Nottingham Crime & Drugs Partnership

Working together to reduce Crime, Disorder and the misuse of Drugs

To be anonymised for publication and dissemination

A Domestic Homicide Review into the Death of Ms MA (Operation Hoplite)

A report for the Nottingham Crime and Drugs Partnership

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Contents

Appendices

1. Introduction

1.1. The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the *Domestic Violence Crime and Victims Act 2004* which came into force on 13th April 2011.

1.2. Multi-agency statutory guidance for the conduct of DHRs has been issued under Section 9 (3) of the *Domestic Violence Crime & Victims Act 2004*. Section 4 of the Act places a duty on any person or body named within that section (4) to have regard to the guidance issued by the Secretary of State. The guidance states that the purpose of a DHR is to:

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

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate, and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3. The Nottingham Crime & Drugs Partnership (CDP) Board commissioned and then agreed its policy for conducting Domestic Homicide Reviews on 25th July 2011. The policy adopts the national guidance and sets out local procedures for ensuring that the principles of the guidance are adopted and followed through each Domestic Homicide Review. Local Domestic Homicide Review Guidance was refreshed and signed off by the CDP Board on 2nd March 2015.

1.4. The Chair of the Nottingham Crime & Drugs Partnership was notified of the death of Ms MA by letter dated 10th February 2015 received from East Midlands Specialist Operations Unit Major Crime. The circumstances of the death fall within Section 9 of the *Domestic Violence Crime & Victims Act 2004* which required consideration of conducting a DHR.

1.5. The Chair of the Nottingham Crime & Drugs Partnership considered the notification, following a recommendation made on 3rd March 2015 by the Nottingham City Adults Safeguarding Partnership Board Serious Case Review (NCASPB SCR) subgroup to undertake a domestic homicide review. The CDP Chair agreed to invite Carolyn Carson, of

CDC Reports Ltd to act as independent chair for the DHR review panel. The rationale for this decision was:

- To enable consistency in the oversight of Domestic Homicide Reviews within the city of Nottingham.
- Carolyn Carson has evidenced she is someone with the requisite skills, knowledge and experience to take the responsibility.
- Carolyn Carson retired from Leicestershire Police in 2011 and has had no connection with the area or the agencies involved in the review.
- The appointee is independent and has no known conflict of interest which would prevent her from chairing the review panel and is not directly associated with any of the agencies involved in this review.

Timescales

1.6. This Review began on 10th February 2015 when Nottinghamshire Police notified the Nottingham Crime and Drugs Partnership of the homicide. The first panel meeting was held on 24th March 2015. The review concluded on 22nd February 2016, due to unavoidable delays. However, although the Review was extended to 13th January 2016 for panel meetings and 27th Januarys 2016 for "sign off" by the Chair of the CDP Board, there was a small amount of slippage which the Chair of the CDP Board was aware of.

1.7. Reviews, including completion of the Overview Report, should be completed, where possible, within six months of the commencement of the review. The criminal investigation, which concluded on 12th October 2015, meant that an extended timescale was required for the completion of this review. Please refer to Appendix B1 and B2 for the request to and the response from the CDP Board to extend the timescales.

Scope of the Review:

Persons Covered by the Review

1.8. The principal focus of the Review is the victim Ms MA. The other involved adult is the perpetrator, Mr HL. Mr HL was found guilty of the murder of Ms MA. It is to be noted that HL is taken from the homicide operation name 'Hoplite'. MA was taken from a discussion with Ms MA's daughter regarding a suitable pseudonym.

Review Period

1.9. Agencies were asked to submit chronologies of their involvement from 1st January 2007, this being the earliest known date whereby domestic violence may be attributed to Mr HL.

Terms of Reference:

1.10. The full Terms of Reference of the Review can be found at Appendix A. The following extract details the matters for consideration within Individual Management Review Reports (IMRs), together with matters for the DHR panel to consider, details of excluded matters and family involvement.

Matters for Authors of IMRs

1.11. To identify all incidents and events relevant to the named persons (Ms MA and Mr HL) and identify whether practitioners and agencies responded in accordance with agreed processes and procedures at the time of those incidents.

1.12. To establish whether practitioners and agencies involved followed appropriate inter-agency and multi-agency procedures in response to the victim's (Ms MA) and/or offender's (Mr HL) needs.

1.13. Consider the efficacy of IMR Authors' agencies involvement in the Multi Agency Public Protection Arrangements (MAPPA) process, and/or management of dangerous person's processes.

1.14. Establish whether relevant single agency or inter-agency opportunities to respond to concerns about the victim, (Ms MA) and the assessment of risk to her and risk to others was considered and appropriate.

1.15. Establish whether relevant single agency or inter-agency opportunities to respond to concerns about the offender, (Mr HL) and the assessment of risk to him and his risk to others was considered and appropriate as a young person or adult.

1.16. To what extent were the views of the victim (Ms MA) and offender (Mr HL), and significant others, appropriately taken into account to inform agency actions at the time.

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

1.18. Identify any gaps in, and recommend any changes to, the policy, procedures and practices of the agency and inter-agency working with the aim of better safeguarding families and children where domestic violence is a feature in Nottingham City and Nottinghamshire.

1.19. Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their

responsibilities and duties to work together to manage risk and safeguard the victim Ms MA, and the wider public.

1.20. To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring/reappearing in this review; taking into account if and when these actions were implemented within the agency.

Matters for the Review Panel to Consider

1.21. On the basis of the evidence available to the review whether there were any modifiable circumstances that could have prevented the homicide with the appropriate improving policies and procedures in Nottingham City and, if applicable, in the wider county of Nottinghamshire.

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

Excluded Matters

1.23. The review will exclude examination of how the victim, Ms MA, died or who was culpable; these are matters for the Coroner and criminal courts respectively to determine. In addition, there should be an exclusion of details of personal health information relating to the victim or offender which are not relevant to the circumstances of the case.

Families and Significant Other Involvement

1.24. Family members, including the daughter of Ms MA and the mother of Mr HL were offered the opportunity to contribute to the review via a meeting with the Independent Author and the Chair of the Review Panel. Their contribution is detailed in section 3 of this report.

1.25. Friends of Ms MA and the former girlfriend of Mr HL were also contacted but have not contributed. Mr HL himself was written to by the Independent Chair of the DHR to notify him of the review.

Contributors

1.26. Agencies participating in this Review and commissioned to prepare Individual Management Reviews are:

- **Nottingham City Children's Services**
- **Nottinghamshire Police**
- **National Probation Service - Nottinghamshire**
- **Nottinghamshire Healthcare NHS Foundation Trust jointly with Nottinghamshire County Council Adult Services**

- **NHS England**
- **Gedling Homes**
- **HMP Ranby**
- **HMP Nottingham**

1.27. A report was also requested from the Crown Prosecution Service. The Community Rehabilitation Company also contributed to a specific meeting held as part of the review process to consider changes in practice.

DHR Panel Members

1.28. DHR Panel members consisted of senior representatives from the following agencies:

- **Women's Aid Integrated Services**
- **National Probation Service - Nottinghamshire**
- **Nottinghamshire Police**
- **Nottinghamshire Healthcare NHS Foundation Trust**
- **Gedling Homes**
- **Gedling Borough Council**
- **MAPPA Unit**
- **NHS England**
- **Nottinghamshire County Council Adult Services**

1.29. The Author of the report is Hayley Frame who is an Independent Safeguarding Consultant. Hayley is independent of all agencies contributing to the Review and has 20 years' experience within safeguarding, as a practitioner and as a manager at various levels, and is a qualified and registered Social Worker.

2. The Facts

2.1. Ms MA was stabbed and killed by Mr HL on or after Friday 30th January 2015 and her body was discovered on Wednesday 4th February 2015. Ms MA was 47 years of age.

2.2. Ms MA was a friend of Mr HL's mother and this is how Ms MA initially met Mr HL. Ms MA and Mr HL had been in a relationship which was believed to have ended at the time of her death. There was a significant age difference between Ms MA and Mr HL.

2.3. The relationship was not known to any agency and nor was it known to most of the friends or the daughter of Ms MA. The author has ascertained from Ms MA's daughter that it is likely that Ms MA did not want people to be aware of her relationship with Mr HL. There are no agency reports of or evidence to suggest that there were incidents of domestic abuse within the relationship.

2.4. On 30th January 2015, Mr HL had been to a party and had consumed a significant amount of alcohol. It is believed that Mr HL visited Ms MA's home at around 10.00pm. Mr HL stated in police interview that he and Ms MA had consensual sex twice before they started to argue. He stated that he strangled Ms MA until she was dead before stabbing her. The post mortem results differ to this account in that there is not an obvious sign of strangulation although there are injuries to the neck. The post mortem revealed three deep stab injuries to the abdomen and although it concluded that there was no single cause of death, it concluded that taken together the injuries would eventually result in death.

2.5. On 4th February 2015, Ms MA's body was found at her home.

2.6. Mr HL was subsequently sentenced to life imprisonment (to serve a minimum of 21 years) for the murder of Ms MA.

Coroner's Enquiry

2.7. The Coroner's inquest was adjourned on 14th October 2015 as all matters were dealt with at the Crown Court.

3. Summary of Individual Agency Contact/Involvement

It is important to note that there was no agency involvement with the victim, Ms MA and that the relationship with Mr HL was not a known relationship.

Nottingham City Children's Services

3.1. The involvement of Children's Services was predominately in relation to Youth Offending Services with Mr HL, although there was some limited historical involvement prior to the scoping period of this review.

Nottinghamshire Police

3.2. Ms MA contacted the police on 4 occasions between 2011 and 2012 unconnected to Mr HL regarding being the victim of crime (burglaries/theft).

3.3. Mr HL has a long history of involvement with the police in relation to incidents, complaints, allegations and arrests. Between 2005 and 2011, Mr HL was convicted of 8 offences including offences against the person, theft, public disorder, offences relating to police/court/prisons and one drug offence. He also received 5 reprimands/warning/cautions between 2003 and 2010 for similar offences.

3.4. Nottinghamshire Police were in attendance at the 3 MAPPA meetings held in respect of Mr HL. They also responded to 3 reports of him being a missing person and responded to complaints of Mr HL being subject to, and of instigating, antisocial behaviour.

National Probation Service - Nottinghamshire

3.5. NPS-Nottinghamshire were involved with Mr HL in 2011 through the preparation of a pre sentence report, offender management whilst he was in prison; as part of his preparation for release and supervision on licence; and by ensuring enforcement action whilst on licence. NPS-Nottinghamshire were also jointly responsible with the prison for exit planning when Mr HL was finally released from custody at the termination of his sentence.

Nottinghamshire Healthcare NHS Foundation Trust

3.6. Mr HL was known to the Trust. These contacts related to a number of Directorates and included Child & Adolescent Mental Health Services (CAMHS), Community Forensic Service (CFS) and Offender Health (OH). Although some records were available for the review, the adult

mental health notes had been transferred to offsite storage, and attempts to retrieve these were unsuccessful as the files could not be located within the storage facility. A Serious Incident has been raised in response to the inability to retrieve the clinical notes; this will entail a full root cause analysis investigation conducted by the Trust outside of this review, with subsequent actions to prevent reoccurrence.

Nottinghamshire County Council

3.7. Mr HL had contact with the Mental Health Team – Social Care.

3.8. The Multi-agency Safeguarding Hub (MASH) received a referral in respect of Mr HL. The MASH has two roles; to gather relevant information, including that from Adult Social Care records, and to make a decision about whether individual MASH enquiries require a safeguarding assessment or an alternative response. In the case of Mr HL, the referral was forwarded to Adult Social Care as it was not deemed to be a safeguarding referral.

NHS England[1]:

3.9. For the purpose of this report, the General Practice involved is referred to as Practice X. This is a semi-rural dispensing General Practice providing General Medical Services to a reported 9300 patients registered at the practice. Practice X is the last practice where Mr HL was registered. Practice X had a significant amount of contact with Mr HL's mother.

Gedling Homes:

3.10. The mother of Mr HL was a tenant of Gedling Homes. Gedling Homes is a Registered Provider of Social Housing. Gedling Homes Neighbourhoods Team which deals with the day to day estate and management issues was the lead team in relation to this tenancy; with Revenues having some contact with regard to the rent account.

HMP Nottingham:

3.11. HMP Nottingham is a publicly funded prison operated by the National Offender Management Service. It holds up to 1060 prisoners. Mr HL

[1] In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended) ("NHS Act"), NHS England has delegated the exercise of the functions to all Nottinghamshire and Nottingham City CCGs to empower the CCGs to commission primary medical services for the people of Nottinghamshire & Nottingham City. Both subjects of this review were registered with and received primary care medical services from GPs in Nottinghamshire and Nottingham City respectively

was recalled to HMP Nottingham in 2012. The IMR provided covered all information contained within the prison services national database and was therefore not restricted to Mr HL's time at HMP Nottingham.

4. Summary of Key Events

NB: The combined agency chronology that was developed as a tool to support the DHR in this case is extensive. This section focuses upon key events.

Author's comments are in bold.

4.1. On 3rd September 2007, the Police were contacted following a domestic argument over money between Mr HL, his mother and sister. No offences were disclosed.

4.2. The Police were contacted again on 28th December 2007, and Mr HL was arrested for actual bodily harm having punched his 16 year old girlfriend to the face causing her nose to bleed. Mr HL, who was 17 at the time, was also arrested for common assault on a Police Officer who was attempting to arrest him. Mr HL was arrested and interviewed and admitted both assaults during a tape recorded interview. The summary of the interview does not include any reasons as to why he had assaulted both victims.

4.3. Mr HL's girlfriend would not make a complaint and refused to attend court. On 14th February 2008, Mr HL attended court and was found not guilty as no evidence was offered. However the following day he attended court again and pleaded guilty to the common assault against the Police Officer and was made subject to an Action Plan Order for 3 months.

An Action Plan Order was a supervisory order for low level offending, in this case lasting 3 months.

It is of note that the assault against the 16 year old girlfriend was not recorded as domestic violence, in accordance with definitions and policy requirements in place at the time, although a Domestic Violence multi-agency risk assessment form was completed and submitted to the Police Domestic Abuse Support Unit. [2]

4.4. Mr HL did not engage with the Youth Offending Team as part of the Action Plan Order and failed to attend a number of appointments. As a result of this failure to engage, Mr HL returned to court for a breach of the order and a new Action Plan Order was made. Again Mr HL was in breach of the requirements due to a lack of engagement and at court on 9th May 2008 the case was adjourned pending the completion of a psychological assessment.

4.5. The Careers Advisor attached to the Youth Offending Team was persistent in her attempts to engage with Mr HL, including completing

[2] There is now in place a Nottingham City Pathway for Young People in Intimate Violent Relationships (see appendix C)

home visits. Mr HL informed her that he had not been in school since he was 14 years of age due to bullying. He also disclosed having problems with local gangs and that he did not like being in crowded places. At a subsequent home visit undertaken by the Youth Offending Team substance misuse worker, Mr HL admitted to daily alcohol consumption.

4.6. On 22nd May 2008, Mr HL was arrested for disorderly behaviour towards Police Officers despite being warned to stop. On 24th May 2008, he was again arrested for being drunk and disorderly. He was charged and bailed to attend the Youth Court on both occasions.

4.7. Mr HL failed to attend court on 13th June 2008 and a warrant was issued for his arrest. He was arrested on 17th June 2008.

4.8. Although concerns were growing regarding Mr HL's dependency upon alcohol, his case was closed to the Youth Offending Team Substance Misuse Worker due to lack of engagement. In addition, his mother reported ongoing problems with local youths.

4.9. On 2nd July 2008, when Mr HL was a few weeks away from being 18 years of age, an independent psychological assessment was completed by a Clinical Psychologist as part of the ongoing criminal proceedings. The report concluded that:

- Mr HL was reporting high levels of anxiety and fear of aggression from gangs of youths in the local area;
- Difficulties were described as long standing and had adversely impacted on his education, social and emotional development;
- His anxiousness and fears included meeting with new people and being in places where he might be exposed to negative attention from others;
- His difficulties were inhibiting his willingness to access support services and cooperate with the Action Plan Order;
- He recognised and accepted that avoidance behaviours would not help his personal situation or matters in relation to the Court;
- He recognised and accepted that change would only occur if he committed to accepting help and cooperated with intervention provided;
- He was at risk of developing long term mental health problems (particularly clinical depression) if his personal circumstances remained unchanged.
- He was beginning to show signs of increasing disturbance (obsessive compulsive behaviours) indicative of high levels of anxiety and distress.

4.10. The Clinical Psychologist found that Mr HL was intellectually bright and articulate with insight into the nature, extent and origins of his difficulties, which when motivated he was able to effect change.

4.11. On 17th July 2008, Mr HL was sentenced at court to a further 3 month Action Plan Order as a result of the offences committed on 22nd and 24th May 2008 and the breach of his previous order. As part of the Action Plan Order, Mr HL was seen by the Children and Adolescent Mental Health Service (CAMHS). He stated that he was trying to manage his alcohol use and disclosed historical cannabis use. It was agreed that he would engage with cognitive behavioural therapy. Although Mr HL did attend the majority of the CBT sessions arranged by CAMHS, he failed to engage with the Youth Offending Team substance misuse worker.

4.12. An allegation of assault was made against Mr HL on 12th September 2008 where it was stated that he assaulted a friend whilst in drink causing black eyes. The victim refused to make a statement and no further action was taken.

4.13. Following expiry of the Action Plan Order, Mr HL was referred to Compass, young people's drug and alcohol services, for ongoing support with his alcohol use. An initial assessment was completed on 20th October 2008 which recorded that Mr HL used alcohol 20-28 days per month, drinking 4 units per day. An alcohol diary was given to establish any patterns of drinking and triggers. Mr HL engaged with Compass and by December 2008 both he and his mother were reporting a much improved picture. Throughout January 2009, Mr HL did not engage with Compass and on a visit completed on 9th February 2009, Mr HL's mother reported that he had gone out with friends, was still making progress and no longer required the intervention of Compass.

4.14. On 17th June 2009, Mr HL visited the GP with his mother. As a result of this attendance, the GP referred Mr HL to the Health in Mind, Psychological Health and Wellbeing Service due to Mr HL experiencing considerable problems with anxiety. On 8th July 2009, the service wrote to Mr HL inviting him to make contact in order to complete an initial assessment. He failed to do so, and on 12th August 2009 he was discharged. The GP was informed.

4.15. On 18th August 2009, Mr HL attended the GP and was keen to be re-referred to the Health in Mind, Psychological Health and Wellbeing Service. The records indicate that he was seen by the service as the GP received a letter from them dated 22nd December 2009 that stated that Mr HL was moving to a county address and would therefore need to be referred by the GP to the County Mental Health Team as he would benefit from cognitive behavioural therapy. It was stated that Mr HL had no idea or intention of suicide, self-harm or harm to others.

The referral to the County Mental Health Team did not take place until several months later. At the time there was no electronic transfer of GP notes.

4.16. On 9th May 2010, Mr HL was arrested having assaulted his adult sister. Mr HL was 19 years of age. Whilst heavily under the influence of alcohol he had hit his sister on the head with a glass bottle, with injuries amounting to actual bodily harm. Mr HL's sister refused to make an official complaint; refused to give a witness statement and signed the attending officer's notebook to that effect. Mr HL admitted the offence during interview and was given a police caution for common assault.

A Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Checklist should have been completed and submitted to the Police Domestic Abuse Support Unit as the incident fell within the criteria of domestic abuse.

4.17. Mr HL was seen by the GP on 4th June 2010 for a new patient registration and it was recorded that he could try counselling and that medication for anxiety was to be considered.

4.18. On 11th July 2010, Mr HL's mother wrote to the GP and reported that her son was experiencing serious social and emotional issues, had been threatened at knifepoint in his own home by local gangs, and was now rarely leaving the house. The letter stated that Mr HL had no self-confidence, was suffering with paranoia and had developed obsessive behaviours to help him cope. The following day Mr HL was seen by the GP where he was prescribed Propranolol. It was recorded that Mr HL was to have counselling and then consider Citalopram.

4.19. Mr HL was seen again by the GP on 29th July 2010 where he was referred to the Community Mental Health Team. The prescription for Propranolol was increased.

4.20. On 23rd August 2010, Mr HL's mother reported him missing to the police after being on a 'bender' for two days. She was concerned that he had anger problems and was very violent. Mr HL, who was by now 20 years of age, returned home later that day and was seen by police officers who reported that he was safe and well. Mr HL had failed to tell his mother that he was staying out overnight. He was graded as a low risk missing from home, meaning that there was no apparent threat of danger to himself or others.

4.21. On 13th October 2010, the Community Mental Health Team wrote to the GP to state that Mr HL did not meet the criteria for their service. Suggestions were made for referrals to support services, in particular for employment support, as this was felt to have potential to improve Mr HL's confidence and social skills. It was recorded that Mr HL's self-imposed isolation had resulted in his loss of social skills and ability to act confidently amongst his peers. There was no suicidal intention, no symptoms of depression or thoughts of deliberate self-harm. Mr HL

was described as giving good eye contact and responding well to questions.

4.22. On 22nd October 2010, the GP referred Mr HL to exercise on prescription under the category of stress/depression and also to Base 51 for employment support. Propranolol medication continued.

4.23. Mr HL was arrested by the police on 3rd November 2010 following an unprovoked knife attack on a 15 year old friend. They had been watching a film in his bedroom when he stabbed the friend 7 times with a 5 inch kitchen knife, requiring 37 stitches. Mr HL was under the influence of alcohol at the time of the assault. Mr HL admitted the offence, was charged with causing Grievous Bodily Harm with intent and remanded into custody.

4.24. On 11th February 2011, at 20 years of age, Mr HL pleaded guilty to GBH with intent and was sentenced to 3 years in a Young Offenders Institution (YOI). This made him a mandatory MAPPA case.

4.25. On 21st February 2011, Mr HL was registered as a MAPPA Category 2 Level 1 offender on the probation system. His case was allocated to an Offender Manager.

4.26. Mr HL struggled to settle at the YOI and he was supported to complete a transfer application.

4.27. On 17th May 2011, a Sentence Planning Board was held. It was recorded that referrals would be made for psychology and alcohol programmes. Mr HL was stated to be struggling to come to terms with his sentence and not being able to understand why he was in custody and why he was assessed as a high risk of harm. The following day, Mr HL moved to another YOI.

4.28. Following the transfer, referrals were made for drug awareness, alcohol awareness, victim awareness and for the involvement of the Mental Health In Reach Team. Over the following weeks concerns were expressed regarding risk of self-harm and conflict with peers. Due to a fight with another prisoner, Mr HL was receiving threats and was concerned for his safety. He was therefore located in a segregation unit pending transfer to another YOI. On 30th August 2011 Mr HL transferred to another YOI.

4.29. With a few days, Mr HL reported that he was not getting on with the other prisoners on his wing and was requesting a move to the segregation unit as he did not want to mix with other prisoners. Again there were recorded concerns regarding the risk of self-harm. Mr HL requested to be moved to another YOI that was closer to his home.

4.30. On 5th October 2011, Mr HL moved to a YOI closer to home. Concerns were noted regarding his low mood and he was placed on increased

observations. Mr HL was offered anti-depressant medication but refused. It was recorded that he was engaging in education and completing an alcohol awareness course.

4.31. Mr HL was referred for MAPPA Level 2 management on 1st November 2011. The initial meeting was scheduled for 14th December 2011. In early November Mr HL's application for release under the Home Detention Scheme was declined as it would involve him returning to his mother's address where there was still tension with neighbours.

4.32. The Level 2 MAPPA meeting held on 14th December 2011 decided that Mr HL would be retained at Level 2 Management. The planned release date was 5th May 2012. A further MAPPA meeting was held on 22nd February 2012 where again it was agreed that Mr HL would continue to be managed at Level 2.

4.33. In preparation for his release, an Approved Premises was identified and referrals to forensic community mental health and alcohol services and an Employment and Training Specialist were made.

4.34. On 4th May 2012, aged 21 years, Mr HL was released to Approved Premises on licence. The following licence conditions were set:

- Not to have contact with victim
- Not to enter a specified area
- Not to have unsupervised contact with children under age of 18
- To reside at Approved Premises
- To attend mental health/alcohol appointments
- Not to enter licensed premises
- To address offending behaviour
- Not to carry any type of bladed article

4.35. On release, Mr HL's OASys assessment was reviewed by his Offender Manager and sentence planning objectives aimed at reducing his high risk of harm were set.

4.36. On 9th May 2012 a MAPPA meeting was held where it was decided to reduce Mr HL to level 1 management as there were only 2 agencies involved and Level 1 Management was considered to be sufficient. Mr HL would continue to be subject to licence conditions until 4th November 2013.

4.37. On 11th May 2012, Mr HL attended an appointment with a Consultant Forensic Psychiatrist, accompanied by his Offender Manager. The report that was written as a result of this appointment indicated that Mr HL represented an ongoing risk of serious violent offences and that his risk of offending would increase should he return to drink or drug use and perhaps when faced with transitions or losses.

Due to the clinical notes being unobtainable, the Review has not established who received a copy of this report. The report does not feature in the GP or the Probation Service records. That said, the Probation Service IMR has established that risk assessments completed by probation did identify the underlying risk factors.

4.38. Mr HL also attended appointments with Double Impact (substance misuse and mental health services) regarding his alcohol use and an Employment and Training assessment where it was decided that he was to apply to attend college.

4.39. Mr HL failed to attend a subsequent appointment with the Psychiatrist and on 30th May 2012 was issued with a warning form by his Offender Manager regarding non-compliance with licence conditions.

4.40. On 12th June 2012, Mr HL failed to return to the Approved Premises by the time of curfew, and was recalled to prison. It transpired that he had stayed at a friend's house overnight and had been drinking heavily. Due to the recall, Mr HL was subsequently discharged by the Forensic Mental Health Team.

4.41. On 5th July 2012, Mr HL was fighting with his cellmate. Following this he threatened self-harm and refused to cell share.

4.42. On 13th August 2012, Mr HL was released back to the Approved Premises subject to the same licence conditions. Support from mental health and alcohol services, as well as Employment and Training was re-established.

4.43. However by 17th August 2012, Mr HL had again breeched his licence by not completing his drink diary, not contacting Double Impact and by visiting the home of a friend where 3 young children were present (a condition of his licence being to not to have unsupervised contact with children under age of 18). The Offender Manager reinforced the licence conditions and Mr HL was given a verbal warning.

4.44. On 21st August 2012, Mr HL attended an appointment with Double Impact and an appointment with the Consultant Forensic Psychiatrist.

The outcome of this appointment is not known as there are no available records.

4.45. Mr HL failed to return to the Approved Premises on 24th August 2012 and was again recalled to prison. However he was unlawfully at large until 13th September 2012 when he handed himself in to the police and was transferred to HMP Doncaster. As a result of this recall, Mr HL was again discharged by the Community Forensic Mental Health Team although he was referred to the prison In Reach mental health services.

4.46. Whilst at HMP Doncaster, Mr HL was seen on a number of occasions by a Consultant Psychiatrist. His diagnosis was of an adjustment disorder with anxiety and depressive symptoms. Due to the prolonged nature of these symptoms, the Consultant Psychiatrist sought a secure hospital gate keeping assessment from a Consultant Forensic Psychiatrist. Whilst the Forensic Psychiatrist agreed with the diagnosis, they did not feel that a hospital admission was appropriate.

4.47. On 21st March 2013, a sentence planning meeting was held and a formal review of Mr HL's OASys assessment was completed, and the risk posed remained high. Concerns were raised regarding Mr HL's threats of self-harm and poor engagement with the In Reach Mental Health Team.

4.48. Mr HL remained at HMP Doncaster until 26th July 2013 when he transferred to HMP Ranby. His Offender Manager did not recommend re-release as it was felt that further engagement with work in respect of his mental health should occur before release. Whilst at HMP Ranby he was seen regularly by the In Reach Mental Health Team. He was also referred to substance misuse services in relation to alcohol use but declined their interventions.

4.49. In October 2013, discussions took place between the Forensic Mental Health Team and the Prison In Reach Mental Health Team. Discussion took place regarding risk and potential safeguarding issues surrounding Mr HL's offence and it was agreed that the Prison In Reach Mental Health Team would share relevant reports and clinical information.

The detail of these discussions, and their purpose, has not been established as the clinical records have not been available to the review.

4.50. On 1st November 2013, the Offender Manager emailed the Community Psychiatrist Nurse from the Criminal Justice Liaison Team to inform her of Mr HL's release and asking whether she had any suggestions regarding referrals to community mental health services. The email also stated that Mr HL's mother would be taking him to register with a GP upon release.

The review has established that subsequent to this email there was face to face conversation between the two individuals and a follow up email from the Community Psychiatric Nurse to the Offender Manager containing a referral form to the Single Point of Access (SPA). This referral form is not contained within the probation records. No referral to community mental health services was made by the Offender Manager.

4.51. On 22nd November 2013, at sentence end, Mr HL was released from prison. He was 23 years of age. Although Mr HL went to reside with his mother, the prison informed the Police that he was released to an

Approved Premises. There was no further information sharing with the police at this time.

Having concluded his sentence, there were no conditions or licence requirements for Mr HL to adhere to therefore Mr HL was not subject to any statutory provisions when released into the community.

4.52. On 27th November 2013, Mr HL was seen by the GP and it was recorded that he was not coping. He was prescribed Citalopram for 2 weeks although the records would indicate that Mr HL did not take the medication.

4.53. Mr HL was reported missing by his mother to the police on 1st February 2014. It was recorded that Mr HL was alcohol dependent and can be violent in drink (information provided by Mr HL's mother). Mr HL returned home the following day, having stayed overnight at a friend's house and not having a phone to contact his mother.

4.54. On 9th April 2014, the police were contacted by a woman reporting being stalked. Mr HL was found in an alleyway at the side of the woman's house in a drunken state. He stated that he had met the woman in a pub 6 months earlier and that she had invited him to her address for sex. This was denied by the woman. Mr HL was taken home by the police and no action was taken as no offences were disclosed.

A verbal harassment warning could have been given as a result of this incident.

4.55. Mr HL was seen by the GP on 16th April 2014 where it was recorded that he was about to move in with his girlfriend who was trying to get him a job. It was also recorded that alcohol 'was a large part of the issue'.

4.56. On 17th April 2014, the police were contacted by the same woman reporting that a male was ringing her doorbell and she believed it was Mr HL, although she did not see who was at the door. Damage had been caused to her door (damage around the lock and a substantial crack to the glass panel) and it was recorded as attempted burglary.

4.57. On 19th April 2014, Mr HL made two 999 calls to the police demanding that the police give him a lift home as otherwise he would 'fuck someone up'. He confirmed that he had been drinking and that he would kill someone or mutilate the next person he saw as he would rather do that, than walk back to his home address. The police located Mr HL shortly afterwards and he was arrested for the attempted burglary which he denied. Mr HL was given police bail with conditions not to contact the witness or attend her address.

4.58. As the investigation progressed, a crime scene investigation was completed and house to house enquiries made. However due to insufficient evidence to link Mr HL to the incident, he was subsequently refused charge. This was explained to the woman, crime prevention advice was given and she was issued with a personal attack alarm.

4.59. Mr HL attended a GP appointment on 23rd May 2014 where he reported that his anxiety was better but that he was drinking more alcohol. The GP tried to contact the Criminal Justice Liaison Team but got no reply.

4.60. Mr HL contacted the police on 31st May 2014 stating that he had been threatened by 4 youths in a car which was part of an ongoing dispute between him and a female within the estate. He was advised to keep a diary of events.

4.61. On 6th June 2014, the woman who believed that she was being stalked by Mr HL contacted the police. She stated that she had seen him near to her local shops on two occasions. She also stated that he used to live in a flat above hers and that she received unwanted attention from him where he would invite himself to her flat.

This was an opportunity to complete the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Checklist.

4.62. Mr HL, now 24 years of age, was arrested on 8th June 2014 on suspicion of harassment and stalking. In interview, Mr HL stated that he knew the woman through a friend as the friend use to live in the flat above and he would visit. He stated that 3 years ago he saw the woman in a pub and she had said that if he was ever passing he should call in with a bottle of wine. With regard to the earlier incident in April, he stated that he was drunk and remembered her offer so had visited her. He denied attending her address on 17th April 2014. With regard to the two occasions where he had been seen near the shops, Mr HL admitted to being there but that on the first occasion he had not seen the woman and on the second occasion he did not speak to her or follow her.

4.63. Mr HL was given police bail with conditions not to contact the woman or attend her local area. The CPS subsequently determined that there was insufficient evidence to support a realistic prospect of conviction. It was recorded that the case amounted to the word of the suspect against that of the complainant and that the two independent witnesses (shopkeepers) tended to support Mr HL. A harassment notice was not considered to be appropriate, as advised by the Crown Prosecution Service, due to Mr HL denying any wrongdoing.

Nottinghamshire Police no longer issue formal harassment warning notices as there is no requirement under the Protection from Harassment Act 1997. This has been the case since 2010.[3]

4.64. On 16th June 2014, Mr HL's mother was sent a conduct letter by her housing provider due to blocked drains caused by Mr HL flushing ladies underwear down the toilet.

4.65. The police were contacted on 18th September 2014 by a man stating that he had been assaulted by Mr HL whilst both he and Mr HL were under the influence of alcohol. He stated that he was hit twice in the head. Due to his intoxicated state Mr HL was not arrested until the following day. The victim informed the police that he and Mr HL had been drinking at Mr HL's home with two female friends. The victim asked Mr HL for money that he was owed which led to an argument and Mr HL allegedly punched the victim twice to the side of his head. The two women witnessed the unprovoked attack but refused to give statements to the police. Mr HL denied punching the victim. Mr HL was charged and bailed to court.

4.66. On 21st November 2014, the mother of Mr HL was visited by her housing provider to discuss the ongoing issue of Mr HL repeatedly putting objects down the toilet. Mr HL did not attend the meeting even though he was expected to.

4.67. On 8th December 2014, the mother of Mr HL reported him missing to the police. She stated that he had been drinking, had split from his girlfriend (Adult A) and had talked about killing himself. Within the missing person report there was reference to Ms MA being a previous partner and the possibility that Mr HL had gone to visit her. Unsuccessful attempts were made to contact Ms MA to see whether she had any information regarding Mr HL's whereabouts (including telephone calls and visits to her home).

This is the only reference to Ms MA with regards to Mr HL within all of the agency records.

4.68. Mr HL returned home later that evening and, following a police referral, was seen by the Triage car mental health nurse[4] who identified that his low mood was due to the relationship with his girlfriend (Adult A) ending. Mr HL was advised to see his GP the next day. He stated that

[3] Nottinghamshire Police Officers had over several years issued harassment warning letters to individuals where it was reported that they have caused harassment to another person. There is no legal requirement to issue these notices and the letters used were not sanctioned by Nottinghamshire Police. There were an increasing numbers of complaints from recipients of these letters and their solicitors concerning their use, their legality and consequences. It was therefore agreed that these letters were withdrawn from use in 2010. (Bulletin number 24/10 dated 16/6/2000). Nottinghamshire Police still issue verbal harassment warnings.

[4] A joint initiative between the police and mental health services

he had no intention of self-harm. Mr HL stated to police officers that he had a darkness come over him at night and that voices talked to him. He could not explain what these voices said other than that they were bad things. Mr HL's mother informed officers that she was scared to live with her son. She also stated that she felt that Mr HL had serious undiagnosed mental health problems.

This was an opportunity to complete the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Checklist given Mr HL's mother's report of being scared to live with her son.

4.69. It was agreed that the Police Community Support Officer (PCSO) would visit the following day, although Mr HL subsequently refused to engage with the PCSO. The PCSO made a referral to the Multi-agency Safeguarding Hub (MASH[5]) using the C51 form (vulnerable adult) on 17th December 2014. The C51 form recorded possible mental health issues.

4.70. Upon receipt of the C51, the MASH determined that Mr HL had a 'care need' rather than a 'safeguarding concern' and the form was forwarded to Adult Social Care for them to progress.

A 'safeguarding concern' is identified where there is a perpetrator whereas a 'care need' is identified where there is adult vulnerability.

4.71. On 18th December 2014, the mother of Mr HL was contacted by the Mental Health Team - Social Care. She was advised to contact the GP for referral into secondary services for Mr HL.

The Local Authority Mental Health Team – Social Care and the Healthcare Trust Community Mental Health Team are two separate teams with different referral routes. A referral from the GP is required to access the Community Mental Health Team

4.72. The police were contacted on 13th January 2015 by a woman reporting having been sent inappropriate messages and images of a sexual nature via Facebook from Mr HL. The police attended and established that the woman and Mr HL were friends on Facebook and had been engaged in a long conversation during which they were equally insulting towards each other. The woman had not been distressed by this, as evidenced by the amount of smiley faces that she posted during the conversation and stated that she did not want any action to be taken. She informed the police that she had called on behalf of her friend who had received an offensive photograph from Mr HL via Facebook, the picture being of his penis. The woman stated that she

[5] The Multi-Agency Safeguarding Hub is a team of social care, police and health colleagues who provide an information sharing and screening service to safeguarding referrals for adults and children.

would be telling her friend to report the incident to the police herself. No further reports were received and no further action was taken by the police.

4.73. Also on 13th January 2015, the trial in respect of the alleged assault committed on 18th September 2014 commenced. On the day of trial, the victim failed to attend and enquiries were made by the prosecutor who contacted witness care and attempted to contact the victim, leaving messages on his mobile phone without success. Without the victim there was no longer a realistic prospect of conviction and the prosecutor had no alternative but to offer no evidence and the case was dismissed.

4.74. On 20th January 2015 an informal round robin meeting[6] was held between Housing Provider staff and Police Beat Managers. It was agreed that a joint visit would be undertaken by the PCSO and housing provider; the PCSO would speak with the local mental health team and would establish whether Mr HL had seen his GP.

4.75. The sister of Mr HL reported to the police on 26th January 2015 that a number of males were threatening Mr HL and that this involved a female that he had been in dispute with since 2014. It was believed that the dispute was in relation to drugs. The incident was classed as antisocial behaviour.

4.76. The following day the Fire and Rescue service visited to complete a fire safety check following alleged threats of arson. A smoke alarm and fire safe letterbox were fitted.

4.77. On 27th January 2015, the PCSO visited as a result of the contact made on 26th January 2015. Following this visit the PCSO made a referral to the Vulnerable Persons Panel[7] in respect of Mr HL. In the referral both Mr HL and his mother were identified as vulnerable. The concerns related to groups of people turning up at the address and intimidating the family. Mr HL had admitted to standing at the door on one occasion with his samurai sword and that he would 'hurt somebody if it came to it'. The referral also stated that his mother was afraid to live with Mr HL but feels that he needs help and has asked many times for a mental health assessment. It was recorded that the 'concerns are around that he may carry out these threats if he is pushed far enough'. The house was described as regularly smelling of cannabis.

The referral was not heard by the Vulnerable Person Panel which is held monthly as Mr HL was arrested prior to the next panel taking place.

[6] The round robin meetings are area based interagency informal information sharing meetings hosted by the Housing provider.

[7] The Vulnerable Person Panel is a multi-agency meeting coordinated by The Borough Council with representation from Police, Youth Offending, Fire and Rescue, Mental Health and Antisocial behaviour teams.

4.78. Also on 27th January 2015, the mother of Mr HL contacted the Team Manager of the Mental Health Team – Social Care and expressed her concerns regarding Mr HL, stating that he had become a recluse and that his sister was very uncomfortable around him. It was suggested again that the GP would need to refer him to secondary services. In light of the concerns raised by the mother of Mr HL, the Team Manager asked for a home visit to be completed by a Social Worker.

4.79. Mr HL's mother then contacted the GP asking him to contact the Community Psychiatric Nurse who was due to see Mr HL that afternoon.

The review has established that a Community Psychiatric Nurse was not visiting that afternoon, it was a Social Worker who due to visit on 29th January 2015 from the Mental Health Team – Social Care.

4.80. The PCSO spoke with Mr HL's mother on 28th January 2015 to enquire whether an appointment with the GP had been made. The PCSO was told that Mr HL was to see the GP on 16th February 2015.

4.81. On 29th January 2015, a Social Worker from the Mental Health Team – Social Care visited the family home. The mother of Mr HL informed the Social Worker of her concerns regarding Mr HL's behaviour, including his unpredictable and explosive behaviour which was often linked to alcohol misuse, and provided a detailed background history. It was also established that the sister of Mr HL and her partner were also living in the flat due to homelessness. The mother stated that she wanted them in the flat for protection from Mr HL as she felt unsafe. Mr HL then spoke with the Social Worker and stated that he was ok and his only concern was the overcrowding and that he hated his sister and the 6 cats. The Social Worker asked if the girlfriend of Mr HL was ok, and she confirmed that she was. A discussion took place regarding a referral for Mr HL to the Community Mental Health Team, and Mr HL stated that he may keep the appointment with the GP to action this.

This was an opportunity to complete the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Checklist given that Mr HL's mother was stating that she felt unsafe.

4.82. On 2nd February 2015, the mother of Mr HL contacted the Mental Health Team – Social Care to state that Mr HL had gone missing on Friday (30th January 2015) and on Saturday (31st January 2015) he had sent her messages stating that he needed help and to come to get him, which she did by borrowing a neighbour's car. The worker stated that she was going to be making a referral for Mr HL to obtain independent accommodation but his mother felt that he was not ready for

independent living. It was agreed that the referral would not be made and that the mother would ensure that Mr HL attended the GP appointment in order to be referred to the Community Mental Health Team. She was also advised to contact the police if she felt threatened or had concerns for anyone's safety.

4.83. On 4th February 2015, the death of Ms MA was reported to the police.

4.84. Mr HL was subsequently arrested and charged. He was 24 years of age at the time of the murder.

5. Family Perspectives

5.1. The mother of Mr HL was interviewed in person. She descried some of the difficulties she had encountered with her son over the years. Her view is that Mr HL can be two different people, “when he drank (excessively) he became this other person”. She feels strongly that Mr HL has an undiagnosed mental illness. Despite this the mother of Mr HL felt that all agencies involved had done everything that they could to assist Mr HL. She felt particularly supported by her GP, the Mental Health Team – Social Care and the Police.

5.2. Mr HL’s mother knew about the relationship between her son and Ms MA and although she confronted Mr HL, she never discussed it with Ms MA. She found out about the relationship in April 2014 when Mr HL messaged Ms MA on Facebook, using his mother’s account. Mr HL’s mother reported that neither Ms MA nor Mr HL wanted people to know about the relationship, which she believed ended in August 2014 although she was aware of further contact between them.

5.3. Mr HL’s mother stated that she was not scared of her son and did not think that he was a danger to her or others, although she worried that he might “flip” when drunk.

5.4. The daughter of Ms MA was interviewed in person. Given the lack of professional knowledge of Ms MA, the input from her daughter was extremely valuable.

5.5. Ms MA was described as a creative, bright and spontaneous woman who loved to travel and to write. She had written scripts, plays, short films and books, and used to work as a TV extra. According to her daughter, Ms MA was a very strong woman who was driven and had raised her daughter to be the same. Ms MA did not care what others thought of her, “She knew what she wanted and believed you can do something if you put your mind to it, like with her books, all she did was write”. Ms MA’s daughter shared that her mother held very strong views regarding domestic abuse, violence in general, drugs and alcohol, racism and homophobia. Ms MA was described as a ‘spiritual’ woman who believed in the afterlife and past life regression. She would often dye her hair bright colours and wear alternative ‘gothic’ clothing.

5.6. Ms MA was a support teacher at a local college at the time of her death. Ms MA had a degree in Psychology and Sociology.

5.7. Neither Ms MA’s daughter nor Ms MA’s closest friends were aware of the relationship between her and Mr HL. Her daughter only became aware of the relationship after her mother’s death.

5.8. Given Ms MA’s close friendship with the mother of Mr HL, both she and her daughter had known Mr HL for many years, from when he was a teenager. Both Ms MA and her daughter were well aware of his violent

history and Ms MA had provided much practical and emotional support to his mother when he was younger. Her daughter stated that her mother would tell Mr HL's mother to leave home and that she (Ms MA) thought he had some sort of psychosis. Ms MA would feel infuriated by the trouble Mr HL brought to his mother's house and the constant issues of having to move area and his mother feeling terrorised on the street due to him.

5.9. For these reasons, Ms MA's daughter cannot understand why her mother engaged in a relationship with Mr HL.

5.10. Ms MA has a friend who lives in London who was aware of the relationship with Mr HL. Ms MA and Mr HL had visited her. The friend informed Ms MA's daughter that Mr HL was very dominant and had been verbally abusive to Ms MA.

5.11. The friend also informed Ms MA's daughter that Ms MA had told her that in two previous lives, Mr HL had killed her (in the same manner in which he did eventually kill her). This has led Ms MA's daughter to question further why her mother would be in a relationship with Mr HL. She thinks that her mother may have believed that she could help Mr HL. It clearly troubles Ms MA's daughter that her mother would keep the relationship a secret but she believes that Ms MA would have known that people would disapprove given Mr HL's history.

5.12. Ms MA's daughter has been provided with the Executive Summary of this review.

6. Analysis

Summary of analysis and/or lessons learned from IMRs

Nottingham City Children's Services

6.1. Given the historical nature of the involvement with Mr HL and the time that has elapsed since; the IMR has determined that any learning regarding both internal and inter-agency practice is limited. This is a consequence of the many statutory changes which have improved services.

Nottinghamshire Police

6.2. The IMR has found that the police response to incidents was in line with force policy and procedures. There were no recorded incidents involving both Ms MA and Mr HL together. Where issues of concern were identified in respect of Mr HL appropriate referrals were made. The only area of practice identified within the IMR that could have been improved was the addition of a 'mental health' warning signal to Mr HL's PNC record.

6.3. The Domestic Homicide Review has found that there were missed opportunities to complete the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Checklist.

National Probation Service - Nottinghamshire

6.4. The IMR found that the Probation Officer followed agency expectations in preparing the court report and consulted widely. During the pre-release stage the Probation Officer made appropriate referrals and also sought the support of MAPPA in bringing agencies together. The Probation Officer followed agency expectations in relation to the release of a high risk offender by referring Mr HL to Probation Approved Premises. She also engaged with partner agencies in securing medium term accommodation arrangements for his eventual return to the family. Consequently there was a clear release plan in place within a framework of additional licence conditions to manage his risk and appropriate referrals had been made to partner agencies.

6.5. The IMR also found that during the licence phase the plan was followed through with close support from the Probation Officer and Approved Premises staff. Mr HL was accompanied to an early interview with the psychiatrist and significant work was initiated around substance misuse and employment and training referrals. All actions were followed up and support given to Mr HL and his family. Recall action was taken for breach of licence in line with agency expectations for a high risk of harm offender.

6.6. The IMR concluded that Mr HL presented a significant challenge for the agencies working with and supporting him although his risk and needs were identified appropriately and there was a good level of contact. Throughout both the custodial and community phases of this sentence there is a recurring theme of limited engagement with staff.

Nottinghamshire County Council/Nottinghamshire Healthcare NHS Foundation Trust

6.7. This was a joint IMR provided by the agencies based on Local Authority and Offender Health records.

6.8. Whilst in prison, In Reach Mental Health Services followed their established processes making appropriate referrals and partaking in risk management processes. The IMR found that there was substantial evidence that Mr HL's needs were identified and appropriately addressed. This included review by a consultant psychiatrist and at one point consideration and assessment in relation to a hospital transfer. Risks were clearly identified in both the internal risk assessment processes and as part of the Prison service Assessment Care in Custody & Teamwork (ACCT) processes. These risks were, on the whole, to himself. The IMR has determined that the identified risks were managed well and that despite transfers between establishments and care providers, pertinent information was communicated between them.

6.9. With regard to risk posed to others, this was identified during his forensic psychiatric assessment completed in 2012. This assessment found that Mr HL represented an ongoing risk of serious violent offences and that his risk of offending would increase should he return to drink or drug use and perhaps when faced with transitions or losses. Whilst the assessment clearly identifies these risks, due to the unavailability of clinical records, the IMR was unable to determine what was done with this information or with whom it was shared. Further assessment and hence formulation did not take place due to Mr HL's recall to prison.

6.10. The IMR has found that when Mr HL was referred to services these were provided in a timely and effective manner. However following his release from prison, no input was requested from agencies or from Mr HL himself until a point of crisis was reached (shortly before the domestic homicide). Analysis of the subsequent Mental Health Team – Social Care involvement indicates that there was evidence that the professionals involved recognised concerns and took steps to address these.

NHS England

6.11. Issues were identified regarding the involvement of different GPs affecting continuity of care and Mr HL's mother's involvement which resulted in an action of care of Mr HL without him being present.

6.12. GPs are the central hub for health information relating to an individual's ongoing health needs. Communication from specialist services is essential to ensure GPs have the full picture upon which to base clinical assessments.

6.13. Practice X felt that they would have found it useful to have had information from the Community Mental Health Team, Framework, MAPPA and in particular with the Prison Service including such items as a Psychiatrists Assessment Report and information pertaining to any medications taken.

6.14. The IMR identified that there was a lack of clarity in relation to the referral to psychiatric services following moving areas/changing of GP in 2010. This led to a delay in accessing help for Mr HL as this was not raised as an issue again until several months later. The letter of recommendation of referral to CMHT when Mr HL had moved was in December 2009; Mr HL registered at the new practice on 4th June 2010 and was referred on 27th July 2010. At the time records were not transferred electronically.

6.15. The IMR also found that within the GP records, medical problems should be recorded under clear "Problem Headers" giving the reader a concise medical history and alerting the reader to any ongoing or past problems quickly.

6.16. The role of GPs in the MAPPA process is now much improved, GP attendance is better and the MAPPA coordinator now has established means to liaise securely with all GP practices in the area.

HMP Nottingham

6.17. ACCT (Assessment Care in Custody & Teamwork) is a prison wide document that identifies those prisoners who self-harm, are suicidal or who staff feel may be at risk of either. It allows for a comprehensive assessment of the issues affecting the prisoner and requires the development of a care plan approach to try and deal with the issues. It is designed to be multi-disciplinary, involving those agencies that can help with the problems. During Mr HL's time in custody an ACCT document was repeatedly opened for short periods and then closed. This would give the impression that he has short periods of feeling low in mood, and ACCT is opened, support provided and the ACCT closed. There is no evidence in the records that any actual self-harm or suicide attempts take place. The IMR considered that there were issues identified by the Prison with regard to risk posed by Mr HL to himself

and that appropriate action was taken including referrals to prison mental health services.

MAPPA Overview

6.18. As part of this review, the Nottinghamshire MAPPA Coordinator completed a review of the MAPPA arrangements within this case. At no stage during Mr HL's period of supervision by the Probation Service, and hence the period to which he was subject to MAPPA management, was there any indication of a relationship with Ms MA or any other female.

6.19. **Referral:** The case was referred to Level 2 MAPPA on 1st November 2011 by the Probation Offender Manager. MAPPA Guidance 2009 specifies that cases should be managed at Level 2 where, in addition to presenting risk of harm, the case requires active involvement and co-ordination of interventions from other agencies to manage presenting risk of harm. The referral cited the serious nature of the index offence- a knife attack on a fifteen year old boy, concerns about alcohol use, mental health issues, Mr HL's admission he had been keeping a knife in his bedroom, and a background of discord within the community where Mr HL and his mother lived and which would affect his accommodation on release. The referral was appropriate and accepted by the MAPPA Unit.

6.20. **MAPPA administration:** all required standards were met. Minutes were produced on time, invites sent over 3 weeks before each meeting, VISOR records were maintained appropriately and archived on VISOR once Level 2 MAPPA management ended.

6.21. **Attendance:** The Probation Service, Prison Service, Gedling Homes and Nottinghamshire Police were invited to all three Level 2 MAPPA meetings. The Probation and Police services attended every meeting. The Prison Service did not attend any meetings but provided a report each time in line with their MAPPA Key Performance Indicator requirements. The GP for Mr HL was invited to the first meeting but did not attend. The family moved area following this and as Mr HL was not registered with a GP in the new area, there was no GP to invite to the subsequent meetings. Gedling Homes attended the initial Level 2 meeting but did not attend the next 2 meetings. Gedling Homes did however keep in regular contact with the Offender Manager outside of MAPPA meetings, and kept the Offender Manager updated as to their progress in assisting Mr HL's mother to move.

6.22. **Risk Management:** The main victim identified was the 15 year old victim of the GBH offence. Licence conditions were put in place excluding Mr HL from the home area and having contact with the victim, requests made by the victim and his mother. Police made contact with the Beat Manager where the victim lived to make them aware of potential risk issues. All other risk factors were adequately

considered by the MAPPA meeting with strategies to address them being put into place. Gedling Homes worked with Mr HL's mother to find long term suitable housing as she and Mr HL wished to reside together. Referrals were made to Community Mental Health Services and to Double Impact to address substance misuse, and Mr HL was instructed to reside in an Approved Premises due to a lack of appropriate release accommodation.

6.23. **Decisions:** At Level 2 meetings on 14th December 2011 and 22nd February 2012 the meeting took the decision to retain Mr HL at Level 2 MAPPA management. MAPPA guidance states that all cases should be managed at the lowest defensible level. At that time, there was further work to undertake in terms of referrals to mental health and substance misuse services, and to re-house Mr HL's mother, so the decision was defensible as the risk management plan was not, at that point, fully in place.

6.24. On 9th May 2012, Mr HL was reduced to Level 1 management. By this stage all agencies had completed all relevant actions for the release of Mr HL, agencies were actively working with Mr HL and working well together, and the risk management plan was in place. As agencies were actively involved, engaging with Mr HL and liaising with the Offender Manager as the lead worker, the Level 2 MAPPA structure was no longer required, as it would not have added value to the arrangements already in place.

6.25. **Actions:** all MAPPA actions set were relevant to the management of risk. All actions were completed in the timescales set in the meetings. It was also evident that there was ongoing communication between all agencies outside of the MAPPA meeting and agencies did not leave it until the next meeting to update the Offender Manager (as the lead worker), which is good practice.

The role of MAPPA will be further considered within the Overview Analysis.

7. Overview Analysis

7.1. This review has established that there was no professional knowledge of the relationship between Ms MA and Mr HL prior to the domestic homicide. There were no indicators or evidence of domestic abuse being a factor within their relationship at all. Very little is known about Ms MA and even less is known about the nature of her relationship with Mr HL. Although there were, at various points, concerns regarding the risk of harm that Mr HL might pose to himself or others, at no point was Ms MA known to be at risk of harm from him, or from anyone else for that matter.

7.2. As a result, this review has focused upon Mr HL and the agency involvement with him, with particular regard to risk management.

7.3. A number of themes/areas of learning have arisen from the review of this case. These can be summarised in the following headings:

- Lack of engagement
- Continuity of support
- Risk management
- Information sharing and recording
- Domestic abuse and the role of the Youth Court
- The use of DASH RIC

7.4. The findings made are highlighted within each theme.

Lack of Engagement

7.5. This review has indicated that Mr HL had a troubled early life. However a significant feature throughout was his lack of engagement with support services. The psychological assessment completed in 2008 found that Mr HL had insight into his difficulties and that he accepted that his avoidance behaviours did not help his situation, and that change would only occur if he committed to cooperating with interventions provided.

7.6. There is evidence to suggest that Mr HL could and would engage when he chose to do so i.e. he attended Cognitive Behavioural Therapy with the Child and Adolescent Mental Health Service whilst refusing to engage with substance misuse services as part of the Action Plan Order. His poor engagement led to breaches of the Order on two occasions.

7.7. Following his conviction for s18 wounding with intent, Mr HL was referred for appropriate support within prison including In Reach Mental Health Services and substance misuse services. His levels of engagement were again poor. Prison records indicate that rather than

address his difficulties; in particular those with other prisoners, Mr HL would try to have himself segregated or move prisons.

7.8. Mr HL was in breach of his licence on a number of occasions due to a failure to comply with the licence conditions, leading to him being recalled to prison twice.

7.9. Prior to the end of his sentence, although he was attending appointments with the In Reach Mental Health Services, it was recorded that he did not fully engage and displayed a negative attitude towards suggested therapies.

7.10. Mr HL had capacity to make choices and as such, his degree of cooperation with support services was well within his control. Although there is evidence of some psychological difficulties, Mr HL's level of functioning and lifestyle was not so inhibited or troubled to preclude him from engaging with services and nor was he diagnosed with a mental illness that would prevent him from working with the professionals who were attempting to support him. Mr HL never met the criteria to be compelled to engage with services (apart from when being a condition of his licence) – engagement had to be his choice. It is significant that Mr HL's difficulties and in particular his propensity for violence appeared to be linked to alcohol misuse and this is the area where he repeatedly failed to engage with support offered, including prior to final release from prison.

7.11. **Finding:** Even when appropriate interventions are put in place; outside of statutory provisions, these can only be effective if the subject chooses to engage and wishes to make, and sustain, changes. A recommendation has not been made from this finding as it is being addressed by the Domestic and Sexual Violence and Abuse Safeguarding Working Group who are looking at non enagement of vulnerable people with capacity.

Continuity of Support

7.12. The review has established that there were occasions where the continuity of support for Mr HL was compromised, in the main due to Mr HL moving addresses or custodial establishments. For example in 2010 he was seen by mental health services who recommended that he be referred by the GP to the County Community Mental Health Team as he was moving area. This did not occur and it was several months later that the new GP made the referral following Mr HL having presented for GP consultation.

7.13. Whilst in prison, Mr HL moved on many occasions, often at his own request, but this compromised the work that was put in place to address his offending behaviour and identified risk factors, including mental health support.

7.14. Although appropriate support was put in place once released into the community on licence, this too was disrupted by his recall to prison on two occasions.

7.15. Post release, at sentence end, it is evident that there were discussions regarding the need for ongoing mental health support, however the necessary referrals were not made by the Offender Manager.

Finding: Where possible, there is a need for planning for continuity of support services, at points of transition or movement. A recommendation has not been made from this finding but this report is shared with agencies who will be tasked to note the findings as well as recommendations and incorporate them into their core business.

Risk Management

7.16. Mr HL was managed by MAPPA at Category 2 (serious violent, terrorist or other sexual offender sentenced to 12 months or more in custody)**,** Level 2 MAPPA management following sentencing for s18 wounding with intent.

7.17. Levels of management are determined as being:

- Level 1: ordinary agency management – risks posed can be managed by the agency responsible for the supervision or case management of the offender

- Level 2: cases where the offender is assessed as posing a high or very high risk of harm; or the risk is lower but the case requires active involvement and coordination of interventions from other agencies to manage the presenting risks of serious harm, or the case has previously been managed at level 3, or multi-agency management adds value to the lead agency's management of the risk of serious harm posed.

- Level 3: cases where the management issues require senior representation from the Responsible Authority and duty to cooperate agencies. This may be when there is a perceived need to commit significant resources at short notice or where there is a high likelihood of media scrutiny or public interest in the case and a need to ensure public confidence in the criminal justice system.

7.18. At the MAPPA meeting held on 9th May 2012, the level was reduced to Level 1. This was appropriate given that relevant agencies were working with Mr HL and there was a risk management plan in place. In addition, he was to remain on licence until 2013.

7.19. The 2012 MAPPA statutory guidance states that when a MAPPA offender is recalled to prison, his or her MAPPA management level must be reviewed before release. The Offender Manager did complete the OASys final risk assessment two weeks prior to Mr HL's release, which includes specific questions with regard to MAPPA management. Mr HL was assessed as high risk of harm to the public.

7.20. When Mr HL was released from prison at sentence end, and therefore no longer subject to a licence, he was no longer a MAPPA Category 2 offender. Had consideration been given for MAPPA management upon release from prison, it would have to have been as a Category 3 offender[8].

7.21. All Category 1 and 2 offenders managed at Level 2 or 3 who are coming to the end of their notification requirements or period of statutory supervision must be reviewed and should be considered for registration as a Category 3 offender. However, Mr HL did not meet this threshold for statutory consideration at category 3 having only been managed at Level 1 prior to sentence end.

7.22. The National Offender Management Service MAPPA Level 1 Best Practice Guidance also published in 2012, states that:

Good practice ordinary agency management will, however, include information-sharing at least between the police and the probation service, especially for high risk of serious harm offenders.

7.23. In the case of Mr HL it may have been advantageous for there to have been discussion between the Police and the Probation Service prior to his release; despite there not being a statutory requirement to do so, especially given the OASys final risk assessment determining that he was a high risk offender. Locally, a pilot scheme between NPS and the Police is being established which will ensure that communication occurs. Offender Managers now inform the Police Intelligence Team of all releases at sentence end date (SED) of offenders who continue to pose an ongoing risk of harm and in particular all High Risk/Very High Risk of Harm offenders. The Intelligence team will then disseminate the information to the local police teams including front line staff in the relevant area so they are aware of their release.

[8] 3.1. The MAPPA statutory guidance states that Category 3 offenders are other dangerous offenders who do not meet the criteria for either category 1 or 2 but who are considered by the Responsible Authority to pose a risk of serious harm to the public which requires active multi-agency management.

3.2. To register a category 3 offender, the responsible authority must establish that the person has committed an offence which indicates that he or she is capable of causing serious harm to the public and reasonably consider that the offender may cause serious harm to the public which requires a multi-agency approach at level 2 or 3 to manage the risks.

7.24. In addition, the Community Rehabilitation Company (CRC) for Derbyshire, Leicestershire, Nottinghamshire and Rutland, which came in to operation in June 2014 is now responsible for delivering resettlement services to all prisoners in resettlement prisons. In the final 12 weeks before release a pre-release plan will be made. The plan will look at practical resettlement needs, and one of support as opposed to risk management. In preparation for release, the resettlement team can collate any relevant appointments; assist attendance at appointments and signpost to specialist services. Although this would have been of benefit to Mr HL in terms of support at sentence end and might have assisted in ensuring ongoing mental health support, it would have required his engagement and cooperation.

7.25. It is evident that concerns regarding Mr HL were becoming apparent in late 2014/early 2015. As a result discussions took place between agencies at the round robin meetings hosted by the Housing provider (Gedling Homes) and appropriate referrals were made to the Multiagency Safeguarding Hub and to the Vulnerable Persons Panel. The MASH referral then resulted in a referral to the Mental Health Team – Social Care.

7.26. The concerns however were predominately that of Mr HL's mental health and potential risk that he posed to himself rather than a risk to others. There was no indication that he posed a risk to his girlfriend Adult A or indeed to Ms MA. There was opportunity to assess any risk posed to his mother given her reports of being scared of her son but this did not occur (see section re DASH RIC below).

7.27. The panel has considered whether the possession of a samurai sword in January 2015 should have triggered a referral to MAPPA. The panel has found that the actions of the PCSO, in that a referral was made to the Vulnerable Persons Panel, plus the fact that the round robin meetings were considering all of the issues, was sufficient. Mr HL would not have met the criteria for MAPPA management at this stage, and there would have been little added value given the multi-agency liaison already in place.

Finding: The risk posed by Mr HL was managed in accordance with locally agreed processes and national MAPPA guidance. Recent local initiatives will strengthen information sharing for offenders who are released from prison at sentence end. As noted in the Changes to Practice section, pg.43 and the pilot is being monitored.

Information Sharing and Recording

7.28. The review has established that there was much evidence of information sharing and communication between professionals. There were examples of innovative practice such as the round robin meetings

and going forward the new initiatives being developed between National Probation Service and the police at sentence end. However there were also instances where communication and recording practices could have been improved.

7.29. It is significant that the forensic psychiatric report completed in 2012 was not evident in the GP or probation records. The loss of the Nottinghamshire Healthcare NHS Foundation Trust clinical notes for Mr HL makes it impossible to establish who the report was sent to, although normal practice would be for it to be sent to the referrer, in this case probation and the GP. The significance of this apparent omission is that the report determined an ongoing risk of harm, and identified triggers. The report findings and the identified triggers should and could have informed future risk management although it has been established by this review that the probation risk assessments identified risk appropriately.

7.30. Another example of a lapse in appropriate information sharing is that the GP did not receive minutes of the MAPPA meetings held in respect of Mr HL to which they were invited.

7.31. The review has considered much evidence of the mother of Mr HL making contact with agencies on his behalf or to express concerns about Mr HL and seek support. This is challenging in terms of consent to disclose information but may also have prevented a true understanding of Mr HL, given the influence of the accounts given by his mother.

7.32. The review has also established that there were opportunities to add flags or warning markers to the records of Mr HL, especially in relation to his mental health, both within police and GP systems.

7.33. With regard to records, the review has been disadvantaged by the lack of records available from the Nottinghamshire Healthcare NHS Foundation Trust and HMP Doncaster, a privately run prison.

Finding: Agencies must ensure that there is an audit trail in place for the distribution of reports/minutes and that relevant warning markers are added to records. A recommendation has not been made from this finding but this report is shared with agencies who will be tasked to note the findings as well as recommendations and incorporate them into their core business.

Domestic Abuse and the Role of the Youth Court

7.34. In 2007, Mr HL was a young person who harmed his 16 year old girlfriend when he himself was 17 years of age. The statutory definition of domestic abuse at the time excluded 16 and 17 year olds.

7.35. This was changed in 2013 to the following:

any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

7.36. In response, locally a care pathway for young people in intimate violent relationships has been developed (see appendix C).

7.37. Due to his age, Mr HL attended the Youth Court in respect of this incident, as would be the case today. However perpetrators aged 18 and over are dealt with locally by the Specialist Domestic Violence Court. The Youth Court does not have a domestic abuse specialism, or the expertise with regard to support pathways.

Finding: Perpetrators of domestic abuse aged 16 and 17 should be responded to within the criminal justice system with the same degree of specialist knowledge in respect of domestic abuse as those aged 18 and over.

The use of DASH RIC

7.38. The CAADA[9] Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Checklist is the multi-agency risk assessment tool used locally in cases of reported domestic abuse. This is well embedded, particularly within the police. However, it is less commonly used in cases of reported stalking and harassment, especially when the individuals are not in a relationship. The DASH RIC could have been utilised following the reports of alleged stalking perpetrated by Mr HL, as could the additional stalking specific risk assessment form[10], although neither are likely to have changed the outcome.

7.39. The mother of Mr HL indicated that she was scared of Mr HL to the PCSO and to Adult Social Care. It would have been good practice to have completed a DASH RIC in order to determine the level of risk to which she was potentially exposed.

[9] CAADA is now replaced by SafeLives
[10] S-DASH (2009) Risk Identification Checklist For use in Stalking and Harassment Cases

Findings: Practitioners should utilise the DASH RIC in cases of reported stalking and harassment.

When family members are reporting being fearful of someone they live with, the DASH RIC will help identify and determine the level of risk.

Good Practice

7.40. The review has considered that the actions of the Mental Health Team – Social Care are to be commended in terms of their swift response to the families increasing need.

7.41. The development of the round robin meetings as a forum to share information and concerns is also identified as an example of good interagency practice.

8. **Conclusions**

8.1. All of the agency information pertains to Mr HL and it is here that most of the learning from the case has arisen.

8.2. The significant difficulty within the case is how agencies can realistically identify and manage unpredictable and random acts of violence committed by a person with capacity[11]. Mr HL has a history of unprovoked violent attacks against people known to him, often when under the influence of alcohol. Due to this history, the focus of this review has been upon risk management.

8.3. Two psychiatric assessments of Mr HL were completed as part of the criminal proceedings following Ms MA's death. Copies were requested to inform this review, however Mr HL refused to give consent for their release, either for this review or to agencies aiming to support him. When sentencing Mr HL, the Judge referred to one of the assessments which diagnosed Mr HL with an antisocial personality disorder. It is evident that Mr HL has demonstrated personality traits that would pose a significant challenge to agencies in terms of engagement and reduction of risk, especially a risk to the general public.

8.4. There are clear and established processes in place to manage risks posed to an identified individual or individuals. The challenge here is how to manage a more generic and unpredictable risk. In order to formulate a robust risk assessment the following factors must be established: the nature of the risk; who is at risk and in what circumstances. These factors were not easily identifiable in the case of Mr HL. It is evident that Mr HL himself maintained responsibility to manage the risk that he posed.

8.5. It is the DHR panel view that agency responses, as outlined through this review, were proportionate and appropriate, and emerging concerns were being considered within the right processes, although there were instances where practice could have been improved. The DHR panel has found that agency responses could not have impacted upon or prevented the death of Ms MA. The relationship between Mr HL and Ms MA was not known, even to some of those friends and family close to them. The risk that Mr HL posed to Ms MA was unknown to agencies and his actions towards her could not have been predicted.

[11] Under mental health legislation

9. Recommendations and Actions from Previous Domestic Homicide Reviews

9.1. Although some of the themes identified in this review have occurred in other domestic homicide reviews undertaken locally such as information sharing, non-engagement and the use of drugs and alcohol, the recommendations and actions arising from those reviews would have had no bearing upon this case.

9.2. It has been agreed that the Crime and Drugs Partnership will seek assurance regarding agency responses to persistent non-engagement, as identified in previous reviews.

10. Changes to Practice

- The role of GPs in the MAPPA process is now much improved, GP representation is better and the MAPPA coordinator now has established means to liaise securely with all GP practices in the area.

- Locally, a pilot scheme between the National Probation Service and the police is being established which will ensure that communication occurs at sentence end for high risk offenders. Offender Managers must now inform the Police Intelligence Team of all releases at sentence end date (SED) of offenders who continue to pose an ongoing risk of harm and in particular all High Risk/Very High Risk of Harm offenders. The Intelligence Team will then disseminate the information to the local police teams in the relevant area so they are aware of their release.

- Over recent months there has been a national review undertaken around MAPPA eligibility. Whilst this work is still in progress it has been agreed that there will be an updating and additional guidance for the management of offenders at level 1 and for those being considered for category 3.

- A separate national piece of work is also underway reviewing recall processes with a view to ensuring that more recalled offenders are released prior to licence end albeit for a short period to allow a period of supervision with a view to helping them reintegrate. Additional guidance on this and training will be provided from April 2016 onwards.

- The Community Rehabilitation Company (CRC) is now responsible for delivering resettlement services to all prisoners in resettlement prisons. In the final 12 weeks before release a pre-release plan will be made. The plan will look at practical resettlement needs, and one of support as opposed to risk management. In preparation for release, the resettlement team can collate any relevant appointments; assist attendance at appointments and signpost to specialist services.

- The new Protocol on the Appropriate Handling of Stalking Offences, which has been jointly drafted and agreed by the CPS and ACPO, focuses strongly on the needs of stalking victims. The protocol also instructs prosecutors to apply, where possible, for restraining orders on both conviction and acquittal in order to protect the ongoing safety and security of victims. Restraining orders on acquittal can be an added protection for victims in situations where the likelihood of abuse may be 'beyond the balance of probabilities', a lower standard of proof than that usually required in criminal convictions of 'beyond reasonable doubt'.

11. Recommendations

11.1. Each agency retains responsibility for the implementation of actions arising from their IMR. In addition, the Crime and Drugs Partnership Domestic Homicide Review Assurance, Learning and Implementation Group provides scrutiny and quality assurance of these agency actions.

11.2. Given the changes in practice identified above and the fact that some findings did not result in an identified need for a recommendation, the recommendations arising from this review are few in number. Although they will improve practice going forward, their implementation would not have altered the outcome in this case. The recommendations are for Nottingham as this is where Ms MA resided. However Mr HL resided in a different Local Authority area and as a result of this, this report and its findings will be shared with the relevant community safety partnership boards for them to consider the recommendations locally.

11.3. The recommendations arising from this review are as follows:

a. Agencies will provide assurance that practitioners have an awareness of the DASH RIC and the S-DASH[12], as well as how and in what circumstances they should be used.

b. Agencies should ensure a refresh of the training regarding the DASH RIC and consider its use for familial domestic violence and abuse, including parents.

c. Young persons who harm aged 16 and 17 should be responded to with the criminal justice system with the same degree of specialist knowledge in respect of domestic abuse as those aged 18 and over.

d. Agencies should also ensure that they have appropriate information sharing policies in place that make reference to third party information.

[12] S-DASH (2009) Risk Identification Checklist For Use in Stalking and Harassment Cases

Appendix A- Terms of Reference

Domestic Homicide Review
March 2015
Terms of Reference Operation Hoplite[13]

Legal Basis of the Review:

The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the *Domestic Violence Crime and Victims Act 2004* which came into force on the 13th April 2011.

Multi-agency statutory guidance for the conduct of DHRs has been issued under Section 9 (3) of the *Domestic Violence Crime & Victims Act 2004*. Section 4 of the act places a duty on any person or body named within that section (4) to have regard to the guidance issued by the Secretary of State. The guidance states that the purpose of a DHR is to:

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

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

3. Apply these lessons to service responses including changes to policies and procedures as appropriate, and

4. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

The Nottingham Crime & Drugs Partnership (CDP) Board commissioned and then agreed its policy for conducting Domestic Homicide Reviews on 25th July 2011. The policy adopts the national guidance and sets out local procedures for ensuring that the principles of the guidance are adopted and followed through each Domestic Homicide Review. Local Domestic Homicide Review Guidance was refreshed and signed off by the CDP Board on the 2nd March 2015.

Instigation of the Review:

The Chair of the Nottingham Crime & Drugs Partnership was notified by letter dated 10th February 2015 from Detective Chief Inspector Simon Firth the Senior Investigating Officer, EMSOU Nottinghamshire Police of a death

[13] Version 5_13th January 2016

resulting from domestic violence. The circumstances of the death fall within Section 9 of the *Domestic Violence Crime & Victims Act 2004* which required consideration of conducting a Domestic Homicide Review. A DHR 1 Notification form, setting out the circumstances leading to the death is attached at **Appendix A.** This outlines Nottinghamshire Police's initial briefing and provides additional information about the case.

The Chair of the Nottingham Crime & Drugs Partnership considered the notification, following a recommendation made by the Nottingham City Adults Safeguarding Partnership Board Serious Case Review (NCASPB SCR) subgroup. The CDP Chair agreed to invite Carolyn Carson, of CDC Reports Ltd to act as independent chair for the DHR review panel. The rationale for this decision was:

1. To enable consistency in the oversight of Domestic Homicide Reviews within the city of Nottingham.

2. Carolyn Carson has evidenced she is someone with the requisite skills, knowledge and experience to take the responsibility. (As set out in paragraph 5.10 of the guidance)

3. The appointee is independent and has no known conflict of interest which would prevent her from chairing the review panel and is not directly associated with any of the agencies involved in this review.

It is the responsibility of the chair of the DHR Review Panel to ensure that she and the panel consider in each homicide the scope of the review process, draw clear terms of reference and consequently report progress to the Chair of the CDP Board.

The initial stakeholder group has been identified as:

- The immediate surviving family members of the victim and offender where appropriate.
- Nottinghamshire Police
- Office of the Nottinghamshire Police and Crime Commissioner
- The Crown Prosecution Service
- Nottingham Coroner
- Departmental Directors of Nottingham City Council
- Women's Aid Integrated Services
- NHS England
- Nottingham City Clinical Commissioning Group
- Nottinghamshire Healthcare NHS Trust
- Nottingham City and Nottinghamshire County Council Public Health
- The Crown Court
- The Magistrates Court
- HM Courts Service
- The Chair of the Nottingham Crime & Drugs Partnership
- Nottingham Crime & Drugs Partnership Board members
- The Home Office
- The Senior Investigating Officer (SIO), Nottinghamshire Police

- The Family Liaison Officer, Nottinghamshire Police
- Registered Social Landlords
- Nottingham City council Adults social care
- Nottingham City council Children's Social Care
- Nottingham CityCare
- Nottinghamshire County Council Adults Social Care
- Nottinghamshire County Council Children's social care
- Nottinghamshire North and East Clinical Commissioning Group
- HM Prison Nottingham
- Gedling Homes
- Gedling Borough Council
- Nottingham City and Nottinghamshire County Youth Offending Service
- Double Impact

It is the intention of the Chair of the DHR that the Review Panel shall engage with the stakeholder group. It is from the stakeholder group that representatives of the Panel will be selected in accordance with the CDP policy. The Independent Author and Independent Chair of the Panel will visit the designated family contact of the victim and offender to outline the purpose of the Review Panel and ensure that the final outcomes are shared with the family prior to publication. Any contact with the family will be in consultation with the SIO and Family Liaison Officer.

The Chair of the Nottingham Crime & Drugs Partnership has made available some resources to undertake the review and will receive the final overview report from the Chair of the Review Panel. Partners will be approached to provide funding for a report author to be commissioned by the CDP on behalf of the Partnership. The Nottingham Crime & Drugs Partnership accepts responsibility including the preparation, agreement and implementation of an action plan to take forward the local recommendations which emerge from the Review Report.

The review will follow the key processes which are outlined in the multi-agency statutory guidance for the conduct of DHRs as supported by the recently agreed 'DHR Practice Guidance'.[14]

Scope of the Review:

Persons Covered by the Review:

Full anonymity of those subject to the review will be applied throughout. The principal focus of the review will be the victim, and she will be referred to as Ms MA. The DHR panel send their sincere condolences to the victim's family.

The offender in this case will be referred to as Mr HL. Should the Panel consider it necessary, on evidence and reflection, to extend the scope of the

[14] Ratified by the Nottingham City Crime and Drugs Partnership on the 2nd March 2015.

review to cover other relevant persons, the terms of reference may be amended by the Panel at a future date.

Review Period:

The scoping period covered by the review will cover events from 1st January 2007, this being the earliest known date whereby domestic violence may be attributed to the offender Mr HL; at a point when he was 17 years of age. Should it prove that meaningful learning can be captured in a shorter time period; the scoping period can be amended accordingly.

If the Panel considers it necessary, on evidence and reflection, to extend the scoping period the terms of reference may be amended accordingly. Authors of independent management reviews must provide, in any event as part of their IMR, a summary of all relevant information prior to that date.

The Chronology will therefore cover events from 1st January 2007. However, any relevant/significant information known to an agency prior to 1st January 2007 will be included in the chronology.
The detailed Individual Management Reviews (IMRs) will cover events from 1st January 2007. However, any relevant/significant information known to an agency prior to 1st January 2007 will be included in the Agency IMR.

The panel agreed to the above timescales due to the amount of detailed relevant information that would be collated and made available for meaningful analysis.

Terms of Reference of the Review:

Matters for Authors of IMRs:

1. To identify all incidents and events relevant to the named persons (Ms MA and Mr HL) and identify whether practitioners and agencies responded in accordance with agreed processes and procedures at the time of those incidents.

2. To establish whether practitioners and agencies involved followed appropriate inter-agency and multi-agency procedures in response to the victim's (Ms MA) and/or offender's (Mr HL) needs.

3. Consider the efficacy of IMR Authors' agencies involvement in the Multi Agency Public Protection Arrangements (MAPPA) process, and/or management of dangerous person's processes.

4. Establish whether relevant single agency or inter-agency opportunities to respond to concerns about the victim, (Ms MA) and the assessment of risk to her and risk to others was considered and appropriate.

5. Establish whether relevant single agency or inter-agency opportunities to respond to concerns about the offender, (Mr HL) and the assessment of risk to him and his risk to others was considered and appropriate as a young person or adult.

6. To what extent were the views of the victim (Ms MA) and offender (Mr HL), and significant others, appropriately taken into account to inform agency actions at the time.

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

8. Identify any gaps in, and recommend any changes to, the policy, procedures and practices of the agency and inter-agency working with the aim of better safeguarding families and children where domestic violence is a feature in Nottingham City and Nottinghamshire.

9. Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their responsibilities and duties to work together to manage risk and safeguard the victim Ms MA, and the wider public.

10. To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring/reappearing in this review; taking into account if and when these actions were implemented within the agency.

In addition to the detailed IMR, authors should ensure that they include at least one paragraph in response to each of the terms of reference above. This will assist in the writing of the final report.

IMR authors should use DD/MM/YYYY format for dates to assist with the writing of the final report.

<u>Matters for the Review Panel to Consider:</u>

Identify on the basis of the evidence available to the review whether there were any modifiable circumstances that could have prevented the homicide with the appropriate improving policies and procedures in Nottingham City and, if applicable, in the wider county of Nottinghamshire.

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

<u>Excluded Matters:</u>

The review will exclude examination of how the victim, Ms MA, died or who was culpable; these are matters for the Coroner and criminal courts respectively to determine. In addition, there should be an exclusion of details of personal health information relating to the victim or offender which are not relevant to the circumstances of the case.

Families and Significant Other involvement:

The family will be offered the opportunity to contribute to this review via a meeting with the Independent Author and the Chair of the Review Panel. Following the completion of the reports a further meeting will be offered to share the outcomes of the review and to provide a copy of the executive summary. However contact with the parties will not be undertaken without prior discussion and agreement with the Senior Investigating Officer in Nottinghamshire Police due to the ongoing criminal process.

Again in consultation with the SIO, the panel may designate that significant other persons may also be invited to contribute to the review and be interviewed by the DHR Author and DHR Chair.

All information obtained from third parties will be shared with the prosecution team.

Previous DHR recommendations and actions

To identify any recommendations and actions from previous Domestic Homicide Reviews that are recurring/reappearing in this review. Taking into account if and when[15], these actions were implemented within the agency and how to address any repetition.

Document security, Preparation of Individual Management Reviews and Interviewing of Staff

Agencies should arrange for all records connected with the individuals covered by the review to be secured.

Agencies will be required to submit chronologies of their involvement with the individuals who are subject to the review in advance of their Individual Management Review, as agreed by the panel on the meetings schedule.

Agencies should immediately consider which staff they wish to engage with as part of their Individual Management Review and prepare to forward their names to the Chair of the Review Panel on Request.

Media Strategy

[15] The recommendation/action from the previous DHR may not have been specific to that agency when the action plan was agreed/the agency was not involved in that DHR Review.

The development of the media strategy will be led by Nottingham CDP to provide an effective joint handling of the media tailored to the circumstances of the DHR. Taking into consideration what information can be shared and when, where criminal and coroners proceedings are still taking place. Please refer to the DHR Hoplite Media Strategy for further information.

Membership of the Review Panel:

Carolyn Carson,	Independent Chair
Jane Lewis	Nottingham Crime and Drugs Partnership
Paula Bishop	Nottingham Crime and Drugs Partnership
Hayley frame	Independent Author
Mel Bowden	Nottinghamshire Police
Julie Burrton	National Probation Service - Nottinghamshire
Julie Gardner	Nottinghamshire Health Care NHS Trust
Val Lunn/ and Rebecca Smith	Chief Executive/Head of Service (Nottingham City IDVA) Women's Aid Integrated Services
Sue Barnitt	CityCare (representing as the DHR Assurance and Learning Implementation Group Chair)
Natalie Snell	MAPPA Unit
Nichola Bramhall	Nottinghamshire North and East Clinical Commissioning Group
Clive Chambers	Nottingham City Council Children's services
Wendy Adcock	Nottinghamshire County Council Adults Services
Nik Foster	HM Prison Nottingham
Danielle Burnett	NHS England
Jacquie Beacroft	Gedling Homes
David Jayne	Community Safety and Safeguarding Manager, Gedling Borough Council

Document Marking:

All matters concerned with the review process will be considered to be Confidential. The transport and transfer of these documents should be in accordance with property marking schemes security guidance.

All agencies involved are reminded of the sensitivity of the information which they will become familiar with and have access to during the conduct of the review panel work. All matters coming into the possession of the panel will potentially be disclosable in any criminal or civil proceedings which may be associated with this case.

The Chair will take personal responsibility to ensure the SIO/Disclosure Officer are informed of the findings of the Review Panel; for them to liaise with their CPS colleagues to assess and guide the likely impact on any criminal proceedings.

Appendix B1 – Request to the CDP Board for the delay in planned work by the DHR Hoplite panel

Nottingham Crime & Drugs Partnership

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

CDP BOARD ITEM NO. 9
23rd September 2015

Domestic Homicide Review Operation Hoplite - update.
AUTHOR OF REPORT: PAULA BISHOP
Sponsor of Report: Candida Brundenell

1.0 PURPOSE OF THE REPORT:

1.1 To update the CDP Board on the progression of the Domestic Homicide Review Operation Hoplite.

1.2 To inform the CDP Board of the delay in the proposed time frame for the completion of this review and submission to the Home Office Quality Assurance Panel.

2.0 BACKGROUND:

2.1 On the 6th March 2015 the CDP Board were notified via email of the commencement of Domestic Homicide Review (DHR) Operation Hoplite after the Chair of the CDP Board had agreed the recommendation from the DHR Panel.

2.2 The initial date for the completion of DHR Operation Hoplite was September 2015. This was in accordance with the Home Office Multi-Agency Statutory Guidance to have the DHR completed within six months of the CDP Board's decision to proceed with the review.[16] However, due to the fact that criminal justice proceedings in relation to this case are still ongoing the proposed completion date has now been amended to 13th January 2016.

2.3 The DHR Panel have a statutory duty to inform the CDP Board of the progress of DHR Hoplite including any delays in the completion of the review. This report sets out the reasons for the delay.

2.3.1 The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Revised applicable to all notification made from and including 1st August 2013' states the following:
"It is acknowledged that some DHRs will necessarily go beyond this further

[16] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Revised applicable to all notification made from and including 1st August 2013. Home Office, 26th June 2013, Paragraph 42, page 15

six month timescale due to the complex scope of the DHR and/or due to on-going criminal justice proceedings. If the CSP believes that the delay to completion of the review is unreasonable, they should refer the issue to the Quality Assurance Panel for further advice." Paragraph 42, page 15.
And

"The Independent Overview Report Author should, in their final Overview Report, make reference to any requests to delay the planned work of the DHR panel, and include a copy of the written request as an appendix so that it can clearly be understood why the request was made." Paragraph 80, page 21.

3.0 CURRENT CONTEXT FOR DHR HOPLITE:

3.1 The initial trawl for information identified the scope of the review which, in the case of the offender, required the involvement of agencies from both Nottingham City and Nottinghamshire County. The victim was not known to any agencies from either area. Due to the involvement of more than one local authority the review will inevitably be more complex.

3.1.1 Colleagues from agencies within Nottingham City and Nottinghamshire County are reviewing information to determine the key themes and learning from this review. However, some information has resulted in requests for further details from other agencies/processes/independent bodies to aid understanding and to ensure that the DHR Panel are fully informed.

3.1.2 As a result, this has meant that information is being requested later than originally planned, which has impacted on the timeframes for writing the first draft of the Overview Report for DHR Hoplite.

3.1.3 Information that is still required to ensure that all panel members are fully informed is:

1. Report from Nottinghamshire County Multi-Agency Safeguarding Hub (MASH) about their processes and thresholds
2. Report from HM Prison Nottingham
3. Independent report from the National Offender Management Service (NOMS), based in London.

3.1.4 We are currently in the process of obtaining this information for the fourth DHR panel meeting on the 3rd November 2015.

3.2 DHR Hoplite has been running parallel with the criminal proceedings for this case. The matter was initially set to go to trial on the 4th August 2015, however, on the 25th June 2015 the offender attended a plea hearing and the trial was postponed to enable a psychiatric assessment of the offender to be completed. A decision will be made in September/October 2015 as to whether the case will go to trial.

1.3 Following Home Office guidance, family and friends of both the victim and the offender have been informed of the DHR process by letter and advised that if they wish to be part of the review then the DHR Panel would welcome their

input but that this cannot be done until criminal proceedings are complete.

3.3.1 The victim was not known to services and the panel are concerned that her voice will not be in the report if the Independent DHR Chair and Independent DHR Author do not meet and speak with her family and friends in order to gather further information.

3.4 Taking these factors into account the Independent DHR Chair, Independent DHR Author, DHR Panel and CDP staff supporting the process propose to extend the time frame for the completion of this review to the 13th January 2016. This will allow time for all of the required information to be collected, the respective families to be spoken to, the Overview Report to be written and the DHR panel to agree the recommendations. The final draft of the Overview Report will be presented to the Chair of the CDP Board on the 27th January 2016 in order to be signed off on behalf of the Board for submission to the Home Office Quality Assurance Panel. The Overview Report will be presented to CDP Board members at the meeting on the 21st March 2016.

4.0 RECOMMENDATIONS:

4.1 That the CDP Board notes the content of this report.

4.2 That the CDP Board agree with the new timeframes to enable information to be collected from agencies and furthermore to allow information from family and friends of both the victim and offender to be sought once criminal proceedings are complete.

Appendix B2 – Response from the CDP Board for the delay in planned work by the DHR Hoplite panel

Nottingham Crime & Drugs Partnership

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

NOTTINGHAM CRIME & DRUGS PARTNERSHIP BOARD MEETING

WEDNESDAY 23RD SEPTEMBER 2015 12:30-2:30PM

BOARD ROOM, CDP, SHIRE HALL

Chair:

JC	Cllr Jon Collins, Leader, Nottingham City Council

Attendees:

CB	Candida Brudenell, Assistant Chief Executive/Strategic Director of Early Intervention, Nottingham City Council
MM	Mike Manley, Temp Chief Superintendent, Nottinghamshire Police
NM	Nick Murphy, Chief Executive, Nottingham City Homes
NW	Nicola Wade, Office of the Police and Crime Commissioner
CO	Christine Oliver, Head of Service, Nottingham Crime & Drugs Partnership
TS	Tim Spink, Head of Service, Nottingham Crime & Drugs Partnership
AC	Alison Challenger, Interim Director of Public Health, Nottingham City Council
CK	Caroline Keenan, Senior Performance & Insight Analyst, Nottingham Crime & Drugs Partnership
WB	Wayne Bowcock, Deputy Chief Fire Officer, Nottinghamshire Fire and Rescue Service
BW	Ben Wild, Interim Operations Director, DLNR Community Rehabilitation Company
AE	Andrew Errington, Director of Community Protection, Nottingham City Council
NH	Nigel Hill, Director, Head of Nottinghamshire National Probation Service
NHe	Cllr Nicola Heaton, Nottingham City Council
AT	Professor Andromachi Tseloni, Nottingham Trent University
DS	Dawn Smith, Chief Operating Officer, Nottingham City Clinical Commissioning Group

Minutes: Philip Broxholme, Nottingham Crime & Drugs Partnership

Apologies:

CW	Ceri Walters, Strategic Finance, Nottingham City Council
KD	Kevin Dennis, Office of the Police and Crime Commissioner

1.0 Introductions, Apologies and Declarations of Interest

1.1 The Chair opened the meeting. Apologies were noted.

2.0 Previous Minutes of the Board from 8th June 2015

2.1 The minutes of the CDP Board meeting held on 8th June 2015 were accepted as a true reflection of the meeting.

3.0 Matters Arising

3.1 All actions from the previous meeting have been discharged.

9.0 DHR Hoplite

9.1 TS summarised a report outlining the reasons for the delay in the progress of this review.

9.2 NH asked what information the DHR Chair was waiting for from the National Offender Management Service (NOMS). TS agreed to discuss this with the DHR Chair and update NH.

THE CDP BOARD NOTED THE CONTENT OF THE REPORT AND APPROVED THE EXTENSION REQUESTED FOR SUBMISSION OF THE OVERVIEW REPORT

Appendix C - Action Plan – specifics of action plan to be determined by the Domestic Homicide Review Assurance and Learning Implementation Group

	Recommendation	Rationale for Recommendation	Scope of recommendation i.e. Local, regional or national	Action to take	Lead Agency	Target Date	Date of completion	Evidence
1	Agencies will provide assurance that practitioners have an awareness of the DASH RIC and the S-DASH[17], as well as how and in what circumstances they should be used.	There were times where Mr HL's mum told agencies (Police/PCSO, Social worker, Housing provider) that she was scared of her son but a DASH RIC was not completed. Mr HL harassed / stalked a woman and a DASH RIC was not completed or the additional S-	Local	To present an overview of the learning and the rationale from this DHR and recommendations 1 and 2 to the DSVA Strategic group. To request assistance with engaging partner agencies to seek assurance that they have raised awareness about how and when to use the DASH RIC and S-DASH and they have supported staff to	DSVA Strategy Group Members, NPS and DLNR CRC	Feb 2017		

[17] S-DASH (2009) Risk Identification Checklist For Use in Stalking and Harassment Cases

	Recommendation	Rationale for Recommendation	Scope of recommendation i.e. Local, regional or national	Action to take	Lead Agency	Target Date	Date of completion	Evidence
		DASH (with the further specific 11 questions).		have a refresh of training for the DASH RIC and S-DASH. The DHR ALIG need the support and assistance from the DSVA Strategy group (and safeguarding board?) for wider partnership assurance to achieve this recommendation.				
2	Agencies should ensure a refresh of the training regarding the DASH RIC and consider its use for familial domestic violence and abuse, including parents.	There were times where Mr HL's mum told agencies (Police/PCSO, Social worker, Housing provider) that she was scared of her son but a DASH RIC	Local	To present an overview of the learning and the rationale from this DHR and recommendations 1 and 2 to the DSVA Strategic group. To request assistance with engaging partner	DSVA Strategy Group Members, NPS and DLNR CRC	Feb 2017		

	Recommendation	Rationale for Recommendation	Scope of recommendation i.e. Local, regional or national	Action to take	Lead Agency	Target Date	Date of completion	Evidence
		was not completed. Mr HL harassed / stalked a woman and a DASH RIC was not completed or the additional S-DASH (with the further specific 11 questions).		agencies to seek assurance that they have raised awareness about how and when to use the DASH RIC and S-DASH and they have supported staff to have a refresh of training for the DASH RIC and S-DASH. The DHR ALIG need the support and assistance from the DSVA Strategy group (and safeguarding board?) for wider partnership assurance to achieve this recommendation.				
3	Young persons who harm aged	There was an incident when Mr	Local	For the CDP commissioning team	CDP, WAIS,	Feb 2017	25th May 2016	Complete. Although it is not part of the

	Recommendation	Rationale for Recommendation	Scope of recommendation i.e. Local, regional or national	Action to take	Lead Agency	Target Date	Date of completion	Evidence
	16 and 17 should be responded to with the criminal justice system with the same degree of specialist knowledge in respect of domestic abuse as those aged 18 and over.	HL had assaulted his 16 year old girlfriend when he was 17. Now processes are in place for supporting young people experiencing DVA in their own intimate relationships. However, it has come to light that the youth court does not provide IDVA / DSVA specialist support or training to court staff around this. Meaning that although pathways are in		to address. To reconfigure the court IDVA work and get the youth court to inform the court IDVA in advance of upcoming cases to ensure support to the court and survivor.	Youth Court			service specification it is part of good practice and WAIS have made links with the Youth Court. An IDVA can be made aware when there is a case and attend court. WAIS are monitoring the number of cases so they can identify if it is a regular occurrence and there is a need for a Youth Court IDVA.

	Recommendation	Rationale for Recommendation	Scope of recommendation i.e. Local, regional or national	Action to take	Lead Agency	Target Date	Date of completion	Evidence
		place, effective measures to support the young person who harms to make changes/hold him/her to account is not happening and the survivor is not receiving the appropriate support.						
4	Agencies should also ensure that they have appropriate information sharing policies in place that make reference to third	A Third party is providing information to a professional and they should not be discussing this. Unless Safeguarding	Local	To seek assurance from agencies regarding disclosure from third party sources, that if risk of potential harm is identified to adhere to local safeguarding	DSVA Strategy Group Members, NPS and DLNR CRC			

	Recommendation	Rationale for Recommendation	Scope of recommendation i.e. Local, regional or national	Action to take	Lead Agency	Target Date	Date of completion	Evidence
	party information.	concerns have been raised.		procedures.				

Appendix D - **The Nottingham City Pathway for Young People in Intimate Violent Relationships**

Nottingham City Council now has a trained **Young People's Violence Advisor (YPVA) (Teen Advocate)** employed by Women's Aid Integrated Services (WAIS) to develop a consistent response to young people who are experiencing relationship abuse, aged between 13 and 17. The YP Violence Advocate directly supports young people and trains staff working in Nottingham City on how to use the YP DASH RIC.

Nottingham City Council has adopted the Care Pathway developed by Nottinghamshire County Council has, in partnership with third sector colleagues. This **Consistent Care Pathway** describes the involvement of Children's Social Care, the Multi-Agency Risk Assessment Conferences (MARACs) and Domestic Violence Specialists in working together to provide a safe and supportive response to teenagers experiencing relationship abuse. **This could include domestic abuse, gang-related violence, 'honour'-based violence, forced marriage and cyber stalking.**

The pathway was launched (in the County) in May 2013 in response to:

• The recent change to the definition of domestic abuse to include 16-17 year olds.

• The inclusion of MARACs in Ofsted's joint inspections of multi-agency arrangements for the protection of children.

• The scale and severity of the abuse: 75,000 children and young people's cases were identified at MARACs in 2012 while 67% of teenagers in adult Independent Domestic Violence Advisor (IDVA) services are experiencing strangulation, rape, broken bones and stalking.

• The growing recognition of the overlap between different forms of violence and abuse in young people's relationships.

Young People Who Harm

The pathway is for use with *victims* of Domestic Violence and Abuse under the age of 18. Where the "perpetrator" is also under the age of 18 they should be referred to as a "**young person who harms**" and we should consider their safeguarding also.

There should be consideration of a referral to the DART where safeguarding risks are identified, and/or where the young person who harms would be willing to engage in support to reduce their harming behaviour. This should be done in additional to any Police involvement required in relation to criminal behaviour of the young person.

Referral Contact Details

Children and Families Direct - Tel: 0115 876 4800,
Email: candf.direct@nottinghamcity.gcsx.gov.uk

Women's Aid Integrated Services (WAIS), Teen Advocate - Tel: 0115 822 1760

DART and MARAC – Tel: 0115 9150494,
Email: dart@nottinghamcity.gcsx.gov.uk, Fax: 0115 8762927

Disclosure of intimate partner violence and abuse from a young person

Significant Safeguarding Concerns Make a referral to Children and Families Direct (C&F Direct) Tel: 0115 876 4800

RED

Complete **Young Peoples' Safe Lives** (Formerly CAADA) **DASH Risk Identification Checklist** (RIC)

Amber

Medium or Standard Risk Refer to Women's Aid Integrated Services **Teen Advocate** (YPVA) – Tel: 0115 822 1760

HIGH RISK (C & F Direct)

HIGH RISK (DV Specialist)

Young person under 16 refer to Children & Families Direct

Children and Families Direct allocated to case as lead professional and Teen Advocate contacted to co-work

Children's Assessment completed

CIN/ICPC/CP meeting with relevant agency involvement in writing CIN/CP plan to address risks identified by the RIC

CIN/CP plan implemented by CSC, Teen Advocate and partner agencies

DART

The DART contacts the referrer and YP or parent for consent, where it is safe to do so. **Referral made to Teen Advocate. If unable to gain consent referral made to Children and Families Direct** The DART will inform Children & Families of the high risk referrals to the MARAC for 16-17 year olds

All High Risk referrals for Young people aged 16 - 17 refer directly to **MARAC –** email: dart@nottinghamcity.gcsx.gov.uk Fax 0115 8762927

The Teen Advocate or IDVA allocated and makes contact with the YP prior to MARAC

Teen Advocate risk assesses and starts safety plan and opens a CAF

Teen Advocate or IDVA represents YP at the MARAC and action plan to reduce risk is developed

YP engages with Teen Advocate /IDVA

Teen Advocate coordinates an initial CAF with all relevant agencies to put together a plan including actions from MARAC

YP declines Teen Advocate /IDVA support

Teen Advocate refers case back to the DART. Children & Families Direct allocated to complete assessment and coordinate a multi-agency strategy meeting

RISK REDUCTION

The Teen Advocate supports all referrals – Standard, Medium and High Risk.