Nottingham Crime & Drugs Partnership

Working together to reduce crime, disorder & the misuse of drugs and alcohol

Domestic Homicide Review

Overview Report

'Lottie'

Died: November 2017

Johnston & Blockley

Paul Johnston
Independent Domestic Homicide Review Chair and Report Author
December 2018 – Reformatted Feb 2019

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PREFACE

Lottie' is not the real name of the person who took her own life in Nottingham in November 2017; the pseudonym was chosen by her family to safeguard her identity. The Nottingham Crime and Drugs Partnership Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Lottie's family and friends.

The key purpose for undertaking a domestic homicide review is to enable lessons to be learnt from homicides where a person is killed because of domestic abuse or where a person takes their own life and domestic abuse was an underlying factor. Numerous studies have shown a connection between exposure to intimate partner abuse and suicide. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

Lottie's death met the criteria for conducting a domestic homicide review under Section 9 (3) (a) of the Domestic Violence, Crime, and Victims Act 2004. The Home Office defines domestic violence as:

'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional'.

Controlling behaviour is: *'A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.'*

Coercive behaviour is: *'An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'*

The term domestic abuse will be used throughout this review as it reflects the range of behaviour encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

1 INTRODUCTION

1.1 This is the Report of a Domestic Homicide Review (DHR) following the death of 'Lottie' in November 2017. An inquest into her death is still to be held, but it is the belief of police officers who have investigated the circumstances of her death that she took her own life. DHRs should be commissioned where someone has died by suicide and there is reason to believe that domestic abuse may have been a factor in their lives.

1.2 The review has not sought simply to examine the conduct of professionals and agencies. To illuminate the past to make the future safer, the review has been professionally curious and has sought to find any trail of abuse and to identify which agencies had contact with the victim, any perpetrator or family and which agencies were in contact with each other. The aim was to recommend solutions to help recognise abuse and either signpost victims to suitable support or to design safe interventions.

1.3 In an effort to view events through Lottie's' eyes so as to understand the reality of her situation, the review sought to involve those around her including her family, friends, and her partner, Adult A as well as professionals.

1.4 The reasons behind every individual suicide are unique and complex, but it is known that common factors and experiences that contribute are relationship breakdowns, bereavement, socio-economic factors and mental-health problems. These factors affect both sexes, but in most countries, suicide rates are significantly higher among men than women, despite the fact that women make a higher number of suicide attempts. Those at risk of suicide often feel so overwhelmed by negativity and worthlessness that they feel they have no other option than to end their life.

1.5 Multiple studies have found that domestic abuse survivors have higher-than-average rates of suicidal thoughts, with as many as 23-percent having attempted suicide compared to three-percent among populations with no prior domestic abuse exposure. It has been estimated that everyday 30 women attempt suicide as a result of experiencing domestic abuse and that every week three women take their own lives to escape abuse. It is not just physical violence that is linked with an increase in suicide. Verbal and emotional abuse is also connected with higher risk, as well as the duration, frequency and severity of abuse, and the presence of other factors such as childhood trauma, depression and substance use. (Please see paragraph 6.2 for details of publications consulted during the preparation of this report).

1.6 This review has been informed by Harmless, a national self-harm and suicide prevention support service. The panel is grateful for their help and the insight they have been able to provide.

2 STRATEGIC GOVERNANCE AND DEMOGRAPHICS OF THE NOTTINGHAM CRIME AND DRUGS PARTNERSHIP

2.1 The key milestones in the development of specialist services and best practice in Nottingham have progressed alongside national developments. However, Nottingham has also at times developed ahead of national improvements in provision and practice.

2.2 In recent years the following initiatives have been developed or extended:

- The guide to working with multiple perpetrators was launched and multiple perpetrator-mapping tool attached to the DASH Risk-assessment
- The MARAC has increased capacity to ensure all high-risk referrals are discussed but additional funding had to be sourced to enable this
- Equations Men's Service for male survivors has been increased to include all levels of risk
- Work with probation and the police DVA IOM Cohort has progressed with an identified group of perpetrators and the provision of IDVA support to their partners
- Nottingham is also one of the three-pilot areas for Women's Aid England Change that Lasts programme
- Nottingham City Council pledge to be a city of Zero Tolerance to Forced Genital Mutilation (FGM)
- Rape crisis has relaunched as Nottingham Sexual Violence Support Service and provides therapeutic support to male and female survivors aged 13 and over
- The Paediatric Sexual Assault Referral Centre (SARC) has been launched and retendered along with the adult SARC
- Health pathways for women and children affected by FGM are established with support from specialist FGM Midwives, gynaecology and paediatric SARC
- In 2018, the Mental Health Strategy for the Nottinghamshire Integrated Care System was commenced. The NHS Nottingham City Clinical Commissioning Group are also to carry out an internal review of the current mental health services that they commission for domestic and sexual violence; this will include but is not restricted to Improving Access to Psychologic Therapies (IAPT).

Comment: *DASH risk-assessment questions are based on extensive research of domestic abuse. The aim is to make an accurate and fast assessment of the danger a person is in, so the right help may be provided as quickly as possible.*

A MARAC is a meeting where information is shared on the highest-risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.

Independent Domestic Violence Advocates (IDVA) are specially trained to provide unbiased advice and information and to work in partnership with other agencies to increase safety for individuals experiencing domestic abuse. Their aim is to reduce the risks of further incidents by carrying out risk-assessments and safety planning. They provide signposting and access to other services, such as health, substance misuse and mental-health. The IDVA's also represent the views of the victim at MARAC's.

2.3 Since 2008 Nottingham City, like other areas has experienced austerity and the impact on service provision. Partnership working has sought to manage this impact. However, funding has been lost for some services and these include:

- Sphere, the Domestic Violence and Abuse therapeutic service for children delivered by Family Care lost its funding leaving a gap that has partially been filled through a successful funding bid by WAIS to provide a children's outreach worker. (The funding ceased in 2018.)

- Funding also ceased for the medium-risk support worker and the Identification and Referral to Improve Safety project (IRIS). (The funding ceased in June 2017).

Comment: *The aim of the IRIS project is to tackle the large public health problem presented by domestic violence and the poor response from primary care. In 2017, the IRIS project funding ceased, and work is underway to address the gap. GP's have been provided with pathways for referral for adults with children (including support for children) and adults without children. However, there is an awareness that survivors are not receiving services in the same way since the demise of the project.*

3 TIMESCALES

3.1 In line with agreed protocols, in December 2017 the British Transport Police and Nottinghamshire Police notified the Nottingham Crime and Drugs Partnership of the circumstances of Lottie's death. The Nottingham City Adult Safeguarding Partnership Board (NCASPB) Safeguarding Adult Review Subgroup met in January 2018, where it was agreed that this review should be commissioned. The Home Office was notified of the decision in March 2018.

3.2 The Domestic Homicide Review Statutory Guidance permits reviews to be proportionate to the nature of the homicide (or suicide), so the partnership proposed to the Home Office that it conduct a smaller focussed review in Lottie's case, because it was clear that themes and recommendations already identified in previous reviews (which are subject of current work to address them), would also be a feature in the review of agency involvement with Lottie. The Home Office agreed this would be acceptable as long as it was clearly evidenced in the report.

3.3 Specifically, the following themes have already been identified by the DHR Assurance and Learning Implementation Group (ALIG):

- Victim non-engagement with services – the DSVA Safeguarding Group is currently creating a Non-engagement framework for agencies.

Comment: *Although Lottie did engage with some agencies, there were instances where she either did not engage at all or she did engage but could not maintain it.*

- Vulnerable people who do not meet care and support thresholds for Adult Social Care – (identified in two previous reviews) – CityCare and the NHS Nottingham City Clinical Commissioning Group have developed a complex person guidance for GPs and which has also been included in their training. There is also a Response to Complexity worker based at WAIS and MAF (Multi-agency Forum) case conference meetings which address complex needs including domestic abuse.

Comment: *Lottie would have met the criteria had she sought help or had been identified as someone who needed the help.*

- Instances where someone is recorded as both perpetrator and victim of domestic abuse - a separate perpetrator working group is progressing this. Equation Men's Service undertake work to assist in identifying the primary perpetrator, including checks with WAIS for what information they hold.

3.4 The review commenced on 27th March 2018 and concluded on 10th December 2018. Until a decision had been made by the Crown Prosecution Service as to whether criminal charges would be preferred against Adult A, the DHR Chair determined that no agency staff or family members/friends of the victim would be interviewed – for fear of compromising the judicial and coronial processes should charges be made.

3.5 On 2nd May 2018, the DHR Chair was informed that criminal charges would not be pursued, so the review recommenced. Not long afterwards, two important witnesses were identified during the review process, so the DHR Chair referred the matter back to the police for further investigation. The police took written statements from the two witnesses which were sent to the coroner. Once the decision had been made that there would be no further police investigation, the review process continued.

4 CONFIDENTIALITY

4.1 The pseudonym 'Lottie' was chosen by her mother so as to protecting her true identity. She was in her 40s when she died, and her self-defined ethnicity was White British.

4.2 Until the report is published it is marked: *Official Sensitive Government Security Classifications 2018.*

5 TERMS OF REFERENCE AND SCOPE OF THE REVIEW

5.1 After careful consideration, the review panel opted to examine each agency's involvement with Lottie and Adult A between 1st November 2013 and the date of Lottie's death in November 2017, subject to any information emerging that prompted a review of any earlier incidents or events that were relevant. The panel decided that the review should also include any information that came to light after Lottie's death which may assist in identifying key learning points for the future.

Comment: *There had been significant contacts between Lottie and agencies in 2006 and 2007, but then very little contact until 2017. However, on 1st November 2013, Lottie and Adult A had been staying together at a local hotel when staff reported their concerns over alleged abuse from Adult A to Lottie.*

5.2 The Terms of Reference (TOR) for the review were set to determine whether:

- *Training or awareness raising requirements are necessary to ensure a greater knowledge and understanding of the risk of suicide in respect of victims of domestic abuse were identified*
- *The incident in which Lottie died was related to domestic violence or abuse including coercive and controlling behaviour in her relationship with Adult A, whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse*
- *There were any barriers experienced by Lottie or her family/friends/colleagues in reporting any abuse in Nottingham or elsewhere, including whether they knew how to report domestic abuse should they have wanted to*
- *Lottie had experienced abuse in previous relationships in Nottingham or elsewhere and whether this experience impacted on her likelihood of seeking support in the months before she died*
- *There were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Lottie that were missed*
- *Adult A had any previous history of abusive behaviour to an intimate partner, a relative or a co-habitee and whether this was known to any agencies*
- *There were opportunities for agency intervention in relation to domestic abuse regarding Lottie and Adult A or to dependent children that were missed*
- *Anyone considered Lottie to have been at risk of taking her own life and whether those concerns were shared and acted upon*

6 METHODOLOGY

6.1 This overview report has been compiled from analysis of the multi-agency chronology, the information supplied in the IMRs and discussions between the DHR Chair and Lottie's mother, an interview with Adult A and one of Lottie's friends. The findings of previous reviews and research into various aspects of domestic abuse have also been considered as well as other relevant references including the Home Office guidance for conducting domestic homicide reviews.

6.2 In preparing the overview report the following documents were referred to:

- The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned
- Suicide: A 15-year review of the sociological literature. Part I: Cultural and economic factors. Suicide and life-threatening behaviour, Stack, S. (2000).
- Constructions of masculinity and their influence on men's well-being: a theory of gender and health. Social Science & Medicine, Courtenay, W.H. (2000).
- When things fall apart: Gender and suicide across the life-course. Social Science and Medicine, Shiner, M., Scourfield, J., Fincham, B. & Langer, S. (2009)
- The gender paradox in suicide. Suicide and Life-Threatening Behaviour, Canetto, S.S. and Sakinofsky, I. (1998).
- Sociological autopsy: An integrated approach to the study of suicide in men. Social Science & Medicine, Scourfield, J., Fincham, B., Langer, S. & Shiner, M. (2012).
- Understanding suicide: A sociological autopsy. Fincham, B., Langer, S., Scourfield, J. and Shiner, M. (2011).
- The social construction of gender and its influence on suicide: A review of the literature. Journal of Men's Health, Payne, S., Swami, V. & Stanistreet, D.L. (2008).
- Agency IMRs and Chronologies.
- www.mentalhealth.org.uk/a-to-z/p/personality-disorders
- Funding a national network of refuges: Women's Aid Federation of England (2018) Self-harm by ingestion: understanding the process and relationship to trauma
- Rebecca Lawday (2018)

6.3 Agencies that had been involved were asked to produce Individual Management Reviews (IMRs). The aim of an IMR is to look openly and critically at individual and organisation processes and practices and to provide an analysis of the service they provided. It should include a comprehensive chronology that charts the involvement of the agency during the period determined by the DHR panel to be appropriate for review. It should also summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to the victim, the perpetrator and their families and whether policy and procedure had been followed. IMRs should be completed with the review 'Terms of Reference' in mind and consider not only whether

policy and procedures had been followed, but whether, on reflection, they had been adequate.

Comment: *The aim of an IMR is to look openly and critically at individual and organisation processes and practices and to provide an analysis of the service they provided.*

6.4 IMR authors were also asked to arrive at a conclusion about the service provided by their own agency and to make recommendations, where appropriate. Agencies with knowledge of Lottie and/or Adult A before the dates set for the review, were asked to provide a summary of their involvement. In addition, they were asked to include information that came to light after Lottie's death that might identify learning for the future.

6.5 The panel determined that matters concerning Lottie's family, the public and media would be managed by the review chair before, during and after the review.

6.6 The IMRs produced during this review were quality assured by the original author, the respective agency and by the panel chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation. The standard of the IMRs submitted was good.

6.7 The chair of this domestic homicide review has been particularly impressed by the air of openness and transparency that clearly exists among agencies that were involved in Lottie's case and the positive culture within Nottingham City of a desire to work collaboratively and to learn from experience.

7 INVOLVEMENT IN THE REVIEW

7.1 ADULT A

7.2 Adult A accepted an invitation to participate in the review and a summary of what he said can be found at section 13 of this report.

7.3 FAMILY, FRIENDS AND WORK COLLEAGUES

Lottie's mother also participated in the review, and a summary of what she said can be found at section 12 of this report. She has been regularly updated about the progress of the review by the DHR Chair and was offered specialist advocacy and the opportunity to meet with the review panel, both of which she declined. The review Chair has not shared draft reports with her because she is likely to be a witness at the forthcoming Inquest proceedings.

7.4 The review identified two friends of Lottie who had not been interviewed by the police during their investigation into allegations she made against Adult A. The police have now spoken to them and details of what they said have been supplied to HM Coroner.

7.5 **CONTRIBUTORS TO THE REVIEW**

7.6 Agencies were asked whether they had any record of past involvement with Lottie or with Adult A, the following responded positively. They were asked to provide chronological accounts of their contact with Lottie and with Adult A during the scoping period byway of IMRs and summary reports. The authors were independent in that they had no previous involvement with Lottie or with Adult or any line-management responsibility for staff that had been involved with them.

