



SHEFFIELD SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

Report into the death of Adult I

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Date: November 2017

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1.0 Introduction

- 1.1 This Domestic Homicide Review has been commissioned due to the homicide of a 22 year old female (known for the purpose of this review as Adult I. Her family asked that the review does not use her own name or a pseudonym and are happy for this to be what she is known as for this review). The perpetrator of the homicide was an ex-boyfriend of hers (known for the purpose of this review as Adult IP). Adult I was murdered in Sheffield however she met and conducted her relationship with Adult IP in Nottingham primarily, but also in Essex.

A Domestic Homicide Review (DHR) is a statutory process under Section 9 of Domestic Violence, Crime and Victims Act (2004) which commenced on the 13th April 2011. The Act states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a) A person to whom he or she was related with or with whom he or she was or had been in an intimate relationship, or
 - b) A member of the same household as him or herself,
- and, is held with a view to identifying lessons to be learnt from the death.

The Home Office definition of Domestic Abuse is:

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

- psychological
- physical
- sexual
- financial
- emotional¹

2.0 Establishing the Domestic Homicide Review (DHR)

2.1 Decision Making

Sheffield First Safer and Sustainable Communities Partnership (SFSSCP) informed the Home Office on 14th June 2016 that the death of Adult I met the criteria for a domestic homicide review (DHR) as defined in the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013. (This guidance was updated in December 2016, which is after this review had started). The guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and states that it should be completed within a further six months.

2.2 DHR Panel

The SFSSCP appointed Dr Russell Wate QPM as the Independent Chair for panel meetings and to be the author of the overview report. The review is supplied by RJW Associates. Russell is an independent practitioner who has chaired and written previous DHR's, Child

¹ The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013

Serious Case Reviews and Multi Agency Public Protection Reviews. He is independent of any agency within the Nottingham, Essex and Sheffield area. He is a retired senior police detective (7 years ago from a police force not connected with any of the forces connected to this review), who is very experienced in the investigation of homicide. Three panel meetings have been held where attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via email and telephone. All of the panel members are fully independent of the case.

2.3 The Independent Panel comprised of:

Member	Role/Agency
Russell Wate Ian Tandy	Independent Chair and Author Assistant to Chair
Standing Panel Members	
Penny Brookes Pete Horner Victoria Horsefield Simon Richards	NHS Sheffield CCG South Yorkshire Police (SYP) Sheffield Safeguarding Children Board Sheffield City Council (SCC) Adult Safeguarding and Quality
Steve Eccleston Ann Powell	Sheffield City Council Legal Services National Probation Service, Sheffield
Co-opted Panel Members	
Paula Bishop	Nottingham Crime and Drugs Partnership (Domestic Abuse specialist)
Co-ordination Team	
Alison Higgins Alison Howard Steve Ashmore Simon Finney	Sheffield Drug & Alcohol/Domestic Abuse Coordination Team (DACT) (Domestic Abuse specialist) DACT Head of Police Investigation Strategic Commissioning Manager for Vulnerable Adults

2.4 Agencies submitting Individual Management Reviews (IMRs)

The following agencies submitted IMR's

- South Yorkshire Police (SYP)
- Sheffield Department for Work and Pensions
- Nottingham CityCare Partnership
- Essex Police
- Nottingham Trent University
- Nottinghamshire Police

- East of England Ambulance Service NHS Trust
- Nottingham City Council Adult Social Care
- Colchester Hospital University NHS Foundation Trust (CHUFT)
- Nottingham University Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust (NHCFT)
- NHS Nottingham City Clinical Commissioning Group (NCCCG)
- Shelter

Other agencies provided chronologies and supplied relevant information as requested. This report has been shared with the Police and Crime Commissioner for South Yorkshire Police.

2.5 Notifications and Involvement of Families

It is important in DHR's that family members, friends and colleagues are given the opportunity to participate. For this review they have contributed and their perspective is included in this report. Adult IP has been asked if he wishes to participate and consent has been requested from him – he has declined to participate.

3.0 Terms of Reference

The purpose of this DHR is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work both individually and together to safeguard and support victims of domestic abuse including their dependent children.
- 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 abuse victims and their children through improved intra and inter-agency working.

