Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Caroline
in April 2018

Report Author: Christine Graham
November 2019

Preface

Ashfield's Community Partnership (the statutory Community Safety Partnership for the area) wishes at the outset to express their deepest sympathy to Caroline's family and friends. This review has been undertaken in order that lessons can learned; we appreciate the support and challenge from families and friends throughout the process.

The review was commissioned by the Partnership on receiving notification of the death of Caroline in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Caroline's death.

Section 3 will provide **overview and analysis of the information** known to family, friends, employers, statutory and voluntary organisations and others who held relevant information.

Section 4 will address **other issues** considered by this Review

Section 5 will bring together the **recommendations** agreed by the Panel

Section 6 will provide the **conclusion** debated by the Panel

Appendix One provides the **terms of reference** against which the panel operated

Contents

Preface		2
Section One – Process of the Review		
1.1	Summary of circumstances leading to the Review	6
1.2	Reason for conducting the review	6
1.3	Process and timescale for the review	7
1.4	Confidentiality	8
1.5	Dissemination	8
1.6	Methodology	8
1.7	Contributors to the review	10
1.8	Involvement of family and friends	10
1.9	Review Panel	10
1.10	Domestic Homicide Review Chair and Overview Report Author	11
1.11	Parallel Review	12
1.12	Equality and Diversity	12
Section Two – The Facts		
2.1	Introduction	14
2.2	Detailed Chronology	14
2.3	The incident	17
Section Three – Summary of information known to agencies, family and friends		
3.1	Information known to family and friends	19
3.2	Evidence of domestic abuse	19
3.3	Detailed analysis of agency involvement	22

Section Four – Other issues considered

4.1 Why did Caroline not feel able to seek help? 24

4.2 What more can be done to support women like Caroline? 24

Section Five –Recommendations 26

Section Six - Conclusions 27

Appendix One – Terms of Reference 28

Section One – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 Caroline and the perpetrator had been in a relationship for six years and had been married for the last three. They had a two-year old daughter together. Caroline also had two children from a previous relationship. They had all lived together as a family in a Nottinghamshire town, but the couple had separated a few weeks prior to this incident.

1.1.2 The Ambulance Service were called at 10.40 pm on a midweek night in April 2018. A caller (now established to be Caroline's partner and this perpetrator) said, 'I've killed her'. The Ambulance Service contacted the police who were able to establish the address from which the call was made. Shortly afterwards, the police and paramedics arrived at the address and found the rear door of the property insecure.

1.1.3 When they entered, they found a Caroline lying on her back in front of the sofa in the living room. She had multiple lacerations to her face and neck and her clothing was soaked in blood. She was not breathing and had no pulse. Efforts were made to revive her, but she was pronounced dead at 11.33 pm.

1.1.4 Officers searched the property and found Caroline's two-year old daughter in the bedroom upstairs. There was no-one else present as the two older children were staying overnight with their father.

1.1.5 A kitchen knife was found in the kitchen covered in blood. The police found the perpetrator in a nearby street. He was arrested upon suspicion of Caroline's murder.

1.1.6 He subsequently pleaded guilty to her murder and was sentenced to 19 years in prison.

1.2 Reasons for conducting the review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, the perpetrator has been found guilty of the manslaughter of Caroline. Therefore, the criteria have been met.

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.3 Process and timescales for the review

1.3.1 Ashfield Community Safety Partnership were notified on 6th May 2018.

1.3.2 A partnership meeting was held on 22nd May 2018 after an initial trawl had been undertaken to ascertain those agencies with knowledge of the victim and perpetrator. This meeting was chaired by the Chair of the Partnership and the decision was taken to appoint an independent chair and report author and proceed with a domestic homicide review.

1.3.3 The Independent Chair and Report Author were appointed in June 2018.

1.3.4 The Home Office were notified of the decision to carry out a DHR on 24th May 2018. The family were notified of the intention to hold a review.

1.3.5 The first panel meeting was held on 10th July 2018. The following agencies were represented at this meeting:

- Ashfield District Council
- Equation[1]
- Mansfield and Ashfield Clinical Commissioning Group
- Nottingham University Hospitals
- Nottinghamshire County Council – Children's Services
- Nottinghamshire Healthcare Trust
- Nottinghamshire Police
- WAIS (Women's Aid)

Apologies were received from DLNR Community Rehabilitation Company.

1.3.6 At this first meeting, the panel considered its composition and agreed that it brought together the relevant expertise in relation to the circumstances of this case. The panel

[1] Equation is a Nottingham-based specialist charity that works with the whole community to reduce the impact of domestic abuse, sexual violence and gender inequality. They work with both men and women who are experiencing domestic abuse

determined its strategy to progress the Review. This included family engagement as key stakeholders, the commission of IMRs and reports and any other such enquiries as were felt necessary.

1.3.7 The panel met again on 13th December 2018. The panel considered IMRs from:

- Nottinghamshire Police
- Nottinghamshire Healthcare NHS Foundation Trust
- Mansfield and Ashfield Clinical Commissioning Group

1.3.8 The panel met for a further meeting and the review was concluded in November 2019.

1.4 Confidentiality

1.4.1 The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the identity of the deceased, her family and friends, Caroline will be used as a pseudonym to identify the deceased hereafter and throughout this report. The person who was found guilty of her murder will be known as the perpetrator.

