why did the Crown Prosecution Service take no further action?

EXPERT OPINION

- Mental health
- MARAC

TIME PERIOD OVER WHICH EVENTS SHOULD BE REVIEWED

Agencies are to supply all information related to any contact with the victim or alleged perpetrator where the IMR author feels that the information could relate to the identification of vulnerability issues; and to provide detailed information and analysis about all contacts that took place since January 2010.

Agencies should also include details and analysis of any relevant significant events or incidents which occurred outside of the time period, but which are, or may be, relevant to the case.

ORGANISATIONS INVOLVED

Following the scoping of the Review, the following agencies will be invited to have representation on the Panel and will also be required to submit an Individual Management Review:

- Essex County Council (Schools, Children & Families)
- Essex County Council (Adult Health & Community Wellbeing)
- Essex County Council (Drugs & Alcohol)

- Essex Police
- Harlow District Council
- National Probation Service
- Princess Alexandra Hospital NHS Trust
- North Essex Partnership NHS Foundation Trust
- West Essex Community Drugs & Alcohol Team

The following agencies will also be required to submit an Individual Management Review but are not invited to have representation on the Panel:

- The Hamilton Practice
- Nuffield House Surgery

The following agencies/individuals will also have a place on the Panel, either to provide expert opinion, or because they were not involved in the case and can therefore offer independent scrutiny to the Panel:

- Essex County Fire & Rescue Service
- Essex Safeguarding Adults Board
- NHS North Essex
- Safer Places

INVOLVEMENT OF FAMILY MEMBERS

Consideration will be given to engagement of family members, if they can be identified.

PARALLEL REVIEWS

There are no parallel reviews being conducted in respect of this DHR.

Criminal investigation

The Panel will liaise with the Senior Investigating Officer in relation to the criminal investigation.

Essex Police are members of the DHR Panel, and any information shared as part of the Review may be referred to the Disclosure Officer by the Police representative as potential third party evidence, if they feel it may have an impact on the case.

Coroner's Inquiry

The Review will be completed and Overview Report written, but both will not be published or publicised until the completion of the criminal investigation.

MEDIA COVERAGE AND ENQUIRIES

The Review plans to bring together the relevant organisations' media teams to prepare a joint reactive media statement, once the Overview Report and Executive Summary have been finalised and approved by the Home Office for publication. Any media statement will be released only on the completion of the criminal investigation and publication of the review.

LEGAL ADVICE

The Panel and Chair do not anticipate requiring legal advice. If legal advice is required this will be sought from partner agency legal teams.

INDEPENDENT CHAIR AND OVERVIEW REPORT WRITER

Jackie Sully has been appointed the Independent Chair and Report Writer for this Review. Jackie has experience of Serious Case Reviews and is independent of the organisations involved in this DHR. She is the Chairperson of the Harlow Local Strategic Partnership and also Chairperson of the Harlow Voluntary Sector Forum.

LIAISON WITH THE HOME OFFICE

Liaison with the Home Office will be managed by Malcolm Morley, Chairperson of the Safer Harlow Partnership, or Lynn Seward, Chairperson of the Safer Harlow Partnership Performance Executive.

PROCESS

The Panel will review the DHR process on an ongoing basis and make recommendations to the Safer Harlow Partnership where developments to the process are identified.

Lynn Seward, Chairperson of the Safer Harlow Partnership Performance Executive will facilitate communication between the Panel and the Safer Harlow Partnership regarding the DHR.