In addition, the following areas will be addressed in the Internal Management Reviews and the Overview Report. These are specific terms of reference considered in undertaking this Domestic Homicide Review as agreed:

- Was there appropriate sharing of information geographically across areas, specifically Nottingham, Essex and Sheffield?
- Was there appropriate disclosure and sharing of information between and within agencies?
- Was there sufficiently detailed recording of information by professionals?
- Was appropriate pastoral care offered by Nottingham Trent University where Adult I was an undergraduate student?
- Was there a possible failure to signpost or refer appropriately, or failure to record signposting at the GP practice in Nottingham?
- There are similarities with other DHR's in Sheffield in that both the victim and perpetrator are migrants to the UK.
- Previous DHR's have also identified issues with GP's and Primary Care information sharing.

- Both the victim and perpetrator are BME migrants but had no language issues; the victim was disabled as a result of the condition scoliosis (abnormal twisting and sideways curvature of the spine.)
- The review will consider any other information that is found to be relevant.
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3.1 Timeframe under Review

The DHR covers the period from 1st September 2013 when the victim Adult I is believed to have met Adult IP to when Adult I died. Essex Police have provided further information outside these time scales regarding incidents involving Adult IP and his ex-partner Adult IPCM in 2012.

3.2 Subjects of the DHR

Deceased female and subject of DHR	Adult I
Male partner of Adult I charged with her murder	Adult IP
Mother of Adult I	IM
Brother of Adult I	IB
New male partner of Adult I	IP2
Adult IP's mother	IPM
Adult IP's previous female partner and mother of his children	IPCM
Male child of Adult IP	IPC1
Female child of Adult IP	IPC2
Female child of Adult IP	IPC3

4.0 Background Adult I and Adult IP

4.1 The victim Adult I moved to the UK in 2005 from Zimbabwe aged 12 years old, with her mother Adult IM and settled in Sheffield. Her brother IB moved to the UK in 2009. Adult I has a father and sister who remained in Zimbabwe but were in contact and kept close as a family. Adult I suffered from a condition scoliosis², it is evident that this impacted on her life in terms of pain, but her family says that this was self-treated by her through off the shelf pain relief. This medication would have been available to adults without prescription from a medical practitioner.

4.2 She studied first at Nottingham University in September 2012 and then moved to Nottingham Trent University in September 2013. Whilst in Nottingham she met the perpetrator Adult IP and they had more than a two year relationship. Adult IP said he was a mortgage broker. The couple did not live together but Adult IP would stay regularly with Adult I in her shared student accommodation in the centre of Nottingham.

4.3 Adult IP was introduced to Adult I's mother in 2014. Adult I found out late in 2014 through social media that Adult IP had three children with a former partner, Adult IPCM. Following this discovery Adult I then tried to break off their relationship at various times through 2015. In December 2015 Adult I and Adult IP are however believed to have been engaged. They

² Scoliosis is the abnormal twisting and curvature of the spine. Back pain is common in adults with scoliosis. Young people with scoliosis may also experience some discomfort but it's less likely to be severe. (NHS Choices)

planned to move to London together as Adult I was now working full time and had agreed with her employer to relocate to London. They did break up shortly after this move took place. She moved to London as planned with Adult IP, but finished the relationship in February, and returned to Sheffield to live at her mother's Adult IM address in March 2016. The family state this was to care for Adult IM following her having had a stroke.

- 4.4 She then formed a new relationship with another man Adult IP2. Adult IP was now living with his mother in Colchester.
- 4.5 During the evening in April 2016 Adult IP went to his ex-partner's address (IPCM) in a car that had been hired to his mother. Adult IPCM would not let him in and so he left a note for the children. He then bought two knives from a supermarket in Colchester and drove to Sheffield. Once there, he waited outside Adult I's home and when she came outside he stabbed her around 40 times and then drove off towards Manchester. He was arrested by the Police later the same day after he handed himself in at a Manchester Police Station. He was charged with and pleaded guilty to the Murder of Adult I. He has now been sentenced to life imprisonment with a minimum to serve of 26 years.