1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- Caroline's family
- Chair, Nottinghamshire Health and Wellbeing Board
- Chief Constable, Nottinghamshire Police
- Chief Executive Officer, Mansfield and Ashfield Clinical Commissioning Group
- Chief Executive Officer, Nottinghamshire Women's Aid
- Chief Executive, Ashfield District Council
- Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust
- Chief Executive, Nottinghamshire University Hospitals NHS Trust
- Chief Officer, Community Rehabilitation Company
- Independent Chair, Nottinghamshire Safeguarding Adults Board
- Independent Chair, Nottinghamshire Safeguarding Children Board
- Nottinghamshire Police and Crime Commissioner
- Senior Coroner for Nottinghamshire

1.6 Methodology

1.6.1 Ashfield Community Partnership was advised of the death by Nottinghamshire Police eight days after the death. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity.

1.6.2 In response to the notification, a partnership meeting was held on 22nd May 2018. This was chaired by the Chair of the Community Safety Partnership. At this meeting, the police provided a summary of incident and those partners present shared the initial information that they held in relation to Caroline and her husband.

1.6.3 Having heard the contributions from the partners present, the Chair took the decision to hold the Domestic Homicide Review because it was clear that, given the information available at the time, there would be learning from this case. The Home Office was informed of the decision to undertake the review on 24th May 2018. This decision demonstrates a good understanding by the Chair of the Partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

1.6.4 Gary Goose and Christine Graham were appointed in June 2018 to undertake the review and the Review Panel met for the first time on 10th July 2018. The Panel met three times and the final meeting of the Panel was in November 2019.

1.6.5 At the meeting on 10th July 2018 all members of the panel were present with apologies from the DLNR Community Rehabilitation Company. At this meeting, the process of the Domestic Homicide Review was explained to the panel with the Chair stressing that the purpose of the review is not to blame agencies or individuals but to look at what lessons could be learned for the future. Prior to this meeting, the Overview Report Author had met with the police's senior investigating officer (SIO) to ensure that Section 9 of the statutory guidance was adhered to. It was agreed that the review would proceed in limited scope until the criminal process concluded.

1.6.6 Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 2018 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.6.7 At this meeting the Terms of Reference were agreed subject to the family being consulted. It was agreed that the Chair and Overview Report author would make contact with the family.

1.6.8 Letters were sent to Caroline's parents and made them aware of the support that was available through AAFDA (Advocacy After Fatal Domestic Abuse) to help them through the review process. Following the trial, further contact was made with Caroline's parents and the Report Author met with Caroline's mother and stepfather in April 2019. Caroline's father also met with the Independent Chair of this Review.

1.6.9 Caroline's previous partner (and the mother of two of her daughters) was contacted with a view to supporting him with explaining the review to his daughters. Unfortunately, he did not respond to the contact and the review respected his wishes.

1.6.10 As there was a criminal process, the review could only proceed in limited scope until this was completed. The Chair and Report Author spent a number of months seeking to engage with Caroline's family. This delayed the completion of the report beyond the six months set out in the statutory guidance.

1.7 Contributors to the review

1.7.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- Ashfield District Council
- Equation
- Nottinghamshire County Council – Children's Services
- Nottinghamshire Healthcare Trust
- Nottinghamshire Police

1.8 Involvement of family and friends

1.8.1 The Chair and Report Author wrote to Caroline's mother and stepfather to explain to them about the review and inform of the support that was available to them from Advocacy After Fatal Domestic Abuse (AAFDA).

1.8.2 Once the criminal process was complete, a further letter was sent. Caroline's mother and stepfather met with the Report Author. During this meeting, details were provided for Caroline's father. He has subsequently engaged by meeting with the Review Chair. A copy of the draft overview report was left with the Caroline's mother and father for them to consider in their own time.

1.8.3 Both Caroline's mother and father were invited to meet the Review Panel but neither wished to do so.

1.8.4 Contact was made with three of Caroline's friends, two of whom went on to meet with the Chair.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Rebecca Whitehead	Community Safety Manager	Ashfield District Council
Dean Dakin	Community Safety and Strategic Partnership Officer	Ashfield District Council
Anthony Webster	Review Officer and IMR author	EMSOU Review Unit
Elizabeth Birch	Head of Men's Service	Equation
Rhonda Christian	Designated Nurse Safeguarding Adults	Mansfield and Ashfield Clinical Commissioning Group
Philip Millott	Safeguarding Adult Lead	Nottingham University Hospitals
Bob Ross	NSCP Development Manager (Child Deaths) Safeguarding, Assurance and Improvement)	Nottinghamshire County Council – Children's Services
Julie Gardner	Associate Director Social Care	Nottinghamshire Healthcare Trust
Hannah Hogg	Corporate Safeguarding Lead	Nottinghamshire Healthcare Trust
Clare Dean	Detective Chief Inspector	Nottinghamshire Police
Rebecca Smith	Head of Services – City and IDVA	Juno Women's Aid

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services, crime and community safety as well as housing, were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.10.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Health-checks which provide an independent view of partnership arrangements. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.10.3 Gary and Christine have completed, or are currently engaged upon, a significant number of domestic homicide reviews. Previous domestic homicide reviews have included a variety of different scenarios including male victims, suicide, murder/suicide, familial domestic homicide, a number which involve mental ill health on the part of the offender and/or victim and reviews involving foreign nationals. In several reviews they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England and Adult Care Reviews.

1.10.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[2]

1.10.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford (September 2018)
- Attended the AAFDA Annual Conference (March 2019)
- Attended AAFDA Networking and Learning Event – Christine (November 2019)

1.11 Parallel Reviews

1.11.1 There were no other reviews in relation to this case.

1.12 Equality and Diversity

1.12.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

1.12.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[3] Women are more likely than men to be killed by partners/ex-partners. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[4]

1.12.3 The perpetrator was from an Eastern European country. Throughout the review, the panel has sought to question whether the circumstances of this case were impacted by the nationality of both parties. There has been nothing to suggest that there were any aspects of this case that were impacted by the perpetrator's ethnicity.

