Hull Safeguarding Children's Partnership

Serious Case Review

Child H

Addendum Report – April 2020

Contents

1 Introduction.

1.1 The original report relates to the death of 'Child H', a two year old who tragically died in Hull in February 2014. A Serious Case Review was conducted and the final report was completed in April 2016. Unfortunately, this could not be published at that time due to the ongoing criminal proceedings, which were not concluded until November 2019, resulting in criminal convictions.

1.2 The *Learning From Individual Cases Group*, part of the Hull Safeguarding Children's Partnership, have reviewed the original report with a view to publication. However, whilst it highlights the improvement work which took place across agencies in the aftermath of the death of 'Child H', it no longer reflects where agencies are in terms of operational delivery in 2020. Whilst some services have progressed and continued to improve within the intervening period, others have become less effective and further improvements are required to provide reassurance.

1.3 Agencies were requested to provide position statements, in line with the Areas of Significant Practice, detailing what work has been completed to address the identified areas, what the current position is and what further work is required. Responses were received from;

Children & Young People Services (CYPS - formerly Hull Children & Families Service).
Neighbourhoods and Housing (N&H).
National Probation Service (NPS).
Domestic Abuse Project (DAP).
Humberside Police.
Hull University Teaching Hospitals NHS Trust (formerly Hull & East Yorkshire Hospital NHS Trust).
City Health Care Partnership CIC Named GP.
City Health Care Partnership CIC (FNP).

1.4 In order to publish a document which is transparent, highlights the issues around this case, but also provides a clear plan moving forward, this addendum report has been produced detailing each agency's positon in 2020, in terms of the identified learning from the 2016 report and highlighting any further improvements which are required. This report should be read in conjunction with the original report. Individual agency responses are in italics.

2 Areas of significant practice identified in the Serious Case Review.

ASP 1: The ways in which professionals communicated and worked collaboratively within a multi-agency context.

ASP 2: The use of 'Letters of Expectation' and 'Family Plans' to address safeguarding concerns.

ASP 3: The extent to which professionals engaged with significant males in the family.

ASP 4: The response of CSC to referrals and notifications and the timeliness and quality of subsequent assessments.

ASP 5: The response by agencies in Hull to incidents of domestic violence and the need to keep the child in focus at all times.

ASP 6: Supervision and Managerial Oversight.

3 Responses corresponding to Areas of Significant Practice.

3.1 ASP 1: The ways in which professionals communicated and worked collaboratively within a multi-agency context.

3.1.1 **CYPS** - *Significant work has been undertaken since 2016 aimed at strengthening multi-agency working. This has included the establishment of the Early Help and Safeguarding Hub (EHASH) and the refresh, and update, of 'Thresholds of Need' guidance[1] (2018) supported by a significant programme of multi-agency training.*

More recent improvements have included the direct involvement of adult substance and DAP workers within EHASH, and increasing evidence of multi-agency involvement in strategy discussions (including schools). Ofsted inspectors[2] (Jan 2019) found that the presence of the DAP worker added value.

However, the Ofsted inspection also highlighted the poor quality of some contacts and referrals to EHASH. The work undertaken by the LSCB in 2018, exploring recurring learning from this and other SCRs, also indicated that practice relating to follow-up on referrals and effectively addressing professional disagreement, remained weak across the partnership.

3.1.2 **N&H** - *The Neighbourhoods and Housing Service is fully committed to multi-agency working, to promote and safeguard the wellbeing of both children and vulnerable adults.*

All staff are required to attend the Hull Safeguarding Children's Partnership approved multi-agency safeguarding training and, since Child H's death, a number of specific actions have been taken to strengthen our multi-agency working arrangements;

• During 2016, a number of senior officers worked closely with Children's Social Care to develop and deliver a Housing and Early Help Workshop for front line staff, across both organisations, in order to forge closer working relationships and a better understanding of one another's roles.

• During 2017/18 we worked as part of a multi-agency team to develop and implement Hull City Council's Neglect Strategy and Observational Tool. Briefing sessions and team discussions took place across all teams within the service, with front line staff who come into contact with families as part of their day to day work.

