For Publication

SAFER BARNSLEY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Karen'

Date of Death – May 2022

Executive Summary

March 2025

Chair and Author — Carol Ellwood-Clarke QPM
Independent Support to Chair and Author — Ged McManus

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1. The Review Process

1.1 This summary outlines the process undertaken by Safer Barnsley Partnership [the statutory Crime and Disorder Partnership] in reviewing the homicide of 'Karen', who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members.

Name	Relationship	Age	Ethnicity
Karen	Victim	53	White British female
Jim	Perpetrator	54	White British male

1.3 Karen was married to Jim. They had been in a relationship for 36 years and had two adult children. In May 2022, Jim called the emergency services and reported that he had stabbed Karen. Karen was found at the family home, unconscious, with multiple stab wounds. Karen was later pronounced deceased. Jim was found to have stab wounds; these were self-inflicted. A Home Office post-mortem determined that Karen died as a result of multiple stab wounds.

1.4 Jim was arrested and charged with the murder of Karen. In July 2022, Jim pleaded guilty to the murder of Karen and was sentenced to life imprisonment, with a minimum term of 12 years and six months.

1.5 The first meeting of the Review Panel took place on 5 January 2023. The first and subsequent panel meetings were held virtually – contact was maintained with the panel via email and telephone calls. In total, the panel met four times.

1.6 The DHR covers the period from 1 January 2020 to 22 May 2022. The start date was chosen to capture relevant information in the two years prior to Karen's murder, including the timeframe during the Covid-19 pandemic. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.

1.7 HM Coroner for Barnsley opened and adjourned an inquest. Following the conclusion of the criminal trial and conviction of Jim, the inquest was closed.

2. Contributors to the review

2.1 Contributors to the review/agencies submitting Independent Management Reviews (IMRs).

Agency	IMR	Chronology
Barnsley Hospital NHS Foundation Trust	✓	✓
NHS South Yorkshire Integrated Care Board – Barnsley (GP Practice)	✓	✓
South West Yorkshire Partnership NHS Foundation Trust	✓	✓
South Yorkshire Police	✓	✓
Yorkshire Ambulance Service NHS Trust		✓

2.2 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

3. Review Panel Members

3.1 The Review Panel Members were:

Review Panel Members		
Name	**Job Title**	**Organisation**
Fiona Bankes	Practice Manager	GP Practice
Alice Barker-Milner	Policy Officer – Domestic Abuse	Barnsley Metropolitan Borough Council, Healthier Communities
Donna Clark	Hub and Helpline Manager	Independent Domestic Abuse Services (IDAS)
Rosemary Clewer	Senior Commissioning Manager	Stronger, Safer & Healthier Communities Business Unit, Barnsley Metropolitan Borough Council
Emma Cox	Associate Director of Nursing, Quality and Professions	South West Yorkshire Partnership NHS Foundation Trust
Carol Ellwood-Clarke	Independent Chair and Author	
Catherine Holliday	Named Professional for Safeguarding	Yorkshire Ambulance Service
Amy Hoyle	Contracts and Relationship Officer – Domestic Abuse	Barnsley Metropolitan Borough Council
Calise Martin	Case Review and Policy Officer	South Yorkshire Police
Claire McEvoy	Area Manager for Barnsley Recovery Steps	Humankind
Ged McManus	Support to Chair and Author	
Gillian Pepper	Adult Safeguarding Nurse Specialist	NHS Integrated Care Board – Barnsley
Rebecca Slaytor	Named Nurse for Adult Safeguarding	Barnsley Hospital NHS Foundation Trust

3.2 The panel met four times and the Panel Chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny.

4. Chair and Author of the Overview Report

4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and authors. In this case the Chair and author were the same person.

4.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair and Author. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not South Yorkshire), in 2017, after thirty years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[1].