- NHS Nottingham City Clinical Commissioning Group
- Nottingham City Council Adult Services
- Women's Aid Integrated Services (WAIS)
- Nottinghamshire Healthcare Foundation Trust (NHCFT)
- Nottingham Hospitals University Trust (NUH)
- Equation Men's Domestic Abuse Service
- Nottinghamshire Police Public Protection and East Midlands Special Operations Unit (EMSOU)
- British Transport Police
- East Midlands Ambulance Service (EMAS)
- DHU Healthcare CIC
- Nottingham City Council - Children's Services
- CityCare
- National Probation Service - Nottinghamshire

7.7 **THE REVIEW PANEL MEMBERS**

7.8 The review panel consisted of the following, all of whom were independent in that they had not previously been involved with Lottie or with Adult A or had line management responsibility for anyone who had:

Paul Johnston	DHR Independent Chair & Author
John Matravers	NCC – Safeguarding Partnerships
Hester Litten	CityCare
Lizzie Birch	Equation Men's Services
Jane Lewis	Crime and Drugs Partnership
Julie Gardner	Nottinghamshire Healthcare Trust
Gareth Davies	British Transport Police
Karen Barker	British Transport Police
Rhonda Christian	NHS Nottingham City Clinical Commissioning Group
Paula Bishop	Crime and Drugs Partnership
Jennifer Allison	WAIS
Julie Burton	National Probation Service, Nottinghamshire (NPS)
Zoe Rodger-Fox	EMAS
Lucy Chambers	CityCare
Anna Clark	Equation Men's Service

Adrian Thorpe	Equation Men's Service
Leia Robinson	NCC Adults Services
Bella Dorman	NUH
Clare Dean	Nottinghamshire Police
Ana Silver	Harmless
Julie Tomlinson	DUH Healthcare CIC

7.9 The IMR authors were:

Alison Robinson	NHS Nottingham City Clinical Commissioning Group
Kelly Gurney	Nottinghamshire Healthcare Foundation Trust
Maggie Westbury	NUH Domestic Abuse Nurse
Sue Taylor	NCC – Adults Services
Anna Clark	Equation
Julie Tomlinson	DHU Health Care CIC
Lloyd Young	Police EMSOU

7.10 The panel met on the following dates:

27th March 2018	21st August 2018
3rd July 2018	3rd October 2018
31st July 2018	21st November 2018

7.10 REVIEW CHAIR AND AUTHOR OF THE OVERVIEW REPORT

7.11 The Nottingham Crime and Drugs Partnership requested tenders from suitable applicants to act as chair and overview report author for the review. Following a competitive process, Paul Johnston was commissioned. He is completely independent of all the agencies and individuals that have been involved in the review. He was once a member of the West Yorkshire Police, but retired from that organisation 14-years ago; he has not been employed by the police in any capacity since that time.

7.12 Paul is a leading authority on homicide review and investigation. He is a former police senior investigating officer who successfully led over 70 murder investigations, many of which were domestic homicides. After being head of homicide review and then head of the criminal investigation department, he took on a senior management role in the review and investigation of over 3,000 deaths in Northern Ireland relating to 'The Troubles'. He has now been involved in numerous domestic homicide reviews and has been an advisor to organisations that provide domestic violence and sexual abuse services including male perpetrator programmes. He is a member of an international investigation facility into sexual and gender-based violence in conflict zones and is a consultant to an independent European Human Rights advocacy service for whom he is an expert witness in cases before the European Court of Human Rights involving abduction, murder and domestic abuse femicide.

8 PARALLEL REVIEWS

8.1 In consultation with HM Coroner, the inquest into Lottie's death will take place once this review process has been completed.

9 EQUALITY AND DIVERSITY

9.1 Lottie's long-term mental-health issues had a substantial and adverse effect on her ability to carry out normal day-to-day activities, so under the Equality Act 2010, she was disabled. No agency however held information that indicated Lottie lacked capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever undertaken.

9.2 There was nothing identified during this review to suggest that any agency involved with Lottie treated her unfairly or without proper consideration of her religious belief, ethnic background, nationality, sexual orientation, disability or social status.

9.3 Lottie's first language was English and there is nothing to suggest other than what is outlined in this report, that her gender precluded her from asking for or receiving services.

9.4 There are some references in this report of the use of alcohol by Lottie, but it is statutorily excluded from the definition of disability under the Equality Act.

10 DISSEMINATION

10.1 Whilst key issues identified by the review will be shared with the relevant organisations, the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Panel. When that happens, it will first be shared with HM Coroner in advance of the inquest taking place into Lottie's death.

10.2 The IMRs and summary reports will not be published. The DHR report will be made public upon conclusion of the inquest proceedings, and the recommendations will be acted upon by the agencies concerned. The content of the report and executive summary is anonymised in order to protect Lottie's identity, the identity of Adult A, relevant family members, staff and others, and to comply with the Data Protection Act 1998 and General Data Protection Regulation (GDPR). The report will be produced in a form suitable for publication after any Home Office approved redaction has taken place.

11 BACKGROUND INFORMATION

11.1 It appears that Lottie had deliberately placed herself onto railway tracks at the back of the house she jointly owned with Adult A. She was struck by a train and died instantly. A post-mortem examination revealed that she had 58 foreign objects in her stomach, including several coins, jewellery, a medal and 16 batteries.

Comment: *Ingesting items is a secretive and personal type of self-harm in that it can't be seen by others. The sort of items ingested by Lottie are not unusual items to swallow because they are usually passable with none or little intervention.*

11.2 On 5th January 2018, the police arrested Adult A on suspicion of engaging in controlling and coercive behaviour, because they suspected he may have been involved in Lottie swallowing the foreign objects that were found in her stomach.

11.3 Adult A denied he had been controlling or coercive towards Lottie and appeared to be surprised when he was told about the items found in Lottie's stomach. He was later released from custody pending a report being sent to the Crown Prosecution Service (CPS). In April 2018, the CPS determined there to be insufficient evidence upon which to mount a prosecution.

Comment: *Self-harm by ingestion is often associated with trauma and is a way of communicating distress. As mentioned previously, it is a something that is done in secret, so Adult A may have had no idea it was happening.*

12 SUMMARY OF INFORMATION PROVIDED BY LOTTIE'S FAMILY

12.1 The review chair has met with Lottie's mother. The review panel is grateful to her for participating in this review at such a difficult time. Lottie's mother was offered an advocate to support and guide her through the DHR process which she declined.

12.2 She said that until she reached the age of 13-14, Lottie had been a happy child, although she had always found it difficult to make friends. She was not particularly gifted academically, but she was an exceptional dancer.

12.3 Lottie's mother added that from being 17 to 19, Lottie had worked as a dancer and had travelled around the world. She had been very happy, but she became ill and had to have time away from dancing. The illness ended her dancing career, so she came home again.

12.4 Lottie worked in a nightclub until she was around 24, when she met her first real partner and quite soon afterwards, they set up home together. Lottie became pregnant and after her first child was born, she began to see her parents less frequently.

12.5 Lottie's mother said that about ten-years ago, she had received a telephone call from her to say her partner had left her, that he wanted custody of the children and that she was struggling to cope. Lottie's mother took her to her GP who prescribed her some medication, but there were no follow-up appointments made, which to her was a surprise.

12.6 She said that shortly before the court hearing, Lottie took an overdose and nearly died. She visited her in hospital only to find Lottie's former partner and his new girlfriend by her bedside. They were trying to persuade Lottie not to fight the child custody proceedings.

12.7 Not long after Lottie's attempt to kill herself, she started seeing Adult A. They soon bought a small house together and Lottie's mother helped them move in. At first everything was

fine, but then Lottie and her mother began seeing less and less of one another. Lottie's mother was convinced that Adult A was behind it and that he didn't like her because she asked too many questions. When Lottie's mother found out that Lottie was pregnant again, she went to see her; she said that Lottie was 'blooming' and that she was really enjoying being pregnant.

12.8 Lottie's mother only saw the new baby twice. She said that several years later she found out that the child had been disabled and had been adopted. Lottie's mother believes that the child being disabled soured the relationship between Adult A and Lottie and that Adult A never forgave her for it.

12.9 After Lottie's suicide, Adult A told her mother that Lottie hadn't been eating properly and that she had completely shaved her own hair off, because she couldn't cope with it any longer. This shocked her because Lottie always loved her hair and took great care of it; she still cannot understand why Lottie would have done such a thing.

Comment: *Some contributors to this review referred to Lottie's hair as having been shaved and some to it having been cut.*

12.10 Lottie's mother's opinion of Adult A is that he is an uncaring individual. She met with him after Lottie's death and he said that Lottie had just lived in the bedroom; he pointed out where she would lay curled-up on the bed, rarely leaving the bedroom.

12.11 She added that she believes Lottie was failed by mental-health agencies, especially when she was with her first partner. She said they knew that Lottie had mental-health problems, but that she didn't receive any real help with it.

13 SUMMARY OF WHAT ADULT A SAID

13.1 The review chair interviewed Adult A at his home address. He said it was the fault of the police and of the hospital that Lottie had killed herself. He said that both knew Lottie had mental-health problems yet neither organisation tried to help her.

13.2 He said he is angry that he has been accused of being a perpetrator, because he "*Wouldn't hurt a fly*". Adult A said he was abused by Lottie and it was not the other way around. He had never been abusive towards her and all he had done was to act in self-defence. He added that Lottie was often verbally and physically abusive towards him and that on the occasion she had broken her jaw, she had drunk a bottle of wine and had 'flung' herself down the stairs.

13.4 Adult A said that Lottie had 'just had enough' and that she didn't want to be here anymore. He said he was not at home when Lottie died because she had attacked him and he knew she would do it again if he stayed.

14 SUMMARY OF INFORMATION PROVIDED BY ONE OF LOTTIE'S FRIENDS

14.1 The review chair also met with one of Lottie's friends. She said that as a result of what Lottie told her, she found the telephone number of a solicitor who specialises in clients suffering domestic abuse and passed it on to her. She also gave her the telephone number of Women's Aid. The police have now interviewed the friend and details of what she told them have been forwarded to HM Coroner. Details of another friend identified during the review have also been provided.

15 CHRONOLOGY OF RELEVANT AGENCY INFORMATION

15.1 The following is a brief synopsis of the events leading up to Lottie's death. The involvement of each agency will be described in more detail as this report progresses:

15.2

LOTTIE		BRIEF SEQUENCE OF EVENTS
NPS	04/2007	Lottie disclosed to a Probation Officer that she was in a relationship with Adult A.
Police	31/12/2013	Third-party report of Lottie being assaulted by Adult A. Lottie declined to provide details; had an injury to her eye but would not say how it happened. Adult A not present when police arrived.
NHS	01/01/ 2014	Lottie told hospital staff that she had fallen down stairs and had injured her face and arm. No disclosures about domestic abuse.
Police	10/2017	Adult A made complaint of being assaulted by Lottie. Lottie arrested but declined to answer questions. Lottie alleged that Adult A had assaulted her. Lottie said that on 31/12/2013 she had been pushed down the stairs by Adult A and that she had not fallen as she had reported at the time. Lottie also said that five-years previously, Adult A had raped her in their home. Adult A attended the police station for a voluntary interview where he denied both allegations, saying he was the victim of Lottie's aggression. Insufficient evidence to charge Adult A and a dilemma for the police over releasing both to the same address (home jointly owned). Domestic Violence Protection Notice considered but not perused. Lottie referred to Women's Aid Adult A referred to Equation Men's Domestic Abuse Service

WAIS	11/2017	Several telephone conversations between WAIS and Lottie, but no face-to-face meetings despite extensive efforts by WAIS. MARAC referral made.
WAIS	11/2017	Lottie signalled willingness to go into refuge, but none available due to difficulties contacting Lottie safely.
NHS 111	11/2017	Adult A telephoned NHS 111 to say that Lottie wants him to kill her, and if he does not she will do it herself.
Hospital	11/2017	Lottie attended hospital (with Adult A) saying that Adult A had pushed her down the stairs causing injuries to her head and face. She also had a small stab wound to her abdomen and broken teeth.
Police	11/2017	Adult A arrested and denied assaulting Lottie. He said she suffered with depression and mental health issues and had been drinking. He was reported for summons for causing Grievous Bodily Harm.
Hospital	11/2017	Adult A attended hospital with minor injuries saying Lottie had thrown a dinner plate at him.
Police	11/2017	Lottie found on railway track at the rear of her home. Pronounced dead at the scene.

16 SUMMARY OF WHAT AGENCIES KNEW

16.1 The next section of this report will detail what each agency knew about Lottie and about Adult A, prior to the dreadful events of November 2017. An analysis of their involvement will follow each section in turn where appropriate.

16.2 ➢ **DERBYSHIRE HEALTH UNITED (DHU) HEALTHCARE CIC**

16.3 DHU Health Care is a 'not-for-profit' community interest Company. It has a subsidiary company, DHU 111 (East Midlands), which has its own in-house call centres providing an NHS 111 service covering Derbyshire, Nottinghamshire, Leicester, Leicestershire, Rutland, Northamptonshire and Lincolnshire.

16.4 In early November 2017, Adult A telephoned the DHU 111 Service saying that Lottie had telephoned him to say she had cancer and that she wanted him to kill her. She had also told him that if he didn't kill her, she would kill herself, (although Adult A told the call handler that he did not know whether she would do it.

Comment: *The national self-harm and suicide prevention support service that has supported this review has been in operation for 11-years. During that time, they have never heard of a person contemplating suicide asking someone else to do it for them.*

16.5 The call handler confirmed that Adult A was not with Lottie when he made the 111 call and also established that there was no immediate risk to Lottie. A Clinical Advisor telephoned Adult A back and told him to call NHS 111 again when he was with her so that a full assessment with Lottie could be undertaken; he agreed to do so. The Clinical Advisor also told Adult A to call for an ambulance if the circumstances were to change and if he felt that Lottie was at risk.

16.6 The call was not viewed as an extraordinary event or an emergency and the DHU 111 Service notified Lottie's GP practice of the call the same day.

16.7 **Analysis of the involvement of DHU Healthcare CIC**

16.8 If a patient calls NHS 111 and discloses suicidal thoughts or threats to end their own life there is a clear NHS Pathway for all staff to follow, which is slightly different when a caller expresses suicidal intention. In those cases, depending on their responses to questions, they may be referred to primary care centres for an urgent appointment. If they consider they are a threat to themselves or to anyone else, their response would be by way of a 999 call to the police.

16.9 A 'remote observer call' system is used by the NHS 111 Service, which gave the misleading impression that Adult A had terminated the call rather than it ending naturally. A recommendation will be made that that element of the system be reviewed.

16.10 ➢ **NHS NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP**

16.11 Clinical commissioning groups (CCGs) enable general practitioners and other clinicians to work alongside NHS managers and commissioners to plan and buy health services for their local population. A major part of its work is the effective 'commissioning' of services - this means ensuring that the organisation has the NHS services that people need and making sure they are high quality and value for money.

16.12 **SUMMARY OF WHAT THE NHS NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP KNEW ABOUT LOTTIE PRIOR TO THE SCOPING PERIOD**

16.13 Lottie was registered with the same GP Practice since 2001. Prior to the scoping period of this review, there was no mention of domestic abuse in her medical records.

16.14 There is a record of her admission to hospital in September 2006, following an episode of self-harm and an overdose (she had taken Paracetamol, Codeine, Hay Fever allergy tablets, Antihistamine tablets and Evening Primrose Oil tablets). She had also tried to stab herself. The records indicate she was supported by the Mental-health Team and that the episode appeared to coincide with the separation from her previous partner and a custody battle for her two sons.

16.15 Adult A was mentioned in her GP records following the birth of their baby in August 2008, their first and only child together.

16.16 Midwifery services identified concerns about Lottie's mental wellbeing during her pregnancy and they tried to encourage her to engage with support services, but she declined the offers. In 2010, after Lottie's child had been diagnosed with a serious medical condition, she visited the practice suffering from insomnia and a poor appetite. She said she was worried and that she felt suicidal. She was referred for psychiatric help and the records indicate that concerted efforts were made by several health professionals over the following years to support her.

16.17 **WHAT THE NHS NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP KNEW ABOUT LOTTIE DURING THE SCOPING PERIOD**

16.18 In April 2014 Let's Talk Wellbeing recommended that Lottie have further psychological therapy because of her ongoing mental-health issues, anxiety, low self-esteem and difficulties with interpersonal relationships. Domestic abuse was not highlighted as an issue at any time by counselling services or by the GP Practice.

