Anonymised for publication and dissemination

DHR Loam

TINA

Died Spring 2019

Domestic Homicide Review

Nottingham Crime and Drugs Partnership

Independent Author and Chair: Hayley Frame

Report Dated: 11th May 2021

Amended: July 2022

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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 the 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.

Persons Covered by the Review

1.3. The principal focus of the Review is the victim, a female who, is referred to as Tina[1]. The other involved adult is the perpetrator, Tina's partner, a male referred to as ADULT A.

1.4. The criminal investigation has now concluded and in November 2019 ADULT A was found guilty of murder and was sentenced to life imprisonment with a minimum of 18 years to be served.

Confidentiality

1.5. The victim, Tina, was 64 years of age at the time of her death. She was White British.

1.6. The perpetrator, ADULT A, was 51 years of age at the time of the fatal incident. He is White British.

1.7. Only those agency representatives that formed part of the DHR panel had sight of this report prior to its presentation to the Nottingham City Crime and Drugs Partnership Board who approved its submission to the Home Office. All agency representatives are bound by confidentiality.

Review Period

1.8. The scoping period covered by the review will cover events from 17/11/2013 which is the earliest known date when domestic violence was identified between the subjects of the review

[1] This is a pseudonym chosen by the victim's family

until the date of Tina's death. Additional relevant information outside of the scoping period has also been incorporated into this report (section 3).

Timescales for the review

1.9. The review commenced on 5th November 2019 and was completed on 21st June 2021. The delay in the completion of this report has been as a result of two significant factors – the Covid 19 pandemic and the ill health of the Independent Author.

Methodology

1.10. Consideration of a Domestic Homicide Review was made, following receipt of a notification on 12th June 2019 from the senior investigating officer, EMSOU Lincolnshire Police of a death resulting from domestic violence. The decision to conduct a DHR was made on 24th July 2019.

1.11. Agencies identified completed an Individual Management Review report or a Summary Report and were represented on a DHR Panel convened to oversee the Review. Hayley Frame, Independent Safeguarding Consultant, was appointed as the Independent Chair and Author for this DHR.

Terms of reference

1.12. The following case specific areas were addressed in the Individual Management Reviews and have shaped the analysis of this Overview Report:

- To identify all incidents and events relevant to the named persons and identify whether practitioners and agencies responded in accordance with agreed processes and procedures at the time of those incidents.
- To establish whether practitioners and agencies involved followed appropriate inter-agency and multi-agency procedures in response to the victim's /or offender's needs.
- Establish whether relevant single agency or inter-agency opportunities to respond to concerns about the victim and the assessment of risk to her and risk to others was considered and appropriate.
- Consider the efficacy of IMR Authors' agencies involvement in the Multi Agency Risk Assessment Case Conference (MARAC) process.
- To establish whether practitioners and agencies involved considered the levels of risk as identified in the DASH RIC appropriately taking into account:
    - The number of incidents in the relationship between Tina and ADULT A, not just incidents against that individual.
    - The referral onto agencies (via the DART) for notification of the abuse (with a specific requirement for DART to provide information regarding the actions arising from each DASH RIC received)
    - Counter allegations
    - The history of abuse in their relationships and previous relationships

- To establish whether practitioners and agencies involved used routine enquiry and scoped patterns of abuse when domestic abuse was discussed / disclosed and how this information was shared with partner agencies.
- To establish whether practitioners and agencies involved recorded information appropriately to identify named persons in their records when domestic abuse was identified and explored relationships, e.g. did not just state partner / son.
- To establish whether the role of IRIS within the GP setting was available and if it was, was it utilised and if not why not.
- Determine if agencies relied too much on self reporting events / information from Tina and ADULT A and did agencies scrutinise and challenge self-reported events.
- To establish if the risk posed by ADULT A was managed appropriately and if how this was impacted by the complexities of the criminal and civil arenas working in silo.
- To what extent were the views of the victim and offender and significant others, appropriately taken into account to inform agency actions at the time.
- 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.
- 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 Tina, and the wider public.
- 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.

Contributors

1.13. Agencies participating in this Review and commissioned to prepare Individual Management Reviews/summary reports are:

- Nottinghamshire Police
- Derbyshire Leicestershire Nottinghamshire and Rutland Community Rehabilitation Company
- National Probation Service Nottinghamshire
- NHS Nottingham and NHS Nottinghamshire CCG (formerly Greater Nottingham CCP)
- Juno Women's Aid (formerly known as WAIS)
- Nottingham City Council Domestic Abuse Referral Team (DART) – a Multi-agency team comprised of Children and Adults services, Juno, Police and CityCare – who provided one summary report detailing DART interventions.

Individual Management Review authors were all independent from any direct management of the case.

The following agencies were written to as part of the scoping process for the review, but held no information:

- CityCare
- Community Protection
- DHU Healthcare CIC
- EMAS – only contact for call out incident at death in Lincolnshire
- Framework Housing Association
- Neighbourhood development
- Nott's Sexual Violence Support Services
- Nottingham City Council - Children's Services – only hold information regarding Grandchildren.
- Nottingham City Council –Neighbourhood Development.
- Nottingham Recovery Network and Clean Slate
- Nottingham Trent University
- Nottingham Trent University
- Nottingham University
- Nottinghamshire Fire and Rescue Service
- Opportunity Nottingham
- Sexual Assault Referral Centre - Topaz Centre
- St Ann's Advice Centre

Involvement of family, friends, work colleagues, neighbours and wider community

1.14. The Independent Author would like to express on behalf of herself and the DHR Panel, our condolences to the family and friends of Tina. Tina was clearly very well loved by many and our sympathies are extended to all who cared for her.

1.15. Tina's adult children were approached to contribute to the Review. Her eldest daughter wished to meet with the Independent Author. This could not occur until the conclusion of the criminal investigation. The meeting went ahead shortly afterwards and her perspectives are included within the report. Tina's daughter received specialist advocacy support through a Homicide Case Worker to engage in the review process.

1.16. ADULT A was contacted in prison. It was planned to visit him however due to restrictions imposed by the Covid 19 pandemic this was not possible. At his request, questions were posed to him in writing. A response was received from ADULT A *after* the DHR was completed but have been included in this version of the report prior to submission to the Home Office.

1.17. Letters were also sent to family members of ADULT A. His sister and brother in law met with the Independent Author and contributed to the review.

1.18. Contact has been made with Tina's employer who has contributed to this review.

DHR Panel members

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

- Juno Women's Aid (formerly WAIS)
- Nottinghamshire Police
- Leicestershire Police
- National Probation Service - Nottinghamshire
- NHS Nottingham and NHS Nottinghamshire CCG (formerly Greater Nottinghamshire CCP)
- Derbyshire Leicestershire Nottinghamshire and Rutland Community Rehabilitation Company
- East Midlands Special Operations Unit
- Nottingham City Children and Families Direct – DART (represented by Children's Services and Adult Services)

In addition, the DHR Panel were supported by two officers from the Nottingham Crime and Drugs Partnership. The names and job titles of panel members are set out below:

Agency	Name	Role
	Hayley Frame	Independent Chair / Author of panel
CDP	Jane Lewis Paula Bishop	Community Safety Strategy Manager (Domestic & Sexual Violence Strategic Lead) DVA Policy Officer Lead
Juno Women's Aid	Jennifer Allison Yasmin Rehman	Head of Services County & Accommodation CEO
Adult Social Care, Nottingham City Council	Ishbel Macleod	Performance and Clinical Change Manager
NHS Nottingham and NHS Nottinghamshire Clinical Commissioning Group	Nick Judge	Designated Nurse for Safeguarding Adults
Nottinghamshire Police	Clare Dean	Ch Inspector PPU DHR Lead
Lincolnshire Police	Andy McWatt	SIO

Agency	Name	Role
EMSOU East Midlands Specialist Operations Unit	Martin Holvey	Regional Review Officer
NPS Nottinghamshire	Lisa Adkins-Young	Deputy Head
DLNR CRC	Sue Parker	Deputy Head of Service
NCC children's services - DART	Samantha Danyluk	Service Manager -CFD-MASH and Duty Service (including EDT)

1.20. The Independent Author/Chair, Hayley Frame, is a qualified and Social Work England registered Social Worker having qualified in 1995. Since 2010, she has authored Serious Case Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews on a self-employed basis. This is the 9th Domestic Homicide Review authored by Hayley. Hayley is not employed by any of the agencies involved in this DHR and is independent from all professionals and agencies that have contributed to this review.

Parallel Reviews

1.21. The criminal investigation in respect of Tina has now concluded. The Coroner did not resume the inquest after the trial.

1.22. A Serious Further Offence Review was completed by DLNR CRC and submitted to the Ministry of Justice.

Equality and Diversity

1.23. Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].

- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].

- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].

- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].

- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

1.24. Both the victim and perpetrator are white British with English being their first language. There is no evidence that any missed opportunities arose because of issues relating to equality and diversity or that access to services was impacted. However, as is explored later in this report, Tina was an older woman and it is known that older women’s experiences of domestic abuse can be different to younger women. Generational attitudes may act as a barrier to the uptake of services and services are not always effectively targeted at older survivors.

Dissemination

1.25. The following organisations/people will receive a copy of the report after any amendment following the Home Office’s quality assurance process.

- The Family
- Nottingham Crime and Drugs Partnership
- All agencies that contributed to the review
- Nottinghamshire Police and Crime Commissioner
- Domestic Abuse Commissioner

2. The Facts

2.1. Tina and ADULT A had been involved in an on/off relationship since approximately November 2013. In spring 2019, Tina and ADULT A went on holiday to the East coast to stay on a caravan park.

2.2. Whilst on holiday, the East Midlands Ambulance Service and Lincolnshire Police attended to a third party report of a woman being assaulted inside a caravan by a male. Tina had received significant and extensive head and facial injuries. She was treated at the scene but sadly died a short time later.

2.3. The Home Office Post Mortem concluded the cause of death was from head injuries. The pathologist stated this was “from a sustained assault, there was extensive injury to the head and face entirely in keeping with kicking, stamping and assaults with a blunt object”.

3. Summary of relevant individual agency contact/involvement prior to scoping period

3.1. Tina was known to have been in previous relationships with two males where there were concerns regarding domestic abuse. Tina made an allegation of assault against one partner in 2005 but after not making a statement about the incident to the police, no further action was taken.

3.2. From 3/7/08 until 16/8/10, Tina made 3 allegations of domestic abuse against her then partner. The first resulted in a caution. The second incident resulted in no further action. The final incident, occurring in 2010, led to a charge of common assault. However, prior to attending court, the alleged perpetrator was admitted to hospital for amputation of both of his legs. Tina then withdrew her allegation. The alleged perpetrator has since died.

3.3. Two of the incidents were risk assessed as high risk and a referral made to MARAC. A MARAC was convened on 10/9/2010. Women's Aid were involved with Tina at the time however the case was closed as Tina did not wish for further support.

3.4. ADULT A has several previous offences, including drugs possession, theft, fraud, criminal damage and assault. He was known in Scotland to be a perpetrator of domestic abuse, for which he received deferred sentences and an 18 month probation order. His history of domestic abuse involved 5 former partners and his own family members dating back to 2006.

3.5. Between 2017 and 2019, ADULT A was known to be making threats towards his sister, his brother in law and their children. Non molestation orders were made.

4. **Summary of key events within the scoping period (author comments in bold)**

4.1. On 17th November 2013, a report was made to the police by a passer-by who saw ADULT A banging on the windows of a house and threatening the occupant; Tina. ADULT A smashed a window and was arrested for public order offences and criminal damage. A DASH RIC was completed and ADULT A was cautioned for the public order offences but refused charge for criminal damage as it was determined that there was no criminal intent or recklessness.

The DASH RIC was graded as standard risk. Tina did not provide any additional details or sign the form. As a result of this, no further action was taken.

4.2. On 25th January 2015, Tina called 999 to report that her ex-partner ADULT A had caused damage to her car and was threatening to set fire to her house. ADULT A was subsequently arrested. A DASH RIC was completed as a result of this complaint and assessed as medium risk.

Tina did not engage with the completion of the DASH RIC and did not sign the form. A check of the PNC and PND systems would have shown ADULT A's history of domestic abuse and could have led to Officers making a referral to the Domestic Violence Disclosure Scheme under the 'right to know' referral route. There was no reference to the Police Officer offering the Domestic Violence Disclosure Scheme to Tina, which would have been good practice.

Without consent to share information, via the signing of the DASH RIC, the DART[2] are unable to act on medium risk cases.

4.3. On 1st February 2015, Tina contacted the police to state that ADULT A had breached his bail conditions by making contact with her by telephone and also attending her home. A further DASH RIC was completed and graded as medium risk. The DASH RIC contains information provided by Tina. She stated that the abuse was happening more often and getting worse. It is recorded that ADULT A would turn up unannounced and threatens her male friends. Tina was recorded as stating that ADULT A has set fire to his flat when someone was in it and that she believed that he had a history for domestic abuse with other women.

Tina gave her consent for information to be shared with agencies and signed the DASH RIC. The DASH RIC was forwarded to the DART who in turn forwarded the form to Adult Social Care. Previously the movement of DASH RIC documentation between DART and Adult Social Care was without robust audit trail. There is now a designated email address and electronic folders that can only be accessed by named personnel.

4.4. On 2nd February 2015, Tina visited her GP due to stress. She stated that she had problems with her ex partner.

The name of the ex partner was not recorded which would be expected practice.

4.5. Following numerous attempts to locate ADULT A, he was arrested on 13th March 2015 and remanded to court. ADULT A subsequently received a 12 month conditional discharge and a

[2] Domestic Abuse Referral Team – a screening team with representatives from social care, health, police and women's aid.

fine. It is recorded that when the police updated Tina, she stated that her and ADULT A were trying to ‘sort their relationship’ and were attending counselling together.

4.6. As a result of the DASH RIC completed, Women’s Aid contacted Tina on 9th March 2015. Tina stated that she still had feelings for ADULT A but described the relationship as having been abusive for 2 years and that he was jealous and isolated her from her friends and family. She also stated that ADULT A had made threats to burn her house down but that she felt that she herself had breached the conditions as she had gone to ADULT A’s home to return possessions and to discuss the relationship. Women’s Aid offered her Sanctuary (a scheme that provides additional security to a survivor’s property) and a fire safety referral but these were declined. Women’s Aid also contacted the DART on that day although there is no record of this within DART recording systems.

4.7. On 13th March 2015, Tina informed Women’s Aid that she no longer wished to pursue a restraining order. On 18th March 2015, the case was closed to Women’s Aid.

Professional curiosity regarding Tina’s wish to disengage with Women’s Aid might have elicited information regarding the relationship continuing.

4.8. On 14th May 2015, ADULT A attended his GP. Issues with mood and aggression were noted and he disclosed being verbally but not physically aggressive to his partner, who was present at the consultation. A long history of depressive illness was recorded and medication was adjusted and a referral made for counselling for ADULT A.

The CCG IMR stated that asking for help with his mood and aggression in the company of a partner was likely to have been viewed by the GP as a positive move. The IMR has questioned whether this was influenced by a rule of optimism. The name of the accompanying partner was not recorded in the GP notes. The impact of verbal aggression upon Tina, and her account of events, was not sought by the GP. Good practice would have been for Tina to have been spoken to separately.

4.9. It was reported to the police on 9th July 2015, that Tina was seen to light some tissues and put them through the letterbox of ADULT A’s home address. The witness and ADULT A would not provide a statement. ADULT A stated that he had not seen any evidence of fire damage and did not see Tina put anything through his letterbox. Tina was interviewed under caution and denied the offence and no further action was taken. A DASH RIC was completed, with ADULT A as the victim and graded initially as standard and then regraded as medium. ADULT A signed the DASH RIC.

There are no records of this DASH RIC within the DART systems. It is known however via the police that ADULT A refused all medium risk interventions.

4.10. On 6th January 2016, Tina attended the Urgent Care Centre with a head injury which she stated was caused when she slipped on a slab and banged her head on a metal unit when rising. A small laceration was treated.

4.11. On 25th July 2016, it was recorded by the police that threats were being made by ADULT A towards his daughter and son in law via text message. ADULT A was given a verbal harassment warning.

4.12. Tina attended her GP on 12th September 2016, with an injury to her elbow which happened during an assault when she was pushed into the road. She attended again reporting rib pain associated with the same incident. Tina was signed off work as a result of this incident.

There is no record of the detail of this incident or of any alleged perpetrators. It would appear that professional curiosity was not demonstrated by the GP on this occasion. Given that Tina had stated that she had been assaulted, the GP should have ascertained who had assaulted her and formed a view regarding ongoing risk of harm.

4.13. It is known from Tina's HR file that she was absent from work due to a rib injury from 19th September 2016 until 29th September 2016.

4.14. Tina was absent from work due to sickness related to depression from 23rd March 2017 until 18th April 2017. The return to work interview record states that Tina shared her personal circumstances but there are no further details regarding this.

It is not known whether Tina was subject to financial abuse. There is no information that has come to light as part of this review to indicate that financial abuse was a factor. She would have been in receipt of sickness pay whilst absent from work. It would seem that her employer was unaware of domestic abuse within Tina's relationship although she had shared that the relationship was problematic with her colleague which led to a number of welfare meetings being held between Tina and her employer.

4.15. ADULT A reported to his GP on 28th June 2017 that he was low in mood and cited issues with his family members. Medication was increased and counselling details given. He attended again with similar issues on 11th September 2017 when his medication was changed.

The review has established that a 6 months non molestation order was taken out by ADULT A's brother in law and nephew on 1st August 2017.

4.16. On 1st January 2018, an incident was reported to the police where Tina had caused damage to ADULT A's property and car following ADULT A and Tina having been in the pub celebrating New Year's Eve. A DASH RIC was completed in respect of ADULT A as the victim and graded as standard. The DASH RIC was forwarded to the men's services, Equation. ADULT A did not wish to support a prosecution, stating that he and Tina were back together and no further action was taken by the police.

4.17. Tina attended her GP on 3rd January 2018 with a bruised eye which she stated occurred on New Year's Eve following a domestic incident where she had hit her face on a window. She was advised to contact Women's Aid.

The details of her partner were not recorded. A week later there was a GP follow up where Tina stated that Women's Aid were involved and were supportive. This review has established that Women's Aid were not involved at this point, although it is understandable that this assertion by Tina would have reassured the GP.

The review has considered whether the police were aware of Tina's injuries when they completed the DASH RIC in respect of ADULT A as they were reportedly sustained during that incident. Police records have been checked and there is no record of Tina having injuries although given the fact that ADULT A did not wish to support a prosecution, it is not known whether Tina was seen by the police.

4.18. Tina was seen to have a bruised eye when she returned to work after the Christmas break.

It is not evident from records that Tina's employer explored the cause of the injury.

4.19. Tina attended her GP again on 16th January 2018. She reported feeling upset and low and referred to arguments with her ex partner although his name was not recorded.

Given the history of presentations to the GP, more detail regarding the reported arguments should have been ascertained by the GP.

4.20. On 5th February 2018, ADULT A sent various threatening messages to Tina, stating that he would not rest until she was dead. He made threats to assault her and to set fire to the school where she worked. Tina stated to the police that she and ADULT A had separated after the New Year's Eve incident after having been together for 6 years. A DASH RIC was completed and graded medium. Tina signed the DASH RIC.

The DASH RIC was shared with Adult Safeguarding within DART but it is not known if any action was taken.

4.21. The following day, Tina contacted the police to say that ADULT A had been contacting her throughout the night and had made more threats towards her. She attended the police station and made a further statement. A new DASH RIC was completed and was graded as medium risk. Again, Tina stated that the abuse was happening more often and was getting worse. Tina signed the DASH RIC giving consent for information to be shared within agencies. Tina was offered appropriate advice by the police including women's aid services, Cocoon watch, Sanctuary (see 4.6 above) and the offer of a personal alarm.

4.22. ADULT A was arrested on 7th February 2018 for threats to kill and harassment. He stated that he and Tina had been in an off/on relationship for 6 years and they had argued following her having caused damage to his property. He stated that he had dropped the charges on the basis of her paying for the damage but she had since refused to pay. He admitted sending the texts but said they were idle threats and he would never physically harm Tina. The CPS decided no further action on basis that both Tina and ADULT A had been contacting each other and the offences were not deemed to be in the public interest.

Tina should have been identified as a repeat victim as she had reported two incidents within a 12 month period. However, the police policy at the time was to review the top 30 domestic abuse victims, identified via a combination of level of risk and frequency of incidents. Tina would not have been placed within the top 30 victims despite being a repeat victim.

The DASH RICs completed were both graded medium despite a threat to kill. It was known by the police that abusive/threatening texts were being sent both ways by both parties however, Tina had told the police clearly that the abuse was happening more often and was getting worse. This should have been an additional factor when considering the grading of the DASH RIC.

Had the threat to kill led to the DASH RIC being graded as high risk this would have led to a MARAC referral. Domestic abuse occurrences have a secondary risk assessment completed by the Police Domestic Abuse Support Unit. This process reviews the

attending officer's assessment with knowledge of the previous incidents to determine whether the risk level should be increased/decreased. The risk level was not altered.

4.23. On 15th February 2018, Equation attempted to contact ADULT A to complete an assessment and a message was left for him on his answerphone. The assessment call took place on 19th February 2018, when ADULT A stated that neither party wanted to rekindle the relationship. He stated that there had been no domestic abuse from either party over the 6 year relationship. ADULT A did not want to engage with the service and so the case was closed.

It is evident that ADULT A was not open and honest regarding the history of domestic abuse when completing the Equation assessment.

4.24. On 28th February 2018, ADULT A's brother in law obtained a further 3 year non molestation order against ADULT A.

4.25. In May 2018, ADULT A was subject to antisocial behaviour processes by his housing provider due to his harassment of his family members.

4.26. On 25th September 2018, ADULT A's nephew obtained a 6 months non molestation order against ADULT A.

The non molestation orders which had been made, had been breached by ADULT A six times throughout 2018.

4.27. On 27th November 2018, ADULT A attended court for two breaches of the non molestation order, the victim being his brother in law. The case was adjourned for a pre sentencing report. The report was completed and it was assessed that there was a moderate risk of re conviction and medium risk of serious harm to family members and future/ex partners. It was recommended that ADULT A be given a 12 month community order with requirements to attend the Thinking Skills programme[3]. A restraining order under the Protection from Harassment Act 1997 was also put in place to protect his family members.

Tina was not named as being at risk of serious harm despite the assessment stating that future/ex partners were at medium risk of harm. In addition, the DHR Panel has considered that the sentencing plan and identified work did not give enough focus to the risks associated with domestic abuse.

4.28. On 3rd January 2019, ADULT A was sentenced to a Suspended Sentence Order with a requirement to attend the Thinking Skills programme and 15 days Rehabilitation Activity Requirement. The management of his case was transferred to the CRC.

4.29. On 22nd January 2019, ADULT A attended his first appointment at the CRC. The offence was discussed plus the sentence plan objectives.

The review has noted that there was limited discussion on previous convictions or intimate relationships which would have been expected practice.

[3] The Thinking Skills programme is aimed at those who demonstrate poor problem solving skills, impulsive behaviour and a lack of consequential thinking.

4.30. 28th January 2019, the CRC completed the initial sentence plan and risk assessment. It concluded that he was medium risk of serious harm through intimidation and violence to known adults including family members and partners/ex partners. It was recorded that ADULT A felt set up by the victims and aggrieved by the sentence. It was agreed that ADULT A would be referred to the Thinking Skills Programme and Safer Choices[4].

Checks with the police and social care were not undertaken as part of this risk assessment which would have been expected practice. The review has noted that there was limited recorded evidence of challenge to ADULT A. His view of himself as the victim continued through subsequent sessions.

4.31. On 25th February 2019, ADULT A attended a planned CRC appointment. It was decided that he would be referred for anger management rather than the Safer Choices intervention.

The review has questioned the appropriateness of this change in intervention. It is known that anger management is unsafe in cases where there are concerns regarding domestic abuse. In addition, ADULT A's attitudes appeared to present issues of power and control rather than emotional control issues.

4.32. Aduly A contacted the police on 23rd March 2019 regarding ongoing problems with Tina who he stated shouts abuse at him when he sees her and had glued his locks at his home, although there was no evidence to support this. He did not wish to support a prosecution but made the call to get a crime number so that his locks could be repaired. The incident was reclassified by the police as having no domestic abuse element and therefore no DASH RIC was completed.

4.33. On 25th March 2019, ADULT A was written to by the CRC with a date for his first Thinking Skills programme appointment on 29th March 2019. He rang the CRC to say that he would not be able to attend as he would be away. He attended his first appointment on 3rd April 2019 where it was recorded that he did not accept responsibility and blamed his sister and her family for the offence. He also denied any domestic abuse and blamed ex partners for incidents that had occurred. ADULT A failed to attend his next appointment on 5th April 2019. Due to ongoing poor attendance the module was deferred.

ADULT A continued to present himself as the victim and this should have been challenged.

4.34. On 11th April 2019, ADULT A attended an appointment at the CRC. He stated that his relationship had ended as his partner had been violent towards him.

This was opportunity to gain more detail about the relationship but there was no record of any detailed discussion. A police check should also have been completed at this point which potentially would have led to a review of the risk assessment.

4.35. Also that day, Tina contacted the police to report that she had separated from ADULT A at New Year but that there had been an argument that day at a local pub. Advice was given to Tina to avoid the pub and to block ADULT A's number. There was no evidence of a crime being committed as the attending officer believed that the abusive texts were "just as bad" from each other.

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[4] Safer Choices is group work for perpetrators of domestic abuse in current or previous relationships and in current or previous offences.

A medium risk DASH RIC was completed however consent to share information was not given and therefore the DASH RIC was not shared with Adult Safeguarding within DART. The DASH RIC identified Tina as a repeat victim. Within the DASH RIC Tina stated that ADULT A was drinking a lot more and smoking cannabis. He was described as being very jealous. The abusive text messages should have been considered in this context.

4.36. On 14th May 2019, ADULT A advised the CRC that he would be on holiday from and would therefore miss another Thinking Skills appointment. It was agreed that he would attend a catch up session.

4.37. On 24th May 2019, ADULT A attended a planned CRC appointment. He advised that he was going to Skegness with his partner.

There was no reference to ADULT A having said in April that the relationship had ended due to violence. This was another opportunity to check with the police regarding domestic abuse call outs. The review has considered whether more information would have led to the holiday not being allowed to happen or enforcement action taken. This is felt to be unlikely although the CRC would have looked at how the holiday was managed such as crisis techniques/risk management strategies being explored.

4.38. Whilst on Tina and ADULT A were on holiday, the police were called to a report of a woman who had been badly assaulted in a caravan. On arrival, paramedics were treating Tina. She was pronounced dead at 23.37 hours.

5. Family Member and Employer Perspectives, to include a pen portrait of Tina

5.1. The independent author met with the adult daughter of Tina, who will be referred to as DT (Daughter of Tina). DT provided detailed information about her recollection, views and perceptions, which are summarised below by the author.

5.2. DT described her mother as being 'bold, bubbly, loud, welcoming and loving'. Tina was described as a strong woman but that her confidence was undermined by her relationship with ADULT A and DT saw a change in her mother's personality as the relationship progressed.

5.3. DT shared that Tina and ADULT A had been together for 6 or 7 years. They met when Tina was approximately 57 years old. DT remembered ADULT A from school as some of her friends knew him.

5.4. When the relationship commenced Tina told DT that she had met a man but that he had a lot of family troubles, had nowhere to live and was struggling with money. DT believes that her mother was flattered that a younger man liked her and ADULT A would spend a lot of time at Tina's home. About a month into the relationship, DT went to visit her mother and found her crying in the kitchen and ADULT A was upstairs packing his belongings. Tina was described as being really upset that ADULT A was going to leave her and DT went to speak to ADULT A and convinced him to stay. DT reflected that this was the first and last time that she tried to intervene.

5.5. DT described how this started a pattern of her mother frequently telephoning her to say that she and ADULT A had been arguing. DT would try to support her mother but she increasingly became concerned about ADULT A's behaviour and its impact upon her mother. DT stated that ADULT A was verbally abusive towards Tina and would try to belittle her. DT would try to visit

her mother when ADULT A was not at home. ADULT A became aware that DT did not like him and he started making threats towards DT. Tina would always tell DT what he had said and would show her text messages which included threats to burn down DT's house when she was in bed. ADULT A also made threats towards DT's husband. Due to the threats from ADULT A, DT felt that she had to take a step back and she stopped visiting her mother as frequently.

5.6. DT recalled how ADULT A then started making threats towards her adult brother. Her brother has learning needs and remained living with Tina throughout his childhood and into adulthood. DT stated that ADULT A threatened to punch her brother and also sent him a picture of a knife saying that he was going to stab him. DT believed that ADULT A felt that Tina's son was 'in the way' and attempting to force him to move out of Tina's home.

5.7. DT described a cycle of her mother and ADULT A separating and reconciling. When they were separated, DT would see more of her mother but then the relationship would resume and she would feel 'pushed out'.

5.8. Every year ADULT A always took Tina to a caravan park on her birthday. DT felt that this was so no one else could see her and he would have Tina to himself on her birthday. DT spoke of an incident where ADULT A threw Tina out of the caravan and told her to walk back to Nottingham. On another occasion, ADULT A and Tina were away at the caravan and ADULT A used Tina's phone to call his nephew and made threats to kill him. DT stated that ADULT A then tried to get Tina to lie to say he had not made threats to kill his nephew. She refused to do so and ADULT A was abusive and threatening towards her and made threats to kill her. They then separated for several weeks. DT stated that Tina told ADULT A's solicitor (who was dealing with the non-molestation proceedings) that she could not be a witness and ADULT A had made threats towards her. It is not known whether this solicitor took any action faced with this information.

5.9. Tina told DT that over one Christmas ADULT A had deliberately opened a window into her face making her fall over and leaving her with a bruised eye. He said it was an accident. It is likely that this is the incident where Tina attended her GP on 3rd January 2018 with a bruised eye which she stated occurred on New Year's Eve following a domestic incident where she had hit her face on a window.

5.10. DT stated that Tina may have experienced other physical injuries from ADULT A but that she was only aware of the bruised eye. She spoke of how he was controlling over her mentally, telling her what she could wear, what perfume she was allowed to use, her hair styles, hair colour. She was not allowed to go out with friends if he was not there.

5.11. DT shared that Tina and ADULT A split up in around March 2019 and Tina met someone else. On Mother's Day all of the adult children went out with Tina and her new boyfriend. DT recalled how this was the first time in years that she had seen her mother smile properly. She remembered Tina saying that she was not used to someone wanting to hold or touch her hands and kiss her. The relationship was short lived as ADULT A found out and then threatened Tina's boyfriend and his elderly mother.

5.12. DT spoke of ADULT A isolating Tina from friends and family. DT said that her mother would not return her calls and ADULT A would prevent Tina from answering her phone to talk to her daughter. She spoke of the local community knowing what ADULT A was like and how he treated Tina and others. DT recalled ADULT A having made threats to many people as well as herself and her husband. He was said to have threatened to make sure that Tina's other

daughter's children were removed from her care and had been threatening and abusive towards Tina's sister in law. DT stated that ADULT A convinced Tina and others that he had the power and capability to carry out his threats.

5.13. DT stated that the school where Tina worked as an assistant caretaker were aware of the abuse that she was experiencing. Tina had let them know as ADULT A had made threats to her and, as she opened the school early in morning, she was worried about the risks to her and others. DT stated that the school circulated a photograph of him to staff.

5.14. Tina's employers have contributed to this review. They shared that Tina had a solid relationship with many staff in school. Her co-worker, the Caretaker, had raised her volatile relationship with ADULT A, which involved alcohol, to the previous head teacher's attention and several welfare meetings were conducted by the head teacher. During these meetings, Tina never directly disclosed information about her relationship, though it was clear from Tina's presentation that this at times had a negative impact upon her wellbeing. Emotional support was provided by the head teacher, which included enquiring whether Tina was supported by her family and regular welfare phone calls were made when Tina was absent from work. The leadership of the school had no knowledge of a photograph of ADULT A being circulated, although DT has confirmed that her mother discussed this with her.

5.15. DT recalled how Tina was not intending to go away with ADULT A for her birthday. They had fallen out and he had been verbally abusive towards her. However, on the Friday she decided to go after having been convinced to do so by ADULT A.

5.16. As part of this review the Independent Author also met with ADULT A's sister and brother in law. They spoke of ADULT A's previous relationships and how there was a pattern of control and that he would stalk his ex-partners. They stated that in their opinion, they felt that ADULT A looked out for women who were vulnerable had experienced poor relationships in the past.

5.17. His sister recalled how ADULT A was aggressive even from being a child and if he did not get his own way, he would hit his head against the wall or on concrete floors. She recalled how he stole from family members and would blame others for his behaviour.

5.18. When her eldest son was 6 weeks old, she recalled that ADULT A had threatened to kill the baby as he was jealous as he was no longer the only boy in the family. He caused damage to his mother's home and was subsequently arrested. He set fire to a bail hostel and was then sent to a Young Offenders Institute. ADULT A was described as being very racist and causing problems in the area and as a result his mother arranged for him to move to Scotland to live with his cousin. It was in Scotland that ADULT A perpetrated domestic abuse against his partners.

5.19. ADULT A's sister and brother in law described years of abuse from ADULT A towards them and their children. They described how they had to change their daily routine due to the abuse and enduring stress caused by ADULT A. They would go shopping at 6am in the morning and not go out on their own. They felt unable to sit in their back garden in the summer because ADULT A would drive round the back and be abusive towards them and throw things into the garden.

5.20. As a result of the abuse, they applied and were granted non molestation orders on 3 occasions, the most recent expires in 2021. They spoke of how as soon as the order would expire; he would start harassing them again. It was evident that the couple felt frustrated with the Orders as they

had power of immediate arrest but that the police rarely did so. They were also frustrated by the fact that ADULT A plead guilty to 2 counts of threats to kill yet only received a suspended sentence.

5.21. This type of obsessive, unwanted and fixated behaviour which caused stress and led to the survivors making changes to their day to day living is likely to have been dealt with now under the Stalking legislation. The numerous breaches would be viewed as a pattern of behaviour and dealt with under the Criminal Justice process or civilly via a Stalking Prevention Order application.

5.22. ADULT A's sister and brother in law only met Tina on a few occasions. They stated that she and ADULT A appeared 'madly in love'. They recalled how once Tina posted a picture on Facebook of her bruised eye and said it was ADULT A's 'gift' to her. Sometime later she stated that the injury had been caused by someone else. Tina would sometimes be abusive to them also but they feel that ADULT A coerced her into behaving this way. They recalled an incident where ADULT A had booked a caravan using Tina's surname. The caravan owner knew of ADULT A's behaviour and then refused to let the caravan to him. They stated that ADULT A then threatened to petrol bomb the home of the caravan owner.

5.23. Throughout this review there has been recurrent theme of alcohol use in that both Tina and ADULT A were frequent visitors to their local pub, where ADULT A was well known and had often behaved aggressively to other people in the pub. That said, neither ADULT A nor Tina were known to have problematic alcohol use.