4.3 Carol was supported in her role by Ged McManus. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Barnsley or an adjoining authority). Ged served for over thirty years in different police services in England. Between 1986 and 2005, he worked for South Yorkshire Police – a contributor to this review – before moving to another police service. The commissioners of the review were satisfied of his independence, given the length of time since he had any involvement with South Yorkshire Police. Prior to leaving the police service in 2016, he was a Superintendent, with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

4.4 Between them, they have undertaken the following types of reviews: child serious case reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. They have both completed accredited training for DHR Chairs, provided by AAFDA.

4.5 Both have previously completed DHRs within Barnsley.

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

5. Terms of reference

5.1 The Review Panel settled on the following Terms of Reference at its first panel meeting on 5 January 2023.

5.2 **The purpose of a DHR is to**:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local Professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

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

5.3 **Specific Terms**

1. What indicators of domestic abuse did your agency have that could have identified Karen as a victim of domestic abuse, and what was the response?
2. What knowledge did your agency have that indicated Jim might be a perpetrator of domestic abuse against Karen, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Jim?
3. How did your agency assess the level of risk faced by Karen? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

4. What services did your agency provide for Karen and/or Jim; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?

5. What knowledge did your agency have regarding any substance/alcohol misuse, and what was the response?

6. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

7. Were single and multi-agency policies and procedures, including the MARAC followed? Are the procedures embedded in practice, and were any gaps identified?

8. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Karen and/or Jim, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to Covid-19.

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

10. Are there any examples of outstanding or innovative practice arising from this review?

11. What learning has emerged for your agency, and how will this be addressed?

12. Does this learning appear in other Domestic Homicide Reviews commissioned by Barnsley Community Safety Partnership?

6. Summary Chronology

6.1 Karen

6.1.1 Karen was brought up in Barnsley by both parents: together with her brother. As an adult, Karen did not have much contact with her brother, until after the death of their mother, when Daughter 1 stated that they became close, especially in the last year of Karen's life.

6.1.2 Karen enjoyed socialising, shopping, walking her dogs, and spending time with her daughters. Daughter 1 stated that growing up, they had nice family holidays, and was complimentary about the way that her parents had treated her and her sibling, and she considered that she had a good and happy childhood.

6.1.3 Jim told the Chair that Karen was a lovely mum who was kind to their children and dealt with most of the day-to-day matters in life, and that Karen was very good at dealing with practical things.

6.1.4 Jim told the Chair that Karen had a high-pressure job that she was very good at. Jim also stated that Karen was sometimes obsessive about work and gave an example that when she was not working, Karen would be thinking about work during her social time, and Jim stated that this sometimes caused tension.

6.2 Jim

6.2.1 Jim was a self-employed painter and decorator. Jim told the Chair that he mainly worked on high-end properties, which sometimes meant that there was a lot of pressure on him to get the quality and timeliness of the work right. Neighbours stated that Jim was meticulous and very proud of his work.

6.2.2 Daughter 1 told the Chair about Jim's mental health and spoke about an incident when she was around 12 years old, when she found her father in the garage with a rope, which he was potentially going to use to try to self-harm. Daughter 1 spoke about a further incident when she was about 17 years old, when she interrupted him when he was about to take an overdose.

6.2.3 Daughter 1 described how her father, Jim, was isolated, and that he did not have any friends outside of the house. Daughter 1 stated that he had gradually stopped seeing anyone else over the years, and that he could be quite difficult and would not easily get on with other people.

6.2.4 Friend 1 described Jim as a passionate man, and that Karen and his daughters were his world.

6.2.5 Jim had no previous convictions and was not known to the police or any other agency as a perpetrator.

6.3 Karen and Jim's relationship

6.3.1 Karen and Jim had been in a relationship for 36 years. Daughter 1 stated that Karen and Jim had never been good for each other, since her early childhood. Daughter 1 recalled that her mother and father had always argued for as long as she could remember. Daughter 1 recalled an occasion, as a child, when the family were staying in a caravan in France and the police were called as result of an argument between Karen and Jim.

