Nottingham Crime and Drugs Partnership

DOMESTIC HOMICIDE REVIEW

'Maria'

Date of Death: August 2020

EXECUTIVE SUMMARY

November 2022

Chair and Author: Carol Ellwood-Clarke QPM

Independent support to Chair and Author: Ged McManus

CONTENTS

Family Tribute

Maria's daughter provided the Review Panel with the below poem, written by Maria to her Mother in 1999 –

I'm Sorry and I Love You

My brother's they have gave you grief,
But I have gave you pain,
Every time I try my best,
I make it worse again.

I always make you worry,
I make you feel upset and cry,
All I want's to make you happy,
though I get it wrong and don't know why.

I hope that you can understand,
that I have never meant to hurt you.
If you understand and hate me not,
I will find happiness that this time is true.

I could even get to like myself,
Just by knowing you understand.
If I know that your behind me,
then on my feet I'll land.

Thanks for being patient,
for always being there,
for always loving me,
for always showing me you care.

I feel honoured with your friendship,

unworthy of love so true.

In debt for all you've done for me,

SO GRATEFUL FOR HAVING YOU.

I Love you Mum, your loving daughter xxx

Dated – 25 October 1999

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Nottingham Crime and Drugs Partnership [the statutory Crime and Disorder Partnership] in reviewing the homicide of 'Maria' a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator.

Name	Relationship	Age	Ethnicity
Maria	Victim	48	White British female
Alan	Perpetrator	59	White British male

1.3 Maria died following injuries sustained in an assault by Alan. Alan was arrested and convicted of the manslaughter of Maria and sentenced to 6 years and 9 months imprisonment.

1.4 Nottingham Crime and Drugs Partnership determined the death of Maria met the criteria for a Domestic Homicide Review [DHR][1]. All agencies that potentially had contact with Maria and Alan prior to the homicide were asked to secure their files. The panel met six times and due to the Covid-19 pandemic all meetings were held online. Maria's family were involved in the review process, having access to the report and contact with the Chair. The family attended a panel meeting to discuss the report and review. The overview report was presented to Nottingham Crime and Drugs Partnership Board Chair on 15 October 2021 for sign off and formally presented to the CDP Board on 13 December 2021.

1.5 Amendments were requested by the Home Office on 21st June 2022 and the amended report was resubmitted to the Home Office on 21st September 2022.

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

2. CONTRIBUTORS TO THE REVIEW

2.1 The table below shows the agencies that contributed to the review and the material they were able to supply.

Agency	IMR	Chronology	Report
Adult Social Care – Nottingham City Council	✓	✓	
Changing Lives CF03 Project			✓
Crown Prosecution Service			✓
Department for Works and Pensions (DWP)			✓
Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company	✓	✓	
East Midlands Ambulance Service (EMAS)	✓	✓	
Edwin House		✓	✓
Framework Housing Association	✓	✓	
Housing Aid – Nottingham City Council	✓	✓	
Jericho Road		✓	✓
Juno's Women's Aid	✓	✓	
MARAC[2]			✓
NHS Nottingham and Nottinghamshire Clinical Commissioning Group	✓	✓	
National Probation Service	✓	✓	
Nottingham Healthcare NHS Foundation Trust		✓	
Nottingham Recovery Network	✓	✓	
Nottinghamshire Police	✓	✓	
Nottingham University Hospitals		✓	✓
Women's Centre		✓	✓
YMCA	✓	✓	

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

[2] MARAC – this is the collective response and collation of information sharing and minutes from MARAC process. The report from MARAC for the purpose of this review identified which agencies held information about individuals, what actions were created and if they were completed.

- Nottingham City Homes
- Equation Men's Service
- Neighbourhood Development Team
- Opportunity Nottingham
- Nott's SVSS
- Nottingham SARC – victim on system but did not have face to face assessment.
- St Ann's Advice Centre
- DHU Healthcare CIC – No 111 contact with victim since 2017
- Nottingham Trent University
- Nottingham University
- Nottingham Fire and Rescue Service
- CityCare
- Community Protection
- Opportunity Nottingham
- Children's Social Care

2.3 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

3. THE REVIEW PANEL MEMBERS

3.1 The Review Panel members were:

Review Panel Members		
Name	**Job Title**	**Organisation**
Lisa Adkins-Young	Interim Deputy Head	National Probation Service, Nottinghamshire
Jennifer Allison	Head of County Services	Juno Women's Aid
Andrew Baxter	Deputy Chief Crown Prosecutor	Crown Prosecution Service, East Midlands
Paula Bishop	Domestic Violence & Abuse Policy Officer	Nottingham Crime & Drugs Partnership
Lisa Del Buono	Service Director	Framework Housing Association
Clare Dean	Detective Chief Inspector	Nottinghamshire Police
Carol Ellwood-Clarke	Independent Chair and Author	
Lucy Gascoigne	Head of Safeguarding	East Midlands Ambulance Service (EMAS)
Jay Grech	Area Manager Midlands and North West	Changing Lives CF03 Project
Kerry Jackson	Advanced Customer Support Senior Leader	Department for Works and Pensions (DWP)
Grace Kinsey	Specialist Safeguarding Practitioner	NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Ishbel Macleod,	Performance and Clinical Change Manager	Nottingham City Council Adult Services
Julie McGarry	Lead for Domestic Abuse and Sexual Safety	Nottingham Healthcare NHS Foundation Trust
Ged McManus	Independent Reviewer	
Sue Parker	Interim Deputy Head of Service	DLNCRC

Yasmin Rehman	Chief Executive Officer	Juno Women's Aid
Debbie Richards	Service Manager	Nottingham City Council Housing Aid
Julie Stevens	Safeguarding and Assessment Quality Assurance Practice Lead	Adult Social Care
Emily Stringer	Adult Safeguarding Specialist Practitioner	Nottingham University Hospitals
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospitals NHS Trust

3.2 The panel met six times and the Panel Chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review Chairs and Authors.

4.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing) in 2017 after thirty years, during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[3].

4.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not Nottinghamshire). He served for over thirty years in different police services in England (not Nottinghamshire). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

4.4 Between them, they have undertaken the following types of reviews: child serious case reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and, have completed the Home Office online training for undertaking DHRs. In addition, they have undertaken accredited training for DHR Chairs, provided by AAFDA.

4.5 Carol Ellwood-Clarke has recently completed another DHR for Nottingham Crime and Drugs Partnership, which is currently with the Home Office for quality assurance.

[3] https://safelives.org.uk/

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The Panel settled on the following terms of reference at its first meeting on 10 November 2020. The DHR panel set the period of review from 1 September 2018 (start of relationship) to 1 August 2020.

5.2 **The purpose of a DHR is to**:

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

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

- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

- 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;

- contribute to a better understanding of the nature of domestic violence and abuse; and

- highlight good practice.
  [Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7]

5.3 **Specific Terms**

1. 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.

2. What evidence did your agency have that identified Maria at risk of domestic abuse, including coercive control? Did your agency's response follow inter-agency and multi-agency procedures in response to the victim's needs?

3. Establish whether relevant single agency or inter-agency responses to concerns about the victim and the assessment of risk to her and others was considered and appropriate.

4. What evidence did your agency have that identified Alan as a perpetrator of domestic abuse, including coercive control? Did that response follow inter-agency and multi-agency procedures in response to the offender's needs?

5. Establish whether relevant single agency or inter-agency responses, to concerns about the offender and the assessment of risk to him and his risk to others, were considered and appropriate.

6. Consider the efficacy of IMR authors' agencies' involvement in the multi-agency risk assessment conferencing (MARAC)[4] process.

7. Consider the efficacy of IMR authors' agencies' involvement in a multi-agency /Multi-disciplinary Team meetings regarding domestic abuse.

8. How did agencies respond to the transient lifestyle, including mental health and substance misuse, of the victim and offender?

9. To what extent were the views of the victim and offender (and where relevant, significant others) appropriately taken into account to inform agency responses?

10. Identify any areas where the working practices of agency involvement had a significant positive or negative impact on practice or the outcome. Including, agencies' response to the victim and offender's engagement with their service.

11. Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to the victim and/or offender, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic and impact on national and/or local policy and guidance.

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 and worked together to manage risk and safeguard the victim, and the wider public.

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.

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4 https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

6. SUMMARY CHRONOLOGY

6.1 Maria

6.1.1 Maria was described by her daughter 'as someone who craved to be loved; however, this craving drove her towards predatory men'. Maria had five children, two of whom were adopted at birth and are living with adoptive families. Maria had a number of relationships which were abusive until she met a male in 2000. Maria started using heroin whilst in this relationship. In 2019 the male committed suicide which then led Maria back to abusive relationships. Maria's daughter stated that her Mother had undiagnosed mental health problems, and at the age of 38 she had been diagnosed with bipolar. Maria consumed alcohol, often to excess. Maria's use of illicit drugs and alcohol led to involvement of Children's Social Care. The last contact with the service being in 1999.

6.1.2 Maria was very literate and enjoyed writing poetry. Maria had written a piece for a national magazine on her life experiences. Maria gave great life advice to her children. Her family described her as being the 'prison mum' who other inmates went to for advice.

6.1.3 After leaving prison Maria went to live with her Mother but was not able to stay in the accommodation long term as she lived in a complex for older people. Maria felt her Mother was judgemental of her past behaviour which impacted on Maria's ability to live with her Mother.