Comment: *There is no policy in place at the GP practice about making direct or routine enquiry of patients about domestic abuse, but GP's do make direct enquiries dependent on the circumstances of each case. The experience of most health professionals is that women tend not to mind being asked about domestic abuse because they understand the reasoning behind it.*

Health services use clinical enquiry when there are indicators of domestic abuse and expectant mothers are routinely asked on at least three-occasions during their pregnancy and post-birth. The GPs had the IRIS Project and training about direct enquiry based on indicators and Information about domestic abuse and support services that are available for it have been provided by health. The information is displayed in locations accessed by the public. Health visitors and Midwives ask routinely.

16.19 Lottie had a review with the GP in June 2014 when she declined a review with the 'Reach Out' counselling service, stating she would prefer to see her previous counsellor. The GP then contacted the service on her behalf.

Comment: *The 'Reach Out' counselling service was taken over by the 'Forces' charity around the beginning of 2018. They have been able to confirm that Lottie self-referred to 'Reach Out' on 27th February 2015 and accessed the service with a counsellor, but that they have no other details of the referral. The counsellor no longer works for the charity. Forces said they would try to contact the counsellor to see if she would share information with the review panel, but to date there has been no response.*

16.20 Lottie had not been seen at the GP Practice since June 2014, but she had accessed the 'Out of Hour's service' in May 2016 and again in May 2017 with toothache and problems with a tooth crown.

16.21 The Out of Hours service (see DHU Healthcare CIC below) notified the practice that Lottie's partner had contacted them saying that Lottie had told him that she had cancer and that she wanted him to kill her. She had also told him that if he didn't kill her, she would kill herself, although he added that he did not know whether she would do it.

16.22 Two-days later, the GP Practice received another Out of Hours Notification, this time stating that Lottie had contacted the service for advice about ongoing pain following a

fracture to her jaw. She had said she was struggling to eat and drink due to the pain. She had added that her partner had made her shave her hair off because she was ugly.

16.23 The GP Practice was sent a DASH Notification that had been completed by the police. It stated that *'Her current partner has knocked her teeth out and pushed her down the stairs'.* It also referred to '*Their relationship isn't great and has been violent in the past'.* It informed the GP Practice that Lottie had been taken to hospital with cuts to both sides of her face and a broken jaw.

16.24 **Analysis of the involvement of the NHS Nottingham City Clinical Commissioning Group**

16.25 The GP practice in question receives a large volume of information from agencies about patients. Information about a patient can be missed unless it Is clearly highlighted that there is an action the GP needs to attend to or that the GP is required to review the information. Although the information was entered onto the GP system in a timely manner, there is no evidence of anything having been done about it.

16.26 The review panel felt uncomfortable about the processes at the GP practice once information was received there. As well as the notification about the DHU 111 call made by Adult A, the GP practice also received notification from the ambulance service about another incident the following day (Lottie had reported at 2.37am that Adult A had pushed her down the stairs and had slammed her face into the floor), but the two notifications were not linked together.

16.27 The review panel feel that the notification to the GP about the telephone call being made by Adult A should have requested that the GP read it, but the panel accepts that it was not viewed as an extraordinary event or an emergency. Had the GP been made aware of the information (and the report by Lottie that Adult A had pushed her down the stairs), he or she may have taken some action, especially given Lottie's mental health issues and her claiming to have cancer. Both notifications were endorsed by DHU *'There was no safeguarding concern',* something the practice acknowledge is very concerning given the circumstances.

16.28 There were also concerns highlighted during the review of information not being entered into Lottie's GP Records until several weeks after the event. This had been due to the fact that the Practice Manager had been absent through illness. There were examples of good record keeping as well, notably, the highlighting of individuals who are at risk from on-going harm.

Comment: *The issue of information not being entered onto a patient's record because of the absence of the Practice Manager has been addressed by the NHS Nottingham City Clinical Commissioning Group and good practice guidance has been developed and circulated to all Nottingham City practices, including processes for receipt of DART updates.*

16.29 A learning point for agencies is that if they are communicating with a GP practice with a view to action being taken by a GP, they must make that fact clearly apparent.

16.30 ➢ **NOTTINGHAM CITY COUNCIL ADULT SERVICES**

Nottingham City Council delivers a range of services to adults, families and communities throughout Nottingham City who require information and advice, support and appropriate assessment to maintain their health and well-being.

16.31 **WHAT NOTTINGHAM CITY COUNCIL ADULT SERVICES KNEW ABOUT LOTTIE AND ADULT A**

16.32 On 1st November 2017, a MARAC referral was received. The Duty Social Worker made telephone contact with Lottie who confirmed she was safe. She told the social worker that she was waiting for Women's Aid to access a refuge for her. Lottie confirmed she was able to contact the police and was able to manage her own needs. No further action was taken in line with policy and procedure.

16.33 On 7th November 2017, an email was received from the ambulance service to the effect that Lottie had reported that her partner had pushed her down the stairs and had slammed her face into the floor. A Health and Social care officer telephoned the hospital to confirm they were aware of the domestic abuse allegations and that a referral had been made to the Domestic Abuse Nurse, and a DASH risk-assessment had been completed. The Health and Social Care Officer also requested that Lottie be given the contact numbers of appropriate services including Adult Services and Women's Aid before discharge from the Emergency department, to ensure she was able to make contact if she required support in the future.

16.34 Because Lottie was known to have two children, a call was also made to confirm that a referral had been made to Children and Family services for screening. The call was followed by an email pointing out that two DART referrals had been received since 26th October 2017.

Comment: *DART is the acronym for the Domestic Abuse Referral Team*

16.35 On the 8th November 2017, a High-risk DART referral was received by Adult Services who attempted to contact Lottie by telephone on 8th, 9th and 10th November, but all the calls went straight to voicemail; no message was left for safety reasons; there was no other means of contact. The case was closed to adult services because no contact had been made after three attempts, as per policy and procedure. No letter was sent because it was not safe to do so with Lottie and Adult A living together. Children's services also contacted adult services to say the referral would not be progressed because there were no children living in the household and there were no identified children's safeguarding issues.

Comment: *The two children had been in the care of their father for several years.*

16.36 ➢ **WOMEN'S AID INTEGRATED SERVICES (WAIS)**

WAIS offers confidential advice, information and support to women and children who are experiencing or who have experienced physical, sexual or emotional abuse from someone with whom they have had an intimate relationship.

16.37 **WHAT WOMEN'S AID INTEGRATED SERVICES KNEW ABOUT LOTTIE AND ADULT A**

16.38 WAIS began their support for Lottie when she telephoned their helpline on 7th April 2017. She said she had suffered abuse over the past 12-years. A DASH risk-assessment was completed with ten-ticks, but it was inaccurate because Lottie kept changing some of her answers. Lottie was asked to ring the helpline back when she had considered her options, including leaving Adult A and going into refuge.

16.39 Lottie telephoned again the following day. She repeated a lot of what she had already said but she also insisted the abuse was 'just' financial and emotional. There was a discussion about what Lottie could do with her belongings, particularly her photographs, if she left. Suggestions were that she could use a storage unit and/or leave her belongings with family or friends. Lottie agreed to have a face-to-face conversation to discuss her options and she was given advice about contacting the police. A referral to the RISE team was made the same day.

Comment: *'RISE 'is the name of the outreach service (it is not an acronym).*

'Standard-risk' means the current evidence does not indicate likelihood of causing serious harm.

Being assessed as at medium-risk means indicators of risk of serious harm have been identified with a perpetrator having the potential to cause serious harm but who is unlikely to do so unless there is a change in circumstances.

A risk-assessment of 'High' is determined when there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Serious harm is defined as a risk that is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

16.40 Attempts were made to speak to Lottie on the phone the following day, but there was no answer. No message was left because it was not known whether it would have been safe to do so.

16.41 Lottie telephoned again on 11th April 2017 and was advised to seek some support from her GP. She agreed to be put through to RISE rather than them trying to ring her back and she asked if WAIS would telephone her again the following day between 9am and 12noon.

16.42 On 13th April 2017, Lottie telephoned again to say she had been expecting a call. The RISE team were asked to call her and then Lottie telephoned once more to say she had missed a call from a withheld number. It was explained to her that calls from WAIS would be from a withheld number. The RISE team were told that Lottie had telephoned, and they agreed to call her back. Lottie talked about her finances being in Adult A's bank account rather than in their joint account, and Lottie being dependent on him for money.

16.43 A 'Drop-in' session was booked for Lottie for 27th April 2017 and calls were made to identify a refuge that Lottie may have been able to access, despite Lottie saying that she didn't feel ready for it; none was found.

Comment: *The drop-in appointment was made so far in advance because it was the first available date that suited Lottie. Lottie did not attend the drop-in session and a WAIS worker attempted to telephone her that day, without success.*

16.44 Lottie sent a text message to say it was safe to ring and when the worker called her, Lottie said she was still in a controlled relationship and that she was feeling low, losing her hair and that she did not feel up to attending an appointment. The worker agreed to keep Lottie on the waiting list for one-to-one support and said that if Lottie felt able, she could present at the women's centre. Lottie confirmed that she had the number for the helpline.

16.45 On 30th May 2017, an attempt was made to call Lottie on her phone but there was no answer. On 2nd June 2017, Lottie told the worker that she did not want ongoing support. Lottie also said that Adult A was controlling and that she felt trapped financially. She confirmed that she would approach the Women's Centre for a drop-in if she decided to leave. Lottie was advised about options open to her and about housing options and refuge. Safety planning was carried out including her establishing a safe room and securing her important documents. She was told that she could come to a drop-in, or if it was out of hours, she could use the helpline.

16.46 Early in October 2017, Lottie telephoned the helpline asking for urgent advice because her husband had left the house two-days previously but had sent her a text message to say he will be returning. She was advised to contact a solicitor to arrange for a non-molestation order to be put into place, that if he came to the house, she should call the police and that she should have a friend with her. The worker asked Lottie for a telephone number on which she could contact her, but she said she did not know it. It was agreed that Lottie would call the helpline again and the police to make them aware that her husband had been in contact.

Comment: *Lottie referred to Adult A as her husband although they were not married.*

16.47 A week later, Lottie telephoned to say that she had no hair because her partner had told her to shave it off because she was too pretty. She also said she had been beaten by her partner during the week and had been left with lots of bruises. Lottie was encouraged to try to get out and to not let her appearance stop her. It was suggested she may wear a hat, but Lottie said she was very concerned about her appearance. She did not answer many of the questions asked of her by the worker who noted that Lottie was more concerned about her appearance than her safety.

16.48 The WAIS worker asked Lottie if the police had carried out a DASH risk-assessment on 21st October 2017, and she said she thought they had. Lottie said that she did not want to carry on anymore and that she had seen her GP. Refuge was discussed but Lottie said that because she and Adult A had a joint mortgage and that he received her welfare income,

she did not want to access refuge. Lottie added that she had pressed charges against her partner, but he had denied the allegations and had been released with no restrictions being placed upon him. Lottie was invited to attend a drop-in session, but she said she would not be comfortable doing so because of her appearance. The staff member said she would chase-up the DASH risk-assessment with the police.

16.49 A taxi was arranged to take Lottie to a drop-in session in early November 2017 (Lottie said she could not make an earlier session on the Thursday). It was agreed that WAIS could telephone Lottie between 8am and 5pm, Monday to Friday, but no text or voice messages would be left. Lottie said she would contact the helpline if she needed any support before the drop-in session. Lottie asked for advice about how she could keep her husband out of the house and she was told that because it was in joint ownership, she would have to call the police if there was an incident. She again talked about her hair and said that Adult A had pinned her down and had shaved it.

16.50 A DASH risk-assessment was completed which came out as high with suicidal thoughts, but that Lottie had no planned intentions of taking her own life. Lottie said she thought Adult A would kill her. Lottie was advised to speak with her GP about how she was feeling and to call for medical help if she was feeling suicidal. A referral was made to MARAC.

16.51 Lottie telephoned to say that someone was going to ring her back, and when she was asked why, she said it was about Adult A shaving her hair and that she couldn't leave the house. She said she had contacted her GP and that she wanted to go into refuge and she could do it that day. She was told that a check would be made about refuge availability and that she would be called back.

16.52 Before refuge availability had been fully explored, Lottie rang back to ask about it. She also asked what she should do about her hair and if she could take her belongings to refuge. She was told she would be called back once refuge availability had been established and it was suggested that she could wear either a hat or a wig. She was advised that she would be able to take some belongings to refuge, but not furniture.

16.53 Lottie later rang the helpline and was told that two refuge spaces were available, and she said she was willing to go to either. When the call was made to Refuge A the space had gone and Refuge B said they had just taken another referral but that they would let the helpline know if they accept it or not.

16.54 Calls were then made to various refuges with Refuge C being the only one with a space. They said they had just taken a referral, but that they would telephone Lottie. Lottie was told that if a space was not available, the plan was to call the Housing Aid's 'Out of Hours' service to find her somewhere safe to go to. The worker suggested that Lottie might go somewhere safe to wait, such as a café because Adult A was due home at 5pm. An offer was made for the worker to telephone Lottie's GP to ask if there was a safe room there that she could wait in, or enquiries could be made for her to go to refuge in Northampton (Refuge D).

Comment: *Refuge C telephoned Lottie three-times but there was no answer and at 5pm they stopped trying because Adult A was due home at the time.*

16.55 Refuge B rang to enquire why the helpline had not sent a referral form for Lottie. It was explained that because the helpline had been told that the space had gone, there had been no need to send one. Refuge B said they did have a space and they would hold it until the morning.

16.56 The following day, the helpline was told that Refuge B had been unable to contact Lottie. The helpline telephoned Lottie who said she was on a tram because she had to deliver some bank statements to her solicitor. She was asked if she still wanted to go to refuge and she said she would have to because Adult A had told her that he was leaving and that she could have the house, but she could not afford to pay the bills. She added that she had been packed since yesterday, ready to go. The telephone signal was not good, so the helpline agreed to call Lottie back.

16.57 The helpline then rang Refuge B and left a message for them to ring back with an outcome for Lottie's referral. Internal arrangements were made for Lottie to be called back the following day between 9am and 5pm to see if she still required refuge. Several attempts were made by the Helpline and the refuge to contact Lottie with no response. Refuge B could not hold the place for her.

16.58 A telephone call was made to Lottie to ask if she still required a taxi to attend the Drop-in appointment and to see how she was, but the phone went straight to voicemail.

16.59 Lottie was called again three-days later, to ask if she wanted to rearrange her Drop-in appointment. She said her phone battery was low and then the line was lost.

16.60 The following day another call was made to Lottie because the DASH risk-assessment had been received for the MARAC in November 2017. There was no answer and no message was left for security reasons.

16.61 Lottie telephoned the helpline to say she had called the previous week and had been waiting for a call back. She said there had been an incident when Adult A had thrown her down the stairs fracturing her cheek bone and jaw and that Adult A had told the police she had fallen down outside. Lottie asked for a worker to visit her at home because she was bruised, and her hair shaved. She added that Adult A was not coming back and asked how she would be able to pay her bills.

Comment: *Lottie had disclosed to WAIS that Adult A had left her and around the time he left, there had been an incident on 21st October where the police were called and that two-days later he texted her to say he was coming back. After the incident where she fractured her jaw, Adult A left again.*

Due to the risk to WAIS staff, a visit could not take place in Lottie's home.

16.62 A call was made to RISE requesting they contact Lottie and they said they would do later the same day. A telephone call was made to Lottie to explain the IDVA/MARAC services and to tell her that her case was being treated as high-risk. Lottie said she was waiting for

a call from the hospital about her broken jaw and that she wanted to speak to them first. It was agreed that she would be called back that afternoon and when that happened, the call went straight to voicemail. Lottie's case was then closed because she had not engaged with the service. Other services were told that they could re-refer Lottie if appropriate.

16.63 On 10th November 2017, two telephone calls were made to Lottie but there was no response. No messages were left for security reasons.