6.3.2 Daughter 1 described how during the Covid-19 pandemic, Karen was working from home, and Jim did not work for a 3-month period: this resulted in them spending a lot of time together in the house, and it appeared as if they were 'on top' of each other. Daughter 1 stated that during this time, Jim shut himself away from everyone and did not socialise.

6.3.3 Daughter 1 and 2 described how Karen and Jim would drink alcohol every day, usually on an evening after they had both finished work. Daughter 1 stated that in the couple of years before Karen's murder, Karen and Jim's alcohol consumption increased, and she would at times find bottles of alcohol in cupboards, as if they had been hidden. Daughter 1 stated that although her parents consumed alcohol, she would not describe them as alcoholics or alcohol dependent.

6.3.4 Daughter 1 stated that arguments would start over a small thing but would quickly escalate, with reference continually being made to old issues. Daughter 1 described how Jim would not stop and would continue ranting – sometimes even to himself. Daughter 1 stated that the arguments were worse when her parents had been drinking and could be about anything. Daughter 1 recalled one argument about pebbles in a fish tank. Daughter 1 described that whilst both Karen and Jim said horrible things to each other, it was Jim who would become fixated on something and not let it go – continuing the argument.

6.3.5 Jim told the Chair that he and Karen had a drinking culture, and that they would drink every day. Jim stated that he would sometimes have periods of abstinence, but Karen would not join in with this. Jim stated that he had

asked Karen to reduce her drinking because of the large amount of medication she was taking, but Karen did not do so.

6.3.6 Jim stated that they would often argue over small matters, especially when they had been drinking. Jim blamed the arguing on Karen and stated that she would find an issue and keep going until he argued back; however, the next day they would pick up things again as if nothing had happened. The Review Panel acknowledged that the views of Jim contradicted those of the family and felt that this was victim blaming. Nonetheless, these views have been included as context for the review.

6.3.7 Jim stated that there had never been any physical violence in their relationship until an incident in December 2021, when he assaulted Karen. This is covered further on in this section.

6.4 Events prior to the timescales of the review

6.4.1 On 29 December 2019, Karen contacted the police to report that one of her dogs had been attacked by another dog whilst she had been out walking them.

6.5 2020

6.5.1 On 13 January, Karen had a telephone consultation with a GP. The consultation discussed Karen's ongoing treatment by respiratory specialists. Karen was issued with a fit note[2] for six weeks.

6.5.2 On 6 February, Karen attended a respiratory appointment. Karen reported feeling depressed and was prescribed antidepressants. A letter was sent to Karen's GP to inform them of the prescribed medication. Over the following months, Karen continued to have frequent contact with the respiratory clinic.

6.5.3 On 13 February, Jim was seen by a practice nurse for an annual asthma review. Jim stated that he was drinking around 15 units of alcohol per week. There was no evidence of hazardous drinking.

6.5.4 On 3 April, Karen was advised by a GP to 'shield' for 12 weeks, in accordance with Government guidelines put in place due to the Covid-19 pandemic.

6.5.5 At the end of August, Karen's mother was discharged from hospital and moved into Karen and Jim's home, where she received palliative care. Jim told the Chair that Karen's mother was unable to go home due to the state

[2] https://www.gov.uk/government/collections/fit-note

of disrepair of her home. Furthermore, there was no place at a hospice, which was why she came to live with them. During that time, many professionals were visiting the house to provide support and palliative care.

6.5.6 On 7 September, it was documented that Karen had been diagnosed with pneumonitis, following a bronchoscopy and CT chest scan.

6.5.7 On 10 September, Karen had a telephone consultation with a GP. Karen requested a referral to an alternative respiratory department in Sheffield. Karen mentioned some stress due to her mother's terminal illness, and that her mother had come to live with the family.

6.5.8 Between September and December, Karen had contact with health professionals in relation to her diagnosed illness. These were routine appointments to respond to her illness. During an appointment on 5 November 2020, it was documented that Karen was consuming 40 – 50 units of alcohol per week. There was no record that Karen had been provided with information or advice in relation to the level of alcohol consumption.