6.1.4 Whilst in prison Maria had reconnected with her Christian faith and upon release had started to attend a Church in Nottingham. After she met Alan Maria stopped going to Church as the family described how it was too difficult for Maria to have time away from him. The review have not been able to identify which Church Maria attended.

6.2 Alan

6.2.1 Alan has a criminal record. He was first convicted in 1974. Alan is known as a perpetrator of domestic abuse with previous partners dating back to 2009. Alan has three convictions for domestic abuse from 2013, 2016 and 2018. On 26 March 2018 Alan was sentenced to 23 weeks imprisonment for an assault of his then partner. Alan was also issued with a restraining order. Alan has been heard at MARAC[5] as a perpetrator of domestic abuse in 2011 and 2018.

[5] Multi Agency Risk Assessment Conference

6.3 Maria and Alan's Relationship

6.3.1 Maria's family described Alan as controlling and violent. The family provided examples of his behaviour during contact with the Chair. The family stated that Maria had recently moved from her Mother's address when her relationship with Alan began. Alan had stable accommodation and an income from his work [undeclared] and this provided Maria with stability. Maria's family felt that she was judged for her past behaviours and would not get the chance of stable accommodation hence her acceptance of her situation with Alan and stated that Maria was prepared to put up with violence in order to stay away from drugs in hostels and other accommodation.

6.3.2 It was quickly apparent to the family that the relationship between Maria and Alan was violent. Maria began drinking excessively again. Maria told her daughter, 'If I get drunk, I don't feel the beatings'. On one occasion Maria's daughter drove to Nottingham concerned for her Mother's safety and described how Alan had been obstructive and had hidden Maria's bank card. Maria's family stated that she always ensured she had the exact change in her purse, to cover her bus fare, should she ever need to flee the violence and return to her Mother's house. The family stated that this was part of her safety planning and recalled how regardless of what situation she would be in, she would never spend the money. The family stated that upon her death, she had that money in her possession.

6.3.3 Maria's daughter described how her Mother was not allowed to bathe on her own, and that Alan insisted that they bathed together every night, and that only he could wash her hair and body. Maria's daughter recalled an occasion where her Mother had bathed at her house, and when Alan came to the house and discovered this he started shouting at Maria, and challenged her as to who had washed her body, stating that it was his, and only he could touch it.

6.3.4 Alan stated that he had met Maria in a pub in Nottingham city centre. She had moved into his flat as the place that she was living was not very nice and they had lived together for a time. Alan said that he was working every day as a jobbing builder and gardener whilst Maria didn't work. Alan said that his relationship with Maria wasn't consistent and that she would come

https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

and go from his flat as she wished. During the times when she wasn't living at the flat, they would still get together, for example Alan might find Maria waiting for him at the bus stop when he went to work in the morning, or they would meet after he had finished work and go for a drink.

6.4 Key Events

6.4.1 In 2014 Maria was assaulted and suffered a significant brain injury. The injury required surgery for a bleed on the brain and medical treatment. The assault was not domestic abuse related.

6.4.2 In October 2017 Maria was being managed by National Probation Service. Maria was referred to Nottingham Recovery Network for her alcohol and substance misuse, her engagement was inconsistent. It was known that Maria did on occasions use illicit drugs and consume excessive alcohol. In December 2017 Maria moved into accommodation provided by YMCA and reporting as homeless.

6.4.3 In February 2018 Alan was discussed at MARAC following an assault on his then partner. An action was raised at the meeting for a DVDS[6] to be considered if Alan became involved in another relationship.

6.4.4 During the first six months of 2018 Maria was in a relationship that was violent. Maria was seen by professionals with injuries sustained from assaults. In April 2018, a multi-agency meeting was held to discuss the risk to Maria and how professionals could support her in understanding the risk and safeguarding options. The offender for these assaults was recalled to prison in June 2018.

<u>September – December 2018</u>

6.4.5 On 11 September 2018 Alan was released from prison on licence until 8 March 2019 and supervision until 11 September 2019. Alan was supervised by DLNRCRC.

6.4.6 On 13 September, Maria reported that she had been assaulted by her partner. This was a new relationship. The perpetrator was not Alan. The male was a known perpetrator of domestic abuse. Maria was referred to

[6] Domestic Violence Disclosure Scheme
https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet

MARAC. Later that month, Maria was seen with facial injuries by staff from YMCA. Maria disclosed that she was 'in another abusive relationship'. Maria provided details of the abuse. The perpetrator was not Alan. Referrals were submitted to Adult Social Care. The case was allocated to a Social Worker and heard at MARAC. Over the following months, Maria was seen by professionals to have injuries sustained from her being assaulted by her then partner.

6.4.7 On 9 December 2018 Maria was assaulted by Alan. The matter had been reported by a member of the public. Alan was arrested. Maria declined to provide the Police with a statement. Alan was interviewed and released from custody. Advice was sought from the Crown Prosecution Service (CPS) and Alan was later charged with an offence of assault. This was the first account that agencies knew of the relationship between Maria and Alan. In December a multi-agency meeting was held to discuss the risks to Maria from her previous relationship (offender now in prison) and her new relationship with Alan.

6.4.8 On 15 December Maria made a 999 call to the Police. The Police found Maria at Alan's address, Alan asked Maria to leave the property. No offences were reported or identified. The incident was not recorded as domestic abuse. Three days later Maria was seen with facial injuries. Maria told professionals her relationship with Alan was just friendship. A MARAC meeting was held, Maria was offered and declined support from an IDVA[7].

2019

6.4.9 On 10 January, the IDVA closed Maria's case. Six days later, Maria's Probation Officer contacted Juno Women's Aid to request support for Maria. Maria was placed on a waiting list for RISE[8] . Contact information was provided for the helpline for emotional support and the Women's Centre. On 18 January the Police responded to a 999 call made by Maria, during which a male could be heard shouting. Both Maria and Alan were intoxicated. Maria was taken to her own accommodation. This incident was not recorded as domestic abuse.

6.4.10 At the beginning of February, the Police received a call that Maria had been assaulted by Alan. Maria was seen several days later and denied that she

[7] Independent Domestic Violence Advocate
[8] https://equation.org.uk/rise-service/
Rise is Nottingham City medium risk support for domestic abuse.

had been assaulted. Maria had no visible injuries. On 6 March Maria was assaulted by Alan. The Police attended the incident and Alan was arrested and later charged with an offence of assault. Alan was released on conditional bail. It was understood that Maria had now moved into Alan's property. A DART[9] referral was completed which was risk assessed as medium. Contact was attempted with Maria, which was unsuccessful and the case later closed.

6.4.11 On 14 March, Maria's case was allocated from the waiting list at RISE; however, there were no contact details for Maria to progress contact. A request was made for contact information from Probation. This was not responded to and a further request for information was made on 12 April. On 10 April, Maria informed her Probation Officer that she wanted to access detox to address her alcohol consumption. A referral was completed for Edwin House.

6.4.12 On 16 April, Alan was arrested as he had breached his bail conditions. On 24 April, the Witness Care Unit sent a text message to Maria's mobile phone to remind her of the trial date. On the same day, Maria's Probation Officer referred her to Jericho Road. It was agreed for her to meet with a worker on 30 April, but Maria cancelled the appointment as she reported she had fallen out of a taxi and bruised her face. A further appointment was arranged for 3 May, which she attended.

6.4.13 On 28 April Maria's daughter contacted the Police and reported that her Mother had told phone her to say she was injured. Police found Maria with Alan. Maria denied that she had been assaulted. Alan was arrested for breach of bail and remanded in custody for the case to be heard on 3 May, when he was released from custody. The assault by beating offences had been dismissed.

6.4.14 In June 2019 Maria was seen in the Neurology Clinic in relation to chronic headaches and concerns in relation to her brain injury from 2014. Maria disclosed that she had recently fallen, which caused facial injuries. Maria was advised to reduce her alcohol intake. Maria was not asked about domestic abuse. On 13 June, Maria was taken to Edwin House, where she was admitted commencing a programme of detox. The following day, Maria self-discharged against medical advice.

6.4.15 On 26 June Alan appeared at court and pleaded not guilty to assault on Maria. This was related to the incident from 9 December 2018. The Court

[9] Domestic Abuse Referral Team

IDVA's had tried to contact Maria, but the contact number they had was no longer in use. The case was closed to the Court IDVA. A trial was arranged for 18 September 2019. Alan was released on unconditional bail. This case was later dismissed, and no further action was taken.

6.4.16 On 7 July Maria approached a Police Officer and reported that she was being controlled by Alan who limited what money she had and how many cans of alcohol and strength she could have. Maria said Alan constantly range her to see where she was, and he had to listen whenever she made a call. Maria provided a witness statement. Alan was interviewed and denied the offence. Maria later stated she wanted to retract her statement and would not support a prosecution.

6.4.17 On 20 August Maria's Mother contacted the Police via 999 and stated she had received a text message from Maria asking for help. Maria's Mother believed she was being assaulted by Alan. Police found Maria at Alan's address. Maria denied that she had been assaulted.

6.4.18 On 19 November, Maria made a 999 call to the Police to report she had been punched in the head and stomach by Alan. The Police were unable to locate or contact Maria for several days. When contact was made Maria declined to make a statement. Two weeks later, on 5 December, Maria approached a Police Officer and reported that she had been assaulted by Alan. Maria was seen to have blood around her mouth. Alan was arrested. Maria declined to provide a statement. The Police gathered evidence to present an evidence-based case to the CPS. This included details of the incident on 19 November. The CPS reviewed the case. No charges were made against Alan. The case was assessed as medium risk and referred to DART. The case was closed in accordance with DART policies.

6.4.19 On 18 December Alan was found rough sleeping by the Street Outreach Team. Alan was provided with accommodation. This was the only occasion Alan was seen to be rough sleeping.

2020

6.4.20 On 31 January, Maria telephoned the Police via 999 to report that Alan had taken her phone. The call was made from a phone box. Maria and Alan were found at his house. The phone was in Maria's bag. The Police took Maria to her Mother's address. On 18 February a member of the public contacted the Police and reported that they had found Maria in the street. Maria was semi-clothed and had been sexually assaulted. The offender was

arrested, and a Police investigation undertaken. Maria was referred to Adult Social Care.

6.4.21 On 16 April 2020 Maria contacted the Police via 999 and reported that Alan had taken her bank card and 'thrown' her out of the house. Maria informed the Police that she had given her bank card to Alan the previous week and had called at his house to collect it. Alan was not at the property. Maria was taken to another address.

6.4.22 On 25 May Maria was seen by the Street Outreach Team rough sleeping. Maria was provided with a contact card and made aware of the referral/assessment process. A week later, Maria was seen again by the Street Outreach Team. Maria stated that she was being abused but would not go into detail.

6.4.23 On 13 June, Maria telephoned the Street Outreach Team asking to be assessed. Maria was seen the following day, outside a volunteer centre. Maria disclosed that she was fleeing domestic abuse, perpetrated by her partner. Maria stated she was worried he was looking for her. The assessment took place on 16 June. Maria was referred to Housing Aid and signposted to somewhere she could get a shower (at her request). Maria's case was allocated to a Housing Aid advisor who called the number on the referral. The phone was answered by a male who described himself as Maria's friend. A message was left with the male asking Maria to call Housing Aid.

6.4.24 Maria telephoned Housing Aid on three occasions, the first being on 17 June, when the Housing Aid advisor was not available, and a message was left that Maria had telephoned. The Housing Aid advisor later called the number left by Maria but was advised by the male who answered the phone that Maria was no longer in his company. The Housing Aid advisor arranged to call the following day. The next day, the Housing Aid advisor made several calls to speak with Maria, these were all unsuccessful.

6.4.25 On 21 June Maria contacted the Police and reported that Alan had been threatening towards hers and would not let her go. The following day, Maria telephoned Housing Aid to speak with the Housing Aid advisor, a message was left for the advisor to call Maria back. The same day, the Police contacted the Street Outreach Team requesting if Maria had been seen due to the incident on 21 June. Maria was not seen by the Street Outreach Team until 22 June. On 23 June, Maria was seen by the Police and stated she was no longer in a relationship with Alan. Two days later Alan was

arrested for an offence of drunk and disorderly following an incident with a group of street drinkers. Alan was later charged in relation to this incident.

6.4.26 On 8 July, the Housing Aid advisor telephoned the Street Outreach Team and explained that they had been unable to contact Maria. A further call was made to the phone number on the referral, the male who answered the call stated he had not seen Maria for several days. On 28 July 2020, Maria was seen by the Street Outreach Team, rough sleeping. The following month Maria was found deceased.

7. KEY ISSUES ARISING FROM THE REVIEW

7.1 Maria had been a victim of domestic abuse in previous relationships and whilst in a relationship with Alan. These relationships were violent and the risk to Maria had at times been assessed as high. MARAC meetings had been held to discuss and manage the risk. Maria chose not to engage with IDVA services. Agencies who worked with Maria provided her with information on services available to support her should she feel confident to seek support.

7.2 Alan was a known perpetrator of domestic abuse. Alan had been convicted and served a custodial sentence for assaulting a previous partner, and upon his release he started a relationship with Maria. The risk that Alan presented to Maria was never disclosed to her. Maria's family advocated that the risk that Alan presented should have been shared wider to family to allow them to support Maria in managing and understanding the risk.

7.3 Alan had been charged with criminal offences following assaults on Maria; however, the cases did not progress, and Alan was never convicted of assaulting Maria. Alan's behaviour towards Maria was coercive and controlling. Maria's family provided the review panel with evidence of these offences. Maria told agencies that she was being 'controlled' by Alan. The family were not aware that Alan's behaviour was a criminal offence, which could have been reported to the Police.

7.4 Maria led a transient lifestyle. At times Maria was sleeping rough and sofa surfing. Agencies response to Maria's lifestyle was not flexible, when seeking to engage and make contact with her. Maria was not aware of key dates surrounding the criminal processes, as contact with her had not been achieved.

7.5 The review identified that the information sharing between agencies did not always provide evidence of Maria's complex needs and identified vulnerabilities, which then impacted on the level of service that was provided. The review identified that a co-ordinated multi-agency response would have been beneficial in this case, to share information, and identify a pathway for engaging with Maria to provide her with information and details of services and key dates.

7.6 The panel identified learning for all agencies and have made recommendations to address the key issues and identified learning.

8. CONCLUSION

8.1 Maria was a vulnerable woman who had been a victim of domestic abuse in previous relationships and during her relationship with Alan. These relationships were violent in nature. Maria would often not disclose the abuse or name her perpetrator to professionals for fear of physical reprisals. Maria's vulnerabilities meant that she was at risk of abuse from known perpetrators of domestic abuse. Maria would minimise this risk to professionals. Maria's family told the Chair that Maria had 'wanted to be loved'.

8.2 Maria led a transient lifestyle with no fixed residence. Maria was known to alcohol and substance misuse services. In the months prior to her death, Maria was reported to be "sofa surfing" and sleeping rough in a car park in Nottingham City Centre. Maria's vulnerabilities meant that she was at risk and a target for perpetrators of domestic abuse.

8.3 Alan was a serial perpetrator of domestic abuse. Alan had convictions for domestic abuse and had previously been sentenced to prison for some of these offences. At the time Alan commenced a relationship with Maria, he was on licence following his release from prison after conviction for assaulting a previous partner. Alan had never completed any work to address his offending behaviour. Information provided to the review by agencies and from Alan, detailed that he did not accept that he was a perpetrator of domestic abuse.

8.4 There were opportunities for Maria to have been provided with information to help her make informed decisions about the risks that she faced. Maria's family told the panel they felt that this information should have been disclosed to them, as well as Maria, as this would have allowed them an opportunity to have provided additional support and intervention with Maria.

8.5 During the latter few months of this case, agencies and professionals were having to work within the confines of local and national restrictions imposed due to the Covid-19 pandemic. This resulted in limited contact and engagement with Maria, with agencies having to adapt to new ways of working.

8.6 There have been significant changes within agencies organisational structures and service delivery, during the completion of this review. Whilst this has been recognised by the panel, the panel have identified learning from the review in relation to engagement with victims, information sharing, knowledge and awareness of domestic abuse and

support services. This learning has been embedded into recommendations. In addition to panel recommendations, individual agencies have identified learning for their respective agencies and made recommendations to address this. Throughout the completion of this review, panel meetings have reviewed individual agencies progression of implementing their learning.

8.7 Maria's family provided a valuable contribution to the review, by providing information, attending, and speaking to panel members via online meetings. In addition, the Chair met with Maria's family to share and discuss draft reports. The panel wish to extend their thanks to the family for this contribution.

9. LEARNING

9.1 DHR Panel learning

9.1.2 The DHR panel identified the following learning. Each point is preceded by a narrative which seeks to set the context within which the learning sits. Where learning leads to an action a cross reference is included within the header.

9.1.3

Learning 1 [Panel recommendation 1]
Narrative
During the completion of this review learning was identified for staff working with perpetrators of domestic abuse, which included understanding and reviewing risk, and gathering all relevant information to inform that risk.
Lesson
Understanding risk assessments and risk management are essential for practitioners who work will offenders of domestic abuse. Whilst work in this area has commenced, the learning needs to be embedded into practice.

Learning 2 [Panel recommendation 2]
Narrative
Victims who live a transient lifestyle may not respond to routine methods of contact such as letters or telephone contact. Services need to be able to adapt in these situations and consider other methods of engagement, including the identification of a lead professional or point of contact, to ensure that victims are informed of key events and dates within criminal court cases.
Lesson
Those involved in engaging with witnesses during the criminal justice processes, need to ensure that they have a flexible approach, and consider all options when seeking contact.

Learning 3 [Panel recommendation 3]
Narrative
Where information is missing from agency referrals, particularly for cases where there is evidence of complex needs and identified vulnerabilities, it creates a situation that the person or agency receiving that referral is not in possession of all the known facts and this can reflect on the level of service that they provide.

Lesson
Referrals for clients who have complex needs and identified vulnerabilities, should contain all relevant information, including vulnerabilities and areas of risk.

Learning 4 [Panel recommendation 4]
Narrative
There were opportunities on this case for information to be shared with the victim to help inform them of the risk that was present in their relationship. This did not occur. Whilst processes have been implemented to address this area of learning, the case has identified further learning around the consideration of sharing information to family members and/or named individuals, to allow those named persons to then provide advice and support to the person at risk.
Lesson
Information sharing with family members and/or named individuals can provide an opportunity for support and advice to be given to victims, in managing and understanding the risk.

Learning 5 [Panel recommendation 5 & 6]
Narrative
A multi-agency response that works with individuals who have identified vulnerabilities can provide a targeted approach that meets the needs of the individual's health and social needs. Professionals need to be aware of the Integrated Care Pathway and how they can refer eligible clients.
Lesson
The learning from this case should be disseminated to the Integrated Care Pathway to inform future commissioning of services. Professionals need to be aware of the Integrated Care Pathway and how they can refer eligible clients.

Learning 6 [Panel recommendation 7]
Narrative
The review identified that coercion and control was not known as a form of domestic abuse by the family. Whilst the review were aware of detailed publicity awareness campaigns that had taken place, it was identified that this had not been accessible to all areas of the community.
Lesson
Publicity campaigns need to ensure that they are accessible to all members of the community and that those campaigns provide information on the

types of domestic abuse, how concerns can be reported and how access to support agencies gained.

Learning 7 [Panel recommendation 8]
Narrative
The review heard how Juno Women's Aid were responding to the learning identified during the completion of this review, and the processes being undertaken to implement organisational change in response to the learning.
Lesson
Nottingham Crime and Drugs Partnership need to be provided with evidence that the changes being implemented, are embedded into practice to address the learning identified.

Learning 8 [Panel recommendation 9]
Narrative
The review identified that agencies needed to understand the complexity and vulnerability of victims, and how this affected engagement and provision of services. Services needed to adapt their methods of engagement and services offered, to ensure that they were inclusive, relevant, and accessible for all victims of domestic abuse.
Lesson
Flexible approaches need to be in place when working with victims, and providing services, including accommodation to victims of domestic abuse.

9.2 Agencies Learning

9.2.1 Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

- Response to accredited programmes for domestic abuse.
- Professional curiosity and challenge.
- Assessment of risk and sentence plans following new information.
- Completion of home visits.
- Risk Management and Supervision

9.2.2 East Midlands Ambulance Service

- Importance of obtaining and documenting the perpetrators details.

- Adult safeguarding referrals- Discussing concerns with the adult, gaining wishes and feelings and where possible gaining consent. Obtaining safe and up to date contact details.
- Recognising the safeguarding risks and impact on health for adults experiencing homelessness, those in temporary accommodation with transient lifestyles, substance misuse and domestic abuse.
- EMAS has no referral pathways into drug and alcohol services with consent. This may be an appropriate pathway for support especially when threshold for adult social care is not met.

EMAS have informed the review that work has begun on the development of a new pathway. As EMAS are a regional service this has been commenced in Lincolnshire once this has been established and proved effective, it will be mirrored across the other areas.

EMAS have provided the review with information in relation to their commitment to safeguarding training which includes –

- Recent review of Domestic Abuse Policy
- Information on 24-hour Domestic Abuse Helpline.
- Delivery of education using 'Think Family' approach. At the end of 2019-2020 EMAS were 93% compliant trust wide for safeguarding education.
- Continuing commitment to Safeguarding Education via a variety of training platforms.
- On 24 November an EMAS article was shared across the organisation to raise awareness with staff about the safeguarding risk associated with homelessness. The short film 'Lone' by Emmanuel House in Nottingham was also shared.

9.2.3 NHS Nottingham and Nottinghamshire Clinical Commissioning Group

- The use of alerts on system1 to note historical domestic violence which may lead the professionals to enquirer further with professional curiosity.
- Use of DASH –RIC with similar patients.
- To establish a process to contact patients who do not attend appointments but have a risk history that may suggest domestic violence.
- Recording of safeguarding outcomes.
- Recording of who present during consultations.

9.2.4 Housing Aid

- Recording of contact with individuals known to service user.

- Ensuring service user aware of available options to access service.
- Awareness of other agencies to facilitate contact.

9.2.5 Jericho Road Project

- Knowledge of vulnerabilities on receipt of referrals

9.2.6 Juno Women's Aid

- Recording on contact details. [This has been addressed within the organisation with more frequent case management and case reviews taking place to rectify this issue]

9.2.7 National Probation Service (Nottinghamshire)

- Information sharing.
- MARAC processes.
- Joint working with CRC Offender Managers.
- Adherence to drug testing policy.
- Management oversight.

9.2.8 Nottinghamshire Police

- Awareness of bad character evidence and processes to record information.
- Holistic overview.
- MARAC actions and outcomes.

9.2.9 Street Outreach Team – Framework

- Training on domestic abuse.
- Recording of information.
- Multi-agency working.
- Responding to additional interventions.

9.2.10 YMCA

- Broader stakeholder input into plans to support a robust approach to risk management and support.

10. RECOMMENDATIONS

10.1 Panel Recommendations

1 The Probation Service to provide evidence to Nottingham Crime and Drugs Partnership that the learning within this review has been embedded into practice.

2 That Nottingham Crime and Drugs Partnership seeks assurances from those agencies involved in the criminal justice system, and in particular the Witness Care Unit, that the learning from this case has been disseminated and embedded into practice. Also, that all options of engagement and contact with witnesses, including the identification of a main point of contact, are considered as part of the witness management process.