5.0 The facts from agencies

Incidents relating to Adult IP & IPCM (Essex Area)

- 5.1 At 06:23 am on 3rd March 2012, Essex Police responded to an emergency call from Adult IPCM who was reporting an incident of domestic abuse and asking for assistance. The operator was told that she was in the bedroom and shouting could be heard. Adult IPCM told the operator that the man involved was her partner Adult IP, and that he had been out but had returned home drunk, smashed a vase and had woken up one of their children. Police Officers attended and found both parties still arguing. They were informed by the Essex Police Domestic Abuse Intelligence Team that there had been no previous domestic abuse incidents involving Adult IPCM and Adult IP. Adult IP had broken a vase but it was discovered that this was his own property. Their three children were present during the argument. The incident appeared to amount to a verbal argument only, and in the officer's view, there was no suggestion of domestic violence. Due to his state of intoxication, at 07:00 am Adult IP was arrested to prevent a further breach of the peace. He was released later that day when sober, with no further action taken. He was collected by Adult IPCM. A DV/1 (A domestic abuse booklet based on a nationally recognised form) and a Domestic Abuse Stalking and Honour Based Violence (DASH) risk assessment were correctly completed scoring as standard risk, and was entered onto the Essex Police Protect database. The three children were recorded as being present and witnessing this incident and so this generated an automatic notification to Children Social Care. Appropriate signposting information was provided to Adult IPCM regarding local domestic abuse services.
- 5.2 At 06:39 am on 28th April 2012 Essex Police received an emergency call from Adult IPCM reporting an incident of domestic abuse and reporting that she was arguing with Adult IP and wanted him to leave. She stated that her three children were at home with her. Essex Police Officers attended this incident and were correctly informed by the Domestic Abuse Intelligence Team of the previous call in March 2012 to Adults IPCM and IP. The Officers found that an incident had started involving a verbal argument only after Adult IP had arrived home drunk and had been verbally abusive towards Adult IPCM. Although no offences were disclosed, the Officers removed Adult IP from the home and took him to his mother's address. A DV/1 and DASH risk assessment were correctly completed, again scoring

as standard risk. The three children were recorded as being present at the home, two of whom who had witnessed the argument. This again generated an automatic notification to Children Social Care. An email referral was also made to the Local Primary Care Trust and information provided about local domestic abuse services. No further police action was taken in respect of this incident.

University period (Nottinghamshire)

- 5.3 On 2nd September 2013 Adult I was welcomed by letter to the BA (Hons) Youth Studies Course at Nottingham Trent University where teaching would commence on 30th September 2013, with induction the previous week. The course was for 3 years.
- 5.4 On 19th October 2013 Adult I registered with a GP at the Nottingham Student Health Centre on the University Campus. This is a satellite site of a larger GP practice and is exclusively for the local student population.
- 5.5 On 24th October 2013 an Action Plan was produced by Student Support Services to make reasonable adjustments for Adult I due to her scoliosis. Teaching and learning support was to be implemented. By now Adult I had made an application for a Disability Support Allowance. Her previous GP records were awaited by her new Practice to progress this and the support was due to the scoliosis.
- 5.6 On 25th February 2014 it was confirmed that Adult I was in receipt of a Disability Support Allowance with entitlements to equipment and travel.
- 5.7 On 14th March 2014 Essex Police arrested Adult IP for non-payment of fines. He was released as the fines were then paid.
- 5.8 Adult I requested a meeting with one of her lecturers as she was struggling to balance her medication with her assignments. A meeting took place on 23rd June 2014 and the University's Notification of Extenuating Circumstances (NEC) process was discussed. She submitted exceptional circumstances against a number of modules on her course due to her disability. After some chasing by the University Adult I provided the evidence requested for the process. Her NEC form stated that she had been diagnosed with scoliosis and was affected on a daily basis. (The family however state that the pain was managed by non-prescribed pain killers.)
- 5.9 On 2nd July 2014 the Board of Examiners met and Adult I was awarded first sittings (retakes) of all her outstanding modules in her next academic year with attendance required at the University.
- 5.10 On 5th July 2014 Adult I was admitted by Ambulance to the Colchester Accident and Emergency Department at Colchester Hospital University Foundation Trust (CHUFT) following an overdose. (It is not known why Adult I was in Essex at this time other than this is the home area for Adult IP). This incident was treated as a suicide attempt as she had drunk toilet cleaner and alcohol, had taken Ibuprofen and Paracetamol and had made cuts to her left wrist with scissors. The attending Paramedics had located Adult I in the toilet. She had been found by friends after her boyfriend Adult IP had sent them round after seeing strange remarks on social media. A female friend made the 999 call for an ambulance at 11:45 am. Adult I was unaccompanied upon her arrival by Ambulance at Hospital.