6.6 2021

6.6.1 On 7 July, Jim attended at hospital with a head laceration. No explanation was provided for the injury.

6.6.2 On 24 August, Karen had an annual medical review with a practice nurse. This took place via telephone. It was documented that Karen reported her alcohol intake to be about 10 units a week. Karen scored 0 on the PHQ-9[3] depression screening.

6.6.3 At the beginning of October, Karen's GP referred her for physiotherapy due to ongoing problems with pain in her leg and hip.

6.6.4 On 7 October, Karen saw a GP due to bruising and swelling to her ankle and knee. Karen was advised to contact radiology for an X-ray, which she did the following day. During the homicide investigation, Friend 1 told the police that the injury had occurred when Karen fell over furniture in the home. Friend 1 provided the police with photographs of the injury, which Karen had sent at the time.

6.6.5 Daughter 1 told the Chair of an occasion prior to Christmas, when Karen and Jim had been having a 'full argument' when a friend called to see Karen. Daughter 1 described how the argument suddenly stopped, and Karen and Jim presented a picture of normality until the friend left:

[3] The 9-question Patient Health Questionnaire (PHQ-9) is a diagnostic tool introduced in 2001 to screen adult patients in a primary care setting for the presence and severity of depression.

whereupon the argument immediately started. Daughter 1 gave this example to demonstrate how arguments could pause and start quickly.

6.6.6 On 23 December, Karen saw a GP due to a chest injury. Karen stated that that the injury had been caused falling over a Christmas tree in the family home.

The following incident was provided to the police during the homicide investigation.

6.6.7 Friend 1 stated that they had visited Karen and Jim in their home on Christmas Eve. Friend 1 noticed that Karen was struggling to walk. Karen stated that she had fallen over a dog's bowl and landed on the hearth, which had caused an injury to her ribs and bruising under her eyes. Friend 1 stated that she queried with Karen how a fall would cause bruising under the eyes, but Karen did not give a response.

6.6.8 Daughter 1 told the Chair that she had asked Karen about this incident and how she had got black eyes from a fall. Karen told Daughter 1 that Jim had assaulted her by elbowing her.

The following incident was provided to the police during the homicide investigation.

6.6.9 Daughter 1 told the police of an incident that had occurred on Christmas Day night. Daughter 1 stated that she had been in her bedroom with her boyfriend and Daughter 2, when they heard Karen and Jim 'bickering' in their bedroom and then heard Karen scream. Daughter 1 stated that they went into the bedroom, and she saw blood on Karen's face. There was also blood on the pillow. Karen told Daughter 1 that Jim had punched her in the face whilst they were arguing. Daughter 1 described how Jim was crying and that he stated Karen had been sat on top of him, with her hands around his neck, and that was why he hit her. Karen told Daughter 1 that she had not been sat on him nor had her hands around his throat. This incident was corroborated by Daughter 2. Daughter 1 stated that she left the family home for a few days after this incident.

6.7 2022

6.7.1 At the beginning of the year, Karen contracted Covid-19, which resulted in her having additional contact with health professionals.

6.7.2 At the start of February, Karen was assessed by a physiotherapist. The assessment took place by telephone, and the outcome was for Karen to have further face-to-face appointments. These appointments took place between February and May.

The following incident was provided to the police during the homicide investigation.

6.7.3 On a date in February, Karen and Jim went to a restaurant with Daughter 1 and 2. During the meal, Karen assaulted Jim. Daughter 1 described how the atmosphere between Karen and Jim was tense: Karen had consumed a lot of alcohol, and Jim had told her to stop drinking. At which point, Karen hit Jim. Daughter 1 described this as a 'back handed swipe'. The incident was corroborated by Daughter 2. Jim left the restaurant and went home in a taxi.

6.7.4 On a date in May, Karen was found deceased at her home address. Jim was arrested and later charged with the murder of Karen.

7. Key issues arising from the review.

7.1 Agencies were not aware that Karen had been a victim of domestic abuse prior to her murder.

7.2 There were opportunities for Karen to have been asked direct questions about her relationship with Jim during contact with health professionals. This included at times when she presented to health professionals with injuries she attributed to having fallen over.

7.3 Karen's immediate family were not aware of any physical abuse sustained by Karen until six months prior to her murder. This was not reported to the agencies, due to concerns that Jim, may self-harm.

8. Conclusion

8.1 Karen was murdered by Jim: her long-term partner and husband.

8.2 Agencies did not know that Karen had been a victim of domestic abuse prior to her murder. There was no information held by agencies that identified Jim as a perpetrator of domestic abuse.

8.3 Karen's family told the Review Panel about their parent's relationship. This consisted of verbal abuse, often on a daily basis, and usually after the consumption of alcohol.

8.4 Towards the end of 2021, Karen had been to her GP practice on two occasions, with injuries she stated had been caused by a fall; there were no indicators during contact with a GP that these injuries were due to domestic abuse.

8.5 At the end of 2021, Karen was physically assaulted by Jim. This was the first time Karen's family were aware of physical abuse in Karen and Jim's relationship.

8.6 There were opportunities during the timescales of this review for Karen to have been asked directly about domestic abuse, particularly during her contact with professionals predominantly working within health organisations. This did not take place. All health organisations involved in this review, identified this as an area of learning and have started to embed changes to their practices.

8.7 As a result of Karen's ill health, she worked from home during the Covid-19 pandemic, with appropriate adaptations and support from her workplace. In the Autumn of 2020, Karen's mother came to stay for palliative care. The review identified that there was a culmination of events during this period that could have placed additional strain on family life. The review recognised that there was an opportunity for Karen to have been provided with information around support that could have been available to help her and her family at this time.

8.8 Karen's death has had a significant impact on her family. The Review Panel expresses its thanks to the family for their support and contribution during the review.

9. Learning

9.1 The Review Panel identified the following lessons. Each lesson is preceded by a narrative that seeks to set the context within which the lesson sits. When a lesson leads to an action, a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
Opportunities arose on this case for direct questioning on domestic abuse to have been asked during contact with health professionals.
Lesson
The use of direct questioning on domestic abuse, allows victims of domestic abuse an opportunity to disclose abuse and for professionals to provide advice and support, including referrals to other agencies and early intervention.

Learning 2 [Panel recommendation 2]
Narrative
The impact of undertaking a caring role was not recognised on this case.
Lesson
The identification of the potential impact on families who are undertaking a caring role, particularly during palliative care, and providing those individuals with information as to how they, and their families, can access support during this time.

9.2 Agencies Learning

Barnsley Hospital NHS Foundation Trust

9.2.1 Use of routine enquiry.

Responding to indicators of excessive alcohol consumption.

Action taken to address this area of learning:

The Safeguarding Team are reviewing and providing safeguarding oversight of the electronic records of all the Emergency Department attendees who have a domestic abuse flag, to ensure the correct procedures are followed.

NHS South Yorkshire Integrated Care Board – Barnsley (GP Practice)

9.2.2 Ensure all staff receive, and are up to date with, regular adult safeguarding training.

10. RECOMMENDATIONS

10.1 Panel and Agency Recommendations

10.1.1 Panel Recommendations

Number	Recommendation
1	That health agencies who contributed to this review, provide evidence to Safer Barnsley Partnership on how they are addressing the learning identified during the completion of this review, in relation to the identification of domestic abuse during contact with patients. This could be achieved by the submission of a report detailing the actions and timescales to embed this learning into practice. It is recommended that the report includes statistical data to evidence the impact of the changes that are made.
2	That Safer Barnsley Partnership disseminates the learning on this case around the recognition and impact on individuals who are undertaking a caring role, including how support can be accessed.

10.1.2 Agency Recommendations

Barnsley Hospital NHS Foundation Trust

- BHNFT to provide assurance that patients attending outpatient appointments are asked if they feel safe at home.

NHS South Yorkshire – Integrated Care Board – Barnsley (GP Practice)

- Ensure all staff receive, and are up to date with, regular adult safeguarding training.

Appendix A: Action Plans

No.	DHR Review Recommendation	Scope local or regional	Reviewers recommended action to take	Key actions	Lead agency	Completion deadline
1	That health agencies who contributed to this review, provide evidence to Safer Barnsley Partnership on how they are addressing the learning identified during the completion of this review, in relation to the identification of domestic abuse during contact with patients. This could be achieved by the submission of a report detailing the actions and timescales to embed this learning into practice. It is recommended that the report includes	Local	Take a report on both reviews including action plans to the Safer Barnsley Partnership Board and Domestic Abuse Partnership to embed learning into practice. This will also ensure partners clearly evidence activity taken in response to this review through providing an additional level of accountability.	1.1 Development and implementation of action plans by Barnsley Hospital NHS Foundation Trust and NHS South Yorkshire Integrated Care Board.	Barnsley Council, Barnsley Hospital NHS Foundation Trust and NHS South Yorkshire Integrated Care Board.	15 December 2023
				1.2 DHR reports and recommendations submitted to the Safer Barnsley Partnership Board and Domestic Abuse Partnership.	Barnsley Council	27 June 2024
				1.3 Submit reports to Home Office	Barnsley Council	15 March 2025
				1.4. Submit further report to Domestic Abuse Partnership and Safer Barnsley Partnership Board which will include: progress/completion of actions and outcomes including statistical evidence.	Barnsley Council and partners	12 November 2024

	statistical data to evidence the impact of the changes that are made.					
2	That Safer Barnsley Partnership disseminates the learning on this case around the recognition and impact on individuals who are undertaking a caring role, including how support can be accessed.	Local	Improve information dissemination, awareness raising and communications campaigns to target harder to reach groups such as informal carers and elderly people. Such as through regular targeted events.	2.1 Establish a communications and campaigns plan for 2024/25 including generic communications, communications targeted at specific services and groups (including informal carers, AGE UK Barnsley) and hold in person events across the borough.	Barnsley Council, IDAS and partners	01 December 2024
				2.2 Review Domestic Abuse traning package and evaluate training delivered to a) identify any gaps in training, quality of training and impact of training.	IDAS and Barnsley Council	05 September 2024
				2.3 IDAS to deliver bespoke training/awareness raising with Barnsley's Carers Service (Cloverleaf) and develop referral pathways between the two agencies.	IDAS	31 September 2024
				2.4 Update Domestic Abuse Strategy webpage to ensure relevant information and advice is available, including what support is available and how to access this.	Barnsley Council	31 December 2024
				2.5 Multi-agency learning from reviews event to be held in Safeguarding Awareness Week 2024. This will cover	Barnsley Council	21 November 2024

				learning from Domestic Homicide Reviews, Safeguarding Adult Reviews, Drug Related Deaths Review, Suicide Reviews and highlighting common themes.		
3	Barnsley Hospital NHS Foundation Trust to provide assurance that patients attending outpatient appointments are asked if they feel safe at home.	Local	Implement process of routine questioning of all patients attending outpatient departments including ophthalmology	3.1. Develop and implement a process to ensure the routine questioning of all patients attending outpatient departments including ophthalmology.	Barnsley Hospital NHS Foundation Trust	Ongoing until March 2025.
4	Ensure all staff receive, and are up to date with, regular adult safeguarding training.	Local	Ensure all staff receive, and are up to date with regular adult safeguarding training.	4.1 Identify staff training needs in relation to adult safeguarding. 4.2. Ensure staff have undertaken and are up to date with the latest safeguarding training, including refresher training.	NHS South Yorkshire Integrated Care Board – Barnsley (GP Practice)	There is no specific completion date. The safeguarding training is a mandatory training requirement and therefore this is on-going.