• Housing is now a virtual member of EHASH and we have a departmental representative on the EHASH Operational Management Group. We also support the MACE and have been active members on a number of multi-agency work streams e.g. Child Sexual Exploitation and Missing, and Private Fostering.

• On an operational level, our staff work closely with partner agencies on a daily basis to support vulnerable tenants and applicants, however we recognise that timely and effective multi-agency working continues to be an area for improvement. Over the next six months we plan to develop and deliver safeguarding awareness sessions for front line staff to complement the corporate safeguarding training. This will be a further opportunity to reinforce the importance of multi-agency working and the importance of calling, attending and effective participation in multi-agency meetings.

[1] **Thresholds of Need Guidance** - http://www.hull.gov.uk/sites/hull/files/media/thresh_needs_0.pdf
[2] **OFSTED** inspection January 2019 - https://files.ofsted.gov.uk/v1/file/50078220

3.2 ASP 2: The use of 'Letters of Expectation' and 'Family Plans' to address safeguarding concerns.

3.2.1 **CYPS** - *Children's Social Care had issued revised practice guidance shortly after the use of a 'written agreement' in this case.*

However, the ILACS inspection (2019) found instances of safety plans or agreements put in place when children's cases are closed following a referral (as was the case with child H). These plans do not have continued professional oversight and place an emphasis on parents complying with a set of expectations, without an assessment of their capacity to carry this out. Their judgement was that some children remain in situations of ongoing and unassessed risk of harm.

Safety planning practice needs to be revisited, in the context of the work currently underway on the social work practice model. There has been a recent emphasis on family meetings; with some evidence that family-led planning is increasing.

3.3 ASP 3: The extent to which professionals engaged with significant males in the family.

3.3.1 **CYPS** - *As a result of learning from this, and other, local serious case reviews, the Board led a significant piece of work on strengthening practice across the partnership. Ofsted inspectors reported that: "a concerted effort to engage with fathers and other males, which is a learning point from serious case reviews, is starting to be evident in some assessments and planning."*

This suggests some improvement but enduring variability in practice.

3.4 ASP 4: The response of CSC to referrals and notifications and the timeliness and quality of subsequent assessments.

3.4.1 **CYPS** - *Ofsted found (inspection – 2019) a timely and proportionate response when children are at immediate risk of significant harm. Weaknesses in the quality of information included in contacts/referrals have already been identified. Recent audit work (January 2020) indicates that significant further improvement is needed (e.g. multiple contacts & referrals). Improvements have been made to systems: feedback to referrers has been strengthened; the multi-agency information boxes on Liquid Logic are used more consistently; there is better multi-agency involvement in strategy discussions.*

Since 2016, training for social workers has been provided on the use of DASH to help inform assessments of risk and this is an expectation reflected in current social work practice standards.

Although there has been significant improvement overall in the timeliness of assessments, the inspection found a lack of child focus, resulting in plans that fail to improve children's situations.

3.5 ASP 5: The response by agencies in Hull to incidents of domestic violence and the need to keep the child in focus at all times.

3.5.1 **CYPS** - *The Board held two 'deep-dive' events (2016 & 2017) with a focus on domestic abuse and the learning from this, and other, SCRs. One of the outcomes was the establishment (2017) of the DA strategic group, with the intention of achieving a more coordinated strategic approach and response across the strategic partnerships.*

There was also a focus, supported by training, on strengthening 'routine enquiry' and use of DASH across the partnership. Daily 'triage' of domestic abuse contacts has recently been established in EHASH: whilst this has been helpful in sharing and embedding learning about domestic abuse, the absence of direct police (and full health) involvement has limited effectiveness.

Despite the work undertaken, inspectors still found "numerous examples of poor-quality assessments which fail to identify the child's lived experience, are overly adult focused and are too descriptive". As a result they found that most planning was over-optimistic and lacking in professional curiosity.