- 5.11 Adult I was reviewed by medical staff in Hospital and her clinical observations on admission were all within the normal limits. The doctor documented that the patient had had an argument with her boyfriend and had taken tablets. There is no hospital record of the fact that Adult I had also taken toilet cleaner, or any cuts to Adult I's wrist, although this is in the Ambulance records. The East England Ambulance Trust has confirmed that they do have proper handover procedures in place and this shouldn't have happened. The doctor also documented that there was no known psychiatric history and intravenous fluids and blood tests were prescribed to identify if there was any harm as a result of the medications she had taken. This doctor documented that they had spoken with her boyfriend, but no name is recorded so it is only presumed to be Adult IP, who had confirmed that Adult I had taken tablets and confirmed that there was no known psychiatric history. This was taken on face value. "TOXBASE" was accessed for the treatment and management of Ibuprofen and Paracetamol overdose. "TOXBASE" is a national electronic database of treatment for substance overdosing and this is the usual treatment and plan of care in patients suspected of having overdosed.
- 5.12 Whilst Adult I was in the Emergency Assessment Unit at CHUFT her clinical condition was stable and her observations were within normal limits. The reviewing doctor has documented that Adult I had been admitted following an argument with her boyfriend and taken an overdose stating that Adult I had said she had taken four tablets and drunk half a bottle of wine. The treatment plan was to await blood results and refer her to the North Essex Partnership NHS Trust Mental Health Crisis Team. (This is a team of Mental Health professionals accessed by CHUFT for the purpose of reviewing patients at risk.) Adult I refused to see the Crisis Team. That evening Adult I was discharged home to the address where she said she lived with Adult IP. An Electronic Discharge Summary was completed the following day but could not be sent as there were no details of her GP recorded. Staff were unaware of any domestic abuse but did not investigate or consider this with Adult I.
- 5.13 On 23rd July 2014 Adult I attended the Out of Hours Walk In Centre in Colchester due to chest pains, fever and swollen glands. A viral infection was diagnosed and medication provided.
- 5.14 On 28th July 2014 Adult I was seen by her GP in Nottingham, for strong headaches and a stiff and painful neck. She was referred to Nottingham University Hospital where tests were completed and pain relief provided with a diagnosis of sinusitis.
- 5.15 On 7th October 2014 Adult I had a meeting with her Personal Tutor to discuss the completion of her work, as the work had not been done. There is no information available to the review as to what reason was given for the failure to complete her work.
- 5.16 On 17th November 2014 Adult I was provided with information about the University's Hardship Fund as she was struggling with her finances.
- 5.17 At 02:55 am on 21st December 2014 Nottinghamshire Police were informed by a taxi driver (this is seen as good practice by him) that Adult I had been assaulted by Adult IP who had rugby tackled her to the floor resulting in a small scratch to her hand. This followed an argument at her home address following a night out. Adult I's mobile phone was also damaged during the incident. The Police attended and found Adult I crying and in a distressed state. She pointed out Adult IP and said he had assaulted her but refused to provide a statement detailing the circumstances. Adult IP was, however, arrested for assault and criminal damage and a public order offence which took place during the arrest when he made threats to a male housemate of Adult I. A DASH RIC (Domestic Abuse, Stalking,

Harassment and Honour Based Violence Risk Identification Checklist) form was submitted with a medium risk level identified. Following Crown Prosecution Service (CPS) advice, he was refused charge on the assault and criminal damage allegation, this was because he had made no comment in interview and Adult I refused to make a statement and there was no independent evidence to pursue a prosecution. Adult IP was charged with the public order offence and bail conditions were imposed on him not to visit Nottingham unless to attend Court. It appears that he then returned home to the Essex area. (He appeared at Court on 27th April 2015 and pleaded guilty to resisting a constable. The public order offence was not pursued. He was given a 12 month Conditional Discharge.)