6. Perpetrator Perspectives

6.1. ADULT A has provided written responses to questions posed to him by the Independent Author.

6.2. ADULT A has stated that his mental health was variable during his relationship with Tina and that arguments negatively impacted upon his emotional wellbeing.

6.3. ADULT A's responses to the questions make reference to him as a victim of domestic abuse by Tina and that he feels that more support from the Police and also support from Victim Support would have been beneficial. He stated that he did not seek professional support regarding the relationship.

6.4. He has stated that alcohol use was a contributory factor to the violence within the relationship and specifically on the night of Tina's death. He has expressed remorse for his actions.

7. Analysis (Terms of Reference)

7.1. To identify all incidents and events relevant to the named persons (Tina and ADULT A) and identify whether practitioners and agencies responded in accordance with agreed processes and procedures at the time of those incidents.

7.1.1. This is considered within the case narrative and author comments.

7.1.2. Within the scoping period, and during Tina and ADULT A's relationship, there were 8 occasions where a DASH RIC was completed. 6 were completed where Tina was the victim and 2 where ADULT A was the victim. Of the 8 completed, 6 were medium risk and 2 were standard risk. The DASH RICs were completed in line with expected practice by officers attending the incidents.

7.1.3. On 3 occasions Tina signed the DASH RIC and gave her consent for information to be shared with agencies. The process would be that the DASH RIC would then be sent to the DART for them to signpost the survivor to appropriate support services. There are no records of this having taken place for Tina. It would seem that the rationale for this was due to Tina not having care or support needs that would meet the criteria for a service from adult social care.

7.1.4. That said she was offered support services via the Police and a referral made to Women's Aid although she did not wish for their involvement at that time.

7.1.5. It is of note that 3 DASH RICs were completed over a period of 5 months in 2015 and 3 completed over a period of 1 month in 2018. However, during both time periods one DASH RIC was in respect of ADULT A and two were in respect of Tina. Processes are in place for the review of frequent repeat DASH RICs completed in respect of individuals but this Domestic Homicide Review has established that there are no processes to consider DASH RICs completed across a relationship. A 'whole relationship' approach to considering risk would allow for all information to be reviewed in its totality rather than being victim and incident specific.

7.1.6. In addition, consideration of the different types of violence/abuse would be useful when determining who is the primary aggressor. There is research to suggest that gender can impact significantly on the types of violent behaviour exhibited. [5]

7.1.7. Tina did meet the criteria for repeat victim status however the position within Nottinghamshire Police is complex due to the sheer volume of domestic abuse incidents reported. The force considers the top 30 victims on a monthly basis, looking at the total number of incidents in the last rolling 12 months. For example, in one month there were 1593 repeat victims identified. In that same month, the victim with the highest incidents in the 12 month period had a total of 34 incidents recorded. The average amount of incidents for a victim in a 12 month period was 18, the lowest amount of incidents being 9 and the highest amount of incidents being 39. Tina had 6 incidents of domestic abuse

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[5] **A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence** *Michael P. Johnson*
Hester, M. (2009) ***Who Does What to Whom? Gender and Domestic Violence Perpetrators****, Bristol: University of Bristol in association with the Northern Rock Foundation*

where she was the victim reported over a 6 year period. It is therefore clear why she would not have been seen at high risk of harm on the basis of reporting alone.

7.1.8. There was opportunity for the DASH RIC that considered the threats to kill made by ADULT A against Tina to be re-graded as high risk. This would have triggered a MARAC referral. However, the police understood that threatening and abusive messages were being sent by both Tina and ADULT A, and it was for this reason that the CPS decided not to take any further action and the DASH RIC remained as medium risk. Again, a greater understanding of who was the primary aggressor would have assisted decision making.

7.1.9. There were 3 occasions where the GP could have taken a far more proactive approach – Tina presented with injuries on two occasions and ADULT A also presented to the GP, accompanied by Tina, stating that he was verbally aggressive towards her. It is clear that with regard to Tina's injuries, greater professional curiosity was required with regard to the nature of the injuries and their cause. She stated that she had been assaulted but even minimum enquiries regarding the nature of the assault and the perpetrator were not made by the GP. Although it was seen to be positive that ADULT A was seeking support for his difficulties when he visited his GP, any support needs or risk posed to his partner were not considered. DT has also raised the fact that Tina was being prescribed antidepressants and the GP could have enquired more about her personal circumstances.

7.1.10. It is clear that the involvement of the CRC with ADULT A could have been more robust and provided greater scrutiny of his personal relationships and the risk of domestic abuse. The initial sentence plan and risk assessment concluded that ADULT A was medium risk of serious harm through intimidation and violence to known adults including family members and partners/ex partners. His relationship status and health of his relationship was not discussed despite their being opportunity to do so. At the time of sentencing he was believed not to be in a relationship but this changed by the time of his initial sentence plan. Tina was not named in the risk assessment.

7.1.11. Within the course of his supervision, in April 2019, ADULT A then stated that the relationship had again ended due to violence however there was no exploration of this. By May 2019, ADULT A was advising the CRC Officer that he was going away on holiday with his partner. There was no discussion regarding the relationship despite the CRC Officer being aware of a reported history of violence, and the risk assessment clearly stating that partners/ex partners were at medium risk of serious harm from ADULT A.

7.1.12. It has been established that domestic abuse and safeguarding checks were not completed by the CRC. Had they been then there should have been a greater understanding of the risk of domestic abuse and led to greater exploration of the risk posed by ADULT A to Tina. It is highly likely that this *would* have altered the risk assessment.

7.1.13. In addition, the sentence plan initially included a referral to Safer Choices, which is a group programme for perpetrators of domestic abuse. This would have been an appropriate intervention for ADULT A. However, this was then changed to an anger management pathway. It would appear that the rationale for this was based on the index offence not being against a partner. However, having up to date information from the police regarding domestic abuse incidents might have altered this decision making.

7.1.14. In addition, there were clearly elements of power and control exhibited by ADULT A towards his family members, and it was also clear from the work completed by the CRC that ADULT A minimised the issues and blamed the victims. All of these factors would suggest that anger management was not an appropriate intervention for ADULT A.

7.2. **To establish whether practitioners and agencies involved followed appropriate inter-agency and multi-agency procedures in response to the victim's /or offender's needs and establish whether relevant single agency or inter-agency opportunities to respond to concerns about the victim and the assessment of risk to her and risk to others was considered and appropriate.**

7.2.1. This review has established that the police dealt with 8 incidents throughout the scoping period with Tina and ADULT A identified as both victim and perpetrator. However, the DASH RIC is incident specific. It is clear that the relationship between ADULT A and Tina was highly volatile and given his history of domestic abuse, information which attending Officers would have had access to via the PNC and PND, the overall risk to Tina was clearly much greater and this was not reflected in the DASH RICs.

7.2.2. The Police IMR notes that there was no recorded mention of the Domestic Violence Disclosure Scheme which could have highlighted ADULT A's domestic convictions in Scotland prior to having met Tina. This request could have been made by officers through the 'right to know' process despite Tina not having made a request through the scheme. This review has established via the contributions of Tina's daughter that Tina did not know about the abuse ADULT A had subjected his ex-partner to in Scotland. The family of Tina have only recently become aware of this due to media interest in the Scottish press.

7.2.3. The Domestic Abuse Referral Team is a multiagency team (police, health and social care) tasked with screening survivors and signposting them for support. Where the survivor is an adult without dependent children, the DASH RIC is considered by a social worker from Adult Social Care. There is no information to suggest that Tina was contacted or signposted for support despite her having given consent to share information on 3 occasions. This is likely to have been due to Tina not meeting the criteria for a service from Adult Social Care.

7.2.4. As outlined above there were missed opportunities for the CRC to liaise with agencies in order to ascertain information regarding ADULT A, which is likely to have changed the risk assessment of him, had the information been known.

7.2.5. It is known that ADULT A has a number of domestic abuse related offences in Scotland dating back to 2010 and 2011. These resulted in convictions at Falkirk Sheriff Court in 2010 and 2011. ADULT A returned to Nottingham in 2012 however the relevant police force in Scotland were unaware of this. ADULT A was not deemed to be a high risk offender in Scotland and as such there was no requirement for him to be monitored. In 2021, *if* the police had information that a perpetrator had moved to Nottingham, they would submit a Scottish Intelligence Database Log with the details for sharing with that local police force, outlining the perpetrators domestic abuse background. This would allow local police to have access to this information quickly, which could then be supplemented with further detail should they make further enquiries or receive an application via their Domestic Violence Disclosure Scheme. Obviously in the case of ADULT A, Scottish Police Forces were unaware that ADULT A had moved back to Nottingham.

7.3. **Consider the efficacy of IMR Authors' agencies involvement in the Multi Agency Risk Assessment Case Conference (MARAC) process.**

7.3.1. No MARACs were held within the scoping period in relation to Tina and ADULT A.

7.4. **To establish whether practitioners and agencies involved considered the levels of risk as identified in the DASH RIC appropriately taking into account:**

- **The number of incidents in the relationship between Tina and ADULT A, not just incidents against that individual.**
- **The referral onto agencies (via the DART) for notification of the abuse (with a specific requirement for DART to provide information regarding the actions arising from each DASH RIC received)**
- **Counter allegations**
- **The history of abuse in their relationships and previous relationships**

7.4.1. There is no current mechanism to allow review of the number of incidents in a relationship rather than just incidents against an individual. The volume of work for identifying repeat victims and repeat offenders is great and to add in additional mapping of incidents against relationships would require additional police resources. Even if this process was established, it would have to focus on the most concerning relationships, and this would inevitably be based on frequency of incidents and levels of risk. As can be seen from the repeat victim data, the numbers of incidents in a relationship are likely to be far greater than those reported in the relationship between ADULT A and Tina. Tina did not meet the criteria for repeat victim intervention and ADULT A did not meet the criteria for serial perpetrator interventions.

7.4.2. It could be argued that the DART would be best placed to have this oversight, as their recording systems can create relationships. Robust scrutiny by DART could provide

opportunity to consider the history of abuse in current and historical relationships. Again, this would mean that additional resources were required and could only be offered to those survivors who meet the criteria for services from Adult Social Care or have dependent children.

7.4.3. If the criteria for a service from Adult Social Care are not met by a survivor, DART cannot provide an intervention. So even if there were to be a system established to consider incidents that occur within a relationship where both partners are victims and perpetrators; an intervention would not be provided if the adults involved did not meet the criteria for Adult Social Care.

7.4.4. It is clear that there is a significant cohort of women who will not meet the criteria for a service from Adult Social Care. If they feel unable to engage with Women's Domestic Abuse Services, then there is often no other support options available. The key challenge is therefore how women are supported to engage with Women's Services. Nottinghamshire Police have developed a protocol where they will follow up medium risk cases with women who do not engage, this is by phone or letter, where safe to do so.

7.4.5. In the case of Tina and ADULT A, 8 DASH RICs completed were over a 6 year period, two of which were standard risk. This review has established that there was no sense of extreme concern for Tina's safety. With the benefit of hindsight, and consideration of relevant research, it is clear that Tina was at grave risk of harm.

7.4.6. Tina was 64 years of age and it is known that she experienced domestic abuse in more than one relationship. Research has shown that survivors aged 61+ years are 48% more likely to experience abuse from a current intimate partner but are far less likely to attempt to leave the perpetrator in the year before they access help. Generational attitudes may act as a barrier to the uptake of services and services are not always effectively targeted at older survivors (Safe Later Lives: Older People and Domestic Abuse 2016 Safe Lives).

7.5. **To establish whether practitioners and agencies involved used routine enquiry and scoped patterns of abuse when domestic abuse was discussed / disclosed and how this information was shared with partner agencies.**

7.5.1. The GP practice had received training on routine enquiry as part of the IRIS scheme until 2017. Subsequent to this Women's Aid services delivered training to the GP practice in November 2019 in relation to recognition of and responding to domestic abuse. There is no record of the GP using routine enquiry with Tina. This is despite her having attended the GP twice with injuries, both of which were as a result of assault. This was a significant omission by the GP.

7.5.2. As had been highlighted above, there were opportunities for the CRC to consider patterns of abuse in their work with ADULT A but this did not occur and fell short of expected practice.

7.6. **To establish whether practitioners and agencies involved recorded information appropriately to identify named persons in their records when domestic abuse was identified and explored relationships, e.g. did not just state partner / son.**

7.6.1. The relationship between ADULT A and Tina was not recorded in GP records despite being patients at the same GP practice. Their names were not recorded despite mention of partner/ex partner in attendances. Indeed, Tina accompanied ADULT A on one occasion and her name was not recorded. Previous DHRs and SCRs have highlighted that relationships and connections are not always made between individuals.

7.6.2. Significantly, Tina was not recorded by the CRC nor was she identified as at risk of medium harm from ADULT A, despite his risk assessment identifying partners and ex partners as at risk. Within the records she is referred to as his partner, not by name, and there is no further information. It is evident that the CRC did not manage the case as being one where domestic abuse is a factor.

7.7. **To establish whether the role of IRIS within the GP setting was available and if it was, was it utilised and if not why not.**

7.7.1. The IRIS scheme was decommissioned in 2017. It was replaced by the Domestic Abuse Referral Scheme which is a dedicated referral pathway for GP practices. There was an 18 month gap between these services being in operation. There is no record that the GP in this case sought support from either pathway.

7.7.2. The Domestic Abuse Referral Scheme has also been decommissioned. A Task and Finish Group is to be established to see how domestic abuse support to GPs will be commissioned / provided in the future. In addition, an Adult Safeguarding Lead post is being recruited to and Protected Learning Time for GPs is to be utilised to spread key themes and messages from learning locally.

7.8. **Determine if agencies relied too much on self reporting events / information from Tina and ADULT A and did agencies scrutinise and challenge self-reported events.**

7.8.1. It is evident that the GP relied on self-reporting from both ADULT A and Tina. Professional curiosity could have elicited more detail regarding the assault that Tina disclosed where she was pushed into a road. The CCG IMR makes reference to the significant pressures that GP practices face in terms of workloads and demand for services. Appointments are time limited and tend to focus on the presenting health concern. Nonetheless, even minimum enquires regarding the nature of the assault and the perpetrator details should have been ascertained by the GP.

7.8.2. When ADULT A attended the GP with his partner and spoke of his aggressive behaviour this was viewed as a positive move by the GP and ADULT A was not seen to be a perpetrator of domestic abuse. Signposting to the national Respect helpline would have been appropriate in this scenario and this should be promoted within GP practices. Had Tina been seen alone, there could have been a greater understanding of the risks posed to her.

7.8.3. The intervention of CRC with ADULT A lacked challenge and exploration of ADULT A's account of events; his beliefs and his values. It is evident from the information shared by family members of ADULT A and Tina that ADULT A was a volatile and aggressive man who made threats to very many people, including Tina. Had the responsible CRC officer investigated the history of domestic abuse, a greater understanding of the risks he posed would have been known. It is clear that due to missing information, the risk assessment completed by CRC was not accurate. This is a significant flaw in the management of ADULT A 's case by the CRC.

7.9. **To establish if the risk posed by ADULT A was managed appropriately and if how this was impacted by the complexities of the criminal and civil arenas working in silo.**

7.9.1. The police IMR states that, for the police, there were no issues of the criminal and civil arenas working in silos as attending police officers would have been fully aware of the civil issues through the police recording systems.

7.9.2. This DHR has considered that the two processes are not well interconnected. For example, ADULT A breached a non-molestation order (a civil order) against family members and the offence only became criminal because of its breach. It does not appear that the probation officer completing the Presentencing report or ADULT A's allocated CRC worker were aware of the reasons for the non molestation orders being made in the first place. Family contributions to this review have provided a narrative of a man who was controlling and aggressive to anyone that he took issue with. There are many accounts of threats to kill being made. The civil proceedings dealt with the threats to kill made against his family members and ultimately resulted in the involvement of the CRC through ADULT A's breaches of the civil orders. However, the threats made to kill Tina, and others (as reported by DT and ADULT A's sister and brother in law) were not known to the CRC. Had they been so, the assessment of ADULT A's risk to others, may have been viewed as high rather than medium.

7.10. **To what extent were the views of the victim and offender and significant others, appropriately taken into account to inform agency actions at the time.**

7.10.1. The DASH RICs were completed using information provided by Tina. However, on 3 out of 6 occasions she did not give permission for information to be shared.

7.10.2. In 2015, Women's Aid became involved with Tina but she declined their support and informed them that she no longer wished to purse a restraining order against ADULT A. The case was subsequently closed.

7.10.3. It is likely that the allegations and counter allegations, plus the reconciliations led to there being confusion or lack of understanding regarding Tina as a victim. Tina did share information with Women's Aid and the police regarding the abuse she was experiencing from ADULT A, and that the abuse was increasing. It is clear from the information shared by her daughter that the relationship was one where ADULT A was controlling towards Tina and isolated her from those who might be able to support her. It is highly likely that it became impossible for Tina to separate from ADULT A.

7.10.4. ADULT A declined the support of Equation and it is clear that he was not honest about his relationship with Tina.

7.11. **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.**

7.11.1. The police IMR has identified that a number of measures have now been put in place to improve the number of Domestic Violence Disclosure scheme referrals. These include internal communications, in house training, inclusion in the DA victim booklet, a consideration for MARAC chairs as an action and promoted as an action for serial perpetrators.

7.11.2. In addition, funding has been secured for 2 x DVDS officers. This process will review which victims would be eligible for a DVDS across all risk levels and offer a right to know where required. This will result in a significant increase in the numbers of DVDS being completed and therefore improved safeguarding for survivors.

7.11.3. The role of DART in cases of survivors without dependent children who do not meet the criteria for support from Adult Social Care should be reviewed. A high proportion of survivors will **not** have care and support needs as defined by the Care Act 2014, and therefore the purpose of DASH RICs being considered by DART for such survivors is questionable.

7.11.4. This review has established that the intervention of the CRC fell below expected practice. The CRC have considered whether this was systemic in terms of agency practice or specific to the CRC Officer involved. They have formed the view that the practice issues were specific to the CRC officer, and that this was not the standard of practice that the Officer would usually demonstrate. That said, the CRC have made recommendations arising from this review that focus upon multiagency information

sharing and gathering. In addition, the CRC have identified a need for greater analysis of their workforce's knowledge and understanding of interfamilial abuse and its links to partner abuse.

7.12. 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 Tina, and the wider public.

7.12.1. A key lesson from this case is that of a distinct lack of professional curiosity. This can be seen from the contact that the GPs had with both Tina and ADULT A and from the DLNR CRC's interventions with ADULT A. The reason for Tina's decision to withdrawn from Women's Aid services could also have been probed further.

7.12.2. Tina's employer should have demonstrated greater professional curiosity regarding the nature of her relationship with ADULT A. They were aware that it was volatile. As a result of this review, the school has made a number of changes to their working practices as an employer. They have reviewed their Trust wellbeing policy and attendance policy with their HR team and have amended the welfare meeting proforma to support open conversations and have given guidance on how to record these meetings. In addition, they have created and distributed a Domestic Abuse Guidance resource to head teachers, with supporting questions, signposting to support services and advice regarding recording. A poster signposting to support services for domestic abuse is now to be displayed in staff spaces. These are all encouraging developments.

7.12.3. The 2016 Domestic Homicide Case Analysis Report for Standing Together which undertook an analysis of themes emerging from 32 DHRs identified that findings from DHRs were underpinned by a lack of fundamental understanding of coercive control, a lack of focus on the perpetrator and the need for more professional curiosity in thinking beyond basic policy and procedure. These factors all apply in the case of Tina. Tina disclosed to the police and Women's Aid that ADULT A was very jealous, and she informed Women's Aid that he isolated her from her friends and family. The information shared by Tina's daughter (at paragraphs 5.8, 5.10 and 5.12) indicate that coercive control was a significant factor in Tina's relationship with ADULT A. He isolated her from her family, including on her birthday each year, controlled what she could wear and her hairstyles and would not allow her to socialise alone with friends. She was prevented from taking telephone calls from her daughter.

7.12.4. ADULT A would attempt to coerce Tina into lying for him and make threats to her family if she did not comply. It is believed that Tina was scared that ADULT A had the capability to carry out his threats. The agency records do not evidence coercive control however the information shared by Tina's daughter provides a very clear picture of the extent of the control to which Tina was subjected to by ADULT A.

7.12.5. ADULT A's threats extended to Tina's adult son who has learning needs and was living with her. ADULT A attempted to force Tina's son out of the home by making threats. There were no agencies working with ADULT A and as such there was no professional awareness of these threats and any risks posed to Tina's son by ADULT A.

7.12.6. The 2016 report also found that in just over half of the cases analysed, the GP missed opportunities to ask the victim about domestic abuse and there was a lack of professional curiosity about relationships with partners. This is evident in the GPs contact with Tina. The same study found that in a quarter of the DHR reports there were missed opportunities for GPs to enquire about domestic abuse with perpetrators. ADULT A visited his GP and spoke of being verbally aggressive but this did not lead the GP to consider whether ADULT A was a perpetrator of domestic abuse.

7.12.7. It is of note that this study also identified that professionals should bear in mind that often friends, colleagues and family ('informal networks') hold vital information around the level of risk to victims of domestic abuse. It is evident in the case of Tina that her daughter and the sister and brother in law of ADULT A held lots of information that was not known to professionals. The CRC would not have made contact with ADULT A's family members in order to obtain further information about ADULT A's harassment and abuse of them as it was not the type of case where victim contact was expected. The CRC will not contact victims unless under the formal umbrella of the victim liaison scheme which was not applicable in the case of ADULT A. This is unfortunate as such contact could have firstly been used to counter challenge his assertions that he was the victim and might also have highlighted his pattern of abusive relationships. The risk posed to Tina may then have been more greatly understood.

7.12.8. Had there been greater professional curiosity alongside the undertaking of safeguarding checks which were expected practice yet not complied with, the CRC Officer would have had a greater understanding of the history of domestic abuse; the seriousness and frequency of behaviour and the risk that ADULT A posed to Tina.

7.12.9. It is known that survivors of domestic abuse are most likely to confide in people that they know and trust. As is stated on the Women's Aid national website 'this can include friends, family or people within their community. But a lack of understanding and confidence can make these people unsure of how to respond when someone finds the courage to speak out.' It is clear in the case of LT and ADULT A that family members who were worried about Tina or aware of the risks posed by ADULT A felt powerless. Women's Aid are attempting to change this via their Change That Lasts Ask Me scheme. This scheme is delivered in partnership with local communities and allows everyday people to become Community Ambassadors. Through training sessions, they will then be equipped with an understanding of domestic abuse and how to respond to survivors. Locally, this will continue to be developed by Juno and Equation.

7.12.10. The Independent Author has considered the Intimate Partner Timeline developed by Dr Jane Monckton Smith. Tina's relationship with ADULT A progressed through the stages of the timeline. Stage one: ADULT A had a history of domestic abuse;

stalking and violence. He did not accept challenge and was confrontational. Stage two: ADULT A started spending time at Tina's home very soon into their relationship (after one month) although he later secured his own accommodation. He appeared to be possessive of Tina from a very early stage in their relationship. Stage three: the information shared by Tina's daughter indicates that ADULT A was jealous and possessive. He isolated Tina and made threats to her adult children. There were incidents of violence and a clear pattern of coercive control. Stage 6 of Dr Jane Monckton Smith's timeline suggest that there may be a last attempt at reconciliation such as a holiday. It is known that Tina and ADULT A separated and reconciled on a number of occasions. When Tina commenced a new relationship, ADULT A made threats to this man to towards his elderly mother. The information provided by Tina's daughter suggests that ADULT A would convince Tina to resume the relationship, and significantly he convinced her to go away with him for her birthday where she was fatally assaulted by ADULT A.

7.12.11. Dr Jane Monckton Smith's research states that where there is progression through stages 3-5, there is a much higher likelihood that separation will be very difficult, impossible or dangerous. Where there is progression to stage 5 to 7, there is a much higher likelihood of an attempt on the victim's life. Tina's timeline, when viewed in the context of this research, indicates that she found it impossible to separate from ADULT A due to the control that he exerted over her.

7.12.12. Learning identified by individual agencies as noted in their Individual Management Reviews are listed below:

Nottinghamshire Police

- All staff engaged in the domestic abuse process should be reminded the DVDS has an element of right to know as well as right to ask.
- Nottinghamshire Police include DVDS questions within the risk assessment process. This will ensure staff consider both elements of the DVDS in each case of Domestic Abuse.

Probation (including DLNR CRC)

- Ensure that all information available on NDelius/from Court/from Police is acted upon appropriately and ensure all relevant checks are undertaken where there is evidence of any domestic abuse.
- Ensure that all decisions linked to a case are fully documented – demonstrate how and why a case decision has been made – this should include changes to planned interventions.
- Use Professional Curiosity to challenge and investigate information provided by the service user particularly in relation to safeguarding issues and share such information with relevant agencies.
- Ensure OASys assessments detail all known concerns and reflect any other assessment made for interventions.
- Review OASys assessment when new information is provided

- Ensure that recent attendance on the Domestic Abuse and Safeguarding Refresher training is transferred into practice and any learning is discussed in Supervision.
- Use of Supervision and Management Oversight recording in NDelius to demonstrate discussions with line manager about domestic abuse and safeguarding concerns.
- An analysis into the knowledge and understanding of staff of interfamilial abuse and links to partner abuse and an action plan if any learning needs are identified.

NHS Nottingham and Nottinghamshire CCG

- The CCG to undertake further analysis into barriers for GPs in completing details of family groups and relationships to identify ways of improving practice.

7.13. **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.**

7.13.1. DHR Chapeau has made the following recommendation which is relevant to this DHR:

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

7.13.2. In the case of Tina, there were occasions where she was seen as the perpetrator and there was a view that both she and ADULT A were equally as volatile and abusive. From the information shared by family members, it is clear that ADULT A was the primary aggressor/perpetrator. A greater understanding of the types of violence and its correlation with gender would assist in agencies correctly understanding the risk to the most vulnerable person.

7.13.3. The process and progression of this DHR has highlighted that there are issues locally in respect of capacity and the provision of support/resources specifically for Adult Social Care and GPs. For example Adult Social Care do not have a designated representative for MARAC and there is no support pathway in relation to domestic abuse for GPs. Although this did not have an impact on Tina, it is evident that this is a gap in local service delivery and should be considered by strategic senior officers.

8. Conclusions and lessons learned

8.1. It is clear from the history of this case that ADULT A had a history of targeting vulnerable women and this dated back to his time spent in Scotland. However, his profile and offending history were such that he did not trigger offender management systems. He was not perceived to be a high risk offender. The police in Scotland were unaware of ADULT A's return to Nottingham and had no requirement or statutory basis upon which to monitor his movements. Once in Nottingham, there was opportunity to offer Tina the DVDS and measures have now been taken to increase police capacity to do so.

8.2. It is clear that greater professional curiosity could have been shown by those agencies in contact with ADULT A and Tina. A more proactive approach to DVDS could have provided information to Tina about ADULT A's history although it is likely that the level of coercive control exhibited by ADULT A towards Tina made it very difficult for agencies to engage and support her.

8.3. Had all information been pooled together by the CRC they would have had a different assessment of risk of ADULT A. However, even if the CRC had obtained all relevant background information and assertively managed ADULT A's case; the likelihood is that he still would not have been deemed to be an offender who was a risk of committing homicide.

8.4. The decision made by ADULT A and his persuasion to take Tina away for her birthday could not have been changed by professional intervention. ADULT A's actions, and his actions alone, caused Tina's death.

9 Overview Recommendations

All agency IMR recommendations are submitted as an appendix to this Review.

The overview findings and recommendations are as follows:

a) As with many DHRs, the issue of recording of relationships on systems requires further action. How agencies record information – names, dates (who, when, what, why) and the linking and recording of relationships by all agencies requires review. The CDP Board and Safeguarding Partnerships should provide the steer for this.

b) A significant factor within this DHR has been that of professional curiosity. This should be embedded within the local failure to engage framework and a briefing note disseminated across agencies within the City.

c) Those women without dependent children who do not meet the criteria for adult social care are slipping through the net in terms of domestic abuse support. Older survivors are even less likely to engage with support services. A review of this cohort and a needs analysis should be completed on a local and national level.

Appendix A: Terms of Reference

Domestic Homicide Review

November 2019, revised January 2020

Terms of Reference Operation Loam

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 inform national and local policies and procedures as appropriate;
4. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
5. Contribute to a better understanding of the nature of domestic violence and abuse; and
6. Highlight good practice.

The guidance also states:

> "It is, however, important to note that reviews should not simply examine the conduct of professionals and agencies. Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions

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.

Instigation of the Review:

A notification was received on 12th June 2019 from Sargent Andrew McWatt the senior investigating officer, EMSOU Nottinghamshire Police of a death 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 briefing note setting out

the circumstances leading to the death is attached at **Appendix A**, this sets out the Nottinghamshire Police briefing giving more information about the case.

The Chair of the Nottingham Crime & Drugs Partnership considered the notification and after having considered and consulted with Board members the Chair agreed to invite Hayley Frame to chair and author the 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. Hayley Frame was known to be someone with the requisite skills, knowledge and experience to take the responsibility. (As set out in paragraph 36-39 of the guidance)

3. The appointee had 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.

Prior to sending the final review to the Home Office Quality Assurance Group, a completed version of the review will be provided to the family. This will allow consideration of the other findings and recommendations. It is then possible to record any areas of disagreement.

Publication of Overview Reports and the Executive Summary will take place following agreement from the Quality Assurance Group at the Home Office and will be published on the local CSP web

The initial stakeholder group has been identified as:

- The immediate surviving family members of the victim and where appropriate the offender.
- Nottinghamshire Police.
- Office of the Nottinghamshire Police and Crime Commissioner.
- The Crown Prosecution Service.
- Nottingham Coroner.
- Departmental Directors of Nottingham City Council.
- Senior management of voluntary sector services involved in delivering domestic violence services.
- NHS England.
- Greater Nottinghamshire Clinical Commissioning Group Partnership.
- Nottinghamshire Healthcare Foundation Trust.
- Nottingham CityCare
- Nottingham City (and where relevant 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.
- HM Prison Nottingham

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 Chair and Author 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.

An advocate for the Family will be arranged to ensure they are considered as key stakeholders throughout the review process.

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 may 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'.[6]

The review will follow the key processes which are outlined in the multi-agency statutory guidance for the conduct of DHRs.

The Terms of Reference are a live document and will be reviewed at panel meetings.

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 Tina. The DHR panel send their sincere condolences to the victim's family.

The offender in this case will be referred to as ADULT A. Should the Panel consider it necessary, on evidence and reflection, to extend the scope of the 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 17/11/2013 which is the earliest known date when domestic violence was identified between the subjects of the review.

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

Terms of Reference of the Review:

Matters for Authors of IMRs:

1. To identify all incidents and events relevant to the named persons (Tina and ADULT A) 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 (Tina) and/or offender's (ADULT A) needs.

[6] Ratified by the Nottingham City Crime and Drugs Partnership on the 11th December 2017.

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

4. Consider the efficacy of IMR Authors' agencies involvement in the Multi Agency Risk Assessment Case Conference (MARAC) process

5. To establish whether practitioners and agencies involved considered the levels of risk as identified in the DASH RIC appropriately taking into account:
    i. The number of incidents in the relationship between Tina and ADULT A, not just incidents against that individual.
    ii. The referral onto agencies (via the DART) for notification of the abuse (with a specific requirement for DART to provide information regarding the actions arising from each DASH RIC received)
    iii. Counter allegations
    iv. The history of abuse in their relationships and previous relationships

6. To establish whether practitioners and agencies involved used routine enquiry and scoped patterns of abuse when domestic abuse was discussed / disclosed and how this information was shared with partner agencies.

7. To establish whether practitioners and agencies involved recorded information appropriately to identify named persons in their records when domestic abuse was identified and explored relationships, e.g. did not just state partner / son.

8. To establish whether the role of IRIS within the GP setting was available and if it was, was it utilised and if not why not.

9. Determine if agencies relied too much on self reporting events / information from Tina and ADULT A and did agencies scrutinise and challenge self-reported events.

10. To establish if the risk posed by ADULT A was managed appropriately and if how this was impacted by the complexities of the criminal and civil arenas working in silo.

11. To what extent were the views of the victim (Tina) and offender (ADULT A), and significant others, appropriately taken into account to inform agency actions at the time.

12. 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.

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

14. 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.

Ownership of IMRs

Clearly identify the purpose of the IMRs and who owns them.

Where an agency has commissioned its own IMR, that agency will own that IMR. Where an IMR has been created which is not owned by an agency e.g. MARAC IMR, the ownership of such an IMR will be determined on a case by case basis.

Matters for the Review Panel to Consider:

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.

Identify areas of good practice from single agency, multi-agency or individual work.

Excluded Matters:

The review will exclude examination of how the victim died or who was culpable, these are matters for the Coroner and criminal courts respectively to determine.

Family Involvement:

The family will be given the opportunity to be involved in this review throughout the whole process. This should be from helping determine the Terms of Reference to actions and recommendations from the review. The Family will be invited to meet all the panel members. Family members will be provided with an independent advocate if they wish to be involved in the review process.

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 / DHR Chair.

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

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[7], 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 together with their Individual Management Review.

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.

Local IMR guidance will be issued to all agencies undertaking an IMR, this includes guidance on interviewing staff and draft letters for use.

Media Strategy

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 Loam Media Strategy for further information.

Membership of the Review Panel:

Hayley Frame, Chair and Author

Jane Lewis, Nottingham Crime & Drugs Partnership

Paula Bishop, Nottingham Crime and Drugs Partnership

Jennifer Allison, Juno Women's Aid

Clare Dean, Nottinghamshire Police

Tamsin Marley / Nat Cunningham / Lisa Adkins-Young National Probation Service – Nottinghamshire

Rhonda Christian / Nick Judge Greater Nottinghamshire Clinical Commissioning Group Partnership

Jon Webb / Sue Parker Derbyshire Leicestershire Nottinghamshire and Rutland Community Rehabilitation Company

Martin Holvey East Midlands Special Operations Unit

Andrew McWatt East Midlands Special Operations Unit

Samantha Danyluk Nottingham City Children and Families Direct - DART

[7] 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.

Ishbel Macleod Nottingham City Adult Services – DART

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.

Version: 2 (22nd January 2020)

Appendix B: CDP Board updates on delays

DHR loam delay October 2019.docx

CDP Board agree to DHR Loam Delay 07-1

DHR update on delay for DHR Loam_ Decer

CDP Board agree to further DHR Loam del

DHR Loam delay due to covid June 2020.dc

CDP Board agrred to delay for DHR Loam 1

DHR Loam update for CDP Board Sept 2(

CDP Board Minutes 21-09-2020.docx

Appendix C: Action plan

DHR Loam Action plan _COMPLETE 1st I

Appendix D: IMR recommendations

DHR Loam IMR actions_COMPLETE.dc