16.64 **Analysis of the involvement of WAIS**

16.65 The service may have appeared confusing to Lottie. She probably did not realise that RISE, the helpline and the IDVA service were all from the same organisation and all had access to her notes. However, given there was never a face-to-face meeting with Lottie and staff were always responding to her specific needs over the telephone, there was little opportunity to explain to Lottie the structure of the organisation.

16.66 The helpline has very little control over refuges. They act as a gateway to referrals and each refuge has different criteria for access and can be receiving multiple referrals for their spaces. The highest-risk women who respond to the calls back are usually prioritised.

Comment: *A recommendation from this review is that the Nottingham Crime and Drugs Partnership should support the national recommendations about maintaining or expanding refuge spaces and there being a centralised referral system.*

16.67 Initially the abuse Lottie described was financial and emotional, but over time her contact with WAIS saw the abuse she described escalate to high-risk and on 31st October 2017, a referral was made to MARAC. The majority of contact Lottie had was through the helpline service (a 24-hour telephone service for women and agencies for practical and emotional support including referral to emergency accommodation).

16.68 At times Lottie presented as chaotic and confused, but no-one from WAIS was able to meet with her face-to-face, despite some creative efforts to try to do so. They suggested ways she could disguise her shaved head, they booked appointments for days and times that she was available and on one occasion they booked a taxi for her, but she didn't use it; it is not known whether that was because Lottie couldn't or wouldn't meet with WAIS.

16.69 Lottie had contact with the helpline, RISE and the City IDVA services and there may have been occasions when she was confused about who she was speaking to who and why; she had to repeat her story to several WAIS staff within a short space of time.

Comment: *WAIS had access to the same on-line information about Lottie, but at times staff responded just to the immediate call from her. A learning point for the organisation is that if the staff had taken the time to read the previous notes they would have had more background information. This has been addressed by WAIS who has ensured that helpline and RISE staff have received internal training about referral processes and how to stop/reduce clients having to repeat themselves.*

16.70 ➢ **NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST (NHCFT)**

Nottinghamshire Healthcare NHS Foundation Trust delivers a range of support and treatment services across the East Midlands Region. It serves adults, their families and communities who are affected by mental-health, substance misuse and other issues through primary, secondary and specialised service as required. The service is delivered as an integrated service in partnership with social care and health.

16.71 **SUMMARY OF WHAT NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST (NHCFT) KNEW ABOUT LOTTIE PRIOR TO THE SCOPING PERIOD**

16.72 In September 2006 and January 2007, Lottie underwent mental-state examinations following Incidents of self-ham and overdose.

16.73 In December 2006 and March 2007, she was referred for a psychiatric report in respect of family court proceedings involving her previous partner who was the father of their two children. In May 2007, Lottie was formally discharged from mental-health services - a letter regarding this and arrangements for her medication were sent to her GP.

16.74 Lottie was referred to the perinatal psychiatry service in August 2008, but she declined the service, so the case was closed.

16.75 **WHAT NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST (NHCT) KNEW ABOUT LOTTIE AND ABOUT ADULT A DURING THE SCOPING PERIOD**

16.76 During the scoping period, NHCT had only one individual significant contact with Lottie and no contact with Adult A.

16.77 On the 21st October 2017, a Criminal Justice Liaison Team (CJLT) mental-health worker spoke to Lottie in a police cell following her arrest on suspicion of assaulting Adult A. The police had referred her because she had appeared distressed when she was arrested.

Comment: *The CJLT aims to identify a person's vulnerabilities at the earliest point of the criminal justice service and, where appropriate services are required and not already available, refer them on, supporting them through the process.*

16.78 The consultation resulted in the following:

- The police were told that Lottie was fearful of what may happen to her when she was released
- The nurse was told that Lottie may need to be reviewed due to health issues
- Lottie was offered community follow-up via an opt-in letter
- Lottie was signposted to Women's Aid
- Confirmation that the police had completed a DASH risk-assessment
- Flagged concerns to the Duty Officer/Officer in the case.

16.79 ➢ **NOTTINGHAM HOSPITALS UNIVERSITY TRUST (NUH)**

Nottingham University Hospitals NHS Trust is an acute health-care provider. The Trust provides a wide range of health services for Nottingham and Nottinghamshire and the surrounding areas. NUH employs a domestic abuse specialist nurse who is partly funded by the Crime and Drugs Partnership in 2017/2018.

16.80 **WHAT NOTTINGHAM HOSPITALS UNIVERSITY TRUST (NUH) KNEW ABOUT LOTTIE AND ABOUT ADULT A**

16.81 **LOTTIE**

Lottie attended the Emergency department on the 1st January 2014, saying she had fallen down the stairs at home and had injured her face and her arm. When asked, she said she had lost her balance at the top. The description of the incident matched her injuries and there was no suspicion that domestic abuse might have taken place.

16.82 On 7th November 2017, Lottie attended the hospital emergency department with Adult A. She said that she and Adult A had argued and that he had then pushed her down the stairs and that she had banged her head into the wall. She added that she was unclear how they had ended up in the emergency department and that she would rather die than stay in the situation she was in.

16.83 Adult A was asked to leave the department, which he did, but Lottie was very annoyed about it because she said wanted him to see her wounds and to see the pain she was in. She tried to telephone him to get him to come back into the room.

16.84 Lottie wanted to get back to her house, saying she did not want Adult A to be there alone, but she did not say why. She then became upset and started crying, saying she couldn't deal with it any longer. When asked, she said she wanted the police to be called, but she then started talking about going home again.

16.85 It was documented that Lottie had a bruise to the back of the head, a laceration to her chin and cheek, grazes on the other cheek and an old small stab wound to her abdomen; she also had some broken teeth. She said that Adult A had been doing it to her for ten-years. She added that she had cut her hair because Adult A had told her that she wasn't beautiful enough to have long hair. She wanted him to stay in the department, but not be in the cubicle with her, because she wanted him to be tired and to suffer (indicating that she didn't want him to be able to get any rest).

16.86 Adult A was tearful when he returned to the department. He said Lottie had assaulted him and that she had had mental-health problems for a number of years but was not taking any medication for it. He said he had wanted to leave her, but while he was packing, she began hitting him and she then fell down the stairs. He told staff that she received the facial wounds after falling outside. He also said that Lottie had threatened to kill herself if he left and that she had stabbed herself with something.

16.87 Examinations revealed that Lottie had a fracture to the upper part of her jaw. No surgical intervention was required, and a follow-up appointment was arranged for 10th November 2017. She was advised to contact her dentist because of the damage to her teeth.

16.88 A DASH risk-assessment was completed which identified the risk as medium, but it was escalated to high-risk on professional judgment, due to the significant injury and also because Lottie had described being isolated from family and friends and having suicidal thoughts.

16.89 The DASH was sent to the DART/MARAC. Lottie was seen by the emergency department domestic abuse specialist nurse, but she refused to discuss anything. Lottie was offered access to refuge from Women's Aid which she declined and an offer of an overnight admission to hospital, but she just wanted to go home. Adult Social Care contacted the emergency department on receipt of a domestic abuse referral from EMAS and checked that the emergency department knew about the domestic abuse incident.

Comment: *Lottie had not been known to adult services prior to the domestic abuse incident. The emergency department confirmed that Lottie was not known to adult social care and that no care needs had been identified.*

16.90 When Lottie was medically fit to be discharged, the police took her home.

16.91 Three-days later, Lottie attended the emergency department again, complaining of dizziness and anxiety following the previous incident. She said that Adult A was harassing her and that he was staying with his mother, but that he still had keys to the house. She told the domestic abuse specialist nurse that she was still seeing Adult A, that there had been no further abuse and that she was not going to contact the police. Housing and support to access refuge as a safe place were discussed, but Lottie declined the offer of support.

16.92 **ADULT A**

Adult A attended the emergency department on 23rd October 2017, stating that while being arrested by the police they had grabbed him, and he had fallen awkwardly onto his knees. He said he had been in pain in both thighs ever since. He had a medical assessment and was discharged.

Comment: *Adult A was arrested at his home address on 21st October 2017, on suspicion of raping Lottie in 2012. He became agitated and started to thrash about and the police found it necessary to strike him twice to the thigh to take him to the ground so that they could place handcuffs on him.*

16.93 Adult A also attended the emergency department on 7th November 2017, when he said he had been assaulted by Lottie and that it was a long-standing situation. He had bruising and a small laceration to his forehead which he said had been caused by Lottie throwing a dinner plate at him. He had healing scratches to the back of his neck and to both forearms, which he said Lottie had caused two-weeks previously and a large fading bruise to his knee

which he said had been caused by the police when he had been arrested. A DASH risk-assessment indicated the risk to be high and he was referred to MARAC.

16.94 **Analysis of the involvement of Nottingham Hospitals University Trust**

Good practice was evident throughout with regards to Lottie. There was a demonstrable awareness of her situation, with staff able to recognise and respond appropriately to the disclosure of domestic abuse. Appropriate clinical enquiry took place, appropriate referrals were made, and relevant information was shared.

16.95 There was documented evidence that a discussion took place with Adult A as to whether he felt safe to return home or if he wanted to access refuge or stay in hospital as a place of safety.

16.96 ➢ **EQUATION MEN'S DOMESTIC ABUSE SERVICE**

Equation's Men's Service provides support and advocacy for men experiencing domestic abuse across Nottingham City and County. Referrals can be for standard, medium and high-risk cases of domestic abuse. Standard and medium-risk referrals come from organisations or self-referrals. High-risk referrals come via MARAC and following a high-risk-assessment through a DASH risk-assessment form.

16.97 **WHAT EQUATION MEN'S DOMESTIC ABUSE SERVICE KNEW ABOUT LOTTIE AND ABOUT ADULT A**

16.98 The police referred Adult A into the service on 23rd October 2017, with Lottie being identified as the possible perpetrator.

16.99 Referral checks were requested from the WAIS helpline because both Adult A and Lottie had been living in the city. On 31st October 2017, WAIS responded, detailing their involvement with Lottie who had been in contact with the helpline on 24th October.

Comment: *The Men's Service specification is to provide support to male survivors rather than to perpetrators. All referrals are checked for their involvement with other services. Where counter allegations are made, the cases are assessed to clarify who is thought to be the primary perpetrator in a relationship.*

16.100 WAIS confirmed that Lottie was an open case with their IDVA Service and that the case was to be heard at MARAC on 23rd November 2017, with both Lottie and Adult A listed as survivors (with each other listed as the perpetrator).

Comment: *Adult A was not contacted prior to the MARAC because of concerns about his abuse towards Lottie and the concern that he was the primary perpetrator in the relationship. Risk to female survivors can be increased if primary perpetrators are misidentified as survivors. It was considered prudent to wait for further information from the MARAC to aid decision making about contact.*

16.101 **Analysis of the involvement of Equation Men's Domestic Abuse Service**

16.102 At the time of the referral all procedures and standard practice were followed. The procedures had been developed to ensure potential perpetrators did not receive a service and increase risk to the true survivor. This has always been seen as a positive protective function of the Men's Service.

16.103 Communication with WAIS was effective because workers were able to share information about the relationship dynamics, which identified Adult A as the primary perpetrator.

16.104 Recently, Equation has made some alterations to its assessment process. The service now contacts most referrals to acknowledge receipt of the referral and to further assess need and suitability for the service. The service will not contact anyone with current criminal proceedings relating to domestic abuse, restraining orders in place, or multiple survivors associated with the individual. All cases are considered on an individual basis. The men's service does not provide support to perpetrators of abuse but, if appropriate, will signpost them to support such as the RESPECT helpline (a national support helpline for individuals who are concerned about their abusive behaviour).

16.105 ➢ **NOTTINGHAMSHIRE POLICE**

Nottinghamshire Police provide a policing service for the population of Nottingham and Nottinghamshire. The population of the City and County is just over one million. The current establishment of the force is in the region of 1900 officers who are supported by 1300 members of police staff.

16.106 **WHAT NOTTINGHAMSHIRE POLICE KNEW ABOUT LOTTIE, AND ADULT A**

16.107 **WHAT NOTTINGHAMSHIRE POLICE KNEW PRIOR TO THE SCOPING PERIOD**

16.108 On four-occasions between June and August 2006, Lottie was recorded as the perpetrator of domestic violence against her previous partner. She appeared at court in March 2007, charged with four counts of assault. She was found guilty on two charges and not guilty on the other two and received an 18-month Community Order.

16.109 In September 2007, together with Adult A, Lottie was given a formal warning not to cause harassment, alarm or distress to their next-door neighbours.

16.110 **WHAT NOTTINGHAMSHIRE POLICE KNEW DURING THE SCOPING PERIOD**

16.111 Late on New Year's Eve 2013, an emergency call was received by the police from an hotel to the effect that Lottie had told staff that she had been assaulted by Adult A.

16.112 Adult A was not there when the police arrived. Lottie was drunk and uncooperative and would only tell the officers her first name. She refused to return to her room because she

said she felt unsafe there. Staff offered her another room and when she declined, they offered to telephone someone to collect her or get her a taxi, but again she declined.

16.113 Lottie had a visible injury to her left eye, but she would not say how it had been caused. The incident was therefore treated as 'non-crime' domestic incident. DASH risk-assessment forms were completed as best they could be due to the extremely limited information provided because Lottie had refused to participate in the process. Lottie was assessed as standard-risk on the information obtained.

Comment: *A non-crime domestic incident is one where the circumstances indicate that an incident, or series of incidents, has taken place which may fall within the definition of domestic abuse and requires to be recorded as such, but where no substantive criminal offence is disclosed.*

16.114 Officers were later called back to the hotel because Lottie had ordered a taxi but had then refused to get in it. She eventually decided to stay in her hotel room and no further action was required.

16.115 At 7am on 21st October 2017, Adult A telephoned 999 to say that Lottie was going to stab him. When the police arrived, they found that Adult A had scratch marks to his chest, neck, face and back. He was standing at the front door and Lottie was in the hallway. She appeared hysterical and confused and an officer took her upstairs to talk to her. Another officer spoke to Adult A downstairs; he too was upset, and he said that Lottie needed help. He added that she had recently had a mental breakdown which had made her attack him when he was making the telephone call to the police. He also said that she had recently shaved her hair off and since then, she had become anxious and had been behaving irrationally; only the day before he had received a telephone call from her stating that she had stabbed herself in the stomach and that she wanted to die.

Comment: *Exactly what happened between Lottie and Adult A and why it happened is far from clear.*

16.116 An officer checked Lottie for signs of self-harm and noted that she had cuts to her wrist and a small wound on her stomach. She said they were self-inflicted and that she wanted to die. She began to cry and she was concerned about how her hair looked.

16.117 After speaking with Adult A again, the police arrested Lottie for assault. On the way to the police station, Lottie said, *"I went and got a knife because he was getting at me. If I didn't stop I would have killed him because I want him out of the way".* Later in the journey she said she had not gone to get a knife but had only thought about getting one and that she wanted help.

16.118 Whilst in custody, Lottie repeated that she wanted to die; she said she had stopped eating and drinking and that Adult A had made her shave her hair. The police were concerned about her, so they arranged for her to undergo a mental-health assessment.

16.119 Adult A told the police that Lottie's behaviour had been out of character, but around seven-years previously she had suffered a mental-health breakdown and had punched him

in the face and had threatened him with a bread knife. After receiving support, there had been no further incidents until that day.

16.120 Adult A also said that in 2011, Lottie had broken his nose and had threatened him and her daughter with a knife. He also said she threw a mobile phone at him which had cut his head. He said he was frightened that she would kill herself and that several years previously, she had taken an overdose and had stabbed herself in the chest. He said Lottie was anxious about going outside into the public and had recently become aggressive because she had shaved her hair off and then decided she didn't like it.

16.121 Adult A said he did not want Lottie prosecuting and only wanted her to get help and support for her mental-health issues. He refused to provide a statement but did complete a DASH risk-assessment and was assessed as being at medium-risk.