- 5.18 On 31st December 2014 a Social Worker from Nottingham City Council Adult Care received the DASH RIC notification for the 21st December incident and deemed that the mobile number was questionable (not safe to call) so sent Adult I a letter. This was to establish if Adult I would like a social care assessment and to see if any safeguarding measures were appropriate. The letter also contained details of information on local Women's Aid services regarding further support. There is no record of the letter on Social Care's systems. Adult I did not respond to this letter or make any contact by telephone therefore no further action was taken. The review author understands that the letter is deliberately discreet.
- 5.19 On 14th April 2015 Adult I attended the Urgent Care Centre (UCC) (which is the CityCare partnership) in Nottingham complaining of back pain. She provided her history of scoliosis and medication. She denied any suggestion of an injury when she was asked and there are no safeguarding indicators recorded that would have prompted further enquiries. Advice was given to her and Adult I was happy with the discharge plan.
- 5.20 On 16th April 2015 Adult I discussed her health issues (not known what the health issues raised were) with her Personal Tutor and was directed to Student Support Services with advice about completing her outstanding modules given to her.
- 5.21 At 06:20 am on 20th April 2015 Adult I made a 999 call to Nottinghamshire Police stating that her ex-partner Adult IP had stayed at her address overnight after coming to collect his belongings and whilst she was asleep he had stolen her bank card. This had then been used to withdraw £200 cash from an ATM and make further purchases to a value of £500. The Police attended and she made a statement to them outlining the circumstances of the theft. A DASH RIC form was completed by the Police where Adult I complained of harassment and the controlling behaviour of Adult IP when she had previously tried to break off the relationship on two occasions and it was classified as medium risk. Adult IP was contacted by the Police and he voluntarily attended a Police Station later that day where he was arrested for theft. He stated that Adult I owed his mother the money which had been loaned to Adult I in order to put down a deposit on her flat and was due to be repaid. Adult IP was bailed pending further investigation with bail conditions not to contact Adult I. Subsequent enquiries indicated that Adult I had been untruthful in her statements made to the police about the origin of the deposit for her flat and it had in fact been loaned by Adult IP's mother. In view of this no further action was taken.
- 5.22 At 10:54 pm on 21st April 2015 Adult I attended the Emergency Department at Nottingham University Hospitals NHS Trust (NUH) having taken 32 tablets of Ibuprofen and had drunk half a bottle of wine. She had been found by her friend who had been in another room during the evening and presumed that she had gone to bed, but checked on her and found her asleep with empty medication packets next to her. After initially denying to staff that she had taken any medication, she explained what she had done. She stated that she had been having problems with her ex-boyfriend whom she alleged had taken money from her account resulting in him being arrested and released on Police bail. She stated that she had

recently left this relationship as he was abusive. She was described as being tearful but denied trying to take her own life and that she had only taken the tablets as she wanted to sleep.

- 5.23 At 00:50 am now 22nd April Adult I was assessed for her mental health and wellbeing by a Mental Health Liaison Nurse (MHLN) from the Rapid Response Liaison Psychiatry Team (RRLP). This entailed a comprehensive assessment of her mental state and she gave information again about her partner's abusive and controlling behaviour. A risk assessment was completed in line with NHCFT policies and procedures with the impression formed that this was an impulsive act due to recent events and her low mood. She agreed to see her GP and agreed with the discharge plan and she was discharged at 02:04 am. There is no evidence that staff explored her disclosures of historic and ongoing domestic abuse.
- 5.24 On 28th April 2015 the DASH RIC by the Police was received by Nottingham City Council DART for the theft incident. It is not known why this delay of 8 days occurred within the DART, it is believed to be due to a backlog in relation to inputting. A further letter was sent by a Social Worker to Adult I to establish if she would like a Social Care Assessment or if any safeguarding measures were appropriate and also highlighting information on local Women's Aid services for her support. A copy of this letter is on Social Care's system. Adult I did not respond to this letter nor make any telephone contact. It is fully accepted by the review author that Adult I did have capacity and it is her choice to accept services or not. The letter that was sent is the subject of analysis further in this review.
- 5.25 On the same day, 28th April 2015 Adult I's GP was contacted by the Domestic Abuse Referral Team (DART) asking them to consider asking Adult I's consent for her to be referred to the Identification and Referral to Improve Safety (IRIS) Project. The DART referral had been assessed as "Medium Risk" by the police but having been reviewed by the GP the Risk Marker on the GP electronic system was changed to "Low Risk". The narrative on the DART RIC to the GP stated that Adult I had money and her bank card stolen by Adult IP. There was no other information included in the narrative other than the consideration of a referral to the "IRIS" service at Adult I's next attendance. However, this is a standard statement which is included on all the correspondence from the DART and the GP's did not view as a direct instruction for Adult I. The risk marker on the email was in small print at the top of the page and it could be this reason that the GP recalculated the risk based on the brief information in the email. The review author understands that the notification template is now much clearer.
- 5.26 Attempts were made in mid May 2015 by her GP to contact Adult I by telephone. