Nottingham Crime & Drugs Partnership

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

Domestic Homicide Review

Overview Report

'Ms S'

Died: July 2018

Mark Dalton
Independent Domestic Homicide Review Chair and Report Author

October 2020

Confidential

Contents

1. INTRODUCTION

1.1 This is an overview report of a Domestic Homicide Review (DHR) under Section 9 (3) of the Domestic Violence Crime & Victims Act 2004.

1.2 The subject of this review will be referred to as Ms S in this review, is a white British female who was 51 years and 8 months old at the time of her death. The precise circumstances of her death are not known. A criminal investigation commenced following the discovery of her body. Initially her partner, who had been with her in the 24 hours prior to the discovery of her body was arrested under suspicion of murder and released under investigation. Thirteen months later the investigation was dropped due to no realistic prospect of conviction. At the inquest held in October 2019 the coroner recorded an open verdict.

1.3 The decision to undertake a Domestic Homicide Review was taken by Nottingham Crime & Drugs Partnership on 28th May 2019 following notification by the Senior Investigating Officer, Nottinghamshire Police, regarding a death where domestic abuse had been identified between the victim and partner. The circumstances of the death fall within Section 9 of the Domestic Violence Crime & Victims Act 2004 which required consideration of conducting a Domestic Homicide Review.

1.4 The guidance states that the purpose of a DHR is to:

a) Establish what lessons are to be learned from a domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result;

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

2. THE REVIEW PROCESS

2.1 The domestic homicide review process commenced with an initial meeting of the Nottingham City Adult Safeguarding Partnership Board Safeguarding Adult Review Subgroup on 3rd July 2019. An initial trawl for information identified 9 agencies who had significant contact with either Ms S or her partner. Independent Management Reviews (IMR's) and chronologies of their contact with Ms S and her partner were requested from these agencies addressing the agreed Terms of Reference. (appendix 1)

2.2 The agencies contributing to this review were:

Nottingham City Council – Adult Social Care.
Equation – Nottinghamshire charity working with Domestic Abuse.
Framework – Nottinghamshire charity providing housing and other support services.
Greater Nottingham Clinical Commissioning Group – GP services.
Juno Women's Aid (formerly WAIS – Women's Aid Integrated Services) – Nottinghamshire charity working with women, children and teens who have been affected by domestic abuse.
Opportunity Nottingham - Nottingham City agency working with people with multiple and complex needs.
Nottingham Recovery Network – Nottingham City agency offering advice, support and treatment for users of drugs and alcohol.
Nottinghamshire Constabulary.
Nottingham University Hospitals NHS Trust – summary report.
Nottinghamshire Healthcare Trust – summary report.

2.3 The Nottingham Crime and Drugs Partnership appointed Mark Dalton to chair the review and to author the overview report. He is an independent registered social worker and experienced SILP (Significant Incident Learning Process) reviewer. He has extensive social work experience in the statutory and voluntary sector and has undertaken DHR's for other Community Safety Partnerships. He has never

previously worked in Nottinghamshire and is independent from all the agencies involved in this case and Nottingham City Adult Safeguarding Partnership Board.

2.4 The Significant Incident Learning Process (SILP) is a learning model which engages practitioners in case reviews, focussing on why those involved acted in a certain way. It follows a systems methodology, SILP reviews also highlight what is working well and patterns of good practice.

2.5 Members of Ms S's family were consulted as part of the review and shared their memories and observations of her. They have decided not to read the final version of this report, although they are aware of where and how the Overview Report will be published.

2.6 Mr K; Ms S's partner at the time of her death, was approached through agencies working with him to participate in this review by meeting with the Lead Reviewer. This approach was supported by Ms S's family who believed that it may provide missing information about her final hours. However, he declined to contribute.

2.7 The Review Panel expresses its sympathy to the family of Ms S their loss and thanks them for their contributions to this review.

3. THE SCOPE AND TERMS OF REFERENCE FOR THE REVIEW

3.1 Equality and Diversity

The nine protected characteristics identified in the Equality Act 2010[1] were assessed for relevance to the DHR. The characteristics of age, disability and sex were discussed by the DHR, and the potential vulnerabilities of mental health and drug and alcohol abuse were recognised by agencies working with Ms S. These factors are analysed in Section 6 of this report. Agencies responded appropriately to Ms S recognising her vulnerabilities in some areas, there is no evidence that barriers existed that prevented her from accessing services.

3.2 Scope of the Review

The scope of the review was agreed to be from May 2017 - when the relationship between Ms S and her partner began until her death in July 2018. Agencies were

[1] The Equality Act 2010 sets out nine protected characteristics and discrimination is recognised when at least one of these characteristics determines the way in which a person is treated. The nine characteristics that are protected are: Age, Disability, Gender reassignment, Marriage or Civil Partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation.

requested to review all their records and provide a summary of any significant incidents outside the scoping period if relevant to the review.

3.3 See Appendix 1 for full Terms of Reference.

4. REVIEW SUMMARY.

4.1 Background Information

The victim will be referred to as Ms S in this report. Ms S is known to have a sister, a brother and a daughter, both her parents are deceased, she was not in regular contact with members of her family. She had been known to health services for problems with alcohol for several years and had sporadically engaged with treatment services but was unable to sustain any long-term recovery.

4.2 Her previous relationships were known to be abusive at times, and Ms S was recorded as the perpetrator as well as the victim of abuse.

4.3 Ms S was intelligent, took pride in her appearance and aspired to improve her life. A strong motivation for her was to re-establish contact with her teenage daughter.

4.4 Ms S had a tenancy in supported accommodation provided by Framework. The eventual aim was for her to learn to cope independently and move on to long term accommodation.

4.5 The relationship with her final partner (referred to in this report as Mr K) began in June 2017. He is a white British man who was 42 years old at the time of Ms S's death. He was reportedly a close friend of Ms S's previous partner who died at around the time he began the relationship with Ms S. Mr K also had problems with alcohol, as well as depression and anxiety. He seems to have been more successful in engaging in treatment programmes; in that he stayed involved with services for longer and seemed to have longer periods of abstinence.

4.6 Mr K was previously married and has three children who live with his ex-partner and other family members. There are allegations of assault on a former partner and abuse towards other members of his family.

4.7 Mr K had his own flat two miles away in another part of the City.

4.8 Ms S and Mr K shared some similar life experiences which may have been significant in maintaining their relationship. Both had been estranged from their children and linked their problems with alcohol to the break-up of previous relationships.

5. TIMELINE OF SIGNIFICANT EVENTS

5.1 **May 2017** – Ms S informed staff at Framework that she was in a relationship with Mr K. In the light of this her Risk Assessment was updated, recognising that Ms S was more vulnerable when under the influence of alcohol and when with Mr K. A Risk Management strategy was agreed with Ms S including the following: staff would communicate risk within the team and with other agencies as appropriate (whilst Ms S consented for information to be shared with other agencies); for staff to be aware of Ms S's domestic violence history and to monitor and communicate any concerns appropriately; for Ms S to report any concerns/incidents of domestic abuse to staff and Police and for Ms S to call the Police at any point if she felt in immediate danger.

5.2 Incidents of domestic abuse were reported by Ms S to the Nottingham Recovery Network naming her previous partner as the perpetrator.

5.3 Ms S was spoken to directly by staff at Framework and she confirmed that she was staying with Mr K and was safe. Mr K had also informed the Nottingham Recovery Network that he was in a relationship with Ms S.

5.4 Framework, Nottingham Recovery Network, Equation, Adult Services and the GP shared information about risk of possible domestic abuse.

Comment: the importance of inter-agency communication is underlined in this case where it was unclear who was the primary perpetrator and who was the primary victim. Services cannot work with both parties because of the risk of collusion and the possibility of increasing the level of risk, therefore it is important that this kind of conversation takes place to identify the primary aggressor.

5.5 **June 2017** – Review of Framework support plan; this noted that Ms S was in a relationship with Mr K who lived close to her former partner, and that she and Mr K had become engaged. Ms S stated she had considerably reduced her alcohol intake since her new relationship had begun. No domestic abuse concerns involving Mr K reported at this stage. Actions from the review included for Ms S to

report any incidents of domestic violence to both the staff and Police (there were still ongoing domestic violence concerns regarding her former partner).

5.6 **July 2017** – Ms S's former partner (and friend of Mr K) died. Mr K reported to Nottingham Recovery Network that he was drinking more. Concerns were raised by Opportunity Nottingham that if Ms S became intoxicated, she may become aggressive towards Mr K. Mr K contacted the Police to complain that Ms S was drunk and causing problems at his home address. Police attended and established a verbal argument had taken place. No offences had taken place. Recorded as Standard Risk Domestic Incident. Ms S was transported to her home.

5.7 Ms S racially abused and assaulted the partner of a neighbour. The Police were called at the time of the incident, Ms S was arrested and subsequently charged with Racially Aggravated Disorderly Behaviour.

5.8 Mr K requested help to control his alcohol abuse from a Mental Health Nurse based at his GP's practice. It was recognised that there were a number of concerns which meant that a full review by his doctor was required before treatment to help with alcohol addiction could begin. In the event this appointment was never followed up by Mr K.

5.9 The following day Ms S reported domestic abuse from Mr K to the Police. Both parties were visited by officers the following day, Ms S confirmed that an argument had taken place but declined to confirm she had been assaulted. No visible injuries were noted by the officer. The incident was recorded as Standard Risk Domestic Incident.

5.10 However, Framework staff recorded that Ms S reported physical violence towards her by Mr K and stated he threw her out following an argument; Ms S was visibly upset, she had cuts and abrasions on her elbows, bloody skin grazed off her ankle, and stated her cheeks and throat were painful. Another similar incident occurred a few days later.

5.11 Framework staff offered to complete a DASH-RIC (Domestic Abuse, Stalking and Harassment and Honour based violence risk identification assessment checklist) but this was declined, Ms S was offered support to self-refer to the Women's Centre, safety advice was offered to Ms S and re-engaging with recovery services was suggested.

5.12 The details of the incident were communicated to Opportunity Nottingham (who were working with Mr K). Mr K stated they had separated; Ms S had visited to pick

up her belongings, he denied any assault had taken place. Mr K reportedly recognised that the relationship with Ms S was stressful and told staff at Opportunity Nottingham that it was over.

5.13 Framework staff completed a DASH-RIC with Ms S with a request that it be referred to the MARAC (Multi-Agency Risk Assessment Conference) because of the likelihood that Ms S would resume her relationship with Mr K.

5.14 The DASH-RIC was picked up by the Adult Duty Team who attempted to make direct contact with Ms S, as she did not have a telephone. The worker was mindful not to leave messages with third parties due to concerns around safety and confidentiality and so sent a letter to Ms S's address which was known to be different to Mr K's, requesting that she made contact if she required support. From the conversations that Ms S had with Framework staff it is clear that she understood that workers were concerned about the risk of further domestic abuse when she was with Mr K. Although some contingency plans were in place (she was asked to check in with staff and advised that she would be reported as a missing person if she did not return to her flat), these were only effective if Ms S cooperated.

Comment: this was possibly a missed opportunity; no attempts were made by the Adult Duty Team worker to contact the referrer to seek out an alternative means of contacting Ms S, or get further information from her Support Worker. This could have provided further insight into the situation and potentially led to direct contact with Ms S.

5.15 **August 2017** - The relationship between Ms S and Mr K resumed almost immediately. Framework staff were concerned that Ms S was at risk of domestic abuse from Mr K.

5.16 Mr K made a complaint to the Police that Ms S had assaulted him, he subsequently refused to make a statement or complete a DASH-RIC form. Ms S made a counter allegation of abuse but also refused to make a statement.

5.17 Ms S spent significant periods of time with Mr K. During a visit from Mr K's tenancy Support Worker, Ms S disclosed to them that Mr K had given her a bruised eye. This information was shared between Opportunity Nottingham and Framework who completed a DASH-RIC and recommended a MARAC.

5.18 Ms S and Mr K were both referred to the MARAC as victim and perpetrator as a result of the 2 incidents which occurred in August. Ms S had physical injuries which

had been documented by Framework staff, and Mr K had reported to his Opportunity Nottingham worker that he had been psychologically damaged by the relationship and suffered some minor injuries.

5.19 As a result of the MARAC, Framework staff encouraged Ms S to access support from Juno Women's Aid and The Nottingham Recovery Network (NRN).

5.20 **September 2017** - Mr K requested support for his problem drinking from his GP. He also acknowledged that he had an on/off partner who also had problems with alcohol and there were issues with domestic violence (Mr K stated that both he and his partner had been perpetrators as well as victims). The GP surgery did not link the 2 names together although they both attended the same GP practice.

Comment: it would have been possible for the practice to link Ms S and Mr K as Mr K had been identified as the perpetrator of abuse towards Ms S in her records. This was a missed opportunity by the GP practice. This information would have been particularly useful for Ms S' records as she was known to be a vulnerable adult. There were several opportunities to make this connection but the link was not identified.

5.21 Ms S did not attend the Women's Aid drop-in as expected because she was under the influence of alcohol and staying with Mr K. Again, Ms S was spending a significant amount of time at Mr K's flat. Consequently, she was missing appointments with her Support Worker and the introduction to Women's Aid. Ms S stated that she no longer needed support as her relationship with Mr K was fine.

5.22 **October 2017** - Ms S contacted Nottingham Recovery Network for support in reducing her alcohol dependency. She also reported that her partner (Mr K) was also abstinent and in treatment services. Despite a positive start all services increasingly had difficulty in maintaining contact with Ms S.

5.23 **November 2017** – Mr K made a further allegation of abuse by Ms S to Nottingham Recovery Network. Ms S acknowledged that alcohol was a major factor in their relationship and recognised that she and Mr K needed time apart, but she did not consider the relationship unhealthy.

5.24 **December 2017** - Ms S was drinking again and therefore medication to support her abstinence was suspended. A possible trigger for her relapse was a recent letter regarding legal proceedings in relation to her daughter. All agencies were struggling to engage Ms S as she felt she could manage independently.

5.25 As Ms S withdrew from professional support, she correspondingly increased the amount of time she was spending with Mr K. Ms S told professionals that she was able to open up to Mr K and had told him things she was not able to share with professionals. However, within days of this discussion, Mr K contacted the Police to complain that Ms S was drunk and causing problems outside his home address.

5.26 **January 2018 – March 2018** - The relationship between Ms S and Mr K appeared to be relatively stable; there was one incident where Mr K contacted the Police to have Ms S removed from his flat, and a further incident where he complained that she has assaulted him but declined to complete a DASH-RIC or give a statement, Ms S also denied the assault.

5.27 Towards the end of March Ms S revoked consent for agencies to share information about their involvement with her.

Comment: this was a decision that potentially increased the level of risk. There are a number of possible reasons for this; Ms S' decision coincided with a legal proceeding regarding her daughter, and Ms S was concerned with portraying the best impression she could of herself to the courts and others. It has also been suggested that she objected to reports of her levels of drinking being shared between agencies.

5.28 **April 2018** - Ms S discussed being abused by Mr K with Framework staff, because she was intoxicated at the time, she could not be clear about the timeline of events, but when sober she minimised the level of disagreement between them and said the relationship was fine. A few days later Ms S was seen with a bruise on her face, although she declined to say what happened.

5.29 **May 2018** - Mr K Informed his worker that Ms S had punched him in the face whilst he was staying at her flat. he subsequently returned home but she followed and caused a disturbance at his address. Opportunity Nottingham completed a DASH-RIC which was discussed at MARAC.

5.30 On the same day Ms S also alleged that she had been assaulted by Mr K and had several visible injuries to her head and face. Ms S declined to report the incident to the Police, who were contacted by Framework staff. Ms S would not confirm an assault had taken place, she declined to provide a statement or complete a DASH-RIC.

5.31 Later in the same month Ms S, with the encouragement of Framework staff, discussed the issue of domestic violence with the Police. While Ms S was prepared to disclose previous abuse, she would not confirm any recent incidents. Ms S did not want the Police to speak to Mr K. At the time of this incident there was no requirement to complete a DASH-RIC, although subsequently guidance on this has changed and an assessment would now be undertaken.

5.32 **June 2018** – A second referral to the MARAC followed from the incidents which had happened in May. Again, Ms S and Mr K have dual status as perpetrator and survivor. The MARAC did not identify that Ms S had also been referred as a victim within the last 12 months.

Comment: The frequency of referrals can be as significant as the degree of risk; Nottingham have a protocol for discussing cases at MARAC if there are repeat referrals in a 12-month period, regardless of level of risk identified.

The MARAC was not able to identify a pattern to the information and did not identify Mr K as the perpetrator of the more serious physical abuse. There were a higher volume of calls to the Police from Mr K reporting Ms S as a nuisance for being drunk and failing to leave his property, whereas Ms S was reluctant to report her injuries (reports from her were usually prompted by staff at Framework observing her injuries and distress)

The impression that Mr K was equally at risk is illustrated by the following record:

5.33 The GP practice summarised the concerns of Opportunity Nottingham about Mr K as follows:

> 'Both survivor and perpetrator abuse alcohol. Survivor states that he is frightened of perpetrator when she is in drink as there isn't any violence when sober and the relationship is great. Perpetrator is physically, emotionally and financially abusive towards survivor. Survivor feels trapped sometimes, due to him wanting to be alone and depending on perpetrator emotionally and for company, however he finds it hard to cope with someone so demanding and violent and doesn't know how to break free. Perpetrator monitors his calls and accompanies him on appointments making it difficult to access support services alone. She follows him everywhere and will only access support services when he does but then continues to drink ensuring survivor relapses. '

5.34 The GP records also stated that Mr K had no previous history of domestic violence although this was not correct.

Comment: this version of events was recorded in the GP notes by an Administrator based on a referral received from Opportunity Nottingham on a MARAC notification. The information was not reviewed by any clinical professional.

5.35 Ms S was seen by Framework staff with injuries to her face and hands and alleged that she had been abused by Mr K. Once again Ms S declined to complete a DASH-RIC, she was encouraged to contact Women's Aid and was offered help on ending the cycle of domestic abuse. Ms S maintained to the Police that she received injuries when she walked into a door. Mr K reported the same incident and was seen at Nottingham Recovery Network with cuts to his hands and nose and alleged that he had been assaulted by Ms S.

5.36 A few days later, a further incident occurred when Ms S was removed from Mr K's address. Mr K contacted the Independent Domestic Violence Advisor (IDVA) at Equation. Mr K stated he had been advised by his keyworker to cover his back. His partner had bruises but Mr K stated he did not know how she got them.

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5.37 Ms S brought Mr K back to her flat and Framework staff attempted to arrange a keyworker session with her for the following day. Ms S postponed this meeting as she said she had other plans.

5.38 Both Ms S and Mr K had been drinking heavily and staying at her accommodation. They left the property on several occasions throughout the day, in order to purchase alcohol from local convenience stores.

5.39 24 hours later, both are known to have left the flat in the morning to purchase more alcohol before returning to Ms S's flat. Mr K later left the flat, leaving Ms S in the premises.

5.40 The following day Ms S was found deceased and lying on the bed in the flat by a Support Worker and the emergency services were contacted. Suspicions were raised by Paramedics at the scene as they believed the body had been moved post death.

5.41 A Home Office post-mortem supports the opinion that the body had been moved after death. Ms S had a number of facial injuries that could not be accounted for and she had also sustained an injury to the brain.

6. THEMES

6.1 Domestic Abuse. Ms S and Mr K had a history of abusive relationships and both had been recorded as the perpetrator and victim of abuse in the past. Just before the relationship with Mr K began, Ms S had been physically abused by her previous partner and was assessed as being at High/Medium risk of domestic abuse from him.

6.2 The level of abuse was exacerbated by Ms S and Mr K's use of alcohol and it is noticeable that every call out to the Police it was recorded that both parties had been drinking. In total Mr K and Ms S either called the Police (or calls were made on their behalf) on 12 occasions. The majority of these calls were made by Mr K reporting that Ms S was causing a disturbance at his flat, there were resolved by the Police transporting Ms S home. There are 3 complaints of assault by Mr K on Ms S and one allegation and counter allegation of assault. It should be noted that the injuries to Ms S were serious and visible injuries to her head, face and throat. However, she was reluctant to involve the Police and declined to make a statement on every occasion.

6.3 The agencies supporting Ms S, particularly Framework were aware of the potential risk of domestic abuse and attempted to build in safeguards to ameliorate risk. Although clearly as an adult with mental capacity Ms S was free to make her own decisions and would only take on advice regarding safety planning to a limited extent.

6.4 When violent incidents occurred between Ms S and Mr K neither cooperated with the Police to make a complaint or provide a statement. There was a large element of denial about the problems in their relationship. The negative influence of alcohol was recognised by both Ms S and Mr K; who both described their relationship as good until they drank. There shared mindset was to blame alcohol for their problems rather than see it as a manifestation of other difficulties they might have.

6.5 It is not possible to know the true level of abuse which occurred in the relationship. While more calls to the Police were made by Mr K, these were usually because Ms

S was causing a disturbance outside his address and he wanted her removed. The one allegation of assault by Ms S, on Mr K did not result in any visible injury. Ms S seldom chose to involve the Police, and they were usually contacted by Framework reporting an incident on her behalf. On 5 separate occasions Ms S was seen to have injuries to her hand, face and head which she alleged had been caused by Mr K.

6.6 Alcohol. It is important to state that alcohol does not "cause" domestic abuse as such but can compound and exacerbate the problem of violence. Alcohol seems to be particularly significant where both parties have been victims and perpetrators of abuse.

6.7 Ms S and Mr K had both received treatment for alcohol abuse in the past. During their relationship had both had periods of abstinence support by counselling and drug therapy. They both also stated that they had a good relationship when drink was not involved. It would also seem to be the case that neither could sustain abstinence when the other was drinking.

6.8 However, for Ms S and Mr K, alcohol was used in times of stress and in one instance during the period under review was prompted in Ms S's case by an impending legal action to secure contact with her daughter.

6.9 Drinking had serious consequences for Ms S, firstly with regard to the agencies attempting to work with her, she would usually agree to engage with agencies who could help her with safety planning measures, but then be unable to keep to these agreements when under the influence of drink. Secondly, the presence of alcohol during the violent incidents tended to dilute and obfuscate the seriousness of the assaults and led into a perception that Ms S and Mr K were "as bad as each other."

6.10 Engagement with Agencies. There are a range of voluntary and statutory services offering support for the victims and, to a lesser extent, perpetrators of domestic abuse in Nottingham.

6.11 The evidence provided for this review shows a high degree of flexibility and responsiveness to meet the needs of people whose lives can be dis-organised and unsettled; for example, appointments can be made at short notice and co-working across agencies is common. The exchange of information was appropriate to the perceived risk, although this changed in March 2018 when Ms S revoked consent for agencies to share information about her.

6.12 Framework had a clear perception that Mr K posed a potential risk to Ms S and provided an enhanced level of support which included regular checks when she was at home and telephone support when she was with Mr K. Staff are very experienced in working with the victims and perpetrators of domestic abuse and encouraged Ms S to take steps for safety planning and used the standard DASH-RIC assessment tool to explore the risks of domestic abuse.

6.13 In addition, Juno Women's Aid tried to engage her in group and individual support but apart from one face to face contact she did not follow up her initial intentions to become involved. Examination of the records suggest that Ms S would agree to offers of support when she had fallen out with Mr K, but once the relationship resumed, she would break contact.

6.14 Ms S and Mr K both engaged with Nottingham Recovery Network (NRN) at different times and with different degrees of success regarding controlling their drinking. Ms S had several treatment episodes with Nottingham Recovery Network, generally showing short periods of engagement, with considerable stability and progress in those periods, followed by extended periods of missed appointments that would ultimately end in Ms S being discharged. When Ms S wished to address her drinking, or was abstinent, she would engage well. During periods where Ms S had relapsed, she would under-report to Nottingham Recovery Network and miss appointments.

6.15 Mr K had received treatment for his drinking problem several times before his relationship with Ms S. Once Nottingham Recovery Network were aware that Ms S and Mr K were in a relationship and there was a potential for violence, they updated risk assessments and shared concerns with other agencies.

6.16 Accepting support and working with agencies was entirely voluntary for Ms S and Mr K. There were no conditions to their respective tenancies or any mandatory involvement that required them to work with anyone. Ms S found it difficult to sustain working relationships and would tend to miss appointments to the extent that she was discharged from services for non-attendance rather than end them formally. Her decision to withdraw consent for agencies to share information about her in March 2018 also affected how agencies could work together to support her.

6.17 Mental health. Mental Health was not a major factor in this review, although both Ms S and Mr K had been in receipt of services at one time or another.

6.18 Ms S had limited involvement with psychological services 2 years prior to her relationship with Mr K. This was the result of her having a "low mood" attributed to problems due to having no contact with her daughter and did not lead to any formal diagnosis. Her mental health was not formally assessed again until 3 months prior to her death; this assessment was prompted by the ongoing child contact issue regarding attempts to re-establish contact with her daughter and did not identify any mental health problems.

6.19 Mr K had a more extensive involvement with psychological services which include interventions after two suicide attempts and two episodes of voluntary inpatient support. The main issue was assessed to be Mr K's impulsivity when intoxicated with alcohol and illicit substances and that he was at risk of suicide when under the influence. Mr K stated that he suffered from depression and anxiety. Mr K on-going difficulties in his relationship with his children and ex-partner.

6.20 Referrals to MARAC. The Multi-Agency Risk Assessment Case Conference (MARAC) is a forum for discussing the cases of domestic abuse deemed to be at the highest risk of further incidents of serious violence or abuse. The MARAC meets fortnightly and discusses 75 cases over a four-week period. All high-risk referrals are discussed at the MARAC apart from duplicate referrals which are merged and MARAC to MARAC Transfers out of the City.

6.21 The MARAC provides an effective way for agencies to share information, identify patterns of abuse and create risk management plans to protect victims and hold the perpetrator to account. The MARAC not only assess risk to the principle protagonists, but also considers other family members or associates who may be as risk.

6.22 The MARAC had limited impact in this case because of Ms S disinclination to engage with support offered to her.

6.23 This is not a criticism of the MARAC process as such; and as a forum for exchanging information to produce a comprehensive assessment of risk it was effective.

6.24 Use of Domestic Abuse, Stalking and Harassment and Honour based violence Assessment and Risk Indicator Checklist (DASH-RIC). The DASH-RIC is widely understood and used in Nottingham; in this case all agencies who had contact with Ms S or Mr K used it at least once. There was consistent scoring of high or medium risk across agencies, while a high score would be discussed at a MARAC, a medium score would only be referred if it were the second referral within a 12-month rolling period.

6.25 There was a missed opportunity to discuss Ms S prior to the second MARAC in June 2018 when she was assessed as medium risk for a second time earlier in the year.

6.26 Ms S was reluctant to engage with the process and it was only because of the obvious signs of injury that she agreed to cooperate with the DASH-RIC. It is possible to make a referral without the consent of the victim for high risk referrals, but it must be clear what legal justifications are being used (the Information Sharing Without Consent form provides these grounds).

6.27 The DASH-RIC is dependent on the information provided by those involved with little opportunity to verify or corroborate. This is both a strength – in that it captures a first-hand account of an incident, but also a deficit because traumatised people may minimise, confuse or conflate incidents leading to an inaccurate impression of the level of risk. To try and address this the DASH-RIC has an option for "professional judgement" to be included as part of the assessment.

6.28 This review also raises a question of whether there is an unconscious gender bias demonstrated by some professionals when completing the DASH-RIC assessment form. It would appear that agencies provide different responses to male survivors compared to female survivors, with male survivors being classified as higher risk. For example, Mr K was referred as high risk due incident where he stated that Ms S had punched him in the face, whereas Ms S was classed as medium risk after Mr K assaulted her resulting in a black eye and swelling above her eyebrow, a split lip and a bruised left ear.

6.29 Identification of the primary Aggressor. "One of the more common challenges for those coming in to contact with domestic abuse is counter-allegations, where both parties allege that the other is abusive. For those less experienced in working with domestic abuse it can be easy to fall into the trap of believing this is so, and that they are 'both as bad as each other'."[2]

[2] Managing counter-allegations – Luke Martin practice blog April 2018

6.30 There are a number of factors which can push professionals to this conclusion; it can depend on which party initiated contact with the police (or other agency) to make the first complaint, which party suffered the more serious injury and who seems more reasonable and prepared to accept help. Parallel problems with alcohol and substance abuse can also serve to confuse and distract from the realities of violence.

6.31 There is a body of research which has studied the differences in how men and women are violent in intimate relationships[3] It may be helpful to recognise the gender differences between violence perpetrated by men and women. Women who are violent to their male partners may possibly be displaying a type of behaviour described as "violent resistance" against violent male partners. Women who use violence in intimate relationships have been categorised into three groups:

a) those who use violence in self-defence to escape or protect themselves,
b) those with a long history of victimisation from previous partners and in childhood and to use violence in order to decrease their own chance of further victimisation,
c) those who the primary aggressors and use their greater physical power to control the partners.

6.32 From the information available to this review it would seem that the first two of these categories could be applied to Ms S. It is possible that concern of alcohol abuse dominated attempts to engage Ms S to the detriment of recognising her other issues and the level of traumatic abuse she had experienced from her previous partner. There are several factors in her history, such as estrangement from family (including her child), experience of abuse that would have had an impact on her self-esteem and wider mental health.

6.33 Furthermore, Mr K's presentation to the Police as a restrained but injured party in the incidents which occurred at his flat betrayed an image of reasonableness which distracted from the seriousness of his abuse of Ms S. Again, research has found that men were effective in making the less seriously violent female perpetrators appear as the primary perpetrators of violence, thus enabling them to excuse their own abusive behaviours so they appear rational, capable and non-violent.[4]

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[3] Portrayal of Women as Intimate Partner Domestic Violence Perpetrators - Marianne Hester is an introduction to this work

[4] Anderson, K., Umberson, D. (2001). Gendering violence: Masculinity and power in men's accounts of domestic violence. Gender & Society, 15, 358-380.)

6.34 The phenomena of bi-directional abuse has been studied and critically considered over the last 20 years and found to be extremely rare, to the point that it is questioned whether it exists at all.

7. CONCLUSION

7.1 There are unanswered questions regarding the death of Ms S, however it is clear that she had been in an abusive relationship with Mr K for just over 12 months when she died as a result of injuries that were likely sustained whilst she and Mr K were intoxicated.

7.2 Ms S had been both the victim and perpetrator of abuse, although the abuse she experienced was noticeably more severe than the abuse suffered by Mr K. The evidence is that she sustained more serious physical injuries than Mr K. These injuries were often visible but never led to any consequences for Mr K. He presented to agencies as a victim of abuse and was never challenged about his violence towards her.

7.3 While incidents of domestic abuse were recognised by the agencies involved with Ms S, she was reluctant to engage with support agencies in any meaningful way. The review has noted that agencies were prepared to be flexible; by offering appointments at short notice, keeping referrals open and offering to meet in different venues. However, there was a pattern of initial agreement, but then a failure to keep appointments. This seems to be linked to the state of her relationship with Mr K, but this is not to say that he forced her to break off contact, but rather that she did not feel the need for additional support when she felt the relationship was good.

7.4 Effectively supporting Ms S would have engaging her in therapeutic support to address her own traumatic experiences of abuse and loss. These resources were not readily available during the period under review and remain extremely scarce. For any person to be able to make use of this kind of help, a prerequisite is they need to feel stable and secure. Ms S was struggling to meet these fundamental needs.

7.5 Patterns of abuse were not identified which resulted in indicators being missed that Mr K was a primary perpetrator of domestic abuse. This was because there was a greater volume of reports from Mr K as the victim of abuse; generally

reporting the same facts of Ms S refusing to leave his property or causing a disturbance. Whereas, Ms S had fewer reports with more severe injuries and evidence of distress, which resulted in confusion when recalling events. Research shows that survivors will generally have trouble separating multiple events at times of distress whereas a perpetrator posing as a survivor will not deviate from a set narrative of events.

8. EFFECTIVE PRACTICE

8.1 The flow of information between agencies was timely and enabled risk assessments to be updated as the relationship was understood by professionals. The MARAC can only be effective if it remains a dynamic process, and this happened in this case.

8.2 Agencies showed a flexibility in their attempts to support Ms S to engage in support and therapeutic services. Framework staff recognised how difficult it was to understand the range of services and meet new professionals and attended meetings with Ms S. Appointments were arranged and re-arranged to try and engage her with support groups and counselling. Importantly her failure to engage was recognised as a symptom of her problems and not a rejection of help.

8.3 Agencies worked in partnership with both Ms S and Mr K as far as possible, respecting their autonomy and right to make decisions about their own life. The decision by Ms S to withdraw consent for agencies to share information was respected and acted on. Services also continued to work with Mr K after the death of Ms S.

8.4 Since this review, Framework have already adopted a change in protocol when a service user asks to withdraw consent. The service is prompted to view such a request over an elongated period, revisiting the decision with the service user. The intention is to provide the service user with a cool off period and also the service to establish some of the thoughts behind the request. This includes prompts about coercion and factors in the service user's social circumstances and/or relationship status and the risks that may present.

9. LESSONS LEARNT

9.1 There was a missed opportunity where Ms S was not referred to the MARAC earlier following the Police referral in June 2018 as this was a repeat incident within a 12-month period. She was noted as the victim and regardless of risk level should have been referred.

9.2 It should be considered that the levels of risk identified for Ms S and Mr K suggest a degree of gender disparity; in that agencies provide different responses to male survivors compared to female survivors with male survivors being classified as higher risk. For example, Mr K was referred as high risk due to an incident where he stated that Ms S had punched him in the face but Ms S was classed as medium risk after Mr K had assaulted her causing a bruised eye and lump above her eyebrow, a split lip and a bruised left ear. This anomaly may be specific to this case but could be reviewed further in similar cases where there are counter allegations of abuse.

9.3 As noted previously, this disparity in how male and female perpetrators of abuse are perceived has been recognised in research [5] and is worthy of further consideration. It may be tempting, in situations where there are numerous allegations and counter allegations of abuse within relationships to have an initial reaction that the parties are "as bad as each other". However, as the nature of the injuries received by Mr K and Ms S indicate the violence which occurred between them was not equivalent[6]. The issue of identifying the primary abuser was further obscured because alcohol was involved and because it was Mr K who made the initial complaints to the Police.

9.4 Agencies other than the Police, need advice on how they can legally record and alert other agencies and service users about the potential risk of domestic violence where the perpetrator does not have a conviction relating to violent or abusive offending, but there are legitimate concerns that they pose a risk.

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[5] A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. Michael P. Johnson (2008) as well as identifying all major types of intimate partner violence, distinctions are also made between the types of violence, motives of perpetrators and the social context.

[6] The research in this area uses the terms "symmetrical" and "asymmetrical" to discuss how violence is portrayed in Domestic Violence situations. See Conflict and Control: Images of Symmetry and Asymmetry in Domestic Violence.

9.5 This review has highlighted two important deficits in current service provision. There is a lack of a non-statutory service for male perpetrators of domestic abuse, at the present time the only option is a referral to a national helpline.

9.6 There is also a lack of resources to offer longer term therapeutic support to traumatised victims of domestic violence. Extensive experience of working with the victims of domestic violence has demonstrated a recurrent theme of those victims having a history of previous trauma and early life attachment difficulties. These are issues which need individualised therapeutic support, potentially over months or years. Even to accept that therapy might be useful can require a leap of faith on the part of the service user, who may have had negative experiences of this in the past.

10. RECOMMENDATIONS

10.1 Not all agencies made individual recommendations for their agency, however the following specific recommendations have been noted:

10.2 Nottingham Recovery Network.

a) Where procedures outline expected discharge actions there is enough flexibility within services to respond differently when necessary.

10.3 Nottingham City Adult Social Care

a) Adult Duty Workers who are responding to DART referrals must ensure they review history of case and do not respond to referrals in isolation, irrespective of risk rating.

b) Adult Duty workers should ensure they attempt to seek out alternative telephone numbers to make contact and speak to relevant other agencies, when involved, to establish the victim's safety.

10.4 Greater Nottingham Clinical Commissioning Partnership.

a) GP Practices to complete the 'Groups and Relationships' Template at every contact with individuals, in order to ascertain current partner/children/family dynamics details. This is especially important when it is known by GP Practice Staff that an individual is 'Vulnerable' and/or 'At Risk of Domestic Abuse' because it is vital that individuals are linked to each other in order to identify individual risks and to offer appropriate support, advice and action planning in a timely manner.

b) 'Routine Enquiry', pertaining to domestic abuse should always take place by all GP Practice Staff when it is known that an individual is 'At Risk of Domestic Abuse' and/or is 'Vulnerable' in any way.

c) Any 'Routine Enquiry' discussions should always be fully documented in the clinical GP Records of the individual concerned, alongside documentation of support offered and any plan of action/follow up.

d) An appropriate Risk Marker Flag pertaining to being 'At Risk of/ Victim of Domestic Abuse' should always be routinely entered into the GP records, as soon as the GP Practice are aware of this information (For example - via verbal disclosure from the victim or via DART or other agency notification).

e) All voicemail messages left by GP Practice Staff should be fully documented into the GP Records of the individual concerned AND any messages left for victims of Domestic Abuse should contain only minimal routine information about health appointments and not relate in any way to domestic abuse/domestic abuse information because this may put the victim at further risk.

f) All DART/MARAC Notifications received by the GP Practice should be entered into the GP Records of the Victim and into the records of the Perpetrator (if the Perpetrator is registered with the same GP Practice as the Victim).

g) DART/MARAC Notifications should be forwarded to a Clinical Professional for review & action planning & documentation into the GP clinical records (of Victim and Perpetrator if appropriate) as soon as the information is received by the GP Practice.

10.5 Framework

Framework to undertake an organisational review of how information is shared between different services, including Opportunity Nottingham and Nottingham Recovery Network. This review has two objectives; firstly, to ensure that there are no systemic, organisational or cultural barriers to effective communication. Secondly to ensure that all services contribute to a shared analysis and understanding of risk.

11. GENERIC RECOMMENDATIONS.

11.1 All Agencies should review their policies for discharging people, to ensure that there is not a "one strike and you're out" ethos. This would help people who present as high risk and struggle to engage with services on a consistent basis.

11.2 Agencies should consider whether individuals dealing with multiple disadvantages can be offered "open appointments" where it is safe to do so. Experience shows that services can then be reactive when individuals require input, particularly at a point of crisis.

11.3 When a service user withdraws consent to share information, the possibility that this has been prompted by a coercive partner should be considered, and the issue discussed with the service user. When a person is high risk for domestic abuse a decision should be made about consent and sharing with other agencies not just referring to the MARAC.

11.4 All MARAC agencies to be reminded that repeat referrals of any risk level within a 12-month period should be referred back to the MARAC. This point to be emphasised in on-going MARAC training.

11.5 Where there are mutual allegations, it is important for agencies to consider the context and pattern of incidents to establish triggers and understand who is at greatest risk.

11.6 There is no local voluntary service for men who are identified as perpetrators and have not been convicted. Presently any male wanting support is referred to national Respect helpline, previously a face to face service was available in Nottingham. This should remain under review.

11.7 All agencies should ensure they apply a strategic approach to the domestic abuse training provided by Equation; and ensure that the most appropriate staff are offered training and prioritise their needs.

11.8 MARAC practice should be reviewed to establish whether the gender disparity apparent in this case is symptomatic of a wider problem. This anomaly may be specific to this case but should be reviewed in similar cases where there are counter allegations of abuse.

11.9 The provision for male survivors of domestic abuse is under-resourced and struggles to meet the current need (there is one dedicated Independent Domestic Violence Advisor (IDVA) for male survivors for County and City).

Commissioning agencies should review the existing provision and seek additional funding or resources.

11.10 Local agencies from the Nottingham Domestic Homicide Review Assurance, Learning and implementation Group (DHR ALIG) should develop Practice Guidance on Multi-agency data sharing to ensure data is shared in a safe and lawful way.

12. NATIONAL RECOMMENDATIONS.

12.1 The Home Office should consider revising the Current Domestic Violence Disclosure Scheme (DVDS) Guidance[7] to address situations where there are mutual allegations and identification of the primary perpetrator creates barriers to agencies correctly identifying the risks to the most vulnerable person in those cross allegations. We recommend that where there are mutual allegations, the focus should be on the most vulnerable party (who is at most risk of harm).

[7] Domestic Violence Disclosure Scheme

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APPENDIX 1

Domestic Homicide Review Chapeau Tol

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APPENDIX 2.

DHR Chapeau Action Plan

DHR Chapeau Action Plan 9 Octob

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APPENDIX 3.

DHR Chapeau update and delay re

Agree to delay in DHR Chapeau_ CDP