Domestic Homicide Review Overview Report On Behalf of Safer Lincolnshire Partnership

in respect of:

Holly

Died Summer 2018

Marion Wright

Independent Overview Author

Date: August 2020

1. Introduction

Preface

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Holly in summer 2018. It examines agency responses and contact with Holly, aged 35 years and her partner Marvyn, aged 27 years and considers relevant contact with Holly's youngest child who lived with her Mother. In order to protect the identity of the victim and the perpetrator in line with national guidance the names Holly and Marvyn are given as pseudonyms. The name Holly was chosen by her Mother in recognition of her love for the Christmas season. The name Marvyn was chosen by the DHR author in the absence of family involvement in the review with whom to discuss a pseudonym. Those involved in the review would like to express their sympathy for the family and friends of the victim for their sad loss in such tragic circumstances.

1.2 In addition to agency involvement, the review will also examine the past, to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the family or community and whether there were any barriers to accessing support.

1.3 The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the ways 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 upon, 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 abuse (D.A.) 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 domestic abuse is identified and responded to effectively at the earliest opportunity.

- Contribute to a better understanding of the nature of domestic violence and abuse. and highlight good practice.

1.4 DHRs were established on a statutory basis under Section 9 of the Domestic Violence Crimes and Victims Act 2004. The provision for undertaking the reviews came into force on the 13th April 2011. The death of the victim in this case met with the criteria for a statutory DHR in that the victim was killed by her partner at her home. The Home Office criteria for reviews includes "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 or she was related or with whom he or she was or had been in an intimate relationship."

It is recognised that a domestic abuse incident, which results in the death of a victim, is often not a first incident and is likely to have been preceded by psychological, emotional abuse, coercive control and possibly other physical, sexual or financial abuse.

1.5 This review is held in compliance with the legislation and follows guidance for the conduct of such reviews issued by the Home Office. I would like to thank those individuals from the different agencies for their contribution and for their significant time, openness and commitment.

1.6 DHR 2018 P Review Panel Members

Marion Wright		Independent Overview Report Author / Chair
Jon McAdam	Head of Protecting Vulnerable People	Lincolnshire Police
Richard Naulls	Regional Review Unit	Leicestershire Police
Sarah Norburn	Domestic Abuse Coordinator	Lincolnshire Police
Colin Matthews	Serious Case Reviewer	Hampshire Police
Yvonne Shearwood	Children's Services	Lincolnshire County Council
Sara Reed	Senior Probation officer (Offender Management)	Her Majesty`s Prison and Probation Services
Rachel Crook	Senior Probation Officer	Lincoln Prison
Claire Tozer	Safeguarding Adults and Children Lead	NHS Lincolnshire Clinical Commissioning Group
Rachel Parkin	Home Choices Team Manager	West Lindsey District Council
Michelle Hillard	Safeguarding Assistant	East Lindsey District Council

Pippa Foster	Head of Care and support	Nottingham Community Housing Association
Karen Ratcliff	Service Manager	We Are With You

Panel Support Members.

Toni Geraghty	Legal Advisor to the Panel	Legal Services Lincolnshire
Teresa Tennant	DHR Administrator	Lincolnshire County Council
Jade Sullivan	Domestic Abuse Lead	Lincolnshire County Council

1.7 To reinforce the impartiality of this report it is confirmed that the Independent Chair / Independent Overview Author, referred to as The Author, is not employed by any Lincolnshire agency in any other capacity and has not previously had any direct involvement in this case. Neither has she had any line management responsibility for those who have been providing services or for those managing the provision of those services. The Independent Chair / Author is a retired Assistant Chief Officer of Probation with forty three years' relevant experience. She had strategic lead for Public Protection including domestic abuse and had been involved in working with offenders who commit crimes of domestic abuse both through individual and group work. The Author was responsible for the management of the introduction of MARAC, in 2009, into the area in which she worked. The Author has undertaken many training courses in relation to domestic abuse and the pattern of behaviour this involves. The most recent event attended was the Domestic Homicide Review Workshop developed by AAFDA (Advocacy After Fatal Domestic Abuse) and Standing Together in November 2019. She has experience of providing Serious Case Reviews for MAPPA (Multi Agency Public Protection Arrangements) and writing numerous Domestic Homicide Reviews. The Author has had a special interest in domestic abuse throughout her career having first undertaken a placement with Erin Pizzey at Chiswick Women's Aid in 1975.

1.8 Both the agency review panel members and the Individual Management Review (IMR) report authors who have provided agency evidence considered by the review are independent from any direct involvement in the case or direct line management of those involved in providing the service.

1.9 In line with the National Domestic Homicide Review Guidance, the decision was taken to undertake a DHR once Marvyn was charged with the murder. The Home Office was informed of the likelihood of a DHR following the notification of the death by the police to the Chair of the Safer Lincolnshire Partnership. The DHR decision

panel sat on the 28th June 2018. Due to a plea of not guilty to the murder, DHR proceedings were postponed until Marvyn was found guilty of the charge. The DHR review panel first met on 28th January 2019.

1.10 Marvyn was sentenced to life imprisonment with a tariff of twenty years before he can be considered for release under the Parole System. The judges sentencing remarks were obtained. They referred to the fact that "Marvyn, falsely, claimed to have seen evidence of text messages some three weeks before the murder, that Holly was arranging to see other men. There was not a word of truth in this. On the day she was killed, according to Marvyn, she asked for a few hours on her own and this was confirmation to him of her being about to see another man and there was enough justification in his mind to launch a frenzied attack on her". Later, the Judge said "In her own living room, you armed yourself with a baseball bat and subjected her to a horrifying and sustained beating with that bat. Holly had called 999 and the attack, unknown to Marvyn, was recorded. It makes chilling listening. Later, you disposed of the phone and the bat. During this attack, you took the young child upstairs so that she could not see what you were going to do. Your self-control was quite evident. However, she followed you down and watched you beat her mother".

1.11 The Judge continued "In short, you are a shallow self-centred and aggressive bully who thinks only of himself. You have shown a total absence of remorse and not a shred of human decency. You have previous convictions for violence. This is not the first time you have used violence to former partners. I have accepted that there was not a significant degree of planning but you had been harbouring seriously maligned thoughts for Holly. Whilst the defence had submitted that the perpetrator had suffered from a mental disorder or disability that lowered his degree of culpability, both Psychiatrists assessing him agreed you are not mentally ill but have personality traits of an antisocial psychopathic type. You can display violence and aggression. You look for plausible rationalisations for your own behaviour and have a tendency to blame others."

1.12 A Coroner's Inquest was opened a short time after the killing and adjourned pending the outcome of the trial. The Inquest was concluded as the case and evidence was fully heard in the Crown Court. There are no other review processes in existence besides this review.

Circumstances that led to the review being undertaken

1.13 Holly lived in the family home with her young pre-school child. Her teenage child lived with her father and paternal grandparents, but she was in regular contact with her mum and visited her at weekends.

1.14 On a Saturday lunchtime in the summer of 2018, Lincolnshire Police received a 999 telephone call via a BT operator. The call was from a mobile telephone number and on the other end of the line a child could be heard screaming accompanied by a thudding/banging noise with a comment “fucking bitch”. Officers tried to call the mobile number back but there was no response.

1.15 Twenty minutes later, a call was received by Lincolnshire Police from a member of the public reporting that a little girl was in the street on her own. She had blood on her clothes and was telling the caller that a man called Marvyn had stabbed her mother.

1.16 Further enquiries revealed the 999 call had originated from Holly’s home address resulting in the officers visiting the address. The doors were locked. On forced entry via the front door, Holly’s body was discovered, lying face up on the lounge floor, with significant and extensive injuries to her head. She was not breathing.

1.17 Forensic evidence from the scene revealed Holly had received a combination of blunt and sharp force injuries leading to her death.

1.18 Marvyn was quickly identified as the suspect and officers were sent to his last known address. Upon their arrival, officers saw Marvyn emerge from the address and on seeing them he started to run away. He was apprehended after a short foot chase and arrested.

1.19 When interviewed, Marvyn said that he was involved in a relationship with Holly and he believed she was seeing another man. Immediately prior to the incident, she had asked him to leave and give her two hours to herself as she was feeling suffocated by him and wanted some time alone. This developed into an argument. He would say he took the bat off Holly and used it against her. He left the address taking the child with him, later leaving her alone in the street. He ran to his mother’s house where he was arrested.

1.20 He admitted hitting Holly about the head and body but denied intending to kill her but admitted wanting to hurt her because she had hurt him inside. Marvyn was charged with the offence of murder and subsequently convicted.

Scope of the review

1.21 The scope of the review for the purpose of Holly and her children was from the time she met and began a relationship with Marvyn. This was approximately the 1st April 2018; however any significant incident prior to her death should also be included. In

terms of Marvyn, the scope was to begin in June 2006 which initial information would suggest was when domestic difficulties between him and his mother were first reported and recorded, up to June 2018, but also to include any significant incidents in his past.

1.22 Subjects included in the scope of the DHR.

- Victim. Holly, partner of the perpetrator
- Perpetrator. Marvyn, partner of the victim
- Child Youngest child of the victim

Terms of Reference (TOR)

1.23 In order to address the key issues, agencies were charged with answering the questions set out below and providing analysis for their answers.

Issues to be addressed: -

a) To examine whether there were any previous concerns, incidents, significant life events or indications that might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions. Had the perpetrator previously been a MAPPA offender and if so, how had his risk been managed?

b) When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse including coercive control and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

c) When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices, including details about Clare`s Law, to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects? Was the victim's perception of danger canvassed?

d) Were issues of mental health, alcohol or drug use a factor in this case and if so, what action had been taken to engage the individual in treatment?

e) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

f) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information or patterns of behaviour and whether action was taken?

g) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

h) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

i) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

j) Were any issues of disability, diversity, culture or identity relevant?

k) Consider the barriers to accessing support and safety in this case.

l) Consider the management oversight and supervision provided to workers involved

m) Consider whether there are training needs arising from this case.

n) Was information shared across area borders in a timely way, in line with agency procedures, leading to effective communication and case management?

Methodology

1.24 The Review Panel was convened by the Safer Lincolnshire Partnership (SLP) and included representatives from the relevant agencies and the Independent Chair and Overview Report Author. The Review Panel commissioned a chronology and IMRs from each agency. Family members and friends were contacted to make a contribution.

1.25 A total of five meetings were held. The Review Panel met to consider information available, to consider Terms of Reference (TOR), and to commission IMRs. A second meeting involved the Chair/Author and the Safer Lincolnshire Partnership support staff to consider cross boundary agency involvement and what action was necessary to capture information from other areas. The third meeting was to consider information contained in IMRs, any apparent learning, to identify gaps and to seek further information and clarification as appropriate. The third meeting was also attended by key report authors and enabled agencies to present their information and to give time for others to ask questions and make comment. A fourth meeting involved the Chair/Author visiting Lincolnshire Police to watch body worn camera footage. A fifth meeting involved the Panel to consider the draft overview report and ensure that it fully and accurately represented the information of those agencies that contributed.

1.26 In order for agencies to prepare their contribution they were asked to consider their contact and practice in providing a service measured against agency policy and procedures and to identify any shortfalls or indeed where current policies or procedures required improvement. Agencies sourced and reviewed a range of information from a variety of systems and interviewed some staff known to have had direct involvement with Holly, Marvyn or Holly`s youngest child.

1.27 Letters of introduction and leaflets explaining about the DHR were sent to the family. Interviews and telephone calls were held with family members and others as identified in the family contacts section.

1.28 The agencies completing IMRs and the profile of their involvement with the individuals were as follows: -

Organisation	Author	Agency Involvement
Lincolnshire Police	Richard Naulls Regional Review Unit	Visited the victim in connection with Marvyn`s behaviour. Attended the scene of the murder, made an arrest and prosecuted the murder case.
Hampshire Constabulary	Colin Mathews Serious Case Reviewer Review Team	Investigated allegations of crimes committed by Marvyn and related incidents between 2006 & 2018. Attended MAPPA and

		MARAC meetings.
HM Prison and Probation Service	Sarah Reed Senior Probation Service North East Division	Provided Court reports, assessed risk and supervised community sentences and provided offender management between 2007 & 2018 in respect of Marvyn
HM Prison and Probation Service	Rachel Crook Senior Probation Officer Seconded to HMP Lincoln	Detained and managed Marvyn through12 prison sentences at 12 different prison establishments. Last released on 26th Feb 2018.
Nottingham Community Housing Association (NCHA) Historical Domestic Abuse Service in Lincolnshire (ELDAS)	Colette O'Neill Contracts Manager NCHA	Offered outreach community based support to Holly between 27th January 2018 & 9th June 2018.
Lincolnshire Clinical Commissioning Groups (CCGs)	Claire Tozer Safeguarding Adults and Children Lead for the four Lincolnshire CCGs	Provided combined IMR including information from Hampshire, Norfolk and Lincolnshire.

1.29 A summary report was received from Lincolnshire County Council Children's Services (CS) Department who had received four notifications of Domestic Abuse Incidents from the Police between August 2017 and June 2018 where Holly was the victim and relating to her young child. There was no direct contact with the family until the murder took place.

1.30 A summary report was prepared by the East Midlands Ambulance Service who had had various calls from Holly prior to 2018 for non-related medical issues and three attendances in relation to Marvyn for non-related health conditions in April and May 2018.

1.31 Southampton Children's Services provided a summary report concerning limited contact between 2006 and January 2008 with Marvyn.

1.32 A summary report was provided by Holly's child's Nursery School where she attended between April and June 2018.

1.33 Southampton Hospital provided information about one admission for Marvyn in April 2018.

1.34 Brief factual information concerning Marvyn was received from Southampton Housing, Southern Health and Southampton Independent Domestic Violence Advisor (IDVA) Service. A previous partner had been referred to the IDVA in 2010 as she was considered to be at risk of harm following an assault by Marvyn.

1.35 Brief factual information relating to Holly and her child was received from local district councils and a local housing group concerning tenancy arrangements. Also from Lincolnshire County Council Adult Social Care and Children's Health, Lincolnshire Community Health Service NHS Trust and United Lincolnshire Hospital Trust about limited contact regarding unrelated matters.

1.36 A specialist Alcohol and Drugs Agency was invited to join the Panel in an advisory capacity. Whilst unable to attend the panel meeting they reviewed the Overview Report to advise on relevant drugs and alcohol issues

1.37 A detailed psychiatric report concerning Marvyn was prepared for the court appearance in late 2018 and was made available to the Author.

1.38 The Department of Work and Pensions provided information about addresses for Marvyn since 2006.

1.39 As Marvyn was supervised for a period in 2006/2007 by the Youth Offending Service, the National Probation Service attempted to access records to include in their IMR but were unable to do so. Given the wealth of offending related information available from 2007, this was not considered a significant gap. Nowadays records are transferred from the Youth Offending Service to Probation at the time of transition.

1.40 As information was received and the trail of abuse became clearer, two other areas of North Essex and Norfolk were contacted to provide any relevant information held.

North Essex provided brief information and Norfolk confirmed they did not have any relevant information.

1.41 Discussion took place with a consultant nurse, safeguarding and mental capacity lead at Lincolnshire Partnership NHS Foundation Trust in relation to identifying a recommendation in connection with abusers who suffer from personality disorders.

1.42 In preparing the Overview Report the following documents were referred to:

1) The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and Revised Guidance 2016.
2) The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Authors.
3) Call an End to Violence Against Women and Girls HM Government published 25th November 2010. Updated 2016.
4) Barriers to Disclosure - Walby and Allen 2004.
5) Incidents of Abuse before Domestic Abuse is reported to the Police - Jaffe 1982
6) Home Office Domestic Homicide Reviews - Common Themes Identified and Lessons Learned November 2013.
7) Clare`s Law 2014
8) Coercive Control - Professor Evan Stark
9) Agency IMRs and Chronologies.
10) Understanding Risk and Vulnerability in the context D.A. – College of Policing.
11) Change That Lasts-Model Approach to Domestic Abuse
12) Victim Blaming Gracia 2014.
13) Domestic Homicide review case Analysis. Standing Together. – Nicola Sharp-Jeffs and Liz Kelly 2016.
14) Domestic Homicide Reviews. Key Findings from Analysis. December 2016.
15) Eight Stages of Domestic Homicide – Dr Jane Monkton Smith.
16) Child First. Nineteen Child Homicides. Women's Aid.
17) Joint Targeted Area Inspections. Domestic Violence Services Should Focus on the Perpetrator.
18) Living in Fear. Stalking and Harassment Thematic Inspection by HMIC and HMCPSI.
19) The Draft Domestic Abuse Bill published 21st January2019.

1.43 Where confidential information has been detailed in relation to Holly and Marvyn, it has been gathered and shared in the public interest and in line with the expectation of the National Guidance for the conduct of DHRs.

Equality and Diversity

1.44 Throughout the review process the panel considered issues of equality and diversity in relation to the nine characteristics under the Equality Act 2010 and applied the

characteristics to the information available. These characteristics include age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnerships, pregnancy and maternity.

1.45 Both Holly and Marvyn considered themselves as white British according to agency records and there were no specific issues identified regarding race and religion.

1.46 In itself, the issue of D.A. being recognised largely as a crime perpetrated by men against women, can be seen to relate to gender and the unequal status of women in society and the thinking, feeling and behaviour associated with this.

1.47 D.A. tears lives apart and has devastating effects on victims most of whom are women. Seven women a month are killed by a current or former partner in England and Wales (ONS. 2016. March 2015 Crime Survey for England and Wales).

1.48 Each year 100,000 people in the U.K. are at imminent risk of being murdered or seriously injured as a result of D.A.. Women are much more likely than men to be the victims of high risk or severe D.A.. 95% of those going to Multi-Agency Risk Assessment Conference (MARAC) to consider a safety plan are women. (Safelives. Charity dedicated to ending D.A.).

1.49 Violence in the home is one of the most pervasive human rights challenges of our time. Findings show that children exposed to violence in the home may suffer a range of severe and lasting effects. (Behind Closed Doors. The Impact of Domestic Abuse on Children. UNICEF).

2 Background Facts of the Case

2.1 Holly and Marvyn met in Lincolnshire in April 2018. Holly had moved to the town in which she lived about six months previously to make a fresh start. Her youngest child lived with her and she had wanted a bigger three bedroomed house so that her teenage child could have her own room when she came to stay at weekends. Her older child lived with her paternal grandparents and father in a nearby village.

2.2 Holly had been in a long term relationship for eighteen years with the father of her two children. They had separated in 2015 but had shared financial commitments and saw each other regularly regarding contact with their children. The youngest child went to visit her father and paternal grandparents, with whom he was living, regularly for weekends. Holly visited her ex-partner's family and home in connection with the girls and had been there the week or so before she was killed.

2.3 Records indicate there were on-going tensions regarding money with her ex-partner. Also, her ex-partner did not want the relationship to end. The Police had been called on three occasions by Holly in connection with this and they had referred her to a domestic abuse agency for support in January 2018. She had had three sessions with the agency which will be referred to later in the report. The

domestic abuse agency was unaware Holly was in a new relationship. The last contact they had being 17th April 2018.

2.4 Whilst physically frail due to on-going health problems in connection with her lungs, Holly was strong in her determination to start afresh following the break- up of her long term relationship.

2.5 The house move meant she lived further away from her parents and family. She did not know anyone in the new town. In the police interview she referred to not knowing people locally and feeling lonely. It was taking her child to nursery locally that she became acquainted with Marvyn's sister who also had young children and lived nearby. It was by chance that Holly met Marvyn and his sister when visiting a local supermarket, during her interview with the police the week before her death she said "Me and Marvyn got chatting, we just wanted to stay in the friends zone for a little while."

2.6 Marvyn had only been released from a two year four month prison sentence weeks before they met. Due to his lack of cooperation and challenging behaviour whilst under the supervision of Her Majesty`s Prison and Probation Service (HMPPS), he had been recalled to prison and was released on his Sentence Expiry Date (SED). This meant he was not under any supervision or post release licence conditions to the probation service. He had, initially, stayed with his sister for a couple of weeks but then returned to Southampton, which was his home town, for a friend's grandmother's funeral. Whilst there, he had abused drugs with his friend, with whom he was staying, and had suffered a drug induced psychosis. He had been hospitalised for a short time but had discharged himself against medical advice and had come to stay with his mother who lived close to Holly and his sister.

2.7 Marvyn and Holly had only known each other for seven weeks when she was murdered. The relationship had become intense very quickly and the threats and aggression had escalated equally as quickly. Holly told police during interview, which was captured on body worn camera that after just a few weeks together Marvyn had thrown paint all over her door and windows. Holly had said to him "Well we're not even together and it already feels like you're controlling". This outburst followed the fact that he was unhappy she was going to a holistic health event with friends. This incident was not reported to the police at the time. He tried to clean the paint off and the relationship continued.

2.8 Holly also told Lincolnshire Police on the one occasion they attended she had been frightened by Marvyn's threats. The police captured the full interview on a body worn camera. The recording has been shared with the report author and in order to capture Holly's voice in the review, elements are quoted in the following paragraphs "It just all spiralled from nothing really, just 'cos I wasn't doing something his way. I could feel the tension. He started shaking and said do you want me to fucking knock you out, I was like I'm not having this and I called the police". Marvyn was aware she had called the police and said "Oh I can't believe you, you bitch! You'll pay for this. You'll pay for this" and he left.

2.9 Holly admitted to being petrified by his aggression. When asked by Lincolnshire Police, she confirmed she had details of local Domestic Abuse Support Services and showed the Police a letter she had recently received. Police provided information about The Domestic Violence Disclosure Scheme (DVDS) and gave her directions to the local Police Station, only a short walk from her home, in order for her to make an application for disclosure of relevant information under “Right To Ask".

2.10 In the same interview with Lincolnshire Police Holly reported that Marvyn told her he had just been released from prison for dishonesty “to get revenge on some old friends”. Marvyn had not shared that he had been abusive in previous relationships but did say he could not see his child because of his aggression. There had not been any physical violence towards Holly but she recognised “I just don’t want to put myself in a situation where I’m going to get hurt in front of my child. I can defend myself a little bit but she can’t.” He had accused her of sleeping with other men. He had threatened to damage her property and talked about being good with knives. She said “When it’s good it’s brilliant. When it’s not so good I am petrified of him.” She answered yes to the Domestic Abuse, Stalking and Honour Based Violence (DASH) question about Marvyn loitering around her property and shared with the police officer some intimidating, unpleasant text messages she had received from him. She referred to him suffering from mental health difficulties and the recent use of the drug Crystal Meth.

2.11 When as part of the DASH assessment Holly was asked if he had ever threatened to kill her and did she believe that he was going to do it. She answered “No, but I do believe if I told anyone about the issues and everything, he would do something to either me, my car or my home. I don’t think this is the backlog of it all yet. I’ve just got it all to come”.

2.12 The Police Officer graded the DASH risk assessment as standard and advised Holly to contact the police via 999 should there be any further difficulties. She was also advised to keep her door locked and only let Marvyn in if she felt it was safe to do so.

2.13 The next known contact with any agency was when Holly dialled 999 eight days later, on the day of her murder. The call handler could hear the sound of screaming and the thudding of the beating that led to her death. The police went to her home and on forcing entry, found her dead. Marvyn was arrested soon afterwards leaving his mother’s home.

Victim Information

2.14 Born and brought up in Lincolnshire Holly remained emotionally close to her parents and spoke to her Mum every other day on the telephone. Having met her long term partner as a teenager they had two children and continued to live in Lincolnshire. The couple bought a home together but struggled financially and had to move into

rented accommodation. Holly suffered significant health problems relating to her lungs and although often physically unwell it is said she could be a forthright, determined person whilst also suffering nervousness and anxiety at other times.

2.15 A committed Mother, Holly loved her children dearly, the pre-school referred to the close bond her youngest child had with her Mummy. The relationship with her childrens` Father was said by Holly, to have finally ended in 2015. However they remained in regular contact regarding their children and their finances, she referred to on-going difficulties in the relationship.

2.16 Keen to make a fresh start for herself and her children and to have a bigger house Holly took the brave step and moved to a new area of Lincolnshire. Her parents suffered ill health and were unable to visit her as it was further away.

2.17 The children`s father had the youngest child every other week-end until he became aware Holly was in a new relationship and the contact changed. The older child lived with him and visited Mum at week-ends.

2.18 Holly met Marvyn through his sister who lived near her. Whilst Holly referred to wanting to take the relationship slowly it developed very quickly to the point where Marvyn stayed every other night at her home. Holly quickly and decisively took action when Marvyn threatened her and rang the Police. Whilst being “petrified” she was not going to tolerate his threats. She rightly assessed he had the capacity to hurt her. However she decided to give the relationship another chance and Marvyn had stayed with her the night before the murder.

2.19 Having worked at a private medical scanning studio on a part time basis for nine years, Holly had had a period of sick leave and only recently returned to work at the time of her death.

2.20 Valuing a calm and serene life Holly was interested in holistic medicine and health, she practised yoga and meditation, and she liked to visit the countryside and went camping when she could. She also liked sailing and her aim was to have her own boat one day. She enjoyed music and dancing and clearly had many interests.

2.21 Understandably her health problems got her down at times and impacted on her day to day life. She indicated, in her interview with the police on the occasion they visited the week before she died, that her life expectancy was low due to her health problems and she worried about her limited future. After moving home, she said she was lonely and tried, through a website to find friends locally. It is likely her isolation made her more vulnerable to Marvyn’s attentions.

Perpetrator Information from Psychiatrist’s Report For The Criminal Trial.

2.22 The second eldest of four children with two half-sisters and a half-brother, Marvyn recalled to the psychiatrist he was a happy child. However, there were family difficulties with his siblings reportedly suffering mental health issues. He remembers

incidents of domestic abuse by his mother to his step-father and that his mother had a number of unstable relationships, which may have had an impact on the children. Marvyn told the psychiatrist that as he got older he had lived an unstable lifestyle with numerous short lived relationships with females, short lived periods of employment together with periods of imprisonment.

2.23 He acknowledged that he had abused drugs and drank alcohol heavily from an early age. He has an extensive criminal history from being a juvenile for offences including violence and dishonesty. There is a recorded history of mood swings and temper outbursts. He acknowledged arguments and what he referred to as minor violence in his relationships with women. He reported “they ring the Police to get rid of me, nobody seems to understand me and they do not realise that it is nothing personal when I become aggressive. When I get worked up about something, I can’t control myself.”

2.24 Previous convictions include violent offences against his sisters and several less serious violent offences against his mother following arguments where he would throw things, damage property and hit her. He lived with his mother until 2010 when she abruptly left the family home leaving just a note to say she had a new relationship. His Mother leaving appears to have had a major impact on Marvyn and his stability. Later in 2010 he threatened suicide intending to jump off a bridge. He was seen by mental health services at the time but was considered to be suffering from stress rather than any mental illness.

2.25 Agency records show that there were recognised and recorded risk of harm issues in Marvyn’s behaviour towards partners and that the risk he presents escalates very quickly. He displays grievance thinking towards women and any woman who behaves in a way contrary to his beliefs or tries to obstruct or resist his controlling behaviour is at heightened risk. As well as assaults on his sisters and mother, there were at least three offences recorded against partners.

2.26 Marvyn can identify a list of psychiatric conditions he considers he previously suffered e.g. bipolar affective disorder, attention deficit and hyperactivity disorder. He has not received any regular psychiatric treatment, he says because he was always “moving on” or was in prison. However, according to his medical records he does not appear to have been diagnosed with any of the psychiatric conditions he refers to.

2.27 The Psychiatric Assessment for the Court at the time of sentence in 2018 identified that he has great difficulty accepting responsibility for his actions. He seeks to blame others and specifically a childhood incident when he was nine years old for all his subsequent behavioural problems. He has a low tolerance to frustration but it does not necessarily follow that he is unable to control his anger. He appears to control his aggression in other situations e.g.at work or in prison where he might put his own safety in jeopardy.

2.28 With regard to his relationship with Holly, he had been released from prison in February 2018. He went to stay with a friend in Southampton, whilst there he was admitted into hospital suffering from drug induced psychosis. He discharged himself

from hospital against advice after a day and returned to Lincolnshire to stay with his mother.

2.29 He met Holly through a chance meeting when he was with his sister and they quickly developed a relationship with him staying every other night at her home.

2.30 After the murder, Marvyn acknowledged he was experiencing negative thoughts about Holly, being convinced she was seeing other men. There is no evidence that this was the case. There had been two known incidents of aggression towards Holly, one where he threw paint over her doors and windows in her absence from home and one where he threatened to knock her out when they were in the kitchen of her home.

2.31 During periods of custody and supervision in the community and whilst on license, attempts were made to involve Marvyn in offending behaviour programmes to explore his thinking and feeling with a view to changing it. These included the Integrated Domestic Abuse Programme (IDAP), Building Better Relationships (BBR) and other cognitive therapeutic inputs. In the main, Marvyn did not engage in such attempts. He was disruptive and failed to comply. As a result, he was either dismissed from the course or when in the community breached for failing to comply, returned to the court and imprisoned as a result. Alcohol was a major criminogenic factor and several tries were made to help him to reduce and control his use.

2.32 He was last released from a two year four month custodial sentence, about six weeks before he met Holly. Due to his failure to comply with conditions of his prison license he had been recalled to prison previously to serve the remaining time of his custodial sentence and was finally released without license on his prison sentence expiry date, in line with legislation. His risk had been previously assessed as high risk of serious harm to partners. Whilst there was no evidence of him being in a relationship whilst in custody, this quickly changed post release. No intervention had been effective in reducing his risk and in the absence of any statutory supervision there was no process for a risk management plan to be put in place.

2.4 Contact with Family and Others.

2.4.1 The victim’s parents, child, ex-partner (and father of Holly`s two children) and his parents (paternal grandparents of the two children and where the two girls currently live) were contacted. All, initially, agreed to contribute to the review process.

2.4.2 The victim’s mother preferred to discuss matters on the telephone. Holly`s elder child, whilst initially agreeing to contribute, felt when the time came, that it was too difficult a subject to talk about and withdrew her wish to be involved.

2.4.3 A home visit was made to discuss matters with the paternal grandparents and Holly`s ex-partner, who lives with his parents. The youngest child joined us as the discussion ended. The paternal grandparents had known Holly for approximately

twenty years and considered her part of their family despite the fact the relationship with their son had ended.

2.4.4 Given the age of the youngest child, together with the extreme trauma she suffered having witnessed her mother being brutally killed, it was considered inappropriate to interview her. At the time, there was no involvement by children`s services and therefore nobody was able to appropriately gather her input for the review. However, her grandparents informed me that a day does not go by without her talking about her mummy and missing her.

2.4.5 The perpetrator's mother, sister and grandmother were contacted and telephone conversations took place with all three.

2.4.6 The perpetrator's mother intimated that she did not want to contribute to the review and that what had occurred "had nothing to do with her".

2.4.7 The maternal grandmother said she was not in regular contact with her daughter or her grandchildren and it was clear she was not aware of details relating to the murder. In the circumstances, it did not appear appropriate to discuss the review with her.

2.4.8 Marvyn`s sister had been in regular contact with him immediately prior to the murder. She had been an acquaintance of Holly and it was through her they had met. She lives very close to Holly`s home and their children attended the same school. Initially, Marvyn`s sister agreed to contribute to the review and by agreement arrangements were made to meet at a local police station around the corner from her home. However, she did not attend the appointment and despite telephone calls and a visit to her home, there has been no further response from her.

2.4.9 The perpetrator was contacted in prison, via his offender supervisor, and written to with a view to contributing to the review. Initially he indicated he would wish to meet the author. However, within days he moved establishments. His new prison offender manager has been contacted and confirmed his behaviour in custody has been erratic and somewhat bizarre on occasions and there are concerns for his mental health. The view expressed by his offender manager is that it would not be in his best interest to be contacted to discuss the incident at this time.

2.5 Employment.

2.5.1 Holly worked part time at a local private medical scanning firm. She had worked there intermittently for nine years. The employer and owner of the firm was spoken to on the phone with a view to contributing to the review but clearly, he did not wish to comment and put the phone down. A follow up letter has not generated a response.

2.5.2 Marvyn had been unemployed for some years prior to the murder, having spent significant time in custody.

2.6 Input from Holly`s Mother

2.6.1 Holly`s Mother was in regular telephone contact with her daughter, ringing her every other day until her death. Her parents had been in regular direct contact with Holly until she moved house in September 2017. The new home was much further away. As both her parents have ill health they felt they could not make the journey to visit.

2.6.2 Her mother referred to difficulties Holly had had in her previous long-term relationship that she had not had an easy time and that she had moved home to make a fresh start. She said she had also experienced difficulties from previous friends, stalking her on Facebook and being unpleasant. This had not been reported to the police. Holly had significant lung problems and her health was an on-going concern. Nevertheless, her mother described her as an independent, capable woman; she was fun and loved music.

2.6.3 According to her mother Holly would not easily have shown her anxieties, keeping her worries to herself. Her Mother had never met Marvyn but knew he existed and could tell when he was at Holly`s home if she rang, as she was quiet and somewhat subdued in not wanting to chat. Her Mother was unaware that domestic abuse was a feature of their relationship but learnt from Holly`s child of incidents where Marvyn had thrown paint at her daughter`s front door and caused damage because Holly had gone out with her friends to a health event. In addition, she was aware from Holly`s friend that he had looked at Holly`s text communications and was jealous, suggesting some were from a man when they were from her girlfriend.

2.6.4 Aware on one occasion that Marvyn and Holly had fallen out, her mother recalls advising her daughter “You want to get shut of him”. She added that Holly had knowledge of local Domestic Abuse services because of the problems in her previous relationship. When asked what more could have been done to prevent the tragic events, Holly`s Mother was satisfied with the services her daughter had received and could not suggest any changes for the future.

2.7 Input from the Children’s Father and their Paternal Grandparents

2.7.1 Holly had previously been in a relationship with her ex-partner for about eighteen years. The couple have two children.

2.7.2 Her previous partner`s parents viewed Holly as part of their family. The adults and children are all suffering the terrible effects of loss and grief.

2.7.3 The eldest child had chosen to live with her grandparents when her mother and father moved house as she did not want to change schools. She stayed with her mother at weekends. The youngest child lived with her mother but visited her father and grandparents on a regular basis and since her mother's death lives with them on a fulltime basis.

2.7.4 Although the couple were no longer in a close relationship, they had regular contact regarding their children and their on-going financial commitments.

2.7.5 Her ex-partner was aware Holly was in a new relationship. He had seen her about ten days before her death. She had been upset by the texts her new boyfriend had sent her. Whilst he did not see the text he suggested "come back to me and you will be ok".

2.7.6 The children`s paternal grandfather had spoken to her on the telephone the week before she died and she intimated she was waiting for the Police to arrive. When asked why, she said she did not want to talk about it.

2.7.7 Had the paternal grandparents known what was happening, they say they would have brought Holly to their home to protect her. However, they recognised that she would not have wanted to go and stay because she felt they supported their son. The family considered Holly had serious health problems. She was physically fragile. She was said to have been frank and forthright and spoke her mind in a bold manner. However, behind this show of bravado, she was said to be vulnerable and insecure. She had not had many boyfriends and had limited experience in new relationships.

2.7.8 Following her move to her current address, she had talked about being vulnerable and lonely and felt "at risk". They recall she was always checking if the doors and windows were secure.

2.7.9 Her ex-partner confirmed he knew Holly was aware of Domestic Abuse Services due to the difficulties in their relationship.

2.7.10 When asked what they felt could be done differently to help prevent such a tragedy in the future, the family identified several issues:-

- That the Police checked the background of Marvyn to better understand the risk he presented.
- That potential victims and those close to them should be able to check what the perpetrator has done before.
- If there are children involved, there should be a system to monitor if they are safe where there is a risk of domestic abuse.
- They felt there should be more information more easily available and greater advertising in the community to educate people about domestic abuse and the services available to support those involved.

There are already processes in place to enable the above actions; however it is clear there is an on-going need to raise public awareness and knowledge of the processes involved.

2.8 Input from Holly's Friend.

2.8.1 Holly and her friend had known each other for almost nine years but had become closer over the last six months of Holly's life. They were in regular contact by text, telephone calls and visits.

2.8.2 Her friend was aware that Holly was in a new relationship and had met Marvyn. She was unimpressed by him, as he had bragged about having been in prison.

2.8.3 Holly had been with her friend at the holistic health event at the National Exhibition Centre when Marvyn had been sending threatening texts. He then threw paint over Holly's house windows and doors. Two of her friends had advised Holly to end the relationship at that point.

2.8.4 Aware that Holly had called the police when Marvyn had threatened to "knock her out"; her friend confirmed that Holly had been very frightened. When asked why she felt Holly continued with the relationship, her friend's view was that Holly felt she could make a difference in Marvyn's life and, if he felt better, his difficult behaviour might improve. Holly was protective of her child and did not like arguments taking place in front of her. She loved both her children dearly and had a good relationship with her elder child.

2.8.5 Her friend recalled "I felt uneasy about Holly's relationship with Marvyn and had an inkling something might happen". Three days before her death, her friend text and telephoned Holly, when she did not get a reply, she drove to Holly's home late at night to check she was safe and well. Holly was fine. She was in bed and answered the door in her dressing gown. Marvyn was at the house at the time.

2.8.6 Her friend saw Holly at her friend's home the day after. Holly was upset and in tears about difficulties with her ex-partner in terms of finances and his refusal to look after her child as planned. All seemed well with Marvyn, although he had complained about her friend visiting the night before.

2.8.7 The friend and Holly arranged to meet again two days later on the Saturday afternoon. Her friend had to change the time of the meeting. She had called and text Holly but received no reply. She heard on Facebook of a tragedy that had happened on Holly's road and dashed to Holly's house to have her worst fears confirmed.

2.8.8 When asked what more could have been done to protect Holly, her friend felt nothing more could have been done and confirmed that Holly had been satisfied with the police response to the one call she had made.

2.8.9 Holly was looking forward to the future. She hoped she would receive compensation for a medical misdiagnosis and planned to open a yoga studio and buy her own boat. She loved sailing and the feeling of freedom this gave her.

The review author would like to thank the family and friends who contributed to the review and who shared their memories of Holly in such difficult circumstances.

3. Chronology

3.1 A full combined chronology of contact with Holly and Marvyn was provided by agencies.

3.2 A multi-agency chronology of key relevant information and significant events is contained below. To aid the reader, it is divided into time periods.

3.3 The scope period for Marvyn starts in 2006 and for Holly in April 2018, the time she first met Marvyn. In terms of relevance in understanding Marvyn's behaviour, there was an incident prior to 2006 when he was nine years old, which he referred to affecting his subsequent behaviour, his lack of trust, and underpinned his antagonism to authority. Marvyn was offered counselling by the Child and Family Guidance Psychology Service but records suggest he did not fully engage with the process.

3.4 Overall, there were sixty-two occasions where the Hampshire Police encountered Marvyn during the review period. Alcohol abuse was a consistent feature. He served twelve periods of imprisonment in twelve different establishments and was supervised by the Probation Service on eight separate occasions between 2007 and 2018.

June 2006 – December 2007

3.5 Hampshire Police were called to several incidents at the family home in Southampton during 2006 and 2007, where Marvyn's mum made allegations of him causing damage. On three occasions she made complaints of him assaulting her by kicking and punching her in the face. These events were interspersed with offences of theft, burglary and robbery. Often Marvyn was under the influence of alcohol and was very drunk when the Police arrested him.

3.6 Southampton Children's Services had been involved with the family however the case was closed in March 2006 due to lack of response. There were several occasions when Children's Services were asked to provide an appropriate adult to attend interviews and Court, as his mother refused to attend.

3.7 In 2007 Marvyn had been made subject to an Intensive Supervision and Surveillance Programme (ISSP) which was the most rigorous non-custodial intervention available for young offenders. He was supervised by The Youth Offending Service. As Marvyn was working positively with the ISSP, Children's Services closed the case. The National Probation Service have attempted to gain the Youth Offending Team records from that time but have not been successful.

2008 – 2009

3.8 Offending behaviour continued throughout 2008 and 2009 with offences of dishonesty. Marvyn, having reached eighteen years old in June 2008, was then sentenced as an adult. The Youth Offending Team ceased involvement and the Probation Service became the relevant criminal justice agency. Marvyn was sentenced to two months Youth Custody for failure to comply with a community sentence. He was supervised post release and sessions focussed on his use of alcohol and temper control. He disclosed he had, as a child, witnessed violence between his mother and stepfather.

3.9 In 2009 there was a further D. A. offence which involved assaulting his mother by hitting her in the face when drunk. There was an additional charge of assaulting a police officer. He was sentenced to twenty-one weeks at a Youth Offending Institute (YOI). He was released from custody in July 2009 on three months` Notice of Supervision.

3.10 He was seen by his GP in August 2009 who referred him to the Community Drug and Alcohol Service. He was put on a waiting list and was given information about self-help groups until he could be seen. In October 2009 the Community Drug and Alcohol Service discharged him due to his lack of response.

2010 – 2012

3.11 In January 2010 Marvyn was made subject to a Community Supervision Order for assaulting his sister in December 2009. He had been throwing things at her, threatening her and ripping curtains from the windows. He had been drinking at the time. Marvyn's life was recorded as being chaotic. His mother had left the family home, moving to another area and he faced imminent homelessness. 2010 saw further offences of assaulting a stranger, damage and burglary. Sentence was deferred and between April 2010 and September 2010 there followed a period of positive engagement with The National Probation Service. Sessions focussed on anger management, use of alcohol and attitudes to women. During a three month period Marvyn disclosed four different partners but did not disclose the nature or extent of any of the relationships.

3.12 In August 2010 Marvyn's behaviour deteriorated again. Police were called as Marvyn was sitting on top of a bridge and passers-by thought he intended to jump. He was upset and distressed and was detained by the police under Section 136 of the Mental Health Act for his own safety. He was assessed in police custody. No mental illness was detected and he was referred to his GP. In September 2010 he assaulted his partner and also her friend when she intervened. They had been in a relationship for only two months. As a result of this latest domestic abuse incident and Marvyn's failure to meet the requirements of the deferment, he was sentenced to sixteen months in a Youth Offender Institution. Whilst in custody at various establishments during this period, Marvyn's behaviour was often disruptive and subject to adjudications. He did not complete any meaningful work to address his risk and as a result, it was felt his risk remained high. In November 2011, he was

referred to the Mental Health Team within the prison due to concerns about his presentation and behaviour.

3.13 In October 2010, the victim of the assault was referred to a Multi-Agency Risk Assessment Conference (MARAC) for a safety plan to be developed she was supported by Women's Aid. Due to the risk assessment of High Risk of Serious Harm to partners made by probation, Marvyn was referred to the Multi-Agency Public Protection Arrangements(MAPPA) by probation and was registered as a Category Three Level Two offender ** (see footnote at end of report after glossary) in January 2011.

3.14 Due to his failure to cooperate with probation on his release in May 2011 Marvyn was recalled to prison and was released on his sentence expiry date in February 2012.Given he was under twenty-one years old ,in line with legislation at the time he was released on a three month Notice of Supervision. He failed to comply and was returned to custody on three occasions. The releases from custody involved a comprehensive range of licence conditions to manage his risk .He was eventually released in April 2012. He again failed to comply but Notice of Supervision had terminated before his arrest.

3.15 In March 2012, Hampshire Police identified that Marvyn had a new partner. An application was made to disclose to her Marvyn's propensity for violence to partners. This was before Domestic Violence Disclosure Schemes were implemented and was considered to be good practice This information was disclosed but she wished to continue the relationship. The case was deregistered from the final MAPPA level 2 meeting in May 2012 as probation supervision was about to end.

2013 -2015

3.16 There was a fifth domestic abuse conviction in August 2013 in North Essex where it is recorded that after a further relationship had ended, Marvyn visited his ex-partner`s address where he pulled her hair, fought with her and damaged her glasses. He then damaged her car and stole a purse from within it. He was sentenced to two months custody concurrent to a sentence for other matters. There are a few months when it is not clear what was happening in Marvyn`s life due to him moving areas and limited agency contact. Lincolnshire Police were able to identify two periods of custody for offending. One involved battery but there are no details. It would appear Marvyn had addresses in Watford, Norfolk and Morecambe around this time.

3.17 Marvyn attended Norfolk Community Healthcare City Reach Services in April 2013 requesting help with his mental health. He said he had been up and down for years and that his brother had bi-polar. He can be happy for a day or two and then be upset by small comments. He reported recent arguments with his girlfriend and had self-harmed. He said he had some suicidal ideation but was not brave enough to take action. He was reviewed for anger reactions and agitation and they documented that "he really needs psychotherapy not medication." He was prescribed an anti-psychotic drug.

3.18 In April 2013 he was seen again. He said he didn't want to take his medication but his girlfriend thought he should. He said he had bi-polar but clinicians did not think he had. They documented that couple counselling would be a good idea and encouraged him to contact MAP (a counselling and mental health service for young people).There was no evidence he pursued the counselling suggested.

2015 - 2018

3.19 There was an assault conviction against his ex- partner in January 2015, which had involved threatening her, wishing their unborn child dead and grabbing her arm causing bruising. In March 2015 he was sentenced to six weeks in custody suspended for twenty-four months with a requirement to attend the Building Better Relationships Programme. The couple had been in a relationship approximately six weeks when it ended in December 2014. The victim later found she was pregnant with Marvyn's baby. He then started sending her abusive text and telephone messages.

3.20 Marvyn gave a Lincolnshire address when he appeared in Court in Southampton in 2015. When contacted by Lincolnshire Probation, he said he would not come to Lincolnshire because people wanted to kill him. He was subsequently breached and the suspended sentence was activated and he was sentenced to three months custody. He never completed the Building Better Relationships Programme He was released in June 2015. Whilst in custody he damaged his cells and furniture. An action was identified in the Risk Management Plan at this time and for subsequent releases for a referral to MAPPA should Marvyn enter into a new relationship or resume contact with his previous partners.

3.21 In August 2015 Marvyn was sentenced to two years four months for three offences of burglary of dwellings, allegedly homes of his friends against whom he referred to as seeking revenge.

3.22 During the first year of sentence, Marvyn moved prison on three occasions and was subject to a number of adjudications for behaviour such as smashing his cell. There is no evidence Marvyn engaged in any interventions during this period. He was released in November 2016 but failed to arrive at the probation approved premises and a recall was initiated immediately. He was returned into custody in December 2016. He had spent some time staying with his sister in Lincolnshire before travelling to Southampton to make an unsuccessful attempt to see his child. He was subject to a restraining order not to have contact with his ex-partner, mother of his child.

3.23 During the last year in prison prior to his release in February 2018, his engagement with his offender manager improved slightly. He made some partial admissions to acts of domestic abuse. However, he minimised this behaviour and there was a level of victim blaming. He also failed to comply with the prison regime again being subject to multiple adjudications. Latterly, he began to self-harm by cutting his arms.

3.24 The Parole Board conducted a single member panel review in early February 2018 and identified risk factors including grievance-thinking, poor temper control,

relationship instability, alcohol misuse, aimless lifestyle and poor thinking and decision making skills. The panel was not satisfied that he was motivated to engage and that it was necessary for the protection of the public that he remained confined to closed conditions without early release. He was, subsequently, released on his sentence expiry date in late February without any supervision restrictions or licence requirements, in line with legislation.

March to June 2018

3.25 Southampton Hospital reported to Hampshire Police that Marvyn who was being held under Deprivation of Liberty Safeguarding under the Mental Capacity Act and had absconded. The Police located him and returned him to hospital. He was suffering from psychosis, in part, induced by the use of drugs. He was hallucinating and was very agitated. Marvyn`s mental health had improved by the following day and he was assessed as having capacity. He discharged himself later that day, against medical advice. At that point, he went to stay with his mother in Lincolnshire.

3.26 Three days later, Marvyn attended an out of hours (OOH) surgery in Lincolnshire with chest pains. Several tests were taken and he was advised to register with a GP. He returned five days later to OOH, again with chest pains. He was advised to attend A&E immediately but refused. The results of the tests were sent to his GP in Southampton. A week later, he again went to the OOH asking for medication. They encouraged registration with a GP and with the Alcohol and Drugs Service. Two weeks later, he registered with a GP near his mother's home but was never seen there, missing one appointment and walking out of two others before being seen.

3.27 In January 2018, Lincolnshire Police had referred Holly to a local domestic abuse agency for support following three incidents involving her previous partner and father of her children. No violence had been disclosed and no offences had been committed. The referral suggested that Holly was reliant on her previous partner for financial support and highlighted her support needs, as budgeting, emotional support and building a social support network. It was recognised she was socially isolated.

3.28 The local domestic abuse agency began supporting Holly in late March, a couple of weeks before she met Marvyn. There were three contact sessions. One was just about the time she met Marvyn in mid-April. She did not disclose to the Domestic Abuse worker that she was in a new relationship at that time. We do not have the exact date the relationship began so this non-disclosure may have been due to the fact it was so new.

3.29 The sessions had covered issues relating to where to go for finances, emotional well-being, and safety planning and establishing a safe word. Holly advised she had obtained a spare mobile phone and had the domestic abuse agencies office and out of hours telephone numbers logged.

3.30 A DASH risk assessment was completed relating to her previous relationship and concluded as standard risk. The following support session, was cancelled by Holly. Over the next two weeks, numerous calls and messages were left for Holly to which

there was no reply. As a result, a no contact letter was sent advising that if there was no contact in the next month, the domestic abuse agency would close the support offer. Holly never responded to the letter but referred to having received it during her interview with the police.

3.31 Lincolnshire Children's Services (LCS) had received the three D.A notifications from the Police relating to her previous relationship. These incidents identified verbal abuse. As there had been three incidents within a twelve month period, consideration was given to whether any action might be taken. LCS assessed there was no indication of the need for an assessment by a Social Worker at the time and no evidence of the younger child being at risk of harm. A decision was made that if there were any further incidents, consideration would be given to the undertaking of an assessment.

3.32 In April and May 2018, the East Midlands Ambulance Service was called in relation to Marvyn having chest pains. Both calls were from Holly's home and he was seen there. The Ambulance crews advised Marvyn to go to hospital but he refused on both occasions to go. In May, the police were called to Marvyn's sister's home due to a domestic disturbance where Marvyn was smashing garden pots. There was no complaint and no action was taken.

3.33 Holly`s young child attended pre-school near to their new home. Holly always collected her. Marvyn went to pick her up with Holly on two occasions. Staff recognised him from an incident that had happened in the schools main office when he had collected his nephew. The incident involved Marvyn being rude and truculent with staff when his authority to pick up his nephew was challenged. The mother of the child, Marvyn`s sister, was contacted and gave permission and the issue was resolved. Staff asked Holly`s child the following day who Marvyn was, she said he was "Mummy`s friend". There was no further involvement with school.

3.34 In June 2018, Holly called Lincolnshire Police to report she had been involved in an argument with her partner, Marvyn. He had left the property before the police had arrived. During the argument he had verbally threatened to "knock her out". She had been in the relationship six weeks.

3.35 Marvyn's mood swings made Holly believe he had mental health issues. She disclosed a previously unreported incident whereby he had been angry about her going out with friends to a holistic health event and also his belief she was sleeping with other men. Whilst she was out, he had thrown paint over her doors and windows and had been sending her abusive texts.

3.36 Marvyn had told Holly he had recently been released from prison, he was known for having a temper and was not allowed to see his child due to his aggression. She disclosed when the relationship was not good she was petrified of Marvyn and had no doubt that he was capable of hitting a woman. Holly intimated she could protect herself a bit, but her child could not. She was asked and confirmed she had information about domestic abuse services; she also had details of the Samaritans. She was advised of the Domestic Violence Disclosure Scheme. She stated she was not aware if there had been previous domestic abuse in Marvyn`s relationships but

there had been an incident at his sister's recently where there had been damage and the police had been called. Advice was given about staying safe and to call the police if there was any reoccurrence. A DASH risk assessment was completed which indicated standard risk and Children's Services were notified.

3.37 Children's Services received notification about the incident three days later. It was communicated that the incident was a verbal altercation and no violence was reported although threats had been made. On being notified, Children's Services did not take any further action as "there were no significant risks" indicated in the notification received from the police.

3.38 Eight days after the first reported incident to Lincolnshire Police, Holly was beaten to death by Marvyn.

4. Analysis of Agency Involvement

4.1 This section will provide an analysis of each agency's involvement.

4.2 Southampton Children's Services.

4.2.1 Children's Services in Southampton had contact with Marvyn's family from before the scoping period of 2006 began. The family were clearly experiencing difficulties with the behaviour of all four of the children. Anger difficulties, school attendance and welfare issues were referred to. Also, Marvyn's abusive behaviour towards his mother and sisters and his general offending were a concern. From an early age, much of Marvyn's behaviour was fuelled by excessive alcohol use. There is no evidence Marvyn's mother engaged with services offered and often would not be at home for pre-arranged appointments. His mother, clearly, withdrew her support for Marvyn on occasions and Southampton Children`s Services (SCS) were asked to provide a responsible adult for support during the Criminal Justice process.

4.2.2 In 2006/2007 the Youth Offending Team became involved and in agreement with them Southampton Children's Services closed the case.

4.2.3 There appears to have been a lack of any effective intervention with the family by SCS in the information they provided. There was, however, evidence of information sharing with Education and the Youth Offending team. Given that the contact was 13 years ago and practice has changed significantly in that time, there are no specific comments or recommendations made.

4.3 Hampshire Constabulary

4.3.1 In the twelve year scoping period, there were over sixty-two occasions that Hampshire Police encountered Marvyn. Marvyn spent his childhood and most of his adult life in the Southampton area. He moved to various parts of the country at different times and then to Lincolnshire to stay with his mum and sister after 2015 and again following his release from prison in 2018.

4.3.2 During the review period, Marvyn came to the notice of Hampshire Police as the perpetrator of a total of nine Domestic Violence incidents against his mother, sisters and three different intimate partners before he killed Holly. Marvyn has displayed controlling, aggressive, possessive and jealous behaviour in all of the relationships we have details for.

4.3.3 As a teenager, Marvyn began to display controlling behaviour towards his mother and sisters. Alcohol was a significant factor in his negative behaviour and he has drunk to excess from an early age. It is not considered that alcohol abuse is a cause of domestic abuse which relates to power and control by one individual over another. However, research finds that many of those who perpetrate domestic abuse have been drinking at the time of the assault and cases involving severe violence are twice as likely to include alcohol. Alcohol is recognised as acting as a disinhibitor to such behaviour.

4.3.4 Whilst Hampshire Police were aware of his alcohol abuse and domestic abuse during his teenage years, the IMR writer reflected that the multi-agency team did little to try and treat and divert Marvyn's behaviour. He was not seen as a child in need but as an offender to be arrested and prosecuted.

4.3.5 Hampshire Police noted that much of Marvyn's violent offending, which was largely but not exclusively domestic based, generally resulted in less serious injuries, did not involve the use of a weapon and attracted charges not above the level of common assault. It was also recognised that the details of the assault against his partner in September 2010 may have amounted to actual bodily harm and that convictions for a lesser assault may mask more serious behaviour.

Comment:

It is important when assessing the risk associated with domestic abuse that the history and details of any assault are considered rather than the charge and conviction which can mislead in relation to the level of seriousness. DASH risk assessment was introduced in 2009 and was completed in connection with the September 2010 assault against his partner and her friend. The risk was assessed as high and safeguarding measures were appropriately taken and recorded.

4.3.6 In 2010 Marvyn and his partner had only been in a relationship for six weeks when he assaulted her. His partner, the victim, commented that Marvyn was very unpredictable, controlling and becoming increasingly violent. He was described as very jealous and had been drinking before the incident. The trigger appears to have been her girlfriend visiting her at her flat against his wishes.

4.3.7 The matter was appropriately referred to MARAC. The case was heard on 12th October 2010 and the victim was supported by Women's Aid and a young women's project.

4.3.8 Due to the risk of domestic abuse he presented at the time, as assessed by probation using OASys, Marvyn was referred by the probation service to the Multi Agency Public Protection Arrangements (MAPPA) process. On 7th January 2011 he was registered under Category three Level two and was considered to be high risk of serious harm to partners.(*See footnote regarding OASys at the end of the report)

4.3.9 Marvyn spent most of the time he was registered as a MAPPA nominal in custody. In March 2012, following Marvyn's release from custody and while he was at an Approved Premises, professionals became aware he had a new partner. He said she knew about his offending. The police rang her to check that she was aware. This was before Domestic Violence Disclosure Schemes came into effect and was considered good practice. The partner was unaware of the true situation concerning his offending against women. At the same time Marvyn was recalled to custody following a breach of licence conditions. Hampshire Police were unaware of his imminent re-release and believing he would be in custody and therefore not posing an immediate risk, did not feel the need to expedite the application process for disclosure of information. When they did become aware that he had been released they obtained the authority and made the disclosure urgently on the same day Despite this knowledge his partner wanted to continue the relationship.

Comment:

The lack of knowledge of Marvyn`s imminent re-release meant there was a missed opportunity to develop a risk management plan whilst he was contained and still in custody.

4.3.10 Hampshire Police flagged her address on the command and control system so that calls would be considered as urgent.

4.3.11 At the final MAPPA meeting on 9th May 2012, Marvyn was wanted on an outstanding warrant for breaching his Notice of Supervision. The period of probation supervision was due to end on 16th May 2012. In the circumstances, the police were actioned by the meeting to consider retaining the MAPPA registration and taking the lead in his risk management. A Detective Inspector from offender management was consulted and took the decision to de-register Marvyn as a MAPPA subject due to lack of Multi-Agency involvement. He was referred to Integrated Offender Management for consideration of registration but was not adopted by them.

Comment:

The deregistration was not based on reduction in the assessment of Marvyn`s risk of serious harm or his risk of re-offending, but due to the lack of multi-agency input. It would now be considered indefensible decision making to deregister and not to have in place an on-going risk management plan with the aim of public protection.

Today an individual would be referred to one of the other high risk management process available through the police.

4.3.12 On reflection, Hampshire Police IMR reviewer considers that the initial registration of Marvyn as a Category Three Level Two MAPPA offender is not something that would happen in 2019 as his behaviour would not now be considered serious enough to meet the threshold for Category Three MAPPA registration and he did not qualify under category one or two. The IMR reviewer considers that at the time of registration, the risk of him re-offending was high but the consequences of such re-offending would not be high level of serious harm. This view is supported by probation and The Review Panel and takes account of the changes in practice since that time. It is likely he would now be referred to the Multi-Agency Safeguarding Hub or The Local prevention and Neighbourhood Policing Teams for on-going risk management planning.

4.3.13 When Marvyn was registered as a MAPPA offender, he was also registered on VISOR, the confidential Violent and Sex Offender Register which is used as a management tool by the police, prison and National Probation Service. It allows each agency to share information with relevant partner agencies in confidence and contributes to the risk management of offenders. When he was de-registered from MAPPA his VISOR record was archived though the flag remains on his Police National Computer (PNC) record screen for information.

4.3.14 Whilst Marvyn may not now have been registered as a MAPPA offender he would with current practice, likely have been subject to on-going police attention given the likelihood of the risk of harm to partners and others. Hampshire Constabulary have realigned and developed focus on managing offenders who pose a threat of harm. Now the Integrated Offender Management Team adopt a cohort of offenders who are considered high risk of committing Domestic Violence. Also a High Harm Perpetrator Team is currently being formed to supplement the work of Local Prevention and Neighbourhood Policing Teams in tackling the next level of violent offenders in the community.

4.3.15 Hampshire Constabulary and its partner agencies established Multi-Agency Safeguarding Hubs (MASH) in 2014. These have been enhanced with a new High Risk Domestic Abuse (HRDA) assessment where high risk reports are activated within twenty-four hours.

4.3.16 In relation to the domestic abuse against his ex-partner, in January 2015 where he had pushed and threatened her and their unborn baby, appropriate risk assessment and safeguarding action was taken, as well as a child at risk report for the unborn baby, which was due to be born in August 2015. The victim made an application for disclosure under The Domestic Violence Disclosure Scheme but this was not authorised as she had said she had already ended the relationship and that non-disclosure would not alter the decision. She had also taken out a restraining order against Marvyn.

4.3.17 On 1st April 2018 Hampshire Police were contacted to locate Marvyn when he had absconded from hospital where he was being held under Deprivation of Liberty

Safeguards under the Mental Capacity Act. He was graded as medium risk having earlier lashed out at staff. Hampshire Police located him and returned him to hospital. No PPNI adult at risk form was completed and no current address recorded.

Comment:

While the police responded quickly to a report of an adult at risk, the wider issue of the risk of re-offending and the risk he posed to the public was not considered by Hampshire Police. There is no evidence that Marvyn's history was researched. Had a researched and informed PPNI been completed and submitted to the Multi-Agency Safeguarding Hubs (MASH) it may have resulted in the agencies recognising the wider risk and taking measures to mitigate and manage that risk including updating the relevant police intelligence systems. Marvyn was being held in hospital under a Deprivation of Liberty safeguard, as he lacked capacity to consent to staying in hospital for care and treatment. This is only applicable until the point someone regains capacity. Police anticipated that the medical professionals would take appropriate measures to manage risk they became aware of.

Comment:

Where the police response was less than would be expected now or at the time, with the exception of the above recent issue in relation to the completion of a PPNI, the Hampshire IMR author confirms that given the changes in practice there are not now specific lessons to be learnt or recommendations to be made.

4.4 **Her Majesty`s Prison and Probation Service.**

4.41 In order to capture all the relevant information there were two separate IMRs completed, one from prisons and one from probation as the recording systems are separate. The offender manager in the community was until recently also responsible for the sentence planning during the custodial element and for the post release licence element of a custodial sentence. The prison is now responsible for managing and supporting the prisoner as well as delivering the sentence plan whilst in custody, the case will be transferred as release approaches to the offender manager in the community. Given the overlap of involvement, analysis will take place in one section.

4.4.2 Marvyn had been supervised by the probation service both in Hampshire and Lincolnshire, on eight separate occasions in the scoping period. He served twelve periods of custody in twelve different institutions. The length of time spent in each was variable and included periods of imprisonment following recall, on remand and as a sentenced prisoner. On occasions, he moved prisons several times during one sentence. He was last released from HMP Northumberland on 26th February 2018.

4.4.3 Both IMRs prepared involved viewing all records that were available. Probation officers responsible for the management of Marvyn in Lincolnshire in 2015 and 2018 were also interviewed by the IMR author.

4.4.4 Each custodial establishment operates within national guidance and prison instructions, interpreting these locally to create individual policies and procedures. A senior probation officer based at Lincoln Prison prepared the IMR and it is recognised that whilst general custodial files have been reviewed, it has not been possible to access and review all the local policies that were in place in all the different establishments. HMP Lincoln's involvement with Marvyn is limited to six weeks in total over twelve years.

4.4.5 During the time Marvyn was in prison and supervised in the community, he consistently failed to comply with sentence requirements. When in custody, he was subject to many adjudications for disruptive, increasingly aggressive behaviour, being abusive to staff, damaging his cell and other property, and self-harm. In the community, he failed to comply with sentence requirements and many efforts to treat and improve his behaviour and manage his risk. He completed no sentence without enforcement action and on many occasions, was returned to prison for his continued breaches of court orders.

4.4.6 A range of appropriate offending behaviour programmes were identified to address and reduce his offending as part of custodial sentence planning and as a condition of post release licences and community sentences. These included the Integrated Domestic Abuse Programme, Building Better Relationships, Alcohol Related Offending Programme and Anger Replacement Training to name but a few.

4.4.7 However, his lack of engagement meant he only ever successfully completed one offending behaviour programme, in 2011, whilst in custody i.e. Thinking Skills. Whilst in prison, his disruptive day to day behaviour appears to have become the focus of much of the contact and case recording. There was difficulty in seeing a consistent thread of offending work during any period of custody that focused on domestic abuse and other risk related behaviour. It was felt that this was due, in part, to case recording being focused on the daily presenting issues but further complicated by the numerous transfers between establishments and changes of offender manager.

4.4.8 It is worthy of note that on the limited occasions that Marvyn's behaviour showed any improvement, he had a male supervising officer. He was often very abusive to staff and the staff he was abusive to, in the main, were female.

Comment:

The recording of contact should be improved to document contact and actions to ensure the presenting risk issues are not lost. Consistency of offender management should be a primary aim but where this is not possible; there should be a system for effective handover to ensure focus is not lost.

4.4.9 From 2009 onwards, risk assessments and risk management plans were completed and reviewed using the Offender Risk Assessment System (OASys). OASys *(see

footnote at the end of the report) is a clinical assessment tool used by the Prison and Probation Service to identify and assess the criminogenic needs and level of risk of harm and of reoffending of individual offenders.

4.4.10 Following the assault on his partner and her friend in September 2010, Marvyn received a sixteen month Young Offenders Institute sentence for this and other offences. At this time, he was assessed as posing a high risk of serious harm to known persons (victim and future partners) and the public. He was assessed as medium risk to staff with a heightened risk to female members of staff whom he perceived as behaving in a manner contrary to his beliefs about women or obstructing or resisting his controlling behaviour. The assessor also notes that Marvyn displayed concerning grievous thinking regarding women. The offender manager, supported by their manager referred Marvyn to MAPPA. He was registered as category three and managed at level two. Details have been referred to under the Hampshire Police analysis.

4.4.12 As part of MAPPA arrangements there was a comprehensive and robust risk management release plan with a range of additional licence conditions. This included, residence at a probation approved premises, curfew, not to contact victims of the assault, to attend an Integrated Domestic Abuse Programme and to disclose any developing relationships. He was recalled to prison for failure to comply with the conditions and never commenced IDAP. When the supervision period ended, he was de-registered from MAPPA as Probation input had ended. An action was identified in all subsequent risk management plans for the offender manager to disclose and undertake safety planning with other agencies should evidence emerge that Marvyn had entered a new relationship. The action only related to when an offender is subject to supervision and would not have been included had a termination plan been completed at the end of sentence in 2018.

4.4.13 There were several attempts throughout contact with Marvyn to refer him to and engage him with mental health services. He either failed to comply or did not meet the criteria for intervention as he did not have an identifiable mental illness. Whatever the underlying cause, it is clear Marvyn was consistently complex, very troubled, unstable and often an unhappy person. The psychiatric report prepared after the murder identified he had traits of a psychopathic personality disorder.

4.4.14 The prison IMR refers to instrumental violence in order to get what he wants. This is also reflected in the psychiatric assessment in relation to him choosing when to be violent and showing an ability to control himself at other times. This resonates with the power and control which is the underlying and sinister motivation for domestic abuse.

4.4.15 Over the years, the National Probation Service has developed practice in terms of the service it provides for highly complex high risk offenders who are likely to have a personality disorder. The Offender Personality Disorder Pathway Programme, run in partnership with the NHS provides an opportunity to support staff managing offenders with complex needs. Had this programme been available it may have been possible to more effectively engage him in supervision and gain some understanding of the factors underpinning his behaviour.

4.4.16 His last prison sentence before the murder was for burglary. He was released on licence in November 2016 but due to his failure to comply with licence conditions, was recalled and finally released on his Sentence Expiry Date (SED). As he was released on his SED, the National Probation Service had no authority to supervise him and he was not subject to any restrictions or reporting requirements and his whereabouts after his release were unknown to them.

4.4.17 Prior to final release, a new OASys was opened in line with process. It was not updated to reflect the fact that Marvyn was being released without supervision. The system, therefore, locked off a cloned version of the assessment completed at the time of his last recall and lacked attention to the crucial dynamic risk factors present at the time of release. This was an omission, however as this information was not shared whilst lacking the expected rigour, it did not materially impact on events.

Comment:

Probation staff should be reminded to ensure the OASys termination plan is completed incorporating the assessment at that time.

4.4.18 The Risk Management Plan included in the last OASys identified that the offender manager should refer to Children's Services if Marvyn was in a personal relationship and there were children. Also, that consideration should be given to formal disclosure to any new partner. At the time of release, Marvyn was not in a relationship. However, had this information been shared and available later it would have provided a clear message about the risks Marvyn presented and some indication of the need for safety planning for Holly and her child.

4.4.19 Due to the lack of on-going statutory responsibility for any agency to manage his risk, this information was not shared with the police or others. This was not a failure of responsibility of any one agency but of the system that does not require information sharing to take place if an offender is being released with no licence. As it is likely that the most difficult offenders who, potentially present a risk of harm (but are not MAPPA offenders), will not have co-operated whist in prison and will be released at SED with no requirements or conditions. It appears an omission that there is no expectation to share information.

4.4.20 HMP Northumberland have processes in place for information sharing for prisoners being released from their establishments. These predominately refer to prisoners who fall within their public protection measures. This includes registered sex offenders, those subject to harassment procedures, those assessed as a risk of harm to children and those who are registered MAPPA offenders. As such, information would be shared with the police. Also if Marvyn had been released on Licence rather than at his sentence expiry date the probation service would have had the requirement to share basic information with police which would have been entered onto local police intelligence systems. This would then have been available for both Hampshire and Lincolnshire Police to have seen had they researched their systems when Marvyn came to their attention.

4.4.21 HMP Northumberland also operate Interdepartmental Risk Management meetings where cases subject to public protection measures are regularly discussed. As Marvyn did not fit these criteria, his case was not discussed within this forum.

Comment:

Consideration should be given to require each prison to hold multi-agency pre-release meetings on all prisoners, where issues of public protection and post release risk management can be discussed and planned.

4.5 **Lincolnshire Police**

4.5.1 The Lincolnshire Police IMR was prepared by an Independent Reviewing Officer from the Regional Review Unit. He examined the file of evidence for the criminal trial and researched a range of police systems. He spoke to the officer who attended the incident eight days before the murder and reviewed the body worn camera footage of that interview.

4.5.2 Prior to her relationship with Marvyn, Lincolnshire Police had a record of three previous domestic abuse incidents involving Holly between August 2017 and January 2018. All these related to her previous long term relationship. All incidents were dealt with appropriately and resulted in standard DASH risk assessments, which were shared with Children's Services. On the third occasion, the police officer made a referral to the local Domestic Abuse support agency, which was considered good practice. There was no escalation issues identified that warranted further action such as critical incident markers to be placed on the address. It is recognised by the Review Panel that Holly`s previous experience of domestic abuse may have influenced her reaction to Marvyn`s behaviour in terms of her tolerance and understanding of the risk he presented to her.

4.5.3 Regarding her relationship with Marvyn, there was one reported incident involving Holly eight days before she was murdered. Marvyn's record on Lincolnshire Police`s Niche System, at the time, indicated previous non-domestic violent criminality and an incident that happened three days before, on 28th May 2018, at his sister's home address. It was alleged on this occasion, that he damaged some garden pots belonging to his sister for which there was no formal complaint. It was unknown to Lincolnshire Police that this sister had been the victim of Marvyn's domestic abuse years earlier in Hampshire. A PNC check was done at the time but no further research appears to have been undertaken into his previous offending history.

4.5.4 When Holly called Lincolnshire Police to report she had been involved in an argument with her partner and he had threatened her, Lincolnshire Police responded quickly. The officer conducted an interview that was recorded on a body worn camera. This is good practice. She indicated that she was in a very new relationship of only six weeks. During the course of the interview, Holly disclosed a

recent unreported incident whereby Marvyn had thrown paint over her windows and front and back doors. He was angry that she had gone to a holistic health event against his wishes. She was not present in the home when this happened. This provided evidence of his emerging controlling behaviour towards her.

4.5.5 The police officer's approach was open and encouraging. It was a very thorough interview (the body worn camera video has been reviewed by the author for the purposes of the review). He asked Holly about her wishes and what outcomes she wanted. A DASH was completed and risk was considered to be standard. Domestic Abuse Support Services and emotional support were discussed which was also good practice.

4.5.6 The Domestic Violence Disclosure Scheme was explained and Holly was encouraged to go to the police station to request information about the risks Marvyn may present. As the police officer did not assess Holly as being in any immediate risk, consideration was not given to the police requesting disclosure of risk under a "Right to Know". Even if a "Right to Know "application had been considered, unless an urgent risk to her was identified in the first risk assessment stage producing an urgent disclosure, the multi-agency process would not have been completed before the murder eight days later. Whilst Holly did not have the details of Marvyn`s past abusive behaviour, her comment to Lincolnshire Police indicated that she had a reasonable idea of his ability to be abusive and had experienced it. When asked at the end of the interview, what are your thoughts about what is going to happen with him; Holly answered "I don't know, I think anything is possible".

4.5.7 In part, due to the skill of the Police Officer interviewing her, Holly provided a significant amount of information that indicated a worrying level of coercive control. Examples of this are as follows:

- "Arguments started as she wasn't doing things his way".
- "She stayed quiet to avoid saying anything wrong".
- "He didn't like her going out with friends as she may be talking about him".
- "He was so angry she went to an event against his wishes, he damaged property".

Other information included:

- "He had just been released from prison".
- "He is known for a bit of a temper".
- "He is not allowed to see his child because of his aggression".

He threatened Holly as she had rung the police. Holly felt his mood swings may have been due to mental health issues.

4.5.8 Holly informed Lincolnshire Police he had been experiencing health problems with his heart following the use of the drug Crystal Meth. He had loitered around her home and sent threatening texts. She said she had no doubt that he would not think twice about hitting a woman. Holly had said she did not know whether he had been in an abusive relationship before and said "When it's good it's brilliant, when It's not I'm petrified of him".

4.5.9 On the occasion the police visited, they reported there had been no physical assault or damage. The significant risks known to be associated with coercive control and the speed with which abuse had escalated did not appear to be recognised or considered as a significant risk factor. Recent research by Dr Jane Monkton Smith identifies an "Eight Stage Domestic Homicide Timeline" where, contrary to a long held belief by the police, practitioners and the public, violence is no longer considered to be the biggest predictor of homicide whereas Coercive Control is considered to be a more significant indicator.

Comment:

Consideration should be given by all agencies to train front line staff in this research by Dr Jane Monkton Smith to inform assessment and develop perpetrator intervention. Currently many cases are unlikely to meet a high risk DASH threshold or receive subsequent safety and risk management planning. Some interventions have been developed in Lincolnshire for those who have a standard or medium risk assessment, to provide women and children with support at the first opportunity. Holly was in receipt of these services due to her previous relationship.

4.5.10 In line with expected practice, the police officer, completed a DASH, which is part of the Public Protection Notice (PPN) and created a Niche system occurrence and ensured the incident log was updated, requesting the PPN be brought to the attention of a Supervisor for checking. The Supervisor reviewed the PPN (DASH) and the standard grading was agreed. There is no formal requirement for a supervisor to review any recorded body worn camera footage. The Lincolnshire Police PVP were notified of the existence of the PPN to ascertain if a referral to a partner agency was necessary or required. On this occasion, the information was shared, three days later, with Children' Services which was considered appropriate.

4.5.11 There was no information readily accessible to the police officer, without further investigation, to indicate Marvyn's domestic violence history which had all occurred in a different police force area and was not available on the local intelligence system. However, the incident log did contain a capture of his Police National Computer (PNC) warning markers, including one for having a VISOR record. Had this been noticed by the staff involved in the investigation of the incident, it should have raised concerns that there was something from his past that may have been of interest in making the risk assessment.

Comment:

Not to have noticed the flag and, subsequently, not to have exercised professional curiosity about what had prompted a VISOR registration was a missed opportunity to have made a more thorough assessment of the risk Marvyn presented and to have considered any necessary intervention .

4.5.12 It has been an expectation that police complete a research of a persons` history, to inform their response, from as far back as 2004 when it appeared in Approved Codes of Practice (ACOP) guidance. In the summer of 2018, there was new guidance issued, relating to the launch of the PPN for police officers responsible for supervision of PPN forms, it contained general advice on what should be checked

following the submission of a form. In December 2018, this advice was updated to contain reference to a previous history review. The guide suggests checking the history of those involved, in particular, when upgrading or downgrading risk. It is important to look at any flags such as MARAC and VISOR. The advice also expands on the use of the Domestic Violence Disclosure Scheme; it is easily and readily accessible to officers and staff on the force intranet.

Comment:

Had Marvyn's offending behaviour been checked, it would have shown his capacity for domestic abuse. This could have, potentially, involved a referral by the police to the Domestic Violence Disclosure Scheme rather than leaving it for the victim to make the request. Also this information if shared with Lincolnshire Children`s Services may have influenced the likelihood of their intervention.

4.6 Lincolnshire Children' Services (LCS).

4.6.1 Following the three notifications from the police to Lincolnshire Children's Services concerning verbal abuse incidents in a previous relationship, a decision was made that if there were any further incidents, consideration would be given to the undertaking of an assessment. There had not been any direct intervention between Lincolnshire Children's Services and the family in respect of these incidents.

4.6.2 There was a further notification from the Police regarding the one reported incident between Holly and Marvyn. The police considered the incident presented as standard risk. On being notified, Lincolnshire Children's Services did not take any further action as there were no significant risks indicated in the information provided. Marvyn was not known to have a history of domestic violence; it was considered a verbal altercation with no violence and there was no evidence of elevated risk. The IMR writer concluded the action was appropriate and in line with procedures.

Comment:

Had the finer details of the incident, previous domestic abuse history, level of risk of harm and dynamic risk factors been shared with Lincolnshire Children's Services it may have resulted in a different response.

4.7 Nottingham Community Housing Association (NCHA)

Domestic Abuse Support Service

4.7.1 The IMR was based on reviewing relevant documents that are held by NCHA and by an interview with the Support Worker who had direct contact with Holly. The

Domestic Abuse outreach community based service offers support to adults experiencing or recovering from domestic abuse. Lincolnshire County Council commissioned the service provided by NCHA to work with standard and medium risk victims of domestic abuse, (based on the DASH 2009 assessment tool), across the county.

4.7.2 Following referral by Lincolnshire Police in January 2018 in relation to a previous relationship, there were telephone calls and three meetings with Holly on 7th February 2018, 27th March 2018 and 17th April 2018. Further support sessions were arranged for 9th April 2018, 30th April 2018 and 1st May 2018. Two were cancelled by Holly and on the third there was nobody in when the worker called. Appropriate work was undertaken at the appointments kept. This included assessment and support planning which was to focus upon maximising income, emotional wellbeing, stay safe domestic abuse and stay safe maintaining contact. The DASH that was completed concluded a standard risk; this was defined as "current evidence does not indicate likelihood of causing serious harm". This would appear appropriate.

4.7.3 Following the cancelled appointments, the worker text Holly asking if she would like a referral to the volunteer "Moving on Together" mentoring service. This together with numerous other calls were made with no answer. The worker left a voicemail on 15th May 2018 for Holly to contact her. As there was no contact, a "No Contact Letter" was sent on 26th May 2018 advising that the service would close the support offer if no contact was received within the month. There was no contact; Holly was killed within days of receiving the letter.

4.7.4 In the recorded interview with Lincolnshire Police, Holly referred to receiving support from the local Domestic Abuse Support Service and said "I did have a support worker on my team, but I changed my number recently, I tried to contact her to give it, so I left a number in the office and she hasn't contacted me. But I've just got a letter, funnily enough, this morning".

4.7.5 The safety plan agreed with Holly was:

- To pack a bag in case she needed to leave at short notice.
- To have a spare mobile with safety contact numbers.
- To remove herself to a safe room, not the kitchen, if she is under threat.

She was advised of the possibility of a critical marker being added to the property. Holly appeared to have done all the things that were suggested to her.

4.7.6 At all times, the discussion in relation to her risk from domestic abuse was in the context of a previous partner. Holly had not said she was in a new relationship. This is likely to be because she could have only started her relationship with Marvyn around the time of the last direct contact with her support worker on the 17th April. Holly had indicated to the police that she had intended to take the relationship with Marvyn slowly. The speed and intensity with which it developed appeared to be a surprise to her.

4.7.7 There were instructions in her records regarding stay safe contact, on what to do if Holly failed to attend support sessions and did not contact the service. Staff were to

call Holly's mother whose phone number was detailed on the support plan. If staff still had concerns, Holly had agreed for them to contact the police and request a safe and well check to be carried out. The support worker described Holly as "A really lovely, chatty woman. The house was well kept and there were no signs of domestic abuse in the home" when she was visited. Had she visited after the paint had been thrown and the damage to the garden, this would no doubt have created concern?

Comment:

Holly had not disclosed a new relationship and consequently the Domestic Violence Disclosure Scheme had not been discussed with her. In light of this review, NCHA are going to provide Domestic Violence Disclosure Scheme information in their service user guide and as part of the risk and needs assessment at the beginning of all client contact.

It is recommended that all domestic abuse services promote the Domestic Violence Disclosure Scheme process to all clients they work with at the earliest opportunity.

4.7.8 The Contact Support Plan agreed with Holly was not followed, as her mother was not contacted when they failed to make contact with Holly, Lincolnshire Police were not contacted regarding a safe and well check. Had these contacts been made it would have provided Holly with an opportunity to update her support worker about her then current situation. Staff did not consider a lack of engagement as a potential indicator of abuse in this case.

Comment:

Following the IMR the agency identified improvements to be made around the practice of:

- Closing support due to non-contact.
- Offering support to obtain a critical marker against an address.
- Amending the review schedule for support plans.

4.8 **Clinical Commissioning Group (CCG)**

4.8.1 The IMR was completed by the CCG and not the registered General Practitioner (GP) as Marvyn had not had any consultations with any of the staff at the practice since registering in Lincolnshire. All other GP contact was in practices outside Lincolnshire. The review was completed using all available information held on System 1 and the old paper records which were accessed via his GP.

4.8.2 During the twelve year scope, Marvyn was registered with five different GPs. He was only seen in practices on three occasions in 2009. All but one of the practices he was registered with were in Southampton. There were a number of notifications on the GP record of other health services or other agency contacts.

4.8.3 There were notifications from the police, when he was a child, regarding violent incidents involving his mother. There were none relating to violent incidents to any subsequent partners. None of the three GP consultations make reference to any violence or anger issues. In 2009, alcohol was discussed in one consultation and an appropriate referral was made to Drug and Alcohol Services.

4.8.4 Following assessment he was considered to be at risk and was drinking approximately two hundred units per week. Later, the GP received a letter from the Drug and Alcohol Service regarding a lack of response from Marvyn and that they were discharging him.

4.8.5 In August 2010, the GP received notification that Marvyn had been detained under Section 136 of the Mental Health Act. He had been attempting to jump off a bridge. He was assessed by Mental Health Services. He did not meet the criteria for Community Mental Health follow up and counselling was advised but there is no evidence he pursued this.

4.8.6 Marvyn used NHS walk-in centres and outreach services more than he did GPs. In Norfolk, in 2013 he requested help with his mental health. He referred to arguments with his girlfriend, anger and self-harm. He was to be referred to Mental Health services. He was prescribed medication and it was noted by them “he really needs psychotherapy not meds”. This appears the only time this medication was prescribed. When he requested more he was advised to see a GP but did not attend the appointment that was made for him. He was encouraged to take up MAP (a counselling and mental health service for young people). There is no evidence he did this.

4.8.7 Following his release from custody in 2018, he suffered drug related hallucinations and was detained in hospital for his own safety. He self-discharged, against advice, before treatment had finished. In April 2018, following three contacts with out of hours services in Lincolnshire because of a heart problem, he was encouraged to register with a GP and Addaction for alcohol and drugs advice. He failed to pursue this.

4.8.8 Due to the very limited contact with GPs, hospitals and other health services, there is little known by health in any detailed way about Marvyn and there were few opportunities to intervene. Where he raised concerns about his alcohol use and his mental health and anger issues, there was an appropriate response and referrals on for treatment. Marvyn either did not pursue the pathways suggested or when he did, failed to keep appointments and comply. A pattern that was repeated with his involvement with the H.M. Prison and Probation Service.

4.9 **University of Southampton NHS Foundation Trust (UHSFT)**

4.9.1 On 31st March 2018, Marvyn was admitted to hospital in Southampton and was assessed as suffering from a drug induced psychosis. He reported he had taken

MDMA (ecstasy), cannabis and was a regular ketamine user. MDMA is a psychoactive drug with the desired effects of altered sensations, increased energy, empathy and pleasure. Ketamine is a painkiller and whilst it can create feelings of pleasure, it can also produce delusional thoughts. He was hallucinating, agitated and paranoid. He was treated with appropriate drugs and monitored.

4.9.2 The following morning Marvyn wanted to leave hospital and became aggressive and attempted to punch a staff nurse. He left, against medical advice. Given his condition and his unwillingness to co-operate, a Mental Capacity Assessment was completed and the police were contacted in order to locate and return him. He was, then, held under the Deprivation of Liberty Safeguards (2009) Mental Capacity Act 2005.

4.9.3 Later that day, the agitation and hallucinations appeared to stop, Marvyn's mental state was considered to have improved and he wished to leave. The Consultant and the Liaison Psychiatrist were made aware. Marvyn discharged himself, against medical advice. He was given health advice and there was no further contact.

Comment:

On reviewing this case for the purposes of this review, the Safeguarding Adult Named Nurse discovered that the initial discharge summary did not, accurately, reflect the manner in which Marvyn left UHSFT. Also, the second discharge summary did not, accurately reflect the agitation and violence experienced by staff in the Acute Medical Unit (AMU) the previous evening. This meant the GP did not receive accurate information about the two admissions which may have affected future assessments and interventions. Since these admissions, there has been work undertaken at both the Trust and AMU level to support the completion of discharge summaries, specifically to avoid these types of errors.

5 Terms of Reference.

5.1 To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects or given rise to other concerns or instigated other interventions.

5.1.1 The concerns regarding previous incidents of domestic abuse committed by Marvyn against his family and three previous partners and their friends is well documented. The incidents were both recorded in police, prison and probation records and had resulted in a high risk of serious harm assessment using OASys in 2010 and subsequent registration as a MAPPA offender in June 2011 until May 2012. The DASH completed at the time indicated high risk and a referral was made to MARAC for his partner who was the victim. Marvyn was also registered as a VISOR offender

due to his MAPPA registration. This was archived when he was de-registered from MAPPA.

5.1.2 The high risk OASys assessment continued throughout his last period of custody between 2015 and his release on 26th February 2018. The risk management plan included consideration of disclosure of the risk he presented should he embark on a new relationship and notification to Children's Services should children be involved. Had he disclosed he was in a relationship whilst in custody, it is likely a risk management plan would have been developed to manage the risk he presented to partners. However he was not in a relationship whilst in prison, meeting Holly weeks after his release

5.1.3 Due to the fact that Marvyn was released from custody at his SED without supervision on licence, The National Probation Service did not have any statutory requirement to share risk and release information with the police or others and therefore did not do so.

5.1.4 Had Marvyn met the criteria for being subject to the prisons public protection measures, HMP Northumberland would have shared information with the police which in turn would have been entered onto the Police National Database (PND). However, as he did not meet the threshold, he was not subject to interdepartmental risk management meetings and information was not shared.

5.1.5 When Holly contacted the police on the first and only occasion regarding her concerns about Marvyn, days before her death, the police officer and his supervisor did not notice the VISOR warning marker and therefore did not investigate Marvyn`s history to fully inform their risk assessment and subsequent actions.

5.1.6 Whilst the Domestic Violence Disclosure Scheme was explained to Holly, no consideration was given by the police to disclosing the information for Holly's protection on a "Right to Know "basis, which was a missed opportunity.

5.2 **When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of Domestic Violence and Abuse including Coercive Control and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?**

5.2.1 The body worn camera footage of the police interview with Holly showed the officer was sensitive, encouraging, supportive and thorough in his gathering of information and in giving information to Holly. Information was discussed about the Domestic Violence Disclosure Scheme, domestic abuse support services and general emotional support. E.g. Samaritans. The officer had received DASH training, and the training and knowledge of the police officers involved was, according to the IMR Author, what was expected in order to deal with domestic issues.

5.2.3 The DASH indicated a standard risk assessment which was confirmed by the officer's supervisor. The officer confirmed there had been no physical assaults or criminal damage in relation to the incident he was investigating. However, there was ample evidence given of coercive, controlling behaviour and previous damage which did not appear to have been recognised either as an indicator of the escalating risk Marvyn presented or that an offence had been committed. Holly indicated that she was very frightened of Marvyn.

5.2.4 Had coercive control and Marvyn's history of domestic abuse been considered, the actions taken may have been different and intervention to disrupt his abusive behaviour considered. Lincolnshire Children's Services relied, totally, on the information provided by the Police and in light of lack of violence and a lack of known history of abuse by Marvyn, they did not consider an assessment regarding the welfare of the child was necessary. As the controlling behaviour had not been recognised for its seriousness, this was not passed on to Lincolnshire Children's Services and did not inform their decision making.

5.2.5 Research recently undertaken by Dr Jane Monckton Smith identifies a timeline of eight stages of events leading to a domestic homicide. It acknowledges that contrary to long held beliefs by the police, practitioners and the public, violence is no longer considered to be the biggest prediction of homicide. Coercive control being a factor in many of the homicides she researched. This new approach to identify stages towards homicide will, hopefully, provide the basis of further training in connection with coercive controlling behaviour.

5.2.6 In the past, there is a history of Marvyn failing to engage and comply with both probation and prisons interventions. This means that there is limited information about his attitudes and background, his family history and intimate relationships. Nevertheless, practitioners identified and responded to incidents of domestic violence and abuse and assessed him as high risk of serious harm.

5.2.7 As a result, he was subject to a significant range of requirements and conditions when he was on supervision in the community or released from custody including:

- Residence in Approved Premises.
- Curfews.
- Attendance on Cognitive Behaviour Programmes to address his offending behaviour.
- No contact requirements with previous victims.

Had he been subject to release from his last sentence on licence, it is likely he would have been expected to notify his supervising officer of any new relationship in order to consider how to protect the individual, as this had been a condition previously.

5.2.8 It would appear none of the interventions were effective in managing Marvyn as he failed to comply with conditions imposed, blamed others and never engaged in a meaningful way with those charged to manage him and protect others.

5.3 When and in what way were the subjects' wishes and feelings ascertained and considered. Were the subjects informed of options /choices including details about Clare`s Law to make informed decisions. Were they signposted to the other agencies and how accessible were the services to the subjects?

5.3.1 The only time Holly communicated about her relationship with Marvyn and her growing concerns was during the one interview with the police the week before she was killed. She was signposted to other agencies and confirmed she was already in contact with a Domestic Abuse Service Support Worker, had the Samaritan's phone number and was aware of other support services in the community. Holly was informed of her option to seek information about Marvyn under the Domestic Violence Disclosure Scheme and how to go about it.

5.3.2 The police officer asked open questions about her wishes. Whilst Holly said she was petrified on occasions and thought that Marvyn would not think twice about hitting a woman, she also intimated that the relationship was only six weeks old and it was early days. She sought reassurance that the police would respond if she needed them again. Appropriately, she was told to dial 999 if needed. Holly did dial 999 when she felt threatened by Marvyn just prior to her murder.

5.3.3 Her contact with her Domestic Abuse Support Worker had explored her feelings and wishes but this did not relate to her relationship with Marvyn and therefore is not considered here.

5.3.4 Due to Marvyn`s lack of engagement and compliance there were only limited opportunities to ascertain his feelings and wishes. There is evidence of referrals to other agencies by probation, police and health providers including to accommodation providers, substance misuse and alcohol services and mental health services. In general he did not engage and failed to commit to any intervention even when he himself had identified the need.

5.4 Were issues of mental health, alcohol and drug use a factor in this case and if so what action had been taken to engage the individual in treatment.

5.4.1 From his childhood, records indicate Marvyn had drunk to excess. Much of his early offending had been alcohol related. He had been referred at various times to alcohol and drug services for intervention both in custody and in the community. Similarly, he had been referred to mental health services and counselling. There is no evidence he persevered in seeking help on a voluntary basis other than one reference to attending an Alcoholics Anonymous (A.A.) meeting in 2013. He refused to engage when it was part of a custodial sentence or a condition of a licence, even though the consequences were to be breached and a return to court or custody. One must conclude that whilst these issues are aggravating factors which

negatively dominated his life, he was not motivated or was unable to access the treatment he needed to manage them.

5.4.2 On the last occasion at the end of March 2018, when he was hospitalised and initially detained due to a drug induced psychosis, he discharged himself as soon as he was able and considered to have capacity.

5.4.3 There is reference in the psychiatric report, to information provided by Marvyn, that he had smoked cannabis the night before the murder. It is recognised that cannabis use can increase feelings of anxiety and paranoia which may have aggravated Marvyn's feelings of jealousy.

5.4.5 There had been concerns about Marvyn`s mental health from his childhood. He had been assessed by mental health professionals on numerous occasions but no mental illness was detected. At times Marvyn recognised he needed help e.g. when he went to see a GP in 2013 and was referred on. At this time it was recorded he "needs psychotherapy not medication". Attempts to refer him to and engage him with mental health services either failed as he did not comply or he did not meet the criteria. The Psychiatrist who wrote one of the reports to assist sentencing for the murder referred to Marvyn showing traits of an anti-social or psychopathic personality disorder. Had this condition been identified before and a forensic assessment undertaken it may have been possible to mitigate harm by identifying risk management interventions to protect others.

5.4.6 It is recognised that the toxic combination of alcohol and drugs, mental health difficulties and previous domestic abuse heighten the risk presented by the perpetrator.

5.5 <u>What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way? Did actions or management plans fit with the assessments or decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?</u>

5.5.1 Following the introduction of DASH risk assessments in 2009 the police undertook a DASH risk assessment at each allegation of domestic abuse. This was in line with expectations. The incident of assault of his partner of six weeks in 2010 resulted in a high risk of serious harm outcome and the partner was, rightly, referred to MARAC.

5.5.2 In a case of an offender subject to a prison or community sentence, the assessment and decision making is most critical at the start of the sentence, immediately prior to release from prison, at the point of non-compliance or at the emergence of evidence to suggest an increase in the risk of harm. For HM Prison and Probation Service, there is an expectation that an assessment should be carried out at all these stages using the OASys system and any other relevant tools. Whilst it was recognised that

Marvyn did not suffer from any identifiable mental illness there was an absence of referral for a forensic psychological assessment that may have assisted in identifying interventions to aid risk management. The Offender Personality Disorder Pathway Programme is now available to probation officers managing potentially dangerous offenders with similar presentations to those of Marvyn.

5.5.3 The National Probation Service assessed Marvyn's risk in relation to the domestic abuse. incident in 2010, on OASys, as high risk of serious harm to known persons (victim and future partners) and the public and medium risk to staff. The assessor noted a heightened risk to female members of the public who Marvyn perceives as behaving in a manner contrary to his beliefs about women or obstructing or resisting his controlling behaviour. He was referred to MAPPA and was registered between 2011 and 2012.

5.5.4 During periods of custody and community sentences, his risk assessment remained the same and there were a range of interventions, requirements and conditions to appropriately manage the risk of harm and of reoffending he presented in the community and to meet his criminogenic need. e.g. Conditions to reside in an approved premise and abide by the rules. He failed to engage with the services provided which quickly resulted in breach action.

5.5.5 Marvyn was deregistered as a MAPPA individual in May 2012. He had been recalled to custody prior to this, due to his lack of co-operation when he was released, and spent almost all the MAPPA registration period in custody. As his supervision by the probation service was ending, the police were actioned from the meeting, (via the MAPPA process), to consider monitoring and managing his risk as a police led MAPPA subject. The police considered this but felt it inappropriate due to lack of multi-agency involvement. He was referred to the Integrated Offender Manager Scheme for consideration for registration but was not adopted by them. Given that Marvyn's risk had not reduced, it would not seem a defensible decision not to have provided some form of risk management including monitoring with a view to public protection.

5.5.6 It should be noted that although a new OASys was opened prior to his final release from prison in February 2018, in line with process, it was not updated to reflect the risks at the time and the fact that Marvyn was being released without supervision. The system, therefore, locked off a cloned version of the assessment completed at the time of his last recall to prison in December 2016. It was an omission not to have updated consideration of the risk he presented and any potential release arrangements necessary at this key time of release. Had Marvyn disclosed he was in a relationship this would have prompted a risk management plan. However it was some weeks after his release that he met and formed a relationship with Holly.

5.5.7 Whilst it is not a requirement for HM Prison and Probation Service to share information with the police and others at the release stage, where an offender is being released on their SED, good public protection practice would suggest it is necessary. Pre-release information sharing and risk management will be subject of a national recommendation from this review.

5.6 Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any historical information and acted upon it?

5.6.1 The police gained useful information from Holly about Marvyn's past i.e.

- He had just been released from prison.
- He was known for having a temper.
- He was not allowed to see his child because of his aggression.

Also about the triggers for his aggression being jealousy, grievance thinking, not doing things his way e.g. the paint being thrown because Holly had gone out against his wishes. However, there was a lack of professional curiosity exercised in further investigating the background of Marvyn who had recently come to the area. The VISOR flag that was showing on the incident log went unnoticed and did not therefore trigger the professional curiosity required to complete a fully informed risk assessment.

5.6.2 The key information about the coercive control and the lack of contact with a child due to aggression was not passed to Lincolnshire Children's Services. Had it been shared there may have been a different response

5.6.3 When Marvyn was reported missing by the hospital in Southampton, on 1st April, there was a lack of professional curiosity by the Hampshire Police in checking the police intelligence systems for historical information that might be relevant to his circumstances. However Hampshire Police were able to locate him quickly and return him to hospital.

5.6.4 NCHA identified a lack of professional curiosity relating to the Domestic Abuse service input when Holly failed to respond to text and telephone messages. They planned to close the support contact if she did not contact them within four weeks. As they did not consider she would be at risk of harm they did not follow the safety plan to contact her mother and undertake a safe and well check. Workers were unaware of the new relationship with Marvyn

5.7 Were the actions of agencies in contact with all the subjects, appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed-? Was the victim's perception of danger explored, believed and acted upon?

5.7.1 The previously recorded high risk of serious harm to partners presented by Marvyn was not identified following the only contact Holly had with the police regarding him.

5.7.2 Holly's perception of danger was explored and believed and she was advised of actions she could take. e.g. contacting domestic abuse services, not letting him in

until she was satisfied it was safe, ringing the police and pursuing a Domestic Violence Disclosure Scheme application.

5.7.3 The police did not make any further investigations to understand the perpetrator and his level of risk of harm. This meant that they did not consider the risk as higher than standard. Consequently there were no steps taken to develop a robust risk management plan.

5.7.4 As Marvyn had been released from prison on his SED with no supervision, the risks he presented to women had not been shared by prison or probation and were therefore not being monitored and reviewed. It is likely his drug use, post release, leading to psychosis and hospitalisation was a further indicator of increased risk. The Police in Hampshire did not complete a PPNI to share this detail internally with the MASH which was a missed opportunity in terms of information sharing.

5.7.5 Whilst Marvyn was assessed as not suffering from any identified mental illness a referral for a psychological assessment may have assisted professionals to manage the risk of harm he presented to others more effectively.

5.8 Did the agencies have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to MARAC or other multi-agency fora?

5.8.1 All agencies involved have policies and procedures for domestic abuse and safeguarding. OASys and DASH assessment tools are nationally accredited and were used in this case. The victim was never subject to MARAC or any other multi-agency fora. The perpetrator had been a MAPPA and VISOR registered offender from 2011 to 2012 when there had been multi-agency involvement in his management.

5.8.2 There was an absence of a termination OASys in 2018 when Marvyn was released from custody and a previous one was cloned and pulled through. This meant that, there was no up to date risk assessment and no consideration of a risk management plan which reflected the fact that he was being released without statutory supervision. The recorded risk from the previous OASys was high risk of serious harm to any future partners and previous partners. His non co-operation with authority increased his risk, reducing the likelihood of protective factors being effective. This was not shared with other agencies on his release.

5.8.3 The Parole Board undertook a review in February 2018, to consider Marvyn's application for executive release before his sentence expiry date. The decision letter identifies risk factors such as grievance thinking, poor temper control, relationship instability, alcohol misuse and several other factors and felt that "it was

necessary for public protection that you remain confined to closed conditions" and, therefore, did not direct his release.

5.8.4 As the police officer nor his supervisor had undertaken historic information checks and information from probation was not available about the risk to future partners especially those with children, they were not aware of Marvyn`s domestic abuse background. As a result the DASH risk assessment undertaken just before Holly's death did not give sufficient weighting to issues of Marvyn`s history of domestic abuse, coercive control and the speed with which the relationship had developed and abuse escalated.

5.9 Were issues of disability, diversity, culture or identity relevant?

5.9.1 Whilst Holly suffered poor health due to lung disease and Marvyn appears to have had long term alcohol and more recently drug abuse with periods of mental instability, neither were considered disabled.

5.9.2 Throughout the review process the Panel considered issues of inequality in relation to the characteristics under the Equality Act 2010.

5.9.3 In Itself, the issue of domestic abuse being recognised, largely, as a crime perpetrated by men against women, can be seen to relate to the unequal status of women in society and the thinking, feeling and behaviour associated with this.

5.10 Consider the barriers to disclosure and accessing support in this case.

5.10.1 Holly had, quickly, taken action to contact the police to access support and safety when she became frightened of Marvyn's threat to "knock her out". This was only six weeks into the relationship and only a week before she was murdered. We know from the police interview that various factors influenced her attitude towards the relationship. She was lonely and isolated having moved to an area where she did not know people. Having been a previous victim of domestic abuse, Holly considered and referred to the fact that "it must be me" to be happening again, the role of self-blaming and self-talk are powerful in influencing a response. Domestic abuse is complex and can take many forms; her previous experiences of domestic abuse had been different than that which she experienced with Marvyn. Holly`s friend considered Holly felt that she could make a difference and change Marvyn`s thinking and behaviour for the better, which in turn influenced her level of tolerance and actions.

5.10.2 Given the newness of the relationship, Holly was unaware of the extent of Marvyn's domestic abuse history and the high likelihood of repeat behaviour. She referred to the relationship as being "brilliant when it was good". Marvyn had given her the

attention and companionship she was looking for and had been kind and thoughtful. He referred to having bought her a DVD that she had wanted the night before he killed her. It appears his behaviour fluctuated between being charming and threatening and controlling which is recognised by professionals as a common feature in abusive relationships

5.10.3 By ringing the police, Holly was seeking protection and safety, believing the police could make a difference. Holly had rung the police minutes before she was killed.

5.10.4 In this case the question is not so much about the barriers to Holly seeking safety and support but more about what action could have been taken to disrupt, divert and manage Marvyn`s offending behaviour. The focus on Holly is only one element of what was required. A multi-agency risk management plan with agencies working together may have provided the best opportunity for effective intervention. The short duration of their relationship and the speed with which abuse escalated mitigated against such a plan.

5.10.5 It was clear from the police interview that Holly was concerned that Lincolnshire Children`s Services would become involved if there were repeat police "Call Outs". It could be she feared this may jeopardise her role as a parent, negatively affect her child`s life and create tensions with her child`s father.

5.11 Consider management oversight and supervision to the workers involved.

5.11.1 Supervision was provided for the police officer involved in the one reported incident. The DASH risk assessment he completed was checked by a supervising officer who added their comment and verified the grading of risk. On this occasion, both the officer and the supervisor missed the VISOR flag on the PNC, this has been covered elsewhere.

5.11.2 The offender manager was subject to supervision in line with agency expectation and there was evidence of supervision on the file. However, the fact that Marvyn was released on SED without statutory probation involvement meant that there was no oversight and supervision at the time of his release. The issue of sharing information at release will be the subject of a recommendation.

5.11.3 The Domestic Abuse Support Worker would usually discuss outstanding support issues and concerns with the manager, before approval to close the case would be given. The worker does not recollect a discussion with her manager around the decision to close the case. However as Holly did not have any outstanding support needs and there was no concern about her safety, it is considered approval would have been received. This issue is the subject of a recommendation regarding Case Closure Policy.

5.12 Consider whether there are any training needs arising from this case.

5.12.1 Probation identified the need to ensure The OASys Termination plan is completed incorporating the assessment at the time.

5.12.2 The Police in Lincolnshire considered reminders were required for all staff involved in the domestic abuse process to ensure appropriate intelligence checks are carried out and recorded for subjects involved in domestic abuse incidents. Also a reminder of the availability to police officers of the right to know route of the Domestic Violence Disclosure Scheme process.

5.12.3 Consideration be given to future multi-agency Domestic Abuse training including:

a) Information on the Eight Stage Timeline leading to Domestic Homicide developed by Dr Jane Monckton Smith.
b) Information on the need for greater understanding of the terminology and detail relating to previous charges and convictions in order to make a thorough risk assessment.

5.13 Was information shared across area borders in a timely way in line with agency procedures leading to effective communication and case management.

5.13.1 At the time of Marvyn' release, there was a lack of information sharing by HM Prison and Probation about the risks Marvyn presented and the subsequent risk management plan . As this was at SED and he was not a public protection case no information sharing was required by the organisations processes. Potentially, this lack of expectation of information sharing is considered an opportunity that was missed to share concerns about the risk Marvyn presented to future partners.

5.13.2 The absence of a PPNI meant that Hampshire Police did not share information about Marvyn`s psychosis and hospitalisation in April 2018 with their MASH. Had they done so they may have researched his background and found his domestic abuse history. This in turn may have prompted further action in terms of trying to assess the impact his recent mental health difficulties may have had on the risk he posed to any partner. This meant that had Lincolnshire Police accessed the PND and contacted Hampshire Police for more information, it would not have included information about Marvyn's deteriorating mental health. On the same issue, information about Marvyn's discharge from hospital to his GP, did not include all the relevant information to inform future medical assessment.

5.13.3 The lack of accessing, by the Lincolnshire Police, of all the historical information that was available about Marvyn meant his domestic abuse history remained unknown. This, in turn, influenced the outcome of the level of the assessment and the information that was passed on to Holly and to Lincolnshire Children's Services. Had the Lincolnshire Police been aware of Marvyn's past history it may have led to different case management and a more pro-active intervention.

6. Lessons Learned.

6.1 It is important that the pattern of escalating risk is identified and considered by those making the Domestic Abuse assessment. Holly had only been in the relationship seven weeks when Marvyn brutally killed her. In that time, there had been one incident of damage to Holly's property that had gone unreported and one reported incident, a week before her death.

6.2 Some perpetrators can progress through the stages of abuse to homicide very quickly. For others, it can take many years. It was a matter of record in Marvyn's case, that previous abuse with another partner had taken place at approximately six weeks into the relationship. There is new academic research and a supporting model to help understand the different stages leading to domestic homicide known as the Homicide Timeline and developed by Dr Jane Monckton Smith. Consideration should be given to this learning, being translated into practice for use by frontline workers and their supervisors, to assist in recognising the critical steps when making assessments.

6.3 In the DASH risk assessment, undertaken the week before the killing, the level of coercive control was not recognised. The focus of the concern was on whether there had been physical violence, of which there was none reported. The coercive controlling behaviour involving threats, damage, abusive texts and calls and an element of stalking was not given sufficient weighting, in risk terms, as an indicator of seriousness. To our knowledge, the first physical assault was the brutal attack that killed her.

6.4 In managing risk, past behaviour is a key factor in understanding future risk. Whilst there had been a history of familial and intimate partner domestic abuse by Marvyn, this was not known to the police officer and others involved with the case involving Holly. The limited information on the local police Niche System was due to the fact that his offending was, predominately, in different force areas, away from the region. Because of this Marvyn's history of being considered high risk of serious harm to partners and a previously registered MAPPA offender was not accessed and investigated. A check of the PND and the PNC systems would have shown his offending history. The VISOR flag on his PNC record had gone unnoticed. This is recognised as an omission.

6.5 Whilst advice was given to Holly on support and staying safe, there were no attempts made to focus upon, manage and divert Marvyn`s abusive behaviour. All options to prevent further abuse by the perpetrator should be considered, including interview, warnings, restraining orders, arrest and charge. A psychological assessment may have assisted in identifying the risk of serious harm and possible risk management interventions.

6.6 There was a lack of information sharing at various stages of involvement in this case. As Marvyn did not meet the criteria to be subject to public protection

processes whilst in prison, the prison was not required to share information at the time of his release in 2018. Similarly as Marvyn was released at his SED, there was no requirement for the probation service to share information. This is subject to a recommendation. Hampshire Police did not update their local intelligence system in April 2018, with information about Marvyn being detained under Deprivation of Liberty Safeguards of the Mental Capacity Act. As the level of coercive control and previous domestic abuse history had not been identified by Lincolnshire Police, it was not included in the information shared with Lincolnshire Children`s Services. Each piece of information provides a crucial part of the whole picture and helps to identify the pattern of emerging risk.

6.7 The quality of the risk of harm assessment underpins the effectiveness of the risk of harm management plan. The OASys risk assessment undertaken at regular intervals during custody had not been completed as required at the termination of contact, as Marvyn was being released from prison. This meant a cloned version of a previous assessment had been pulled through, it was out of date and therefore lacked the rigour expected. The risk management plan linked to the outdated assessment did however refer to informing any new partner of the risk presented by Marvyn and the need to inform Children's Services if there were children involved. Whilst remaining relevant the lack of any statutory supervision meant this plan was not shared nor activated.

6.8 During Marvyn`s time in custody the management of his difficult, disruptive behaviour became the focus of contact. This obscured the aims of sentence planning and risk of harm management. The frequent changes in prison establishment and the changes of offender manager created a further distraction.

6.9 The process surrounding the implementation of the Domestic Violence Disclosure Scheme has a government support timeframe of thirty six working days, regardless of right to know or right to ask unless it is considered urgent. In this case if there had been a non-urgent request to share information the communication would not have taken place before Holly was killed. The "Right to Ask" element of the DVDS was explained to the victim. Speed of action can be fundamental a review of the Domestic Violence Disclosure Scheme process has been undertaken in Lincolnshire in 2020 and also there has been national case law pushing for quicker timeframes on such applications.

6.10 It was recognised that whilst Marvyn had previous convictions for domestic abuse offences against his mother, sister and intimate partners, there was never a record of a weapon being used. The convictions were for common assaults which did not always reflect the frightening nature of the attacks or the victim's experience. The details of what actually took place in previous domestic abuse incidents should be investigated and understood by those undertaking any new risk assessment.

6.11 When Marvyn was deregistered from being a MAPPA offender in May 2012, it was not due to a reduction of risk but due to the fact that his supervision by the National Probation Service had come to an end. The Hampshire Police did not consider it appropriate as a single agency, to take on the risk management through the MAPPA process, which fundamentally requires a multi-agency approach. Whilst this

decision related to multi-agency involvement there was a lack of Hampshire Police considering any other capability to manage the risk that Marvyn posed. The Hampshire Police reviewer has provided details of different approaches that have been developed within the force since 2012 which are designed to provide just that kind of risk management, through Integrated Offender Management and through High Harm Capabilities within local policing.

6.12 Accurate recording underpins quality information. The discharge summaries from UHSFT following Marvyn being detained under the Deprivation of Liberty Safeguards of the Mental Capacity Act were inaccurate and did not provide the full information of events to the GP. The need for improved recording was also identified by Her Majesty`s Prison and Hampshire Constabulary in relation to the completion of the PPNI.

6.13 The Domestic Abuse Support Service identified a lack of professional curiosity relating to case closure. They were about to move to case closure without adequate consideration of the reasons behind the lack of contact and without following the agreed plan of contacting Holly`s Mother followed by a safe and well check by the police if necessary.

7. Conclusion.

7.1 The speed with which Marvyn moved from meeting Holly to coercively controlling, threatening and murdering her has shocked all those close to Holly and those undertaking this review. He had a history of domestic abuse against his family and intimate partners. It is recorded that his controlling, abusive behaviour escalated to violence very quickly in previous relationships where abuse had been reported.

7.2 The risk Marvyn presented was known by some criminal justice agencies. He had been registered as a MAPPA offender and MARAC had been involved with one of the victims in Southampton. He had moved around the country and spent periods in twelve different prisons. He had never engaged or complied with the vast range of interventions planned to manage his risk. He had been subject to adjudications in prison and recalled to custody for failure to comply on Licence and with community supervision. On the last occasion he was released from custody, due to his lack of co-operation, it was at his SED and there were no Licence conditions or monitoring.

7.3 Marvyn decided to move to Lincolnshire where his mother and sister lived. He was not on any local agency's radar due to his recent move and spending the last two years in custody. There was a lack of local knowledge. He was often convicted of common assault which is the lower level of the violent offences which did not reflect the frightening and abusive nature of his behaviour. There was no record of Marvyn previously using a weapon

7.4 Holly was lonely and isolated having recently moved home to make a fresh start with her young child. She was forthright and determined and called the Police

immediately she felt at risk from Marvyn. Her friend indicated she gave Marvyn another chance believing she could make a difference and change his behaviour.

7.5 Holly was not prepared to tolerate his controlling behaviour and on the Saturday asked him to go to his mother's house for a couple hours as she was feeling suffocated by him. This appears to be the trigger that led to his anger at her resistance to his control and he killed her.

7.6 Whilst agencies had information of Marvyn' risk and patterns of behaviour, this was not easily accessible to those making the most recent assessments and decisions. Had the risk Marvyn presented and his domestic abuse history been shared with Holly, it is not known what her response would have been. We do know that she wished to protect her child from such risks.

7.7 It is hoped the lessons learned from this review will influence improvements in practice. However, it is clear it was not the action or lack of action by any of the agencies that resulted in the killing of Holly. It was, solely, Marvyn's decision to take her life and he, alone, is responsible.

8. Relevant changes in agency practice already taken place since involvement.

8.1 Hampshire Constabulary

8.1.1 With partner agencies, established multi-agency safeguarding hubs (MASH) in 2014. These have been enhanced with a new High Risk Domestic Abuse Assessment process (HRDA) whereby high risk reports are activated within 24 hours.

8.1.2 Introduced an updated PPNI referral form for all types of referrals into MASH. This streamlines the process and focuses on wider vulnerability and the effects of domestic abuse on other vulnerable people, most notably children.

8.1.3 All frontline officers and staff received Safe Lives Domestic Abuse training in 2018, focusing on why victims fail to report abuse, the importance of safeguarding and the nature of coercive control.

8.1.4 There is a Chief Officer led, force wide drive on identifying those who need help, this is one of the six key areas of focus.

8.1.5 It is unlikely Marvyn would now be considered as a subject for MAPPA given the lower level of his past violent convictions. It is likely he would now be the subject of interest, action and monitoring on a local policing level.

8.1.6 The Integrated Offender Management Team now adopt a cohort of offenders who are considered at high risk of committing offences of domestic violence.

8.1.7 A High Harm Perpetrator Team is currently being formed to supplement the work of the local Prevention and Neighbourhood Policing Teams in tackling the next level of violent offenders in the community.

8.2 HM Prison and Probation Service.

8.2.1 Protocols are now in place to ensure that all information is shared between the Youth Offending and National Probation Service on an individual's transition to adult services. A process that did not happen in 2008

8.2.2 Processes are now embedded within the National Probation Service (NPS) to ensure information is sought from the police regarding call-outs to incidents of domestic abuse to better inform risk of harm assessments. Training, knowledge and understanding in relation to working with domestic abuse perpetrators has developed considerably.

8.2.3 The Offender Personality Disorder Pathway Programme is now run by the NPS in partnership with the NHS. This provides case consultation for highly complex and challenging offenders who are likely to have a personality disorder and who pose a high risk of harm to others. This includes the development of a psychologically informed understanding of that individual's history, presentation and risk.

8.3 NCHA (Domestic Abuse Support Services)

8.3.1 Nottingham Community Housing Association was in the process of handing over the delivery of Domestic Abuse Support Services to another provider when they were in contact with Holly. In August 2018, NCHA ceased to be involved in the service and the staff team left the employment of NCHA as part of the handover of the service.

8.3.2 To raise awareness the organisation now promotes the Domestic Violence Disclosure Scheme at the earliest opportunity and widely in everyday practice through posters, in refuges, in the service user guide and as a section in the user needs and risk assessment.

8.4 Lincolnshire Police.

8.4.1 In December 2018, guidance for officers responsible for the completion and supervision of Public Protection Notices (PPN) was updated. The update included reference to undertaking and recording a full check of the previous intelligence

history of subjects to inform assessments. In particular, in connection with the upgrading or downgrading of risk. This includes looking at any flags such as MARAC and VISOR. The advice also expands on the use of the Domestic Violence Disclosure Scheme. It is readily and easily accessible to officers and the staff on the force intranet.

8.4.2 The PPN form has been updated to contain a section whereby the officer inputs what historic research has taken place with regards to the person(s) involved along with a section to confirm the victim has been made aware of the Domestic Violence Disclosure Scheme.

8.4.3 Lincolnshire Police, with partner agencies have undertaken a campaign locally to raise public awareness of the Domestic Violence Disclosure scheme.

8.4.4 Lincolnshire Police have reviewed the Domestic Violence Disclosure Scheme locally and re-launched information to ensure changes are communicated force-wide.

8.5 University Hospital of Southampton NHS Foundation Trust.

8.5.1 Since April 2018, There has been significant work undertaken both at Trust and Acute Medical Unit level to support the completion of accurate, timely and detailed discharge summaries.

9. Recommendations.

9.1 **National Probation Service – Lincolnshire.**

9.1.1 Ensure the OASys termination plan is completed incorporating the assessment of risk and need at the time.

9.2 HM Prison Service.

9.2.1 Recording of contacts should be improved to consistently document contact and actions and to ensure information related to identified and presenting risks is included in each case.

9.2.2 Ensure the overarching aims of sentence planning and emerging patterns of behaviour are not lost in the day to day practical issues of managing those prisoners who display challenging and disruptive behaviour.

9.2.3 A primary aim of service delivery should be consistency of offender manager wherever possible. Where this cannot be achieved, a process should be developed to ensure effective handover of the case between offender managers and prison establishments to ensure the aims of sentence planning and risk management are prioritised.

9.3 NCHA

9.3.1 Project managers to review all contact plans and associated case notes to ensure staff are following the plan. Caseload supervision will include checks on contact plans.

9.3.2 Contact Policy to be amended to include the standard practice of contacting agencies involved if contact is not established, including safe and well checks. This practice will be shared with service users at sign-up to the contract.

9.3.3 Case Closure Policy will be reviewed to include recorded discussion and approval from the project manager.

9.3.4 Staff and managers must satisfy themselves that contact has been established either through NCHA staff, agencies or the police before closing support. NCHA staff will complete a DASH risk assessment with service users at final support session.

9.3.5 NCHA staff will provide contact details for national domestic abuse helplines and other services relevant to the service user before a case is finally closed.

9.3.6 Staff will offer support to obtain a critical marker on the address at the point of the needs and risk assessment for new service users and at point of move-on for refuge service users.

9.3.7 Project Managers to review all initial support plans to ensure staff are reviewing them within 30 days. Caseload supervision will include checks on review periods.

9.4 Lincolnshire Police.

9.4.1 Remind staff not to rely on an act of physical violence to take action against the perpetrator. Coercive control is an offence and can be a predictor of high risk of harm and requires consideration for charges to be brought.

9.4.2 Ensure police officers responding to allegations of domestic abuse are able to identify and fully investigate coercive controlling behaviour.

9.5 University of Southampton NHS Foundation Trust.

9.5.1 To discuss this case at the Acute Medical Unit Governance Forum in order to share learning.

9.6 Hampshire Constabulary.

9.6.1 Hampshire Constabulary's Response and Patrol Command should review the guidance given to frontline response officers with regard to their responsibilities for completion of a detailed and informed PPNI form when dealing with vulnerable people.

9.7 Lincolnshire Partnership NHS foundation Trust.

9.7.1 Lincolnshire Partnership NHS Foundation Trust to lead a piece of multi-agency work to consider the prevalence of personality disorder in perpetrators involved in Domestic Homicide Reviews and Child Serious Case Reviews in Lincolnshire over the past five years. The purpose would be to consider a process for identifying potentially dangerous abusers in order to undertake a full forensic assessment with a view to mitigating harm and identifying risk management interventions to provide public protection. The findings to be shared with The National Domestic Homicide Review Panel to inform national developments.

9.8 Safer Lincolnshire Partnership.

9.8.1 Continue to raise awareness of the role of coercive control in domestic abuse cases.

9.8.2 Consider expanding current multi-agency training to include information on the Eight Stage Timeline leading to Domestic Homicide developed by Dr Jane Monckton Smith.

9.8.3 Write to The National College of Policing to request consideration be given to The DASH risk assessment review including questions relating to Dr Jane Monckton Smith`s Eight Stage Domestic Homicide Timeline.

9.8.4 Ensure multi-agency domestic abuse training includes information on the importance of having all details of the perpetrators previous domestic abuse charges ,convictions and behaviours. This information is key to understanding the level of the risk posed when making a thorough risk assessment.

9.8.5 Consider developing a “Managing Perpetrators Strategy” which captures all existing structures in Lincolnshire for managing domestic abuse perpetrators.

9.8.6 Consider requesting that the National Domestic Abuse Perpetrators Strategy addresses the issues of improving processes when working across area boundaries.

9.8.7 Write to Her Majesty`s Prison and Probation Service nationally to share the learning from this review relating to the need to share information regarding an offenders risk of harm at the pre-release stage. The sharing of information refers to those offenders that do not meet the MAPPA threshold or the other current public protection categories e.g. sexual offences against children. This review suggests consideration be given to extending the practice of pre-release multi-agency meetings on all relevant prisoners as conducted at HMP Lincoln.

9.9 <u>The Home Office.</u>

9.9.1 Consider developing a published list of contacts in every community safety partnership area to facilitate the timely gathering of relevant information across area boundaries to inform the preparation of DHRs and to avoid unnecessary delays.

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Independent Overview Author

10. Glossary of Terms

AA	Alcoholics Anonymous
AAFDA	Advocacy After Fatal Domestic Abuse
AMU	Acute Medical Unit
BBR	Building Better Relationships
CCGs	Clinical Commissioning Groups
CRU	Central Referral Unit (Police)
CS	Children's Services
D.A.	Domestic Abuse
DASH	Domestic Abuse, Stalking and Honour Based Violence
DHR	Domestic Homicide Review
DV	Domestic Violence
DVDS	Domestic Violence Disclosure Scheme
ELDAS	Historical DA Service in Lincolnshire until 2018
FCR	Force Control Room
GENIE	Police Intelligence Search Engine
GP	General Practitioner
HMIC	Her Majesty's Inspectorate of Constabulary
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services
HMP	Her Majesty's Prison
HMPPS	Her Majesty`s Prison and Probation Service
HRDA	High Risk Domestic Abuse Assessment Process
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
ISSP	Intensive Supervision and Surveillance Programme
LCS	Lincolnshire Children's Services
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hubs
NCHA	Nottingham Community Housing Association
NHS	National Health Service
NICHE	Police Recording and Intelligence Management Systems
OASys	Offender Assessment System
OOH	Out Of Hours
PNC	Police National Computer
PPU	Police Public Protection Unit
PND	Police National Database

PPN	Public Protection Notice
SED	Sentence Expiry Date
TOR	Terms of Reference
UHSFT	University of Southampton NHS Foundation Trust
VISOR	Violent and Sex Offenders Register

Footnote:

***** OASys Definitions of Serious Harm:

- **Low risk of serious harm** – current evidence does not indicate likelihood of serious harm.
- **Medium risk of serious harm** – there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.
- **High risk of serious harm** – there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.
- **Very High risk of serious** – there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently and impact would be serious.

** Multi-Agency Public Protection Arrangements.

There are three categories of violent and sexual offenders who are managed through MAPPA:

1. Registered sexual offenders are required to notify the Police of their name, address and personal details, under the terms of the Sexual Offences Act 2003. The length of time an offender is required to register with the Police can be any period between 12 months to life, depending on the age of the offender, the age of the victim, and the nature of the offence and the sentence received.
2. Violent offenders who have been sentenced to 12 months or more in custody or to detention in hospital and who are now living in the community subject to Probation supervision.
3. Other dangerous offenders who have committed an offence in the past and who are considered to pose a risk of serious harm to the public.

MAPPA offenders are managed at one of three levels according to the extent of agency involvement needed and the number of different agencies involved. The great majority are managed at level one 1 (ordinary agency management). This requires information sharing but does not require multi-agency meetings. The others are managed at level 2 if an active multi-agency approach is required (MAPP meetings), and at level 3 if senior

representatives of the relevant agencies with authority to commit resources are also needed.