APPENDIX 2

ACTION PLAN

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
1. All Initial Response Team and Emergency Duty Service staff, who have not done so, to receive LSCB commissioned or similar training in domestic abuse.	All Initial Response Team and Emergency Duty Service social workers will undertake appropriate training in domestic abuse.	31.12.13	Children's Social Care	In the light of the findings from a Serious Case Review and from previous DHRs, together with an overall acknowledgement that multi-agency practice in this area needed to change, a decision was made in 2013 to set up a multi-agency Domestic Abuse team. Since September 2013 a Joint Domestic Abuse Triage Team (JDATT) has been established. The focus of this team is to provide a multi-agency response to all DV1's (domestic violence notifications), thereby managing risk more effectively and ensuring a more rapid and robust response to those DV incidents considered to be most serious. The JDATT team consider each notification within the context of relevant information held by Police, Social Care and other agencies. This includes analysing the history and patterns of previous referrals, and analysing and assessing the levels of risk involved. Staff from all agencies working within the JDATT are considered to have good working

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				knowledge in respect of Domestic Abuse and the associated risks. This includes having received appropriate training in this specific area. At present all DV notifications are processed through the JDATT and only those reaching threshold for L4 intervention (Specialist Services) are passed through to IRT. DV training remains a high priority for all social work staff within Family Operations. The existence of a JDATT team ensures a very specific, specialist overview of Domestic Abuse Incidents, from within a multi-agency context.
2. New Initial Response Team and Emergency Duty Service staff to receive such training as above within one year of joining these teams.	All Initial Response Team and Emergency Duty Service social workers will undertake appropriate training in domestic abuse.	Ongoing	Children's Social Care	All new staff in IRT have development plans for their training needs. Domestic Abuse is one of the core elements of this training. Staff within JDATT itself have access to training and are developing specific expertise due to the very focused nature of the work they undertake in relation to Domestic Abuse. The focus of JDATT is on appropriate information sharing between partners to allow for better management of risk and ensure robust and timely interventions to safeguard those at most risk.
3. Update and disseminate	Guidance for social	Update by	Children's Social	There is clear guidance available

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
guidance for social workers.	workers will be updated as set out in paragraph 17.2 of the Children's Social Care IMR.	31.01.13 Disseminate by 28.02.13	Care	to social work staff. This specific issue has though been overtaken by the setting up of the JDATT team and the understanding within the team that appropriate information will be sought from relevant partner agencies (whether MAPPA , mental health agencies or substance abuse agencies). The MAPPA information (referred to in the original DHR and this recommendation) is now always available via police records.
4. All investigations by Children's Social Care to include a check with the MAPPA Coordinator as routine.			Children's Social Care	The JDATT team are aware that all investigations must include the necessary checks with other agencies (see below).
5. Where there is a history of drug abuse, alcohol abuse and mental ill health identified with a referral or investigation, the information to be flagged on all IT systems.			Children's Social Care	The development of the JDATT team ensures that where appropriate, relevant information is shared. This may for example include where Children's Social Care have information pertaining to parental alcohol or substance misuse that is not known to the police, and where the presence of these factors raises the risk or heightens the concerns and as such may change other agencies response to an incident. Currently all information shared and actions taken is recorded on

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				each individual agencies IT system. As part of the ongoing development of JDATT a separate IT system is being considered where all agencies can accurately record all the information in one place. This work is in progress.
6. In future, all Essex Probation decisions about case allocation and transfer are made on the basis of: • An assessment of current risk of serious harm. • The need to continue planned interventions.			Essex Probation	Continuity of offender management continues to be a principle that guides decisions about case allocation. Since 2007/09, licence cases where the offender has a condition to complete a domestic abuse requirement would be held by a band 4 offender manager (who holds cases where risk to others is higher).
7. In future, Essex Probation's offender management of a case should directly relate to the risk of harm posed by the offender and include: • Recording of all risk management activity. • Relevant inter-agency liaison. • Consideration of appropriate licence conditions.			Essex Probation	There is a process of monthly "thematic" inspections of cases with a DV alert. The case inspector will assess the management of the case against compliance with the Essex Probation's policies and procedures. The Domestic Abuse policy and practice instructions have been revised since 2007/09 when TM was being supervised. Thematic inspections evidence that over 90% of cases are judged to be of a sufficient standard.

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				The introduction of JDATT will provide offender managers with information about current police involvement. This information will inform the risk assessment and decisions about managing continued risk.
8. Internal processes with Essex Probation to flag an alert when an offender with a history of violence and domestic abuse discloses that they have started or are in a new relationship.	Essex Probation staff will be alerted to the possibility of the onset of domestic abuse and monitor.		Essex Probation	There are practice instructions to staff to ensure that an alert is applied to the case record, indicating domestic violence, MAPPA and MARAC (where applicable). Where cases dealt with in the MAPPA arena, normally a licence condition to inform the supervising officer of developing relationships.
9. Appropriate conditions of release to be placed when an offender, who has been convicted of domestic abuse, is released. To include a requirement to stay away from previous victims.	On release, domestic abuse offenders will be required to, as a minimum, stay away from previous victims.		Essex Probation	Offenders continue to be discussed at MAPPA prior to release where licence conditions are discussed. The victim unit is represented at this meeting. A risk management plan, including victim safety is in place prior to release. Thematic inspections monitor compliance. In all relevant cases, exclusion condition is normally added to protect victim and others, such as children, from risk of serious harm; non-contact with victim, and reside as directed.
10. Adult Safeguarding training will be mandatory for primary care			Adult Safeguarding Team, ECC	As of 01.04.2013 Primary Care contracts are managed by NHS

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
with regular updates. Training to extend to practices: GPs, front line and administrative staff and include domestic abuse and MARAC.			WECCG	England. GP Practices are independent contractors and therefore accessing training via the CCG is not mandatory. However, WECCG still has a responsibility to improve quality within Primary Care. Accordingly WECCG has set up a GP Training calendar offering Safeguarding Adult and Children training (including Domestic Abuse). In addition to the above the CCG has delivered training to Administrative and reception staff from practices in Harlow and Epping. A future date is planned for Uttlesford Practices. More specialist training around Domestic Abuse available through Essex Safeguarding Adults Board. To date Safeguarding Essex has not been invited to contribute to any safeguarding training for GPs but will be giving a presentation on the adult LADO role at a west GP shutdown on 14th May 2014. Safeguarding Essex will not be arranging any separate GP training but remains happy to assist with any training arranged by the CCG or NHS England or with any individual practices if

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				requested.
11. Individual practices to put in place policies that make all staff aware of the issues of domestic abuse.			WECCG	As of 01.04.2013 Primary Care contracts are managed by NHS England. GP Practices are independent contractors and therefore accessing training via the CCG is not mandatory. However, WECCG still has a responsibility to improve quality within Primary Care. Accordingly WECCG has set up a GP Training calendar offering Safeguarding Adult and Children training (including Domestic Abuse). In addition to the above the CCG has delivered training to Administrative and reception staff from practices in Harlow and Epping. A future date is planned for Uttlesford Practices. More specialist training around Domestic Abuse available through Essex Safeguarding Adults Board.
12. Information for patients relating to domestic abuse will be updated in the Hamilton practice.			WECCG/Hamilton Practice	The Hamilton Practice is participating in the Daisy GP Project. Up to date information would be made available to the practice to use.
13. Practices to flag up DNAS by patients attending outside agencies to which they have been referred – those agencies			WECCG/GP Practices	GP Practices have the IT resources to flag DNAs on their system and this is routinely carried out.

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
should immediately inform the practice so that an entry can be made on the patient journal and therefore seen by the practitioner.				The CCG will follow up cases where providers do not inform the GP Practices of DNAs in a timely manner.
14. All GP practices to have a named person for adult safeguarding and policies for escalation of concerns.			WECCG/GP Practices	With effect from 01.04.2013, all GP Practices must register with the Care Quality Commission. Outcome 7, regulation 11 of the Essential Standards of Quality and Safety clearly outlines the expectations upon GP Practices around adult safeguarding. This will be monitored by CQC.
15. Implementation of RCGP Safeguarding Children and Young People Toolkit (incorporating all domestic abuse).		01.04.13	Essex Safeguarding Children Clinical Network (SCCN)	June 2013 Child Protection leads locality meetings focused on Toolkit and practice implementation. All surgeries sent Toolkit with covering memo. DV coding identified in toolkit.
16. Simple toolkit be developed regarding domestic abuse and referral pathways.	Clinicians and practice staff will be coached to ask pertinent questions regarding domestic abuse and be confident in their referrals.		WECCG	WECCG is working closely with Safer Places on the Daisy GP Project. Part of the project involves coaching clinicians and practice staff to ask pertinent questions and to refer cases on to the Daisy Project worker.
17. Significant Event Form recording protocol		15.10.12	WECCG	Achieved – now current practice
18. Domestic Violence Incident Reports to be taken to weekly Primary Health Care Team meetings.		01.01.13	WECCG/GP Practices	This best practice is encouraged by the CCG and reinforced by Daisy Project.

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
19. General Practices to be included in the MARAC process and elect their own representative.	Information from MARAC will be cascaded to general practices.	Ongoing	WECCG	WECCG is working closely with Safer Places on the Daisy GP Project. Part of the project involves supporting the practice to become involved in the MARAC process.
20. Community Midwife to attend Primary Health Care Team meetings.		28.02.13	Princess Alexandra Hospital	Community midwives are now linked to GP surgeries and therefore are required to meet with their allocated GP surgery on a regular basis for updates and information sharing. The community midwives also meet regularly with health visitors to ensure joint working and appropriate information sharing.
21. Domestic Abuse/adult safeguarding policy at PAH to be approved and ratified.		Immediately	Princess Alexandra Hospital	The domestic abuse policy was ratified on 28/01/2013 and is available in public folders on the trusts computer system that all staff members have access to. The safeguarding adults' policy has not yet been updated as the trust was waiting for the SET procedures to be updated. As these have now been updated, the lead nurse for safeguarding adults is now updating the policy and will be completed by the end of May 2014.
22. Continue with training for staff at PAH in relation to domestic abuse and adult safeguarding.			Princess Alexandra Hospital	Since Jan 2012 -175 Staff have undertaken specific domestic abuse training. This includes training as part of the DAISY

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				project for midwives, which is due to be rolled out to Accident and Emergency staff as another branch to this project. 3/4/2014 -To date 215 staff have been trained within midwifery. The A/E project is underway and training has commenced with 31 staff having attended training since the project started in November 2013. ELearning is available and face to face training will recommence early June 2014. All staff have domestic abuse awareness on induction and yearly updates as part of their safeguarding training. All staff within the hospital are trained in relation to Safeguarding Adults and is part of the trust's mandatory training program. As of the end of March 2014 95% of staff within the trust had completed their training in relation to the protection of vulnerable adults.
23. Review outcome of Daisy Project and implement lessons learnt / improved outcomes within PAH.			Princess Alexandra Hospital	The Daisy project staff hold a monthly steering group meeting with key stakeholders to review the current outcomes of the project, implement any necessary changes to the project and to work jointly with PAH staff to

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				ensure that positive outcomes are achieved.
24. Expand the Daisy Project into A&E.			Princess Alexandra Hospital Safer Places	The daisy project was expanded into Adult A&E as of November 2013.
25. Implement Maternity Electronic Patient Record system in PAH to include safeguarding alert systems.		June 2014	Princess Alexandra Hospital	The Electronic patient record system goes live at Princess Alexandra Hospital in June 2014. Included in the release is a safeguarding alert system which will be maintained by the safeguarding team.
26. A named adult safeguarding person to be available at all times.		Has been in place since 2010	Princess Alexandra Hospital	The lead nurse for safeguarding adults is available within normal office hours. Outside of these times, all safeguarding adult concerns are managed by the duty matron team which is a 24/7 service. There is also a robust escalation process in place where by safeguarding concerns are raised to the director of nursing and quality within normal office hours. Out of these hours, concerns are raised to the manager on call and the executive director on call.
27. When domestic abuse concerns are raised, the patient to have continuity of care and be seen by the same midwife.			Princess Alexandra Hospital	The manager for the community midwives is currently reviewing the referral criteria for the teenage pregnancy team and the vulnerable/complex case midwife. Once this has been completed, high risk cases will be held by the

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				appropriate individual midwife to ensure continuity of care.
28. Referrals to social care or any other agency to be underpinned by appropriate follow up procedures by the referral agency.			Princess Alexandra Hospital	Once a referral to social care has been made, the safeguarding children's team for the trust is made aware of the referral via, fax and telephone message. The safeguarding children's team then follow up with social care to establish what action has been taken around the case and feedback information to the individual who made the initial referral.
29. All MAPPA and MARAC reports to be uploaded to NEPFT electronic database when received and referred to when undertaking patient assessments.	MAPPA and MARAC information will be entered on Carebase as a priority and referred to.		North Essex Partnership NHS Foundation Trust	MAPPA and MARAC information is recorded on Remedy – Trust electronic record system; risks remain in NEP regarding MARAC information as there are insufficient resources within NEP to audit or provide assurance that this is occurring in practice. Achieved.
30. NEPFT Care Coordinators to contact service user's GP personally by telephone or arrange professionals meeting prior to discharging from service.	Closer liaison with GP's re failure to engage high risk service users.		North Essex Partnership NHS Foundation Trust	Where a service user is discharged, a discharge letter is sent to the referrer. It is not practical or possible to telephone GP's in person for all service users discharged from NEP. Where a case is recognised as high risk, then professionals meetings are organised with referrers. Achieved.
31. Carers and family members to	Increased priority on		North Essex	All Carers are offered CPA Carers

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
be assessed by services and recorded as appropriate.	Carers assessments particularly where safeguarding issues are suspected.		Partnership NHS Foundation Trust	Assessments in accordance with NEP policies. Achieved.
32. Training to be identified regarding adult safeguarding for front line staff and forensic assessment skills and offered to appropriate staff involved in assessing service users.	Training input with regard to forensic assessment.		North Essex Partnership NHS Foundation Trust	All clinical-facing staff in NEP completes both Safeguarding Adults and Safeguarding Children Training to level 3. In addition every clinical team includes staff that have completed training in using the DASH risk assessment tool. Clinical staff make referrals for specialist forensic assessments where required. Achieved.
33. Develop an escalation policy to alert other agencies of the likelihood of domestic abuse.			North Essex Partnership NHS Foundation Trust	NEP makes appropriate referrals to Social Care (SETSAF1 and ECC999) when Domestic Abuse is identified. Achieved.
34. Children and/or unborn child identified within an abusive relationship to be flagged as routine and referred to Children's Social Care.			North Essex Partnership NHS Foundation Trust	This is existing component of Trust Safeguarding Policies, with secondary risk assessment (DASH) being conducted where appropriate. Achieved.
35. Amend approach to risk classification once there is a record of domestic abuse on file.	Previous domestic abuse offences will be taken into consideration when offenders are risk assessed.		Essex Police	We already do this. DASO will look at the history and intelligence for both parties prior to conducting a secondary risk assessment for the victim. This forms part of DASH assessment.
36. DV/1 forms to indicate the risk to any children or unborn child.	Children or unborn child will be identified as being at risk of domestic		Essex Police	Where children or pregnant women are noted on the DV1's and automatic notification is sent to Children Social Care at

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
	abuse.			midnight every day. This has been in place for a number of years now.
37. DV/1 forms to include previous incidents of domestic abuse.	Partner agencies will be better informed regarding previous domestic abuse incidents.		Essex Police	The relevant agencies are notified when an incident occurs and they should keep a record of this on their system, so when they receive another referral or notification they will see there has been a previous incident. Agencies should make sure their records are kept up to date and they can then monitor these themselves. With our current IT we are not in a position to do this. Athena may assist with this in the future. Due to launch Feb 2014.
38. To consider a face to face response service for clients presenting themselves homeless and at risk of domestic abuse.	Vulnerable or abused clients will receive a more compassionate and responsive service.		Harlow Council	Achieved.
39. Raise the value and importance of adult safeguarding training and awareness to that of children's safeguarding end ensure such training includes domestic abuse.			All	
40. Develop information sharing protocols that can override barriers caused by separate IT systems and the laws			All	

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
regarding data protection.				