3 (Women's Aid Domestic abuse is a gendered crime, n.d.)
4 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

Section Two – The Facts

2.1 Introduction

2.1.1 Caroline was 31 years old at the time of her death and the perpetrator was 32 years old. They had been in a relationship for 6 years and married for nearly 3 years having met in a local bar.

2.1.2 Caroline and the perpetrator have one daughter together and Caroline has two older children, under the age of 10.

2.1.3 Caroline died from twelve separate stab wounds. She had been stabbed a number of times to her face, neck and chest. The blade had broken, and two parts were left in her body.

2.1.4 A full chronology of events and a summary of information known by family, friends and agencies will follow within this report.

2.2 Detailed chronology

2.2.1 **Background information**

2.2.2 Caroline was a white British female. The perpetrator is a Romanian national who, it is believed, entered the UK during the last 10 years and had worked in the construction industry. The date of his entry to the UK is not known.

2.2.3 They had been married for approximately 3 years but had been estranged for around 6 weeks prior to Caroline's death.

2.2.4 **Chronology**

2.2.5 **2014**

2.2.6 On 22nd June 2014 Caroline's brother contacted the police to report an argument between Caroline and the perpetrator whilst had been drinking. Caroline had telephoned her father to tell him about the argument and he had in turn called her brother. Officers attended the address and Caroline said that no assault had taken place and that her brother had over-reacted by calling the police. A DASH risk assessment[5] was completed with the risk being assessed as STANDARD.

2.2.7 The police made a standard referral to Children's Social Care on 2nd July 2014. As neither of Caroline's children were present there was no children's social care involvement.

2.2.8 On 16th July Caroline saw her GP as she was experiencing intimate bleeding and abdominal pain but stated that she felt well in herself. The GP spoke with a gynaecology doctor and an appointment was made at Queens Medical Centre hospital for that evening.

2.2.9 Caroline's GP followed up with her on 22nd July and she said that she had not attended as she had problems with her car and the bleeding had stopped.

[5] Domestic Abuse, Stalking and Harassment risk assessment

2.2.10 On 16th August 2014 Caroline attended Accident and Emergency with a suspected miscarriage which was confirmed two days later by the Early Pregnancy Unit.

2.2.11 On 22nd September Caroline was seen by her GP as she had taken a pregnancy test that morning which was positive. The doctor carried out a further test to confirm this.

2.2.12 Caroline was seen by the Early Pregnancy Unit on 13th October 2014 with friends. Caroline attended Accident and Emergency on 17th November 2014 as she was 11 weeks pregnant and was concerned as she was experiencing some bleeding. She was discharged for another clinic appointment. At this appointment she gave her mother as her next of kin.

2.2.13 On 26th November Caroline was seen by the midwife at her GP surgery. A full history and assessment were taken, and she confirmed that the perpetrator was her partner, but he did not attend. She attended with friends and therefore it was noted on the record that the domestic violence questionnaire was not used.

2.2.14 **2015**

2.2.15 On 7th January 2015 Caroline attended a routine midwife appointment at her surgery and was asked about domestic violence at home to which she replied, 'no, never'.

2.2.16 Caroline had an emergency appointment with the midwife on 22nd January as she had not detected any foetal movement for two days. She was seen with the perpetrator and a foetal heartbeat was detected. This was the first occasion where it was recorded that she was seen with the perpetrator. It is recorded that, as this was an urgent appointment, she would not be expected to have been asked about domestic abuse.

2.2.17 On 23rd February Caroline was seen by her GP when she discussed that she was becoming more anxious and finding herself obsessing about things that she knows are not true (ie doubts about the paternity of the unborn baby but she knows she has not been unfaithful to her partner). She was able to rationalise and know that these thoughts were wrong, but they kept reoccurring. The GP advised that she spoke to a family member or friend and told her that he would share this with the midwife and, if the thoughts continued, she could be referred to a perinatal psychiatrist.

2.2.18 Caroline reported, at her routine appointment with the midwife on 18th March, that her moods were very chaotic, and she had left her job as a carer due to pelvic pain. She declined a referral to the Mental Health Team and specialist midwife. There is no record of her having been asked about domestic abuse.

2.2.19 On 6th May Caroline was seen by the midwife with her mother. She had previously requested an STI screening due to symptoms she was experiencing. She was advised that this had returned as positive and Caroline was very upset as a previous test had proved negative. The records state that she was not asked about domestic abuse as her mother was present.

2.2.20 On 8th June Caroline was visited at home by the health visitor, following the birth of her daughter, and strong emotional warmth was noted by both parents towards the baby. It was recorded that domestic abuse was not discussed as the perpetrator was present.

2.2.21 At a follow up visit on 24th June, the health visitor saw Caroline alone with the baby. Caroline stated that she was the happiest she had been and could not stop smiling. There is no record of domestic abuse having been discussed.

2.2.22 On 14th July the health visitor carried out the 6-8-week development review of the baby. Caroline reported that she had a supportive family network around her. She said that the perpetrator was very supportive and helped her a lot with the children. On this occasion she was asked about domestic abuse and responded, 'no, never'.

2.2.23 **2016**

2.2.24 Caroline saw her GP on 4th April, and it was confirmed that she was pregnant. She was very shocked as the pregnancy was not planned and she was worried about how she would cope and the possibility of post-natal depression. She said that life was going well, and she was back at work. She also told the GP that the perpetrator wanted to keep the baby. A month later, Caroline had a termination. It is not known if this was for medical reasons as the reasons are not recorded.

2.2.25 On 14th June Caroline was seen by the health visitor for her daughter's 12-month review. The perpetrator was present and there were no issues of note. It was recorded that they said that Caroline's family had supported them financially.

2.2.26 **2017**

2.2.27 On 24th February Caroline saw her GP has she had done a positive pregnancy test five days earlier and was now experiencing problems which led her to think that she may be miscarrying. She also asked the GP about sterilisation. She then told the GP three days later that she had a negative pregnancy test and again asked to be referred for sterilisation.

2.2.28 On 17th May Caroline telephoned her GP as she has had long standing anxiety and felt that it was getting worse and that she needed to seek help. She was offered an immediate appointment but, as she would have had to take all the children, she made an appointment for two days later.

2.2.29 When she saw the GP on 19th May she was prescribed anti-depressants and was advised to self-refer to IAPT for cognitive behavioural therapy.

2.2.30 Caroline saw the GP again on 21st June when her medication was changed due to side effects. She was asked about IAPT, but she said that she could not get through the first time she had rung and had not tried again as her daughter had been ill. The GP explained the benefits and urged her to ring again.

2.2.31 On 19th July she was sterilised.

2.2.32 On 16th August the GP spoke to Caroline's mum when they discussed that Caroline had missed the review of her medication due to the sterilisation. The GP asked her if she knew the underlying cause of Caroline's anxiety. She said that she felt that it was due to concerns about becoming pregnant and said that she thought that she would be more relaxed now that she had been sterilised.

2.2.33 On 24th August 2017 a home visit was made by the health visitor following the transfer of the children to Nottinghamshire Healthcare Trust. Caroline was seen with her three children and the perpetrator was not present. There were no health concerns identified and no safeguarding concerns were raised. There was no record of any routine enquiry about domestic abuse having taken place.

2.2.34 On 3rd April 2018 Caroline informed the children's school that she had separated from the perpetrator. It was also noted that she had been seen in the community with a bruise to her eye a couple of weeks earlier.

Recommendation One

It is recommended that Nottinghamshire schools have a clear policy about how they will respond when they are made aware that parents have separated to ensure that there is clarity about how issues, such as collection of children and altercations in the playground, will be dealt with.

2.2.35 Caroline called the police on 7th April 2018 as she said that the perpetrator was aggressive and 'driving her mad'. He would not leave the property. The police attended and both Caroline and the perpetrator were seen. No offences were identified, and it was recorded as a verbal argument. The perpetrator left the property and went to stay with a friend. No DASH risk assessment was completed.

2.2.36 On 28th April 2018 the incident occurred.

2.3 The incident

2.3.1 There are only two people who know exactly what happened on the night that Caroline lost her life. However, from the evidence presented in court, we know that the perpetrator says that there was an argument. We do not know what this argument was about. We do know that the couple had been separated for a number of weeks. We know, from research, that the biggest trigger for a man to commit fatal violence is separation or the threat of separation[6].

2.3.2 The perpetrator said that, following some sort of argument, he took a knife from the knife block in the kitchen, pointed it at her and quite calmly told Caroline that he was going to kill her. Not only did he stab her to her face, neck and chest but he filmed her last minutes on his mobile phone. We can only imagine what prompted him to do this, but it does mean that we know the callousness with which he took Caroline's life.

2.3.3 When sentencing, the judge noted that, although there was not a significant degree of planning or premeditation, it was not the case that he acted entirely on the spur of the moment. The judge said that the perpetrator was not acting like a man who in a rage had lost control. There was a coldness in the way he treated Caroline. There was time enough for her to be terrified of him and what he was about to do.

2.3.4 Although the judge said that he was remorseful and had called an ambulance and told them what he had done, he then left his daughter alone in the house and called a friend. He sent two texts to Caroline's mother (which she found after she had been informed of Caroline's death) that said, 'Take care of the girls' and 'sorry'.

[6] Domestic abuse, Homicide and Gender, Jane Monckton-Smith and Amanda Williams with Frank Mullane, Palgrave Macmillan, 2014 , p58

2.3.5 Although he gave himself up to the police when he came across them in the street, he did not admit the offence at the first opportunity.

Section 3 – Summary of information known to agencies, family and friends

3.1 Information provided by family and friends

3.1.1 The review is very grateful to Caroline's family and friends who have helped us to understand what she was like. She has been described as 'a bubbly and outgoing woman who always made lots of friends. She loved animals and her mum described how she would always bring home strays. She described her having brought a dog home when she was 11 years old. He was a 'stray' and so she had adopted him. It turned out he had just got out of his garden nearby and was reunited with his owner.

3.1.2 Her friends described her as being devoted to her children and her aim in life was to have a family. Caroline was very close to her mother who described her as a 'little firecracker'. They talked about everything together. Her mum described her as being like her 'second skin'.

3.1.3 Those spoken to were able to speak about their knowledge of abuse in the relationship and this will be discussed in more detail later in the report.

3.1.4 Whilst there was some knowledge held by agencies about the couple's relationship. None of those agencies had a volume of, or detail of, information that could or should have indicated this awful outcome.

3.2 Evidence of domestic abuse

3.2.1 It is very clear that little was known by agencies of the abuse that Caroline experienced. Her family and friends had some knowledge but did not understand the full extent of the abuse she was experiencing. The review is indebted to her family and friends for helping us to understand Caroline's life so that we can endeavour to learn from her tragic death.

3.3.2 When the perpetrator first met Caroline, he was very charming. Her mother recalled that he would arrive with flowers and wine and sweets for the girls. This charm also extended to Caroline's mother and he would bring her flowers and help out with decorating etc.

3.2.3 Caroline's children were her life and the perpetrator used this love, in differing ways, to control her.

3.2.4 Isolation

3.2.4.1 Caroline was not allowed to have her friends to the house, although the perpetrator would constantly have his friends and family round. Caroline told a friend that she had to go with him every Sunday to meet his Romanian friends. They would all drink heavily. Presumably, as she could not speak Romanian, and they spoke very little English, she was not able to interact with people at these gatherings.

3.2.4.2 Caroline began to stay at home rather than go out with her friends, as she had in the past.

3.2.4.3 The perpetrator did not like her having friends and talking to other people. If they were out together, he would not speak to her friends.

3.2.5 Physical abuse

3.2.5.1 Those close to Caroline saw her with bruises and marks on her neck. One friend said that marks began to appear on her, mainly bruising. One day she was limping badly, and she said that she had stubbed her toe. Her friend said it was black and that she believed that the perpetrator had stamped on her foot.

3.2.5.2 On one occasion, she had a big bruise on her face, and she said that she had walked into the door of a kitchen cupboard, but she was not tall enough for this to have happened.

3.2.5.3 On Christmas Eve in 2016 the perpetrator wanted to go out with his friends, but Caroline had planned a family evening. He threw her down the stairs and went out, not returning until Boxing Day.

3.2.5.4 On one occasion, Caroline attended a friend's barbecue with a black eye, and she said that she had fallen out of bed and the perpetrator had said that she must have been drunk.

3.2.5.5 Caroline was out with friends on one occasion and she had received a message from the perpetrator telling her to go home. She returned later crying and had red marks on her arms. She said that he had locked her in the kitchen and had been hitting her.

3.2.6 Emotional abuse and intimidation

3.2.6.1 The perpetrator would constantly tell Caroline that he could take their daughter abroad without a passport and she was terrified that he would take her to Romania and not come back.

3.2.6.2 He constantly told her that, after Brexit, he would be deported. She was terrified of this happening as she knew that she would have to go with him (because of their daughter) but she knew that she would lose her other children.

3.2.6.3 All of Caroline's friends described her as highly strung and on edge towards the end of her life. She would jump when the phone rang.

3.2.6.4 One of Caroline's friends described how the perpetrator would belittle her in public.

3.2.6.5 On one occasion, Caroline and her friend were going out and, as they drove along the road, they saw the perpetrator. Caroline wound down the window to speak to him and he immediately became aggressive, asking where she was going and whether his dinner was ready. He spat at Caroline through the car window and walked off. Her friend asked what was going on and Caroline wiped the spit from her face and said, 'he is probably tired from work'.

3.2.6.6 Caroline's mum heard the perpetrator telling their daughter that Caroline was a 'naughty mummy'. She challenged him about this and told him to stop. We can assume that he was speaking to the children about their mum in this way when no-one was around.

3.2.7 Economic abuse

3.2.7.1 The perpetrator was welcomed into Caroline's family and they paid off a £5,000 debt for them which was for credit cards, loan shark etc. The reason that the couple fell into debt was because the perpetrator was 'squandering' the money and not paying the household bills.

3.2.7.2 About six months before her death, Caroline got a job. She was thrilled as this was a job she had wanted since she was 17 years old. The perpetrator was not happy about this as he realised that she was not so dependent upon him.

3.2.7.3 When they separated, the perpetrator would not contribute financially.

3.2.8 Coercion and control

3.2.8.1 The perpetrator had to constantly know where Caroline was when she was out of the home. Whenever she was visiting her mum, he would keep ringing up to see where she was, and her mum had to speak to him to prove that she was with her.

3.2.8.2 Caroline's friends also talked about her having to answer the phone when she was out. One friend said that if she did not answer her mobile, he would call the landline in her home.

3.2.8.3 The perpetrator was described, by one of Caroline's friends, as the 'cat that had the cream' as he had an English wife and a visa.

3.2.8.4 One friend said that Caroline began to change the way she dressed.

3.2.8.5 Caroline was sexually assaulted by a relative of the perpetrator whilst he was in bed. When Caroline went to tell him about it, he would not believe her and made her believe that it was her fault. Caroline felt that he treated her as if she was his property and men in his family could treat her in the same way.

3.2.8.6 The review is aware that Caroline was sterilised at the relatively young age of 30 years old. We know that her mum said that she thought that she was anxious about becoming pregnant again. We cannot be certain, but it is likely that Caroline did not wish to have any more children with the perpetrator due to the way in which he used threats about his children to control her. For example, he would tell her that he would take his children back to his home country and she would have not choice but to go to, leaving her older children in the UK.

3.2.9 Gaslighting

3.2.9.1 Gaslighting is a manipulative tactic in which a person, to gain power and control, plants seeds of uncertainty in the victim. The self-doubt and constant scepticism slowly and meticulously cause the individual to question their reality.

3.2.9.2 The perpetrator would taunt Caroline about drinking alcohol, although she was nothing more than a social drinker. He also told her that she was a bad mother and that he would tell social services about her drinking and that they would take the children away from her.

3.2.9.3 Caroline had always been a confident young woman, but she began to doubt herself and would be constantly asking her mum if she was doing the right thing. This was about anything including her parenting.

3.2.9.4 On one occasion, Caroline was preparing dinner and the perpetrator popped to the shop to get some wine and cigarettes. Whilst he was out, he rang Caroline's mum and asked her to speak to Caroline as she was always forcing him to do things. He said that he forced him to go out and buy wine and he was fed up with it. Her mum rang Caroline and her response was, 'what do you mean, I am preparing salad and he has popped out for wine and cigarettes'.

3.3 Detailed analysis of agency involvement

The chronology sets out in Section 2 details about the information known to agencies involved. This section summarises the totality of the information known to agencies and others involved during the years leading up to the incident. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement.

3.3.1 Nottinghamshire Police

3.3.1.1 The police had contact with Caroline between 2005 to 2011 but these interactions are not relevant to this review. The police had no record of the perpetrator prior to 2014. The police had contact with Caroline and the perpetrator on two occasions prior to her death.

3.3.1.2 **22nd June 2014**

3.3.1.3 Caroline's brother reported to the police that there had been an argument between Caroline and the perpetrator, who was in drink. Caroline had reportedly phoned her father and told him about the argument. He had then instigated Caroline's brother's involvement, who reported the incident to the police.

3.3.1.4 Officers attended the address and Caroline stated that no assault had taken place and that her brother had over-reacted by calling the police. The incident was recorded as a domestic incident. A DASH risk assessment was completed with the risk being assessed as STANDARD.

3.3.1.5 **7th April 2018**

3.3.1.6 On this occasion, Caroline called the police. She reported that she needed to get her husband, the perpetrator, out of the house. She stated that he was being aggressive and was 'driving her mad'. She also said that she had split up from him and she wanted him to leave.

3.3.1.7 Officers attended and both Caroline and the perpetrator were seen. No actual offences were identified. The perpetrator left the address to stay with a friend. The incident was recorded by the attending officers as an argument and not a domestic incident. A DASH risk assessment was not completed.

Whilst the officers did not complete a DASH risk assessment as this was not considered to involve domestic abuse and this was in line with force policy at the time, given the

heightened risk to a victim of domestic abuse when they leave the relationship, the officers should, arguably, have completed a DASH risk assessment and sought to give her advice about where she could access support.

Recommendation Two

It is recommended that Nottinghamshire Police raise awareness of the change in its policy in July 2018 which means that, in this case a risk assessment would have been undertaken. Awareness should be raised in order that officers understand that incidents where a relationship has come to an end or where complaints are withdrawn increase the risk to the victim.

3.3.2 Greater Nottingham NHS Clinical Commissioning Partnerships

3.3.2.1 On 16th July Caroline saw her GP as she was experiencing vaginal bleeding and abdominal pain but stated that she felt well in herself. The GP spoke with a gynaecology doctor and an appointment was made at Queens Medical Centre hospital for that evening.

3.3.2.2 Caroline's GP followed up with her on 22nd July and she said that she had not attended as she had problems with her car and the bleeding had stopped.

The review agrees with the IMR author that it was good practice to refer Caroline immediately to a specialist.

During the timeframe of this review, Caroline was seen by the GP, midwife and health visitor on a number of occasions. There are some examples of her either having been asked about domestic abuse or the reasons for not asking (such as friends present) being noted. However, there are a number of occasions when there is no mention in the records about domestic abuse having been considered. Given that she had an unwanted pregnancy and was seeing the GP about anxiety, the review considers that these represented missed opportunities to encourage her to disclose the abuse.

Recommendation Three

It is recommended that the GP practice reminds all practitioners of the importance of using their professional curiosity and asking about domestic abuse at every opportunity, especially when dealing with those who are pregnant or presenting with anxiety.

3.3.3.4 On 19th May 2017 Caroline saw the GP as she was experiencing anxiety. She was prescribed an anti-depressant and advised to self-refer to IAPT.

The review notes that the correct procedures were taken by the GP to prescribe antidepressants and to offer therapy services. The review agrees with the IMR author that the risk presented did not warrant a mental health referral without Caroline's consent.

Section Four – Other issues considered

4.1 Why did Caroline feel unable to seek help?

4.1.1 Although we know that Caroline had separated from the perpetrator in the weeks leading up to her death, she had been experiencing abuse at his hands for most, if not all, of their relationship. The police had been called on only two occasions and, at those times, Caroline minimised the situation and did not feel able to be honest with the officers.

4.1.2 One of the saddest parts of this is that Caroline was so close to her mother and told her everything but did not feel able to confide in her about her relationship. Caroline had told her mother that if her family did anything, they would not see Caroline and the grandchildren. The control that the perpetrator exerted over Caroline was such that she believed him when he made threats to isolate her from her family and even take their daughter to a foreign country.

4.1.3 Caroline felt that she had married the perpetrator and therefore it was down to her to sort it out. Caroline wanted a family unit and she feared losing this is if she reported the abuse she was experiencing.

4.1.4 When asked why they thought that Caroline did not really tell anyone what was going on, her family and friends say that she was proud and would have felt ashamed. She did not want anyone to think badly of her.

4.2 What more can be done to support women like Caroline?

4.2.1 It is interesting to note that it was clear that Caroline's friends did not know about the National Domestic Abuse Helpline, in fact one friend suggested 'there should be a helpline like Childline'.

4.2.2 Caroline's friends were asked what they thought could be done to support women like Caroline and one friend suggested that there should be domestic abuse trained specialists in schools who can provide support to parents. She felt that, as a mum, you could be going into the school to talk about anything and it would give the opportunity for victims to go and ask to speak to the named member of staff without drawing attention from their friends and other parents in the playground. The recommendation below is made as a direct result of this conversation.

Recommendation Four

Whilst it is acknowledged that there is much work done to raise awareness, it is recommended that the partnership considers more innovative ways of getting the messages to young women, such as Caroline, who are not having contact with agencies.

Recommendation Five

It is recommended that the role of school safeguarding leads is reviewed and incorporates the opportunity for victims of domestic abuse and others who have concerns to have confidential conversations and make reports in a safe environment.

4.2.3 The review has been told that, on one occasion Caroline did speak to a friend of a friend who was a police officer. She was advised that she should report his behaviour. Her biggest fear was that someone had told her that if she reported him for being violent to her, then her children would be taken from her.

The review panel considered the responsibility that a police officer has if a friend or acquaintance makes them aware of a criminal offence (in this case domestic abuse). The review has not made a direct recommendation as the information came from a third party and it would be unfair to judge the actions of the police officer without knowing exactly what was said. We have been told that the police officer *did* tell her to report the incident.

Recommendation Six

It is recommended that publicity messages focus upon the support that social services can provide to women experiencing domestic abuse with a view to allaying their fears that their children will be taken away.

Section Five - Recommendations

Nottinghamshire Schools

5.1 It is recommended that Nottinghamshire schools have a clear policy about how they will respond when they are made aware that parents have separated to ensure that there is clarity about how issues, such as collection of children and altercations in the playground, will be dealt with.

Nottinghamshire Police

5.2 It is recommended that Nottinghamshire Police raise awareness of the change in its policy in July 2018 which means that, in this case a risk assessment would have been undertaken. Awareness should be raised in order that officers understand that incidents where a relationship has come to an end or where complaints are withdrawn increase the risk to the victim.

GP practice

5.3 It is recommended that the GP practice reminds all practitioners of the importance of using their professional curiosity and asking about domestic abuse at every opportunity, especially when dealing with those who are pregnant or presenting with anxiety.

Ashfield Community Partnership

5.4 Whilst it is acknowledged that there is much work done to raise awareness, it is recommended that the partnership considers more innovative ways of getting the messages to young women, such as Caroline, who are not having contact with agencies.

5.5 It is recommended that publicity messages focus upon the support that social services can provide to women experiencing domestic abuse with a view to allaying their fears that their children will be taken away.

Nottinghamshire Safeguarding Children Board

5.7 It is recommended that the role of school safeguarding leads is reviewed and incorporates the opportunity for victims of domestic abuse and others who have concerns to have confidential conversations and make reports in a safe environment.

Section Six – Conclusion

6.1 In this case a young woman's life was tragically cut short by an act of calculated violence. The fact that the violence was filmed by the offender and the victim was likely to have known what was going to happen to her makes it all the more appalling.

6.2 Added to the terrifying nature of the attack is the fact that this victim has left behind three young children and a family and friends who loved her dearly. She was killed in her own home by someone she had loved, trusted and was the father of her youngest child.

6.3 The motivation for this dreadful act of violence has never really been explained. It is reasonable though to conclude that jealousy, power and control all feature as factors and once again demonstrates that the point of separation is a time of high-risk in domestically abusive cases.

6.4 Little was known about Caroline to those agencies charged with the responsibility for safeguarding her. The fact that some of her friends and family had knowledge of what she may have been going through demonstrates yet again that more has to be done to afford people the confidence to speak to others about their concerns. Over and again, individuals will say that they would not report concerns for fear of social services involvement and the probability of the children being taken into care. Whilst professionals know that this is not the case, the general public still have this misunderstanding and fear.

Appendix One – Terms of Reference for the review

Domestic Homicide Review: Operation HIGHWIRE

commissioned by

Ashfield Community Safety Partnership

1 Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by Ashfield Community Safety Partnership in response to the death of **Caroline** which occurred in **April 2018.**

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The aim of the review is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about.

2 Background

2.1 The Chair of Ashfield Community Safety Partnership, was notified by letter dated **6th May 2018** from **DI Rebecca Hodgman** at the Police Major Crime Unit of the death of **Caroline**

2.2 The circumstances of the death fall within section 9 of the Domestic Violence Crime and Victims Act 2004 which requires consideration of conducting a domestic homicide review. Appendix 2 sets out the Nottinghamshire Police briefing document giving more information about the case.

2.3 Ashfield Community Safety Partnership considered the notification at its meeting on **14 March 2018** and decided that it was appropriate in the circumstances to commission such a review.

2.4 The Chair of the partnership has appointed **Gary Goose MBE** and **Christine Graham** to undertake the role of Independent Chair and Overview Author for the purposes of this review.

2.5 **Gary Goose MBE** and **Christine Graham** are known to have the requisite skills, knowledge and experience to take this responsibility.

2.6 **Gary Goose MBE** and **Christine Graham** have no known conflicts of interest which would prevent them from taking responsibility for chairing the review panel and is not directly associated with any of the agencies involved in this review.

2.7 Ashfield Community Safety Partnership Chair has delegated authority to the Service Manager - Community Safety at Ashfield District Council to agree the Terms of Reference for the review; in consultation with the designated Chair of the Domestic Homicide Review Panel **Gary Goose MBE**.

2.8 Ashfield Community Safety Partnership also delegated the responsibility to agree the constitution of the Domestic Homicide Review Panel, in accordance with the multi-agency statutory guidance in order that it could be set up and start to discharge its responsibilities as early as possible.

2.9 Ashfield Community Safety Partnership have agreed to secure the resources required to undertake the Review from within its membership and will receive the final Overview Report from the Independent Chair, **Christine Graham.**

2.10 All other responsibility relating to the Commissioning Body (Ashfield Community Safety Partnership) has been accepted including the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the Overview Report.

2.11 The review will follow the key processes that are outlined in the multi-agency statutory guidance for the conduct of domestic homicide reviews which was published in December 2016.

3 Scope of review

The purpose of the review is to:

3.1 Establish the facts that led to the incident in **April 2018** and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together.

3.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

3.3 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

3.4 Additionally, establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

3.5 Contribute to a better understanding of the nature of domestic violence and abuse.

Persons covered by the review

3.6 The principal focus of the review will be **Caroline and the perpetrator.** Should the review panel consider it necessary on consideration of evidence and reflection within the panel, to extend the scope of the review to cover other family members, the terms of reference may be amended by the panel at a future date.

The review period.

3.7 The detailed chronology period covered by the review will cover events primarily since **1 July 2016**. If the panel considers it necessary on evidence and reflection to extend the period, the terms of reference may be amended accordingly. Authors of Independent Management Reviews (IMRs) will provide in any event, as part of their IMR, a summary of any relevant information prior to that period.

Timescale for completion

3.8 The aim is to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

4 Terms of Reference of the review

Matters for the Author/Chair

4.1 Seek to establish whether the events in **April 2018** could have been reasonably predicted or prevented.

4.2 Draw up a chronology of the involvement of all agencies involved in the life of Caroline to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of The Act.

4.4 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.5 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.6 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and make any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

Matters for authors of IMRs

4.7 Identify significant incidents and events relevant to the case and identify whether practitioners and agencies responded appropriately to these.

4.8 Identify whether practitioners and agencies involved followed appropriate interagency and multiagency procedures in response to the victim's needs.

4.9 Establish whether single agency and interagency responses to concerns about the victim and alleged offender's needs and welfare, and the assessment of risk to themselves and others was considered and appropriate.

4.10 Identify whether the views of the victim and alleged offender appropriately taken into account to inform agency responses.

4.11 Identify any areas where the working practices of agency involvement had a significant, positive or negative, impact on practice or the outcome.

4.12 Identify any gaps in, and recommend any changes to, the policy, procedures and practice of the agency, and interagency working, with the aim of better safeguarding families and children where domestic violence is a feature in Nottinghamshire.

4.13 Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their responsibilities and duties, and worked together to safeguard the victim, the family and the wider public.

Matters for the review panel (in addition to the above)

4.14 Identify, on the basis of the evidence available to the review, whether any intervention and / or omission would have had a significant negative impact that may have affected the eventual outcome with the purpose of improving policy and procedures in Ashfield/Nottinghamshire.

4.15 Identify from both the circumstances of this case, and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office.

4.16 To critically reflect on the Individual Management Reviews (IMR's) and the multi-agency chronologies and to pull from the information provided, with the Overview author, the lessons learned and to assist the Overview author to understand how and why actions took place within each agency.

4.17 To receive and ensure that the IMRs and the overview report produced is of a high standard and to ensure organisations and individuals are satisfied that their information is fully and fairly represented in the overview report.

4.18 To agree arrangements to engage and communicate with the family and to identify and agree arrangements to engage with significant other individuals such as the perpetrator, friends and employers.

4.19 To ensure that actions are appropriate.

4.20 Monitor the progress of the DHR and to identify where any additional information that indicates that there is need to review the Terms of Reference

4.21 To seek legal advice as necessary, so findings from other relevant process e.g. Criminal proceedings, IPCC reports, Inquests are incorporated into the DHR.

Responsibility of Individual Panel Members

4.22 To represent their own agency and be responsible for any additional enquires required within their own agency and facilitate effective and efficient communication between their agency and the DHR Panel Chair and Overview Author.

4.23 To support their own IMR author to ensure that they deliver a high-quality report agreed by the respective/appropriate Chief Officer.

4.24 To challenge practice in both their own and other individual's agencies.

4.25 To be prepared for the panel meetings by reviewing documents and undertaking actions by agreed deadlines.

4.26 To work with other panel members to identify areas of good practice and areas of and recommendations for change and to facilitate feedback in their individual agencies.

5 Excluded matters and considerations

5.1 Domestic Homicide Reviews are not inquiries into how **Caroline** died or who is culpable. That is a matter for coroner's and criminal courts.

5.2 This review will be cognisant of, and consult with the process of inquest held by HM Coroner.

5.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

6 Family Involvement

6.1 The quality and accuracy of the review is likely to be significantly enhanced by immediate family, friends and wider community involvement. Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. The chair/review panel should make every effort to include the immediate family and ensure that when approaching and interacting with the family best practice is followed.

6.2 As the chair cannot be the advocate for the family as they need to be fully independent and may reach conclusions that the family disagrees with, the family will be provided details of an independent advocacy that they may wish to contact.

6.3 Contact with the family should be initiated by the Police Family Liaison Officer who will already have close contact with next of kin. Contact with the parties will not be undertaken without prior discussion and agreement with the Senior Investigating Officer in Nottinghamshire Police due to the ongoing criminal process.

7. Legal advice and costs

7.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

7.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Ashfield Community Safety Partnership will be the first point of contact.

8. Media and communication

8.1 The management of all media and communication matters will be through the Review Panel.

9 Membership

9.1 The membership of the review panel is as follows:

Gary Goose MBE	Independent Chair
Christine Graham	Author
Rebecca Whitehead	Ashfield District Council
Antonio Taylor	Ashfield District Council
Dean Dakin	Ashfield District Council
Emmy Hill	Ashfield District Council
Adrian Morgan	Nottinghamshire Police
Rebecca Hodgman	Nottinghamshire Police
Clare Dean	Nottinghamshire Police
Julie Burton	National Probation Service (NPS)
Val Simnet	Clinical Commissioning Group (CCG)
Sue ??	Nidas
<NAME>	Nottinghamshire County Council Adult Social Care
<NAME>	Nottinghamshire County Council Children's Social Care
Hannah Hogg	Nottinghamshire Healthcare Trust (NHT)
Julie Gardner	Nottinghamshire Healthcare Trust (NHT)
Nicola Dobson	Nottinghamshire Healthcare Trust (NHT)
Elizabeth Birch	Equation
Rebecca Smith	Women's Aid Integrated Services (WAIS)