3.5.2 **N&H** - *Working with partners to recognise and support victims of domestic violence is a service priority.*

We work closely with the Hull Domestic Abuse Partnership and fund a Domestic Violence Housing Specialist officer who is located in Hull DAP and works with housing staff across the service to help provide appropriate, timely and effective support for victims of abuse.

During 2019 the Housing Options and the Housing Landlord services were assessed by the Domestic Abuse Housing Alliance as meeting all of the necessary requirements for accreditation and became one of the first local authorities in the country to be recognised as setting the benchmark in how housing providers should be tackling domestic abuse.

All front line housing staff are now in the process of completing Routine Enquiry / DASH training.

3.6 ASP 6: Supervision and Managerial Oversight.

3.6.1 **CYPS** - *Frontline children's services were restructured in April 2018. One of the prime drivers was to tackle weaknesses which were evident in relation to both supervision and management oversight. This restructure was supported by investment in training for supervisors and supervisees. Regular, routine audit of practice shows an increase in the evidence of supervision and management oversight on children's records, but with more still to do to improve the quality and impact of this.*

Ofsted (2019) found that manager oversight of the work in EHASH was too often vague and lacking in direction. They did, however, find that supervision was now regular, although variable in quality across teams, with not all records evidencing reflective discussion to improve practice. An audit of supervision is being undertaken in March 2020.

The most recent monitoring visit (Jan 2020)[3] also highlighted weaknesses in relation to management oversight (at all levels).

[3] **OFSTED** monitoring visit January 2020 - https://files.ofsted.gov.uk/v1/file/50144788

4 Responses to Actions arising from Single Agency Learning.

4.1 **National Probation Service.**

4.1.1 Offender Managers to pass on external documents for inclusion in the case management system.

Clear practices are in place to ensure documentation awaiting risk information is made available to Children's Services and is routinely and appropriately shared with other partner agencies to inform risk assessments and inform family plans.

The National Probation Service (NPS) Offender Assessment Systems (OASys) Risk Management Plan is routinely shared with Children's Social Care and relevant partner agencies to ensure robust information sharing and joint risk management planning is in place.

Identified escalation of risks to children is escalated to Children's Social Care via a referral process following EHASH procedures.

Lead Safeguarding Children NPS Manager undertakes joint evaluation audit of cases with EHASH partners. Safeguarding Children audits of relevant cases are undertaken on a continuous basis and reflective practice undertaken in supervision. Management Oversight entries are monitored and quality assured in all safeguarding cases.

Robust arrangements are in place to ensure immediate responses to requests for information, documentation and reports required by Hull City Council CSC for Court proceedings. We have recently flagged with the National Probation Service (HMPPS) a potential delay in responding to such requests following the recent implementation of the Offender Management in Custody Programme which transfers responsibility for case management for a cohort of offenders to Prisons. A resolution and updated guidance will be produced.

All staff within NPS are required to undertake mandated Safeguarding Children training.

4.1.2 Licence conditions in respect of developing relationships for domestic abuse cases.

This SCR involved a perpetrator who was subject to a Community Order at the time the death of Child H sadly occurred. Therefore, Licence Conditions requiring a perpetrator to inform of developing relationships due to their domestic abuse history was not applicable. However, where domestic perpetrators are eligible for Licence Conditions, every case will be required to have consideration for mandatory inclusion of this Condition.

NPS Heads of Local Delivery Units have the powers to vary a Licence to include the above Condition if information comes to light concerning domestic abuse risks following release on Licence.

4.1.3 Disseminate information about the role and responsibilities of Family Nurse Practitioner Programme.

The roles and responsibilities of Family Nurse Practitioner Programme were shared with practitioners via the established cascading of Safeguarding Children's Board Findings following Serious Case Reviews, which was established practice following Serious Case Reviews at the time. However, more latterly, regular Safeguarding Children Briefings are undertaken in the Local Delivery Unit and this information will be revisited in Briefings to staff.

4.2 **Hull University Teaching Hospitals NHS Trust.**

4.2.1 Clearer process identified for when child misses appointment.

The Trust has a WNB brought guidance that includes an agreed escalation pathway dependent on level of safeguarding concern. The incorporated pathway has been agreed with primary and secondary health provider services.

4.2.2 Review of processes to ensure that women receive their postnatal assessments within 24 hours of the expected assessment date.

- *If a baby has been admitted to NICU the woman should receive her postnatal assessments/care within 24hrs on Rowan ward.*
- *If baby is discharged home the woman will receive her postnatal care with baby within 24hrs in the community with the community midwife.*

Further audit of records in relation to the timeframe i.e. 24hrs needs to be completed to give assurance that the timescale is being met.

4.2.3 Pathway for referral to CSC has been reinforced within the organisation.

The pathway for referral to CSC has been reviewed and evaluated and since this SCR there have been several changes led by organisational change in CSC and ways of working. Review is continuous re quality of referrals and outcomes. The Safeguarding Team is regularly involved in MA Case audits with CSC ¬ which review escalation of concerns via the referral pathway.

4.2.4 Senior Midwife identified to support capacity for staff within the maternity service to support SCR process.

The Trust has a Head of Midwifery and since this review the Trust has a Named Midwife 1 x WTE (currently covered by 2 part time staff), and a Specialist Midwife for Vulnerable women 1 x WTE.

4.2.5 Improved information sharing processes around DA and Pregnancy.

A system of information sharing is now in place from DAP to the children safeguarding team which helps to identify those families DAP are working with where there is a pregnancy/unborn. The Trust also receives copies of all DASH referrals where there is a pregnant woman. A safeguarding alert and additional information is then added to the woman's electronic records to help inform the practice of frontline midwifery practitioners.

4.2.6 Development of a vulnerability toolkit and pathway to support midwives providing care for women with complex social factors.

A pregnancy vulnerabilities risk assessment is completed for all pregnant women at specific points during pregnancy. This helps to identify women with complex social factors and increase vulnerability. This includes teenagers, victims of Domestic Abuse, alcohol and drug use. A structured pathway which sits alongside the assessment provides midwives with guidance on the actions they should take when vulnerability is identified.

4.3 **City Health Care Partnership CIC Named GP.**

4.3.1 To raise awareness of the risk factors of teenage pregnancy with the GPs.

This has been addressed through level 3 GP training material delivered over the last 3 years.

A GP forum planned for March 2020, where SCR/LLR summaries will be reviewed and discussed, is an opportunity to highlight teenage pregnancy and the associated risks.

4.3.2 To raise awareness of the importance of documenting who a minor is accompanied by with the GPs and enquiring about the family relationship to the child.

This has been flagged with GP's in the past 18 months through written communication reminding them of the importance of this as good practice.

There will be ongoing opportunities through future GP forums and during training to revisit this and remind GPs.

4.3.3 Flag up in the notes in an easily noticeable place that there is a history of domestic violence in the family (i.e. on the home page).

A Hull-wide Protected Time for Learning Event was held in April 2018 focussing on DA. This encompassed an admin session focussing on coding/adding alerts to records and case discussion which highlighted this aspect.

4.3.4 Consider referring to DAP for further support if there is evidence or suspicion of domestic violence.

A Hull-wide Protected Time for Learning Event was held in April 2018 focussing on DA. The DAP Manager presented a session to practice clinical staff informing them of available support through the DAP service.

Practices have been offered written materials around the referral process that can be used in consultation with patients.

We did not identify any further GP specific learning in the report. The role of the Named GP now sits with the Hull CCG (transferred around 4 years ago).

4.4 **City Health Care Partnership CIC (FNP).**

4.4.1 Raise the profile and ensure that other agencies are aware of the Family Nurse Partnership model.

This is no longer valid for CHCP as FNP was decommissioned in Hull in October 2017 and recommendations for FNP would require escalation to the National FNP Team.

Initially CHCP were funded by Hull PCT/NHSE to provide the Family Nurse Partnership Service. The commissioning of the programme then transferred to Hull City Council as commissioners for Public Health. FNP offered an optional, intensive, structured home visiting service to first time teenage parents, which was additional to the Midwifery and Health Visiting Service already offered. Child H and family opted to receive this service.

In October 2017 the FNP service was decommissioned by Hull City Council and funding to CHCP was reduced.

Following the decommissioning of FNP, CHCP were asked to provide an alternative enhanced service for vulnerable families. The commissioning of the new enhanced service began in June 2018 following consultation and agreement with the commissioners on what the model should look like/provide.

The Enhanced Family Support Pathway (EFSP) was not a replacement for the FNP model but aimed to provide a specific service (in addition to the core offer by the Health Visiting service) to vulnerable women/families who met the specific inclusion criteria.

A brief summary of the pathway:

The Enhanced Family Support Pathway is an optional offer that was introduced into the CHCP Health Visiting Service in June 2018 to provide an early intervention enhanced home visiting programme for women assessed as being vulnerable in their antenatal period and up to 4 weeks postnatally.

The programme is designed to support families through pregnancy, transition to parenthood and for the child's first three years of life through targeted intervention to improve parental confidence, to build parent/child relationships and to develop readiness for school. Through a range of assessment, interventions and additional visits ranging between 5-11 (above core offer).

The 4 eligibility inclusion criteria are; open to social care and subject to a Section 17/47 pre-birth assessment, parental diagnosis of mental health disorder currently under the care of Let's Talk Service or secondary mental health services, parental diagnosis of a learning disorder and current parental misuse of drugs and or alcohol under care treatment services.

Referrals are accepted/identified during the pregnancy period and up until 4 weeks postnatally, via the Midwifery 'booking-in' appointment, Children's Social Care and through assessment by the named Health Visitor.

During the antenatal period and up till 4 weeks postnatally the designated HV can currently 'step down' the mother/child if after assessment they no longer fit the eligibility inclusion criteria or following contact do not require additional services. Discharge from the pathway is on the child's 3rd birthday after which point care will transfer back in to Universal Health Visiting Services at the appropriate service level dependent upon assessed need.

4.4.2 Safeguarding Children team to review CHCP CIC internal referral process to ensure quality of referrals and that professionals know how and when to escalate concerns relating to professional disagreements.

All referrals received via the CHCP safeguarding team are quality assured for accuracy of information and quality of the referral. Clarifications are sought from practitioners where information/concerns are unclear/omitted. The escalation process is available to all staff within the Safeguarding policy and reiterated during training. As well as access to regular planned supervision, all staff have the support of a duty safeguarding practitioner/Named Nurse for ad-hoc supervision and/or discussions where the practitioner requires support with escalating their concerns within the multi-agency arena. The safeguarding team are in the process of developing an escalation pro-forma for use by CHCP staff when they are escalating concerns.

4.4.3 Safeguarding Children team to review quality of supervision.

The safeguarding children team conduct regular audits of supervision for both quality and compliance. The monthly safeguarding supervisors meetings have a quarterly learning focus (delivered monthly for the 3 months of the quarter). The question of challenge within supervision has been a recent focus along with learning from SCR and LLR.

5 Responses outside of Areas of Significant Practice and Actions arising from Single Agency Learning.

5.1 Domestic Abuse Partnership[4].

Since 2016 the DAP DA Support Service has implemented the following actions;

5.1.1 *The DAP team have worked with the HSCB DA trainers to provide a half-day DASH briefing session to the following agencies; CSC, CHCP and to all other agencies through the Multi-agency DASH training provided via the HSCB training offer. This also includes raising awareness of MARAC, MARAC threshold and how to refer. DASH training has also been integrated into the 2 day DA awareness training.*

5.1.2 *All DA training provided via the HSCB training offer includes references to the learning from this SCR. It also provides information on the Domestic Violence Disclosure Scheme, 'Right to Know' and 'Right to Ask'[5].*

5.1.3 *The DAP DA Support service victim booklet was refreshed in 2016 and 2019 and includes information on the impact DA has on children and young people and also provides information on the Domestic Violence Disclosure Scheme, 'Right to Know' and 'Right to Ask'.*

5.1.4 *In 2016, 2017, 2018 and 2019 dedicated awareness raising materials have also been refreshed and developed. The following have been developed in partnership with young people for young people;*

- *How to support a friend experiencing DA.*
- *How to support a child experiencing DA.*
- *A dedicated leaflet for both male and female young people who may be experiencing DA.*
- *A dedicated poster for young people.*

The resources have been distributed around the city and are available in PDF format. The information contained in the booklets also provides useful information for professionals.

5.1.5 *The DA Support Service held a number of meetings with the safeguarding children board support staff and CSC in order to develop a more specialist training offer to enable professionals to identify and respond to 'new' male partners so risk management and interventions can be more effective. The HSCB support staff took the lead on this and planned to develop this further with Hull University.*

[4] **Domestic Abuse Partnership** - https://www.hulldap.co.uk/

[5] **Domestic Violence Disclosure Scheme** - Gives members of the public a 'right to ask' Police where they have a concern that their partner may pose a risk to them or where they are concerned that the partner of a member of their family or a friend may pose a risk to that individual - https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance

- https://www.humberside.police.uk/clares-law

5.1.6 *The Hull Domestic Abuse Strategy[6] was refreshed in 2017 and includes themes from this SCR.*

5.1.7 *A strategic DA working group has been established who continue to monitor and review the implementation of the DA strategy and action plan. The group have also developed a DA minimum standards framework and are actively encouraging partnership with agencies to adopt these standards. The group are currently undertaking a review of all DA training offered in the city.*

5.1.8 *The DAP DA Support Services currently co-locate a DA Practitioner everyday within the EHASH which has proven to be beneficial in terms of sharing information to inform multi-agency decision making and working. Unfortunately, this will cease in March 2020 unless further funding is found.*

5.2 **Humberside Police.**

Responses refer to specific pages and paragraphs within the original report.

5.2.1 Page 4 1.3 - DASH - *It is now force policy that a DASH[7] must be completed for every DA incident, the attending officer must complete a risk assessment. The DASH is then secondary risk assessed by a Domestic Abuse Coordinator, who will make the required safeguard referrals with partner agencies and Child Care Social Service.*

In completing the secondary risk assessment the DAC will review all intelligence and previous incidents, to identify if there is an escalation.

If the couple are deemed as high risk they will be managed by the DA local teams and refer to MARAC.

Any incident in which a child of school age is present and a disclosure will be made under Op Encompass[8].

We still need to improve in relation to documenting children on the DASH, in the last 4 months patrol have had further briefings from the DA unit in relation to children. The PS's in the DACT are monitoring and feeding back to supervision any poor DASH forms which have been submitted.

5.2.2 Page 16 6.31 - Police checks - *Police checks are completed by the FCR for all DA incidents and the patrol officer should be updated whilst en-route. For High and emergency the DACT are informed and they will liaise direct with the attending officer, and the Officer cannot leave the scene until they have spoken to the DACT PS to ensure that all intelligence is known and safeguarding is completed. With the DACT are now IDVA's who will make contact by telephone is a victim requests or is the victim is not engaging and the attending officer has concerns that the victim is diminishing the incident.*

5.2.3 Page 24 7.74 - Timeliness of information sharing:- *The DASH queues have significantly reduced owing to the full complement of staffing now being in place; with High risk there are no delays they are secondary risk assessed on the day they are received, with the relevant referrals and safeguarding being completed on the day. Medium risk are completed within 48 hours and standard up to 72 hours. Now the DACT is fully staffed within the Jan 2020 Op Encompass will be the responsibility of the DACT as they cover 24 hours a day. At*

[6] **Hull Domestic Abuse Strategy** - http://www.hull.gov.uk/crime-and-safety/domestic-violence/domestic-abuse-strategy
[7] **DASH** – Domestic Abuse reporting form, used by practitioners.
[8] **Operation Encompass** – A unique Police and Education early intervention safeguarding partnership which ensures that a child's school is informed that there has been an incident of Domestic Abuse to which the child or young person has been exposed.

present any Op Encompass are completed by 7:45am and then fed through during the day as the staff complete the secondary risk assessments.

5.2.4 Page 31 7.9.2 - Current DA response - *All reports of DA are attended, if the call is a High or emergency a patrol will be dispatched, (see response for Page 16) for Medium and Standard, an appointment will be made whilst the victim is on the phone, unless it is in progress and then a patrol will be deployed. The FCR will complete all the required intelligence checks and liaise with the DACT if they have any concerns.*

The DA incident log queues are monitored and the Patrol Inspectors have responsibility to ensure that the appointments are met. If a patrol attends a medium and increases to a High the Inspector must be made aware, who will then ensure that the suspect is circulated as wanted, arrest attempts are a priority which are monitored via PACESETTER[9]. The DA team made aware to ensure safeguarding and referrals.

For all DA incidents there is a mandatory requirement that Officers will switch on body worn video, so we are evidence gathering from the point on arrival, which will also assist in progressing victimless prosecutions. The DASH form is now electronic and on the Officers PRONTO[10] device, all DA incidents have a DASH submitted. They only delay is if the victim has been taken to hospital and medical needs come first.

Any children that are present must be checked by the officer, if they have any concerns, Supervision to be updated and dealt with accordingly.

All High risk should be allocated to the CID to deal and Medium and Standards to PCT; this is currently not the case and the majority are being dealt with by PCT on the North and patrol on the South, work is ongoing to standardise these procedures and waiting on a confirmation from COG that a dedicated DA investigation team is being set up.

The DACT complete the secondary risk assessments and highlight if a DVDS is required these are then progressed by the DA team.

There are two dedicated staff who work within investigation in relation to applications for DVPN's.

From June 2018, all new police officers receive a 2.5 day training in DA, which prior to this, was just half a day. They have the DA Matters training included.

5.2.5 Page 32 7.9.6 - Action Plan - *A review was completed of how Humberside Police respond and deal with DA, in order to improve the service the Domestic Abuse Coordination Team (DACT) was established, who cover 24 hours and work within the FCR. The DACT officers are available to give dispatchers and officers advice on how to deal with DA incidents, check intelligence databases for all relevant information, and make contact with the victim to provide support. Also there is now an IDVA sat with the DACT who is available to provide support to the victims. There were a number of actions plans generated from the HMIC review, which are overseen by DCS (Head of Crime), as such we now have a better response to DA and ensure that we work in line with best practice.*

The DA Det. Supt, DCI and DI are all accountable to the ACC, and provide regular updates to ensure that we are achieving best practice and continually improving the service.

[9] **Pacesetter** - Pacesetter are daily meetings, chaired by the Divisional Commanders in which risk is discussed and managed. Any item on the pacesetter will be tracked by the owner providing daily updates, to ensure that effective work is on-going to manage and reduce the risk. Once the chair is satisfied that the risk is managed / reduced the item will be removed from the document. Any item of exception / posing force risk will be raised in the Force Pacesetter, which is chaired by the duty Gold.

[10] Pronto – A suite of software applications allowing frontline officers to perform functions and submit forms from mobile devices, whilst on patrol.

5.2.6 Page 32 7.9.9 - Management of High Risk DA offenders - *All high risk are monitored by the DA locality teams, who are responsible for making referrals to MARAC and ensuring the safeguarding of the victim. The DA staff currently do not investigate DA, but link in and support Communities Investigation. Any repeat high risk that starts a new relationship. As soon as we are aware a DVDS right to know disclosure is made. North bank works closely with DAP who have an offenders programme called Strength to Change[11]; the Bluedoor[12] on the South have something similar, but only in Grimsby at present; there is no offender programme in Scunthorpe. Under the Whole system approach, Humberside has embedded MATAC in conjunction with partner agencies.*

MATAC is offender monitoring / prevention; through RFVG[13] scoring the offenders are identified then monitored through multi-agency working to reduce their offending, whether this is by education or the criminal justice.

The DA teams monitor the TOP 5 DA offenders and victims, with the aim of reducing the risk. There is a dedicated officers North and South who monitor, this is just in the early stages of development.

5.2.7 Page 36 8.3 - Demand Data - Data obtained from Humberside Police shows that recorded incidents of Domestic Abuse in Hull, have increased since the original SCR report was written. Between 2016/17, there were 9100 recorded incidents, with a repeat victim rate of 17%. That increased to 9720 recorded incidents for the period 2017/18, with a repeat victim rate of 16%. For 2018/19, the number increased to 11668 with a repeat victim rate of 18%. The latest data for the period 2019/20 shows that recorded incidents have increased again to 11612 with a repeat victim level of 19%.

During 2018/19, Hull DAP received 2420 referrals and provided support for victims and 7417 children affected by Domestic Abuse. Data is still being analysed for the period 2019/20, but early indications are that it is at a slightly increased level. Their referral rate for repeat victims is currently around 20% of all referrals received.

[11] **Strength to Change** – A service for men who are concerned about their violence and abuse in their intimate relationships. This initiative is led by NHS Hull and is aimed primarily at enhancing the safety of women and children while giving men an opportunity to change their behaviour.

[12] **Bluedoor** - A specialist service who provide support to anyone that has experienced domestic abuse and sexual violence in North and North East Lincolnshire and those who have experienced rape and serious sexual offences in Hull and the East Riding of Yorkshire through a variety of advocacy, outreach workers, groups and programmes.

[13] **RVGF** - This is scoring tool that has been adopted by Humberside Police following on from the Home Office pilot to implement MATAC within the force. The scoring is used to identify DA offenders, who pose the highest risk. They are then reviewed by a member a staff and then if deemed suitable are put forward to be discussed at MATAC. This a monthly meeting held with partner agencies to address the offending behaviour.

6 Acronyms

ACC	Assistant Chief Constable
ASP	Area of Significant Practice
CCG	Clinical Commissioning Group
CHCP	City Health Care Partnership
CIC	Community Interest Company
CID	Criminal Investigation Department
COG	Chief Officer Group
CSC	Children's Social Care
CYPS	Children and Young People's Services
DA	Domestic Abuse
DAC	Domestic Abuse Coordinator
DACT	Domestic Abuse Coordination Team
DAP	Domestic Abuse Partnership
DASH	Domestic Abuse, Stalking, and Honour based abuse
DCI	Detective Chief Inspector
DCS	Detective Chief Superintendent
Det Supt	Detective Superintendent
DI	Detective Inspector
DV	Domestic Violence
DVDS	Domestic Violence Disclosure Scheme
DVPN	Domestic Violence Protection Notice
EHaSH	Early Help and Safeguarding Hub
FCR	Force Control Room
FNP	Family Nurse Practitioner
GP	General Practitioner
HMIC	Her Majesty's Inspector of Constabulary.
HMPPS	Her Majesty's Prison and Probation Service

HSCB	Hull Safeguarding Children Board
HSCP	Hull Safeguarding Children's Partnership
IDVA	Independent Domestic Violence Advisor
ILACS	Inspections of Local Authority Children's Services
LLR	Lessons Learned Review
LSCB	Local Safeguarding Children Board
MA	Multi-Agency
MACE	Multi-Agency Child Exploitation
MARAC	Multi-Agency Risk Assessment Conference
MATAC	Multi-Agency Tactical and Coordination
N&H	Neighbourhoods and Housing
NHS	National Health Service
NICU	Neonatal Intensive Care Unit
NPS	National Probation Service
OASys	Offender Assessment Systems
OFSTED	Office for Standards in Education, Children's Services and Skills
PCT	Priority Crime Team
PS	Police Sergeant
RFVG	Risk, Frequency, Gravity, Victim.
SAL	Single Agency Learning
SCR	Serious Case Review
WNB	Was Not Brought (to appointment)
WTE	Whole Time Equivalent

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