3 That all agencies involved in this review provide evidence to Nottingham Crime and Drugs Partnership that agency referrals, where there is evidence of complex needs and vulnerabilities, are populated with all relevant information including vulnerabilities and risk factors.

4 That the Home Office and Government consider the learning from this case in relation to third-party disclosure of information when reviewing current legislation and guidance in relation to domestic abuse.

5 That Nottingham Crime and Drugs Partnership ensures that the learning from this review is used to inform the ongoing work around the remit of the Integrated Care Partnership.

6 That all agencies involved in this review provide evidence to Nottingham Crime and Drugs Partnership that their agency is aware of the Integrated Care Pathway and referral pathway.

7 That Nottingham Crime and Drugs Partnership's Domestic Abuse Strategy details how it will respond to raising awareness on domestic abuse for all areas of the community, in particular, those with complex needs and additional vulnerabilities.

8 That Juno Women's Aid provide evidence and assurances to Nottingham Crime and Drugs Partnership that the operational changes and learning from this review have been embedded into practice. This recommendation should be completed within six months.

9 That all agencies involved in this review provide evidence to Nottingham Crime and Drugs Partnership on how their agency has embedded the learning from this review, in terms of engagement and services, including accommodation to victims of domestic abuse.

10.2 Agency Recommendations

10.2.1 DLNR CRC

1 Following new information relating to risk, service users should be instructed in for an additional appointment to discuss new concerns in a timely manner. There should be an appropriate response to this new information by the supervising officer e.g. reassessment of risk.

2 All domestic abuse perpetrators to have the following condition added to their licence. "To notify your supervising officer of developing intimate relationships".

3 Probation staff to be reminded to follow the existing policy for full risk assessment and sentence plans (OASYS Layer 3) to be completed on all domestic abuse perpetrators and for risk to be reviewed when there is new significant information.

4 Probation staff to be reminded to use all available sources of information, e.g. previous records when making risk assessment and sentence plan recommendations.

5 Probation staff to be reminded to follow the existing policy for police/safeguarding checks to be carried out on all domestic abuse perpetrators at the start of supervision and at points when new information relating to risk emerges.

6 Probation staff to be reminded to follow the existing policy for home visits to be carried out on all domestic abuse perpetrators upon release and at points when new information relating to risk emerges.

7 Probation staff to be reminded of the existing policy that new information received pertaining to risk is discussed with all appropriate agencies including the agency that provided the information.

8 Probation staff to be reminded to consider issuing formal warning letters to service users in cases where action e.g. recall for breach of licence conditions, is considered but not taken.

9 Probation staff to be reminded to refer to Pathway Interventions e.g. Safe Choices/Spectrum for domestic abuse perpetrators, when accredited programmes are not applicable.

10 Probation staff to be reminded to record details of one-to-one work carried out as per existing policy.

11 Probation staff to ensure that the principles of professional curiosity are applied to the risk assessment and risk management of service user.

12 Ongoing quality audits are completed by line managers to ensure that the expectations and requirements of key policy documents are implemented

10.2.2 EMAS

1 To continue to raise awareness to all EMAS staff via education, alerts, articles and audit the need to make safeguarding personal and the importance of discussing referrals with patients as well as consent.

2 EMAS to explore creating Pathways to drug and alcohol services for referrals with consent.

10.2.3 NHS Nottingham and Nottinghamshire CCG

1 The CCG need to explore the barriers to completing DASH-RIC in primary care services.

2 GP Services to apply a did not attend process for high risk/vulnerable patients with support of the CCG linking with primary care.

3 Use of alerts on system1 to guide professionals to make every contact count.

10.2.4 Housing Aid

1 Consider safe contacts and how to reach the victim where domestic is identified within referral. Be aware when speaking to 'friends' of the individual and record name and relationship to the individual within casefile.

2 Where contact cannot be established directly with the individual the Officer will make contact with the referring agency for support in making contact.

3 In person appointments / drop in offered where victims of abuse are identified and where they do not have their own means of contacting the service.

4 Where the service is unable to reach the individual consideration will be given to whether it is appropriate to refer to the Police for support.

10.2.5 Nottinghamshire Police

1 Nottinghamshire Police promote and raise awareness amongst staff of the use of Bad Character evidence in domestic abuse investigations.

A "living" document, for repeat perpetrators, could be created and flagged within NICHE for repeat perpetrators to reduce duplication of effort in repeat cases.

2 Nottinghamshire Police promote and raise awareness amongst staff, involved in the investigation of domestic abuse cases, the need to include the DV history of the victim and perpetrator in prosecution/ decision files.

3 Nottinghamshire Police ensure there is a process in place to manage actions, which may be protracted, raised at MARAC meetings.

10.2.6 Framework Housing Association

1 All staff will be fully trained with a refresher course on Domestic Abuse.

2 To consider a web based programme for the recording of information to mitigate any further risk of technology issues (access through the Citrix platform).