16.122 A mental-health assessment was carried out which revealed that Lottie was fit to be detained and interviewed.

Comment: *Checks revealed that Lottie was known to mental-health services but that she was not open to any mental-health teams.*

16.123 On legal advice, Lottie declined to answer any questions (during police interviews) about the incident for which she had been arrested. After the interview, she said she had acted in self-defence and that when Adult A had told her he was going out to watch a football match, she had said she would go out as well. When she then tried to leave, he had grabbed her around the throat and she had scratched his arm to get him off her. She said he then pushed her, so she scratched his neck in self-defence.

16.124 Lottie then went on to say that Adult A had raped her about five-years previously in their home and that on another occasion he had punched her in the face after an argument. She then talked about the incident in the hotel and said she didn't tell the police what had happened at the time, but that Adult A had assaulted her; she required stitches to her face and leg and she also lost a tooth. She said she was with him in the hotel bar when someone bumped into them by accident, spilling some drinks. Adult A had told her it was her fault and when they went to their room he had pushed her down some stairs. Adult A was arrested on suspicion of rape.

Comment: *It was during this arrest that Adult A was struck by the police to take him to the ground so that he could be handcuffed.*

In some instances, both parties in an abusive relationship may be vulnerable and have multiple complex needs. In cases where there are counter allegations, it can be difficult to identify the primary perpetrator and some individuals who perpetrate abuse are at a significant risk of retaliatory abuse from those they abuse and that a serious incident or injury can result. Evidence from previous DHRs suggests that where there are mutual allegations of domestic violence (especially where the couple have alcohol problems and chaotic lifestyles) there is a significantly increased risk of extreme violence and potential homicide. In complex cases where there are concerns regarding risk management for both parties, current local practice is to refer both individuals to MARAC so that information regarding risk can be shared and appropriate support put in place. There is a gap locally and nationally for a multi-agency forum to risk manage perpetrators of abuse who pose a risk to others but who are themselves, under threat of abuse/retaliation.

Alongside this, a recommendation emanating from this review is that in complex cases where there are mutual allegations, partner agencies should move away from an incident-based approach to a pattern-based approach, in an attempt to establish who is instigating the abuse. There is a need for agencies to better understand whether, for example, a primary perpetrator is exhibiting controlling or abusive behaviour that does not necessarily involve physical violence but is responded to by a survivor out of retaliation or self-defence.

16.125 A DASH risk-assessment was completed after the rape allegation, during which Lottie stated that:

- She was frightened of Adult A controlling her
- Adult A drank a lot
- She felt isolated and depressed
- She had suicidal thoughts
- She was subjected to 'arrogant verbal abuse'
- Adult A didn't like her talking to her friends or family
- She was being financially abused

Comment: The Officer recorded her risk-level to have been medium.

16.126 With Adult A in custody, Lottie was taken home to allow her to rest prior to undertaking an 'Achieving Best Evidence' (ABE) interview the following morning.

16.127 The Public Protection Unit (PPU) investigated the rape allegation. Following Lottie's release from custody, she was spoken to on the telephone and said she would not be interviewed again until she had a wig to hide her hair and that it was a matter of personal dignity to her. She said she was suffering bad panic attacks because of it.

16.128 When she was seen, she initially agreed to conduct a video recorded interview, but she then changed her mind and declined to make a statement as well. She went on to say that she did not know if the allegations she had made were true and that she did not know if she would be strong enough to see the matter through to court.

Comment: *It has been a feature of many domestic homicide reviews that the victim of domestic abuse made a conscious decision not to make a formal statement of complaint or to support a prosecution. The reasons are varied and are known to include a lack of confidence, (the impact of coercive relationships erodes the self-confidence of those being subjected to abuse), emotional attachment with the abusive partner, a fear of reprisals and a real fear of being made homeless.*

16.129 Lottie said she had disclosed her allegation of rape to two friends.

Comment: *Lottie declined to divulge to the police the identities of either friend and neither was traced during the criminal investigations. The identity of both was established during this review. As a result of what one of the friends disclosed to the review chair, a decision was made not to interview the second friend and to refer the matter back to the police for further investigation. The review panel understands that the police have taken statements from the witnesses and that they have been forwarded to the Coroner in readiness for the inquest proceedings.*

16.130 When Adult A was interviewed about the allegations, he denied everything. He said that Lottie was mentally unstable and that she needed help. He stated that Lottie had telephoned him at work and told him that she wanted him to kill her. She then told him that she wanted to die and had stabbed herself in the stomach. He also said that there had been issues since their child had become ill and that it had sent Lottie *"Over the edge"* and that she had then started abusing him.

16.131 A decision by the Custody Sergeant was made to take no further action against Adult A due to a lack of evidence.

16.132 Prior to Adult A's release, Lottie was advised to re-contact her solicitor for advice, to seek help from Women's Aid and to see her GP about her depression and anxiety.

16.133 Lottie was told that Adult A would be released soon and that the police did not have the legal authority to prevent him from returning home. It was suggested that she might prefer to stay with a friend or relatives for the evening or to ask one of them to stay with her, but she was insistent on not leaving her house and on Adult A staying away.

Comment: *The police faced a dilemma when it came to the release of Adult A. Lottie and Adult A jointly owned their house; both said they were victims of domestic abuse and not perpetrators, there was insufficient evidence to charge either of them with a criminal offence, so there was no opportunity to impose police bail with conditions and in the judgement of the officer in charge of the case, the Domestic Violence Protection Notice (DVPN) legislation was inappropriate because it was not possible or fair to 'Pick a side' with a view to having one of them removed from the property.*

Domestic Violence Protection Notices and Orders are aimed at perpetrators who present an on-going risk of violence to a victim with the objective of securing a coordinated approach across agencies for the protection of victims and the management of perpetrators.

A DVPN is the initial notice of immediate emergency protection that is issued by a police force. It can only be issued by a police officer of the rank of superintendent or above. Within 48 hours, an application for a DVPO must be heard at a Magistrates court.

A DVPO is an order made by the Magistrates court after a DVPN has been issued. The protective conditions available to the Magistrates court include provisions to prohibit the perpetrator from molesting the person for whose protection it is issued. This would encompass the perpetrator using or threatening violence, intimidating and harassing behaviour and restrictions on coming near or entering the victim's premises, even if co-habiting. A DVPO may be in force for between 14-28 days, beginning on the date it is made by the Magistrates court.

Nottinghamshire Police has reviewed the use of DVPN's for perpetrators of domestic abuse. In the year since the decision by the officer in this case, the need to consider the use of DVPN's has been reinforced to officers and the numbers have been, and are still, increasing. Staff have all been briefed in the Vulnerability briefings and Superintendents have been advised around the recording the rationale behind their decision making in respect of DVPNs.

16.134 During the early hours of the morning of 7th November 2017, Lottie was admitted to the hospital emergency department (with Adult A). While at the hospital, Lottie made an emergency call to the Police reporting that Adult A had attacked her, knocked her teeth out and had pushed her down the stairs. She said the incident had occurred the previous day around 5pm.

16.135 When they got there, Lottie told the officers that she had been pushed into a wall at the top of the stairs at her home address, had fallen down two-steps and had banged her head. She said it had happened in the early hours of that morning, following an argument.

16.136 She said that she did not want to make a statement or support a prosecution and that all she wanted was to see a dentist. An Officer then completed a DASH risk-assessment during which Lottie said it wasn't the first time she had been injured and that she was frightened of Adult A causing her more injuries. She said the abuse was happening more often and was getting worse and that Adult A had control of her money; she felt isolated and had suicidal thoughts. Lottie was assessed as being at medium-risk.

Comment: *The incident was later re-assessed by the Domestic Abuse Support Unit. The risk-level was raised to high and arrangements were made for the case to be heard at the next MARAC on 23rd November 2017.*

16.137 The police telephoned Adult A and asked him to attend an Interview. He agreed, and arrangements were made for him to come to the police station as soon possible. He arrived a short time later and was interviewed. He said he had pushed Lottie because she had been 'lunging at him', and she had banged her head; she then went into the garden, only to return with facial injuries. He said she had depression and mental-health issues and had been drinking.

Comment: *A recommendation to come out of this review is that Nottinghamshire Police need to evaluate the use of voluntary attendance in respect of domestic abuse flagged crime, to ensure it is appropriately used and is effective. The issue has also been covered in the recent vulnerability briefings given to all staff.*

16.138 Lottie died four-days later, and it was during the post-mortem examination that it was discovered she had the coins, jewellery, a medal and batteries in her stomach.

Comment: *Adult A appeared to be surprised when he was told about the items found in Lottie's stomach. Self-harm by ingestion is often carried out in secret, so Adult A may well have been unaware that Lottie had swallowed the objects.*

17 ADDRESSING THE TERMS OF REFERENCE

17.1

- *Whether Lottie's death was related to domestic violence or abuse including coercive and controlling behaviour in her relationship with Adult A, whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse*

There is certainly evidence that Lottie considered herself to be have been coerced and controlled by Adult A and she also made allegations that he was physically abusive towards her. She disclosed as much to friends, the police, WAIS, the ambulance service and to hospital staff. At times, Lottie had physical injuries that supported what she was saying, but it must be stressed that Adult A strenuously denies he was in any way abusive or violent towards Lottie and that in fact he was the victim of abuse from her.

17.2 Whether Lottie was a perpetrator of domestic violence and abuse, a victim of it or both, there is no doubt that the awful spectre of domestic abuse subsumed her. The review

however, has not uncovered any clear causational link between the abuse and Lottie's death.

17.3 There were warning signs because Lottie contacted the agencies mentioned above. She was clearly reaching out for help, but at various times there was an imbalance between Lottie accessing support and it being available when she needed it most; she tried to access refuge, counselling and she engaged with WAIS, but barriers prevented her from engaging face-to-face.

17.4 There was no unwillingness by people or by services to support Lottie, but the reality is that services cannot accommodate everyone just when they want it; it is not always possible to have a person-centred approach.

17.5 There is always more that can be done to raise awareness of domestic abuse and Nottingham City actively promotes and raises awareness of it through campaigns such as 'Ask Me' and 'Change That Lasts'.

17.6

- *What barriers were experienced by Lottie or her family/friends/colleagues in reporting any abuse in Nottingham or elsewhere, and did they how to report domestic abuse should they have wanted to?*

Lottie and at least one of her friends contacted specialist domestic abuse services for support. There were nevertheless barriers for Lottie such as her mental-health issues and difficulty she had in actively engaging with services. According to Lottie's mother, one thing that Lottie had great difficulty in coming to terms with was being abandoned. Adult A left Lottie on her own towards the end of October 2017 before announcing two-days later that he was going to return and then he left her again four-days before her death.

17.7 Lottie clearly lacked self-confidence which in itself is a significant barrier to reporting, but she had also become isolated in her own home; Adult A pointed out to Lottie's mother where she would lay curled-up on the bed, rarely leaving the bedroom. Whether Lottie cut off her own hair, or if Adult A had done it, the effect on her must have been devastating and the embarrassment of it probably explains in part at least why she didn't feel able to leave the house or to meet support workers or go into refuge.

17.8 A major worry for Lottie was losing her home which she believed would happen if she went into refuge or if she had agreed to stay somewhere else when the police were ruminating over which address she and Adult A should be released to. Apart from refuge, Lottie had nowhere else to go; she had no independent access to her money and no other means by which to support herself.

17.9 Added to all of these barriers, Lottie must have felt emotionally and physically overwhelmed. She must also have been in severe pain having swallowed the batteries and the other objects that were found in her stomach.

17.10 ➢ *Had Lottie experienced abuse in previous relationships in Nottingham or elsewhere and did it impact on her likelihood of seeking support in the months before she died?*

There is anecdotal information that Lottie made allegations that she was the victim of abuse in a previous relationship, but the evidence is that she was convicted of being a perpetrator. There is no direct evidence of that experience impacting upon her likelihood of seeking support in the months before she died.

17.11 ➢ *Were there any missed opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Lottie?*

No missed opportunities to make routine enquiry about domestic abuse were identified during the review.

17.12 ➢ *Did Adult A have a history of abusive behaviour to an intimate partner, a relative or a co-habitee and was it known to any agencies?*

No agencies were aware of any historic allegations of Adult A being involved in abusive behaviour to an intimate partner.

17.13 ➢ *Were there missed opportunities for agency intervention in relation to domestic abuse regarding Lottie and Adult A or to dependent children?*

Lottie signalled a willingness to go into refuge and the fact that that did not happen must represent a missed opportunity. Currently there is no national referral mechanism, so refuges are contacted individually. If a refuge has a bed space and there is more than one woman wanting it, the refuge will call the first referral and if they cannot contact her, they will work down the list. Nottingham City is committed to supporting the ongoing work to create a UK-wide refuge network.

17.14 There had been issues around record keeping within the GP practice which meant that notifications to them were not picked up by practice staff. There was a missed opportunity to collate the notifications and had that been done, practice staff may have considered it appropriate to refer them to a GP for action. The policy has since been reviewed and measures have been put in place to ensure that full and accurate records are maintained and that contingency arrangements are put in place in the event of planned and unexpected staff absences.

17.15 The use of the DVPN process was considered by the supervising Pubic Protection Detective Sergeant who decided that on that occasion it was not appropriate. Such decisions are subjective and are based on circumstances as they are presented at the time. It cannot be said therefore that the non-use of the DVPN process represented a missed opportunity.

17.16 There was also a missed opportunity for the police to have arrested Adult A when they decided instead to allow him to voluntarily attend the police station for interview.

17.17 ➢ *Did anyone consider Lottie to have been at risk of taking her own life and were those concerns shared and acted upon?*

The only person close enough to Lottie to have been able to form a view about the risk of her taking her own life was Adult A. He called the out-of-hours service on 6th November 2017, to say that that Lottie had telephoned him to say she had cancer and that she wanted him to kill her. She had also told him that if he didn't kill her, she would kill herself. Adult A told the call-handler that he was not sure that Lottie would kill herself.

17.18 Because there was no immediate risk to Lottie, the Clinical Advisor followed their established policy and procedure and told Adult A to call 999 for an ambulance or call NHS 111 again when he was with her, so that a full assessment could be undertaken. The out of hours service then sent a notification to Lottie's GP practice, but it did not contain an action for the GP to read it.

17.19 On 7th November 2017, the GP practice logged two incidents that had occurred the previous day. One was about the attendance of the ambulance crew when Lottie had told them that she had tripped over her dressing-gown cord having drunk half a bottle of wine and had then fallen down four or five flights of stairs. After the crew had asked Adult A to leave the room, Lottie told them that Adult A had pushed her down the stairs and had slammed her head into the floor several times. The other incident was a report from DHU Healthcare CIC (111 service) about the call from Adult A about Lottie having cancer and wanting to kill herself.

Comment: *Hospital staff agreed to call the police when the ambulance crew handed Lottie over to them.*

17.20 The GP practice concerned is large and as such it receives a myriad of information about its patients every day. All of the information about Lottie was entered on the GP system in a timely manner, but it was not accompanied by specific actions for the GP to read it; had there been, the GP may have linked the two incidents and may have instigated some action because of Lottie's mental-health record and that she was claiming to have cancer.

17.21 Lottie disclosed to WAIS that she felt suicidal which prompted WAIS to complete a DASH risk-assessment, which through professional judgement was deemed to be high, with a resultant referral to MARAC.

17.22 ➢ *What training or awareness raising requirements are necessary to ensure a greater knowledge and understanding of the risk of suicide in respect of victims of domestic abuse?*

Training and awareness raising for relevant staff about suicide and self-harm in respect domestic abuse would be very beneficial.

18 CONCLUSIONS

18.1 The dynamics of the relationship between Lottie and Adult A are far from clear. There is conflicting evidence with on the one-hand Lottie being the perpetrator, maybe while suffering mental-health issues and on the other hand, documented complaints from Lottie that she was abused by Adult A, something he strenuously denies.

18.2 Where there are mutual allegations, it is important for agencies to move away from an incident-based approach to a pattern-based approach, in an attempt to establish who is instigating the abuse and to explore whether for example a perpetrator is exhibiting controlling or abusive behaviour that does not necessarily involve physical violence but is responded to by a survivor out of retaliation or self-defence.

18.3 Previous domestic homicide reviews have revealed many permutations of abuse between couples and the review panel is alive to the fact that Lottie may have been a perpetrator towards Adult A, which may even have been brought-on as a result of her living with abuse. Adult A could have been physically violent towards Lottie who retaliated, or Adult A may have been abusing Lottie at the same time as using her mental-health issues to hide what he was doing or to shift the blame onto her. Experience has shown that on occasion's perpetrators use a victim's mental-health issues to hide the abuse, but it should be stressed that there is no evidence to show that Adult A was doing so.

18.4 Lottie had long-standing mental-health issues and was well supported by her GPs until she stopped accessing the service in June 2014. Sustained efforts were made to obtain the most appropriate psychological support for Lottie between April 2012 and June 2014, but despite those efforts, Lottie never undertook a prolonged period of counselling and the reasons why are not clear.

18.5 Good practice and adherence to NUH Trust policy was shown in relation to the contacts the Trust had with Lottie and Adult A. Staff showed good understanding of domestic abuse and the risks to the victim following a disclosure. There is evidence that staff continued to support Lottie and tried to get her to engage with the appropriate agencies to support her following the alleged assault.

18.6 Good practice was also shown in response to the disclosure of domestic abuse by Adult A with an appropriate risk-assessment and referrals being made.

18.7 It is apparent that latterly Lottie and Adult A were in a relationship that involved alcohol, violence and reported suicidal thoughts by Lottie. It is not known whether the sharing of this information directly with Lottie's GP and agencies such as Women's Aid would have prevented the tragic occurrence, but the panel is of the view that a MARAC was entirely appropriate in line with the Medical Centre and Public Protection Unit referrals.

19 KEY LESSONS LEARNED

19.1 GENERIC

19.2 A point of learning for agencies is that if they are communicating with a GP practice with a view to action being taken by a GP, they must make that fact clearly apparent.

19.3 ➢ NHS NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP

19.4 The two GPs who saw Lottie tried their very best ensure that she was referred to the most appropriate psychological services provider, but those providers referred Lottie to other services because they felt them more suitable for Lottie. Eventually, Lottie completely disengaged from the GP (in June 2014) and from counselling services (in February 2015), which may have been because she felt she was being 'passed from pillar to post'. The learning is that the transition points and information available to Lottie was unhelpful or unclear. Lottie may also have felt let-down by the GP Practice because, despite their best efforts and following agreed protocols they had not managed to source Lottie an appropriate service to meet her complex mental-health needs.

Comment: *An example is that Lottie had engaged with Let's Talk Wellbeing, but she needed a service that could provide more intensive and long-term counselling. The GP tried to refer her back to Let's Talk because she had developed a good relationship with the counsellor and had engaged with the service, but what Let's Talk Wellbeing could offer was not suitable for Lottie.*

19.5 The review highlighted the fact that there had been issues around record keeping within the practice. There was a clear data recording policy in place, but due to the prolonged absence of a key member of staff, records had not been maintained as they should have been. The policy has since been reviewed and measures have been put in place to ensure that full and accurate records are maintained and that contingency arrangements are put in place in the event of planned and unexpected staff absences.

19.6 ➢ NOTTINGHAM CITY COUNCIL ADULT SERVICES

19.7 The learning for Adult Services (and all other agencies) is to explore how best to communicate with a potential survivor who is living with the potential perpetrator without compromising the survivor's safety. The perpetrator may have control or access to the victim's phone, so careful consideration needs to be given as to whether a safe message on voicemail could be left that would alert the victim that support is available.

Comment: *A 'safe message' and a means of delivering it to a survivor who is living with a perpetrator has to be in the context of the situation and the people involved. Some creative solutions, for example asking a GP to pass on a message during an appointment, are 'hit-and-miss'. A recommendation from this review is that the CSP should explore the issue to see if a structured, coordinated approach can be developed locally.*

19.8 ➢ WOMEN'S AID INTEGRATED SERVICE

19.9 Learning for WAIS was that not only did Lottie minimise the abuse she was suffering, there were other obstacles preventing her from accessing support; her hair had been cut off

which meant she didn't want to be seen in public, she was only able to access support when Adult A was at work and she was financially dependent on him.

19.10 Another learning point for the organisation is that if the staff had read Lottie's notes before speaking to her it would have meant that she wouldn't have had to repeat so much information. This issue has already been addressed through additional training.

19.11 ➢ **NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST**

19.12 Interaction with Lottie was very limited and there were no key learning points identified.

19.13 ➢ **NOTTINGHAM HOSPITALS UNIVERSITY TRUST**

19.14 There was no specific learning for the Nottingham Hospitals University Trust to come out of this review.

19.15 ➢ **EQUATION MEN'S DOMESTIC ABUSE SERVICE**

19.16 Learning for Equation was that in a wider sense discussions and decisions need to be made about whether there should be a local response or support service designed specifically for referrals who are identified as potential perpetrators. (Equation provide a service for male survivors of abuse and are not currently resourced to support perpetrators of abuse. Where possible and appropriate, Equation will signpost individuals who disclose concerns about their own behaviour to the RESPECT helpline. Routine signposting or referral to the RESPECT helpline is not advised for individuals who are not taking responsibility for their behaviour or seeking help as this may increase risk to survivors).

19.17 ➢ **NOTTINGHAMSHIRE POLICE**

The key lesson learned by Nottinghamshire Police was the need for them to evaluate the use of voluntary attendance of a suspect for interview in respect of domestic abuse flagged crime.

20 RECOMMENDATIONS

The following recommendations are made:

20.1 GENERIC

- Agencies should undertake a training needs analysis in respect of domestic abuse related suicide and provide assurance that it has been done.

- The Public Health Suicide Prevention Group should consider whether something should be put in place similar to the MARAC regarding the impact of domestic abuse on suicide.

- The CSP should explore whether a structured and coordinated approach can be developed around the delivery of 'safe messages' by agencies to a survivor who is

living with a perpetrator and to consider how the 'Change that lasts' project uses safe messages.

- That the national recommendations about maintaining or expanding refuge spaces and there being a centralised referral system is supported by the CSP.

- That in complex cases where there are mutual allegations, partner agencies should map incidents rather than looking at them in isolation in an attempt to establish who is instigating the abuse.

- That Understanding and Responding to Domestic Violence and Abuse (URDVA) training includes more information about suicide and the impacts on it of domestic violence and abuse.

20.2 ➢ **NOTTINGHAMSHIRE POLICE**

- The force needs to evaluate the use of Voluntary attendance in respect of Domestic Abuse flagged crime, to ensure it is appropriately used and is effective.

Comment: *This has been covered in the recent vulnerability briefings given to all staff but is an on-going piece of work within the falling arrest rate review.*

20.3 ➢ **NHS NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP**

- Consideration should be given to the type of training GP's and primary health-care require in order to identify victims of abuse and address their holistic needs appropriately.

- That the NHS Nottingham City Clinical Commissioning Group recirculate the Primary Care Domestic Abuse Referral Team (DART) Notifications Good Practice Guidelines (by the Safeguarding Adult and Children Team) to all GP Practices across NHS Nottingham City Clinical Commissioning Group / Greater Nottingham Clinical Commissioning Partnership and that they are also made available on the Safeguarding Adult and Children Safeguarding Website.

- That the News Fact Sheet Safeguarding Newsletter is re-circulated to all GP Practices in NHS Nottingham City Clinical Commissioning Group/Greater Nottingham Clinical Commissioning Partnership on the subject of domestic abuse and the risk of suicide amongst victims.

- That GP Practices ascertain the patients preferred method of contact (e.g. via telephone, text or letter), when patients register at GP Practices and also when any member of the GP Practice staff reviews patient personal details.

- That the IAPT services and Primary Care Mental-health Services are linked into the System One F12 project to ensure all GP's, including locums are aware of services are available in the city.

- Assurance is sought from primary care that all practice staff have access to domestic abuse training through the GP self-assessment checklist

- That the Mental-health strategy for the Nottinghamshire Integrated Care System (ICS), which is currently under review, takes account of the learning from this DHR.

20.4 ➢ **DHU HEALTHCARE CIC**

- The automated 'remote observer call' system should be reviewed so as not to give a misleading impression that a caller has terminated a call when it had ended naturally.

20.5 ➢ **NOTTINGHAM CITY COUNCIL ADULT SERVICES**

- That the regular action learning workshops continue for all DART/MARAC practitioners to share information and ideas about cases and the service provided.

- That training will be reviewed to increase the understanding of the risk of suicide and the impact of poor mental-health for domestic abuse survivors.

- Nottingham City Council should continue to explore different methods of contact with survivors and record why particular methods were not used.

- DART workers should contact the survivor's GP when a survivor has been assessed as 'High-risk' and telephone contact has been unsuccessful, to request that contact details of Adult Services and Women's Aid are provided at the patient's next consultation.

20.6 ➢ **WOMEN'S AID INTEGRATED SERVICE**

- All WAIS staff should have a process within their service handbook on how to gain information from case notes and staff members working with a woman to prevent too many staff members contacting the woman and her having to repeat her 'story'.

20.7 ➢ **EQUATION MEN'S DOMESTIC ABUSE SERVICE**

- The Men's Service should continue only to offer a service to male survivors and follow procedure to assess relationship dynamics.

- The Men's Service should identify how to improve timescales of referral checks and case notes.

- The Men's Service identify whether to engage with all referrals identified as perpetrators who acknowledge their behaviour to give advice on how to get support with their abusive behaviour.

- The potential for bringing more clarity to the engagement with the service of men where it is unclear whether they are a victim, or a perpetrator should be explored.

20.8 There are no recommendations to be made in respect of any of the other agencies involved in this review.

Appendix A– Report to the CDP Board advising of the delay in completion of the DHR AIS overview report.

Information not related to this review details in the original copy of this report have been removed.

Nottingham Crime & Drugs Partnership

Working together to reduce crime, disorder & the misuse of drugs and alcohol

Meeting:	CDP Board
Date:	11th June 2018
Agenda Item:	12
Report Title:	Update on the progression of the Domestic Homicide Reviews (DHRs) currently being progressed by the DHR Assurance and Learning Implementation Group (ALIG).
Report Author/s:	Paula Bishop
Sponsor/s of Report:	Councillor Collins

Relevant Statutory Aims (please place an 'X' in the relevant box(es) below)	
Reduce Crime	X
Reduce Reoffending	
Reduce Substance Misuse	
Reduce Anti-Social Behaviour	

Relevant Strategic Priorities (please place an 'X 'in the relevant box(es) below)	
Violence	X
Serious Organised Crime	
Hate Crime	
Burglary	
Drug and Alcohol Misuse	
Anti-Social Behaviour	
Board Governance *(e.g. Finance, TOR etc.)*	

1.0 PURPOSE OF THE REPORT:

1.1 To update the CDP Board, since the last update on 18th September 2017, of the progress on the implementation of the DHR action plans and audits which is

managed by the Domestic Homicide Review Assurance and Learning Implementation Group (DHR ALIG).

2.0 RECOMMENDATIONS:

2.1 For the CDP Board to note the contents of the report and the following recommendation:

- For CDP Board members to acknowledge the reasons for the delay in completing DHR AIS and agree to the proposed time scale.

3 REASON/S FOR THE RECOMMENDATIONS:

3.1

4.0 SUMMARY OF KEY POINTS:

DHR AIS

4.7 The CDP Board were informed of the commencement of DHR AIS on 25th January 2018 via email notification by Tim Spink on behalf of Cllr Jon Collins.

4.8 Partner agencies held the 1st panel meeting on 27th March 2018, to determine the scoping period, who will be reviewed in this period and to identify specific factors to be included in the Terms of Reference, Appendix B provides a list of panel members and participation.

4.9 The DHR Panel have a statutory duty to inform the CDP Board of the progress of DHR AIS including any delays in the completion of the review as directed in the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – revised December 2016:

4.10 "It is acknowledged that some DHRs will necessarily go beyond this further six month timescale due to the complex scope of the DHR and/or due to on-going criminal justice proceedings. If the CSP believes that the delay to completion of the review is unreasonable, they should refer the issue to the Quality Assurance Panel for further advice." Paragraph 46, page 16.

4.11 “The report author should, in their final reports, make reference to any requests to delay the planned work of the DHR panel, and include a copy of the written request as an appendix so that it can clearly be understood why the request was made, taking into account any data protection restrictions.” Paragraph 86, page 24.

4.12 Paul Johnston from Johnston & Blockley is the Independent Chair and Author for the completion of this DHR. He would like to advise the following with regard to the delay in the completion of DHR AIS.

4.13 “A conscious decision was made by the Panel that until a decision had been made by the Crown Prosecution Service as to whether criminal charges would be preferred against the victim’s partner, no agency staff or family members/friends of the victim would be interviewed – for fear of compromising the judicial process should charges be made. This course of action was supported by the police senior investigating officer.

4.14 There were also concerns as to whether to continue the DHR would risk compromising any inquest proceedings and liaison was established with the Coroner.

4.15 On 2nd May 2018, the Coroner advised the Review Chair that she had been notified that criminal charges would not be preferred and that the inquest had been adjourned to 6th November 2018. The Coroner expressed a desire that the DHR proceed and that she be updated prior to the inquest taking place.

4.16 So, although much of the background preparation for the DHR took place prior to 2nd May, the review (interviewing staff – preparation of IMRs – visiting family/friends etc) could only take place after that date.”

4.17 This has resulted in a delay in the 6 month period from notification to the Home Office on 19th March 2018 to the intended completion of the Overview Report in September 2018.

4.18 It is intended that the Overview report is completed towards the end of this year.

Appendix A2– Response from CDP Board for Delay in DHR AIS process

Nottingham Crime & Drugs Partnership

Working together to reduce crime, disorder & the misuse of drugs and alcohol

NOTTINGHAM CRIME & DRUGS PARTNERSHIP BOARD MEETING

MONDAY 11TH JUNE 2018, 2-5 PM

ROOM 208, BYRON HOUSE

EXTRACT OF MINUTES

12.0 Domestic Homicide Reviews

12.1 TS presented an update on progress on the implementation of the DHR action plans and audits.

12.2 The reasons for the delay in completing DHR AIS, as advised by the Independent Chair and Author for the completion of this DHR, were outlined in the report and were as follows:

12.4 "A conscious decision was made by the Panel that until a decision had been made by the Crown Prosecution Service as to whether criminal charges would be preferred against the victim's partner, no agency staff or family members/friends of the victim would be interviewed – for fear of compromising the judicial process should charges be made. This course of action was supported by the police senior investigating officer. There were also concerns as to whether to continue the DHR would risk compromising any inquest proceedings and liaison was established with the Coroner, so on 2nd May 2018, the Coroner advised the Review Chair that she had been notified that criminal charges would not be preferred and that the inquest had been adjourned to 6th November 2018. The Coroner expressed a desire that the DHR proceed and that she be updated prior to the inquest taking place. So, although much of the background preparation for the DHR took place prior to 2nd May, the review (interviewing staff – preparation of IMR's – visiting family/friends etc) could only take place after that date."

THE BOARD SIGNED OFF DHR HOPLITE ACTION PLAN AS COMPLETE AND AUDITED.

DECISION: THE BOARD CONSIDERED THE REASONS FOR THE DELAY IN COMPLETING DHR AIS AND AGREED TO THE PROPOSED TIME SCALE FOR COMPLETION.

Appendix B – DHR AIS Action Plan

DHR AIS Action Plan

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence	RAG
1	Agencies should undertake a training needs analysis in respect of domestic abuse related suicide and provide assurance that it has been done.	The review has identified the need for the appropriate staff in agencies to be trained in understanding domestic abuse and suicide. The level of training may vary depending on	Local	All agencies involved in DHR AIS (provided IMRs / summary reports) to review training regarding domestic abuse and suicide. To identify what training is required and for which staff roles and provide assurance of this review and implementation.	CDP (coordinate)	October 2019			red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence	RAG
		the agency and the role of staff – e.g. awareness of these issues to understanding the risks and recognising people at risk of suicide.		1. British Transport Police 2. CityCare 3. DHU Health Care CIC 4. East Midlands Ambulance Service 5. Equation 6. National Probation Trust - Nottinghamshire 7. NHS Nottingham City Clinical Commissioning Group 8. Nottingham City Council – Adults Services 9. Nottingham City Council – Children's Services 10. Nottingham University Hospitals Trust					

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence	RAG
				11. Nottinghamshire Healthcare Foundation Trust 12. Nottinghamshire Police					
2	The Public Health Suicide Prevention Group should consider whether something should be put in place similar to the MARAC regarding the impact of domestic abuse on suicide.	Public Health have a suicide prevention group with a live action plan, but when asked they did not hold any data or information in relation to DVA and suicides apart from recognising it as a risk factor.	Local	Review of action plan and process for reviewing domestic abuse and suicide.	Nottingham City Council Public Health	TBC			red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence	RAG
3	The CSP should explore whether a structured and coordinated approach can be developed around the delivery of 'safe messages' by agencies to a survivor who is living with a perpetrator and to consider how the 'Change that lasts' project uses safe messages.	Where a survivor lives with a perpetrator of domestic abuse it is not safe for agencies to send letters or leave messages for the survivor because it may increase survivor risk if the perpetrator becomes aware. Some agencies use "safe messages" to overcome this barrier which	Local	Review of safe messages with Change that Lasts and other dsva specialists. Determine what approaches can be utilised.	CDP	October 2019			red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence	RAG
		are agreed with the survivor. It would be beneficial for agencies to review if and how they leave safe messages.							
4	That the national recommendations about maintaining or expanding refuge spaces and there being a centralised referral system Is supported by the CSP.	Accessing refuge for survivors can be complicated and a centralised system would streamline and simplify this e.g. one assessment per survivor rather than	National	Raise nationally the issues and points to consider.	WAIS and CDP	TBC			red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence	RAG
		per refuge contacted, up to date information on spaces available. Limited refuge space further impacts this.							
5	That in complex cases where there are mutual allegations, partner agencies should map incidents rather than looking at them in isolation in an attempt to establish who is instigating the abuse.	Both parties had been identified as perpetrators and survivors. By reviewing all the information patterns would be more identifiable.	Local	All agencies involved in DHR AIS (provided IMRs / summary reports) to map incidents. 1. British Transport Police 2. CityCare 3. DHU Health Care CIC 4. East Midlands Ambulance Service 5. Equation	CDP to coordinate	Oct 2019			red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence	RAG
				6. National Probation Trust - Nottinghamshire 7. NHS Nottingham City Clinical Commissioning Group 8. Nottingham City Council – Adults Services 9. Nottingham City Council – Children's Services 10. Nottingham University Hospitals Trust 11. Nottinghamshire Healthcare Foundation Trust 12. Nottinghamshire Police					
6	That Understanding and	To review the URDVA	Local	CDP to review training	CDP	Oct 2019			red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence	RAG
	Responding to Domestic Violence and Abuse (URDVA) training includes more information about suicide and the impacts on it of domestic violence and abuse	training to ensure it is up to date with learning regarding DSVA and suicide.		programme with Equation.					

Appendix B2 - DHR AIS agencies IMR Action Plan

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
1	**Nottinghamshire Police**							
1.1	The force needs to evaluate the use of Voluntary attendance in respect of Domestic Abuse flagged crime, to ensure it is appropriately used and is effective	Ensure it is appropriately used and is effective	Local	Review how to address	TBC		16/01/19 – Police Legal team have advised cannot mandate arrest for DVA a necessity teat is case by case. Data has been evaluated and it is high in numbers and low in arrests. Police are looking at alternative ways.	Amber
2	**NHS Nottingham City Clinical Commissioning Group**							
2.1	Consideration should be given to the type of training GP's and primary health-care require in order to identify victims of abuse and address	DVA support to GPs since the cessation of IRIS project.	Local	Review funding options and ways to cover this gap.	TBC		16/1/19 – review of support to GPS for DSVA training and referrals and funding currently under review	amber

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
	their holistic needs appropriately							
2.2	That the NHS Nottingham City Clinical Commissioning Group recirculate the Primary Care Domestic Abuse Referral Team (DART) Notifications Good Practice Guidelines (by the Safeguarding Adult and Children Team) to all GP Practices across NHS Nottingham City Clinical Commissioning Group / Greater Nottingham Clinical Commissioning Partnership and that they are also made available on the Safeguarding Adult and	Refresh to all staff	Local	To recirculate the Guidelines.	TBC		16/1/19 – to recirculate	red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
	Children Safeguarding Website							
2.3	That the New Fact Sheet Safeguarding Newsletter is re-circulated to all GP Practices in NHS Nottingham City Clinical Commissioning Group/Greater Nottingham Clinical Commissioning Partnership on the subject of domestic abuse and the risk of suicide amongst victims	Refresh to all staff	Local	To recirculate Guidelines. Have information on GP Safeguarding Database.	TBC		16/1/19 – to recirculate the guidelines and all CCG Safeguarding leads have been asked to provide training on suicide prevention to all health leads and then request NHS Eng. to cascade to Safeguarding Teams.	red
2.4	That GP Practices ascertain the patients preferred method of contact (e.g. via telephone, text or letter), when patients register at GP Practices	Ensure means of contact are up to date.	Local	To circulate by CCG Newsletter to GP's.	TBC		16/01/19 – to be included in the next CCG Newsletter.	red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
	and also when any member of the GP Practice staff reviews patient personal details							
2.5	That the IAPT services and Primary Care Mental-health Services are linked into the System One F12 project to ensure all GP's, including locums are aware of services are available in the city	Ensure GPs especially locums are aware of what service provision there is locally.	Local	To ensure details of IAPT (Improving Access to Psychological Therapies e.g. let's Talk Wellbeing and other Mental Health Services are on the "F12" and it is up to date.	TBC		16/1/19 – they should be on the system but checks currently being made to confirm they are listed on "F12".	Amber
2.6	Assurance is sought from primary care that all practice staff have access to domestic abuse training through the GP self-assessment checklist		Local	To update GP self-assessment checklist and request assurance from GPs	TBC		16/1/19 – to request assurance from GP practices.	Red
2.7	That the Mental-health strategy for the Nottinghamshire	To ensure learning identified in	Local	To share with the relevant mental health leads to review learning	TBC		16/1/19 - Relevant learning has been shared with mental	Amber

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
	Integrated Care System (ICS), which is currently under review, takes account of the learning from this DHR	factored in the review taking place.					health needs and they are reviewing learning.	
3	**DHU Healthcare CIC**							
3.1	The automated 'remote observer call' system should be reviewed so as not to give a misleading impression that a caller has terminated a call when it had ended naturally	It can be misleading to GPs and others provided with the summary of information regarding how the call ended.	Local	To review the electronic caller system and how the closure of the call is documented.	TBC		31/12/19 – update - We have found that there are indeed some disparities in the information shown in the call report which could make it confusing for a GP reading through the case. There is a specify box however available so until we have made the changes would urge users to detail in this who has terminated the call so it is clear.	Amber

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
							Please be advised this will be passed for scoping and change. We are unable at present to detail exactly when this will be but please be assured there is agreement from a quorate group that change is required. Until changes are made within NHS Pathways our staff (111 service) have been asked to record in the notes who terminated the call.	
4	**Nottingham City Council Adult Services**							
4.1	That the regular action learning workshops continue for all		Local	Continuation of meetings	TBC		16/01/19 – update required	amber

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
	DART/MARAC practitioners to share information and ideas about cases and the service provided							
4.2	That training will be reviewed to increase the understanding of the risk of suicide and the impact of poor mental-health for domestic abuse survivors	To address a gap in training for staff.	Local	To review training and source appropriate training.	TBC		16/01/19 – update required	red
4.3	Nottingham City Council should continue to explore different methods of contact with survivors and record why particular methods were not used	To review how to leave safe message for survivors.	Local	Explore types of safe messages that can be left for survivors and how they can be appropriately delivered.	TBC		16/01/19 – update required	red
4.4	DART workers should contact the survivor's GP when a survivor has	To ensure GPs are aware of the risk levels and provide	Local	Adult Service DART staff to inform GPs and	TBC		16/01/19 – update required	red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
	been assessed as 'High-risk' and telephone contact has been unsuccessful, to request that contact details of Adult Services and Women's Aid are provided at the patient's next consultation	another option for engagement with the survivor.		request details passed onto the survivor.				
5	**Women's Aid Integrated Services**							
5.1	All WAIS staff should have a process within their service handbook on how to gain information from case notes and staff members working with a woman to prevent too many staff members contacting the woman and her having to repeat her 'story'		Local	Review service handbook to ensure up to date. Ensure all staff are aware of this process.	TBC		16/01/19 – update required	red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
6	**Equation's Men's Domestic Abuse Service**							
6.1	The Men's Service should continue only to offer a service to male survivors and follow procedure to assess relationship dynamics	The men's service is for male survivors of dsva, it does not work with perpetrators	Local	Continue ways of working with male survivors and means of identifying who the primary perpetrator is.	TBC		16/01/19 – update required	Amber
6.2	The Men's Service should identify how to improve timescales of referral checks and case notes		Local	To implement set timescales for referral checks.	TBC		16/01/19 – update required	red
6.3	The Men's Service identify whether to engage with all referrals identified as perpetrators who acknowledge their behaviour to give advice on how to get support with their abusive behaviour	To provide support information to perpetrators of domestic abuse.	Local	Where a perpetrator acknowledges their abusive behaviour to provide information of the national perpetrator helpline.	TBC		16/01/19 – update required	red

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Target Date	Date of Completion	Evidence	RAG
6.4	The potential for bringing more clarity to the engagement with the service of men where it is unclear whether they are a victim, or a perpetrator should be explored		Local	Review if / how the service can support males when it is unclear if they are the primary perpetrator without increasing risk to either person.	TBC		16/01/19 – update required	red

Appendix C - Letter from Home Office advising the smaller scope of the review.

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Tim Spink
Head of Service
Nottingham Crime and Drugs Partnership
Byron House
Maid Marion Way
Nottingham
NG1 6HS

5 April 2018

Dear Mr Spink,

Domestic Homicide Review – Operation AIS

Thank you for your letter of 19 March confirming the decision taken by the Chair of the Nottingham Crime and Drugs Partnership to commission a Domestic Homicide Review (DHR) following the death of a female adult in Wollaton.

We note that an independent chair and author has been appointed to undertake the review.

In relation to your proposal to conduct a focused smaller review, the statutory guidance permits reviews to be proportionate to the nature of the homicide (or suicide) and references to themes identified in previous reviews and work undertaken to address these can be articulated in the current DHR.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

Appendix D - Nottingham City Domestic Homicide Reviews (DHRs) Learning – Common Themes – Oct 2018

Nottingham City Domestic Homicide Reviews (DHRs) Learning – Common Themes – Oct 2018

The themes and learning should only be interpreted as a means of highlighting common / recurring issues for improvement that could significantly prevent or reduce the risk of harm or death.

This has been included in the overview report to highlight the themes that have been identified from all DHRs undertaken in Nottingham City. The themes identified in this particular review are discussed in section 5.

	Themes	**Overview**
1	Information Sharing	Overall the recommendations relate to: Improving existing procedures, roles of agencies in sharing information and staff being aware of agency procedures.
2	Complex / Vulnerable People	Three reports highlighted the compounding issues of working with and supporting people who had complex issues and / or were vulnerable (but did not meet the safeguarding definition / thresholds for a vulnerable person). Agencies should prioritise making themselves more accessible to these groups. Also issues identified in isolation NOT systemic. The most recent DHR highlighted a difference with this where the person could engage to a certain extent but it could not be maintained or was not with the appropriate service.
3	Record Keeping	Two of the reports highlighted gaps in consistent practice in record keeping and best practice. The most recent DHR highlighted where records were kept appropriately but staff did not always read them before speaking with the person meaning repetition for the person.
4	Mapping of the family /domestic violence and abuse	Map the pattern of abuse in the family / household, not a series of incidents in isolation.
5	Criminal Justice Processes - perpetrators	Instances were highlighted where perpetrators repeatedly did not abide by bail conditions and yet the same conditions would be set each time.

	Themes	Overview
6	Children	This highlighted the use of the “Think Family” approach and to consider all children who are living with or associated with a perpetrator when completing assessments.
7	Training and Awareness	Where Domestic Abuse training is not part of a mandatory training programme there are gaps in staff knowledge.
8	Non Engagement with Services / Failure to Engage Service Users	The following factors were identified: Closing cases where there is non engagement without exploration was a feature. Agency barriers for service user – e.g. preference for contact not asked Joint working or increased communication between agencies would assist service users / clients feeling overwhelmed by agency contact. Senior support from agency when closing a case where there has been a failure to engage the service user who has complex needs is a vulnerable person. Service User was engaging but could not maintain engagement / engage with the required services.

Failure to Engage Service Users Framework

Engagement and Support

Staff Support

Supporting adults who experience difficulties engaging with services in Nottingham City

The following framework is for use by all services in Nottingham City when they are working with adults who do not engage and there are concerns of risk of harm or other safeguarding factors.

Nottingham City Domestic and Sexual Violence and Abuse Safeguarding Group (membership from multiple statutory and voluntary agencies in the City) would like to acknowledge that this framework is adapted from Slough Safeguarding Adults Board.

Contents

Nottingham City Failure to Engage Service Users Framework

Draft Version 5

1. Introduction

Recent Serious Adult Reviews and Domestic homicide Reviews have identified support and processes are required for service users and professionals when trusting relationship with services users who have mental capacity are not developed or maintained, which in turn may impact on them accessing services.

Adults who have complex and diverse needs who do not engage with services (for whatever reason), are often known to different agencies. Their needs are generally longstanding and recurring and they may put themselves and others at risk.

This framework needs to be followed where there are concerns that there is a level of risk which professionals find unacceptable, and all other reasonable attempts to minimise this risk have failed.

Where the adult has parental responsibility for any children / or the children are living in the household, there is a statutory duty for all agencies to ensure the safety of the children and referrals to children's social care is mandatory.

This framework can and should be used by any agency from the statutory and voluntary sector.

2. Aims of the Framework:

- To improve outcomes for adults at risk who do not engage with services.
- To develop a person-centred, multiagency / multidisciplinary co-ordinated response.
- For agencies to work in partnership and share information to ensure best outcomes for the person.
- Understand agency barriers which stop people engaging.
- Understand a person's circumstances which are barriers to prevent them from engaging.
- Support to staff for closing cases where everything has been done to engage the person.

3. How to use this Framework

This document is a resource to integrate into existing policies and practice with regards to a person's support. The framework provides support options for staff as well as the person the agency is trying to support.

4. Definition of a complex person

Dr Lyndsay Harris, Assistant Professor in Criminology at Nottingham University undertook research into the pilot project Response to Complexity[1], which sought to provide a coordinated response to support survivors of domestic and sexual abuse with complex needs.

The research evidenced that there were multiple definitions of "complex needs" and some sectors did not like the terminology and further labelling people. It also identified 'that there was different understanding of the term 'complex needs' across the statutory and voluntary sector. This often meant that some services which would be suitable for survivors with multiple disadvantage are inaccessible due to a defined criteria of eligibility'.
'This led to efforts to reconsider "complex needs" in the context of protected characteristics and issues that intersect to disadvantage survivors/victims. It is argued that when discussing victims/survivors with complex needs this should be understood as:
"*Victims / survivors who experience multiple disadvantages and require a person-centred, trauma-informed approach* ***but experience barriers and challenges in accessing essential services,*** *which would enhance their safety, well-being and quality of life*." (Harris 2017)'[2].

5. Guiding principles

- People who have the mental capacity to make decisions about their lives also have the right to make restricted choices / or 'unwise' / 'unsafe' decisions. The person may also have limited or no options/choices if they are being controlled or coerced by another person refer to section 6 for the definition of control and coercion. However, their choices may impact upon others and/or leave them at risk of harm; this process will consider how best to balance these conflicting views.

- Information sharing by all agencies is implicit for this framework; consent should be sought to share information from the service user, unless to do so places the person or those around him/her at further risk of harm. At which point a Safeguarding Referral should be made to the local authority if the service user has care & support needs.

- Staff should seek advice from senior managers throughout the process, regarding safeguarding and legal options.

- This is a multi-agency / multidisciplinary process and each agency is required to nominate a lead worker of sufficient seniority, to agree actions and make operational decisions.

[1] R2C is a Department of Communities and Local Government (DCLG) 6 month funded project.

[2] Response to Complexity: OPCC Women's Safety Reference Group, 28th February 2018, Dr Lyndsey Harris, Assistant Professor in Criminology, Nottingham University.

- One agency should be identified as the lead agency. The agency instigating the multi-agency / multidisciplinary meeting should be the lead agency. However, this can be determined at the initial meeting as to who is best suited to be lead agency.

- If there is a service that is able to maintain a relationship with the service user then they should ensure that the individual remains "visible" to the other services by sharing relevant information with.

6. Understanding barriers to engagement:

- Systems - The methods an agency uses to contact an individual.
    - *E.g. person will not open letters but letters are automatically generated.*
    - *E.g. is provision / support time limited, "Did not attend / engagement policies" and case closure.*
    - *English is not the person's spoken language.*

- Perceived ideas about an agency and what they can provide to that individual.
    - *E.g. failed interactions with this agency before.*
    - *E.g. "word of mouth" - negative experiences with a service.*
    - *E.g. does not understand what the agency can do to support / signpost.*

- Threat / fear of agency involvement and consequences for the person and or family.
    - *E.g. social care removing the child.*
    - *Charge or custodial sentence for the offender.*

- The individual does not see the concerns as a problem.
    - *E.g. Lifestyle choice.*
    - *It is not a priority for them at this time, e.g. dealing with their housing issues as opposed to drug & alcohol addiction*

- The services required are not commissioned / thresholds to accessing services are too complicated leading to people not feeling able to engage as the service cannot meet this individuals needs
    - *E.g. difficulty accessing housing.*
    - *E.g. the overlap of a person's multiple needs / multiple disadvantages.*
    - *The location and accessibility of the service – disabilities, travel cost and time.*

- Control and coercion by another person.
  Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
  Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

- *E.g. domestic abuse, modern slavery and / or gangs.*

- Fear of consequences from others for engaging.
  - *E.g. threats from: gang members, the wider community (honour based violence), family members and / or the perpetrator.*

- Staff may not be clear or be aware of: processes, information sharing agreements, protocols and who they can share information with and when.
  - *E.g. documents not easily accessible to staff.*
  - *E.g. staff do not understand the trauma the person experienced due to domestic and sexual abuse, modern slavery, and gangs.*
  - *E.g. appropriate training is required.*

7. When to instigate this Framework

As a single agency you have exhausted all options to engage the person and the risk remains high or a concern. Refer to Appendix B for the referral pathway.

Ensure escalation to a manager within your own agency to either instigate a multi-disciplinary meeting / multi agency meeting and agree who should be invited, or refer the person to an existing and appropriate multi-agency / multidisciplinary forum. To consider General Data Protection Regulation (GDPR) Article 6 for the legal process of sharing the persons information with other agencies, when the person has capacity but difficulties in engaging. Depending on the persons circumstances this can be done under *Vital Interests* of that person or others (generally life or death matters), *Public Task* or *Legitimate Interests*.

Senior management oversight is required throughout the process. Staff from each agency should discuss the case with their line manager following meetings and not carry risk on their own.

'Research has highlighted that when there is a coordinated approach to service provision for survivors with complex needs this improves the quality of service provided. In the R2C project led by a steering group the results have included:

a) Increased cooperation and awareness of constraints of partner agencies.
b) Ability to highlight training needs and provide access to additional training for all stakeholder partners.
c) A reduction in the number of inappropriate referrals between agencies and the number of times a survivor has to 'tell their story'.
d) Survivors reported that they were no longer being "passed from pillar to post" without getting anywhere'[3].

8. Stages in the process to determine the risk and needs of the individual:

[3] Response to Complexity: OPCC Women's Safety Reference Group, 28th February 2018, Dr Lyndsey Harris, Assistant Professor in Criminology, Nottingham University.

- If mental capacity has not been considered it should be ascertained as soon as possible. If the person lacks capacity “best interest” decisions should be followed.
- Ascertain whether any children or other vulnerable adults are at risk. If there are children at risk you MUST refer to Children’s Safeguarding immediately
- Have all existing processes been considered and tried? Is there an existing multi-agency / multidisciplinary forum that may be appropriate or utilised? Either for the meeting or as an action from the meeting.
- Obtain relevant legal advice if necessary/appropriate.
- Discuss with your line manager whether to proceed with or continue a multi-agency meeting / multi-disciplinary team meeting and alternative options.
- Contact the Safeguarding Adults Team for discussion about the case and agree a way forward, if the adult has care and support needs.
- Are services meeting the needs of the person? Review what needs are being met and consider the gaps.
- Conducting regular assessments is not possible if the person won’t engage but should be seen as a risk
- Is there a safe number to contact the person or ways of sending / leaving and a “safe message” if she/he does not answer the phone or withheld numbers dependent on the persons individual risks.
    a. Female survivors - contact WAIS DSVA Helpline on the professional number 0115 947 6490 (9:00-17:00 Mon-Fri), for advice on options and further advice.
    b. Male survivors - contact Equation Domestic Abuse Service for Men on 0115 960 5556 (9.30-16.30 Mon-Fri), for advice and options.

9. Support and Engagement Multiagency Meeting / Multi-Disciplinary Team Meeting

The purpose of the meeting will be to consider the situation (by sharing all relevant information) and clarify what further action can be taken, making the necessary recommendations.

Invite all agencies who have, or could have had, involvement with the person or anyone else living in the home. Consider inviting the service user or someone to act as their representative.

Map the circumstances by reviewing all events / information – risks, concerns identified and what has been shared. Do not look at events in isolation.

These meetings should include a separate minute taker. The meeting should be chaired by the lead agency identifying concerns, unless otherwise agreed.

The level of risk should be identified at the first meeting and updated in light of information from other agencies. The use of a risk assessment tool may assist with determining risk.

Risk should be regularly reviewed.

It is the collective responsibility of all those who attend the meeting to discuss the risks and consider the following within your standing agenda:

- What is the risk / concern?
- Do we know what the service users want & why they cannot engage at this time?
- What is already in place to reduce the risk?
- What are the barriers for removing risk?
- What action needs to be taken?
- Where has safety increased and risk reduced?
- Ways / means of empowering her/him.
- Are statutory powers being considered?
- Agree action plan, with timescales and named leads.
- Agree a review meeting date.
- Identify who is best placed to engage with the person and inform her/him of the decisions that have been made.

All representatives at the meeting should receive copies of the meeting minutes. The actions agreed at the meeting should be progressed and monitored, working to agreed timescales. Regular assessments of the person should take place.

It should be documented in the minutes of the meetings whether consent has been given and the rationale for sharing information where consent has not been given. Throughout the process it is important that decisions and actions are accurately recorded, and a record made of those involved in the decision making process.

To ensure an accurate view of the person's mental capacity, assessment should be regularly considered throughout the process.

10. Review Meeting (See Appendix A for suggested risk assessment tool)

- Agencies will share any new information.
- Review actions and agree a revised action plan, with named leads and timescales.

- Update the risk assessment.
- If insufficient progress has been made with the person, reflect on the interactions and consider an alternative approach. Decisions need to be set that are realistic and if not achievable clearly noted why, e.g. not possible to refer service user to a project as its funding has ceased / closed all referrals.
- This review process will be ongoing until the risks are managed. This does not mean that the risks have been completely negated, but that they are at a point where the multi-agency / multi disciplinary group is able to act and react in a planned and consistent way. At this point of the process, regular meetings can be stopped. If the person is still not engaging refer to section 12.
- As part of the plan or if regular meetings are going to cease, identify and agree at what point another meeting may be required, i.e. if issues change significantly or there are new concerns
- Can support timescales be increased if required? E.g. to assist with building trust and time to work on the complexity of issues the person may have.

11. Ongoing Support

When risks are at a level where they are considered to be managed, consider what support is needed to meet any ongoing needs and ensure the well-being of the person and anyone else living within the home.

If an agency has fulfilled their support and has to close the case they must inform other agencies that they are doing so by either informing the lead agency (if multi-agency / multidisciplinary meetings are still taking place), or inform all agencies that were involved.

Any ongoing support must be clearly identified and agreed by relevant agencies. This should include any services that are commissioned.

The outcome should be shared with the senior management within your organisation e.g. through supervision / case management reviews.

12. If the individual is unable to engage

- The individual worker must seek support from their agencies senior management team.
- If all members of the Multiagency Meeting / Multi Disciplinary Team (MDT) are satisfied that all options / efforts have been exhausted this should be clearly documented in all agencies records and escalated to managers.
- Provision must be made for the person to be able to seek support at a time that suits them. Joint work with other agencies may be required to meet this e.g. weekend or evening meetings.

- A risk assessment has been undertaken which indicates the situation has reached a level of risk that is unacceptable to professionals involved. Are there options / thresholds now available due to the increase in risk?

- Consider statutory powers for the person to engage.

- The Multiagency Meeting / Multi-Disciplinary Team (MDT) may decide to delegate an individual to keep contact e.g. every 3 months call to person / staff.

    - This needs to be monitored by senior management and the lead agency to ensure these cases are tracked and regularly reviewed by a senior manager.

- Individual workers must be offered supervision by senior managers and their individual organisations will carry the risk of closing the case when the person will not engage and it has been evidenced that all options have been exhausted. This decision will have been decided (when all options exhausted) through the Multiagency Meeting / Multi Disciplinary Team. All members of the multi-agency / multi disciplinary meeting and their senior managers must agree that there are no further options available.

13. Sharing Learning and Development

- Any learning and good practice should be shared with immediate colleagues and wider networks, including the Safeguarding Adults Board.

- Everyone has responsibility - commissioners, service providers and multi-agency / multidisciplinary partnerships to recognise how their services might facilitate a person centred approach to address any wider barriers to essential services. Even though the person is not engaging, agencies need to keep the persons needs at the centre.

This is meant to be a dynamic process and this pathway will be amended as learning is developed.

Review Date
To be reviewed October 2019.

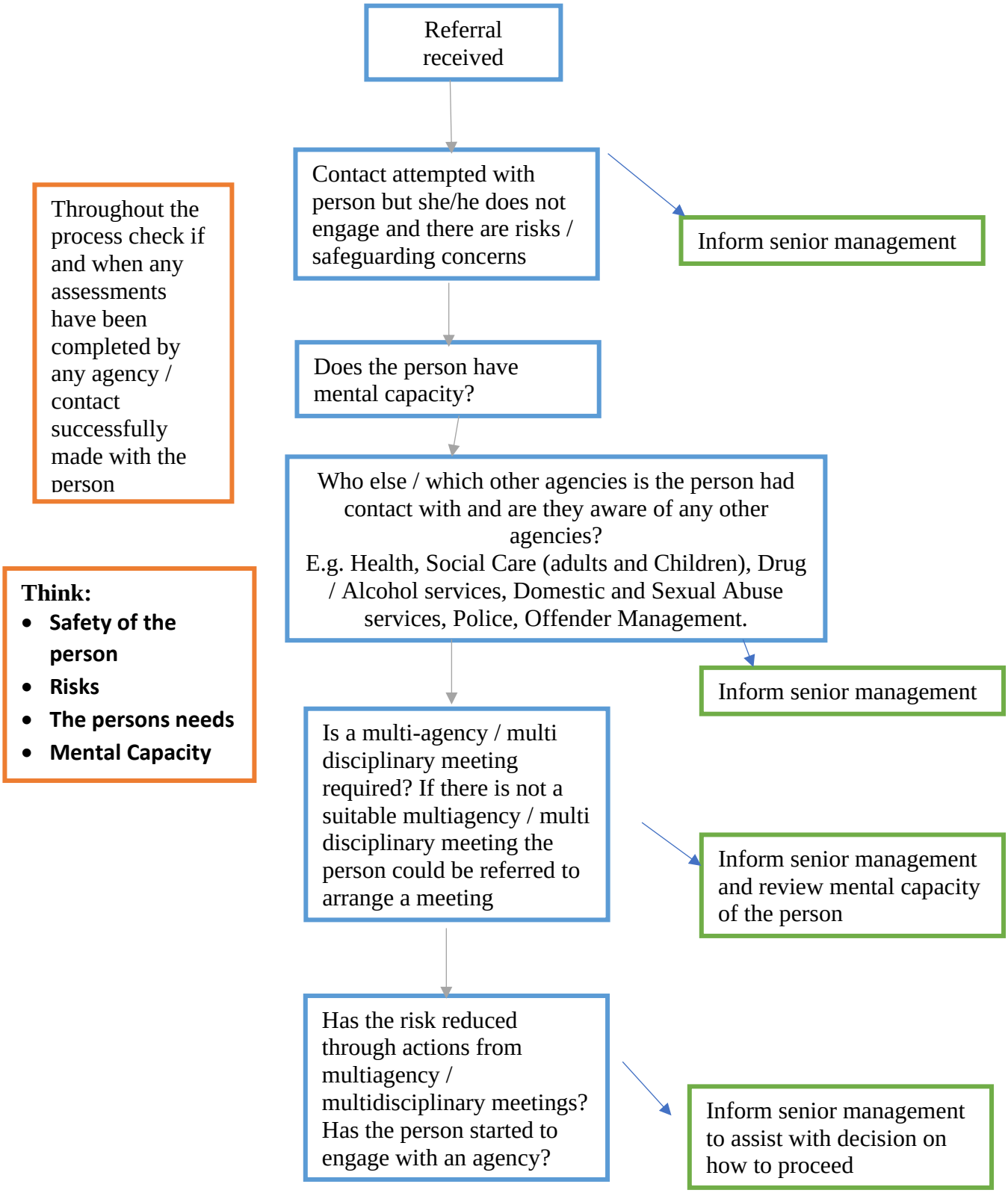
Appendix A **Multi Agency Risk Assessment**

Date of assessment:
Name of person being assessed:
Address:

Agencies involved:

What is the risk? Consider risk to the person AND to others	**What is already in place to reduce the risk?**	**What are the barriers to removing the risk?**	**What action needs to be taken? By who? By when?**

Appendix B Process for Service Users who are unable to engage



Appendix F – Glossary

Acronym / Term	Meaning
Official Sensitive 2018	OFFICIAL The majority of information that is created or processed by the public sector. This includes routine business operations and services, some of which could have damaging consequences if lost, stolen or published in the media, but are not subject to a heightened threat profile. This report is classed as official until it has been approved by the Home Office.
MARAC	Multi Agency Risk Assessment Case Conference.
IDVA	Independent Domestic Violence Advisor (Highly trained specialist in domestic abuse).
DASH / DASH RIC	Domestic Abuse Stalking Harassment and Honour based Violence Risk Identification Checklist. Used to determine the level of risk someone is experiencing from domestic abuse.
IOM	Integrated Offender Manager.
DV / DVA	Domestic Violence / Domestic Violence and Abuse.
PPU / PP	The Public Protection Unit.
WAIS	Women's Aid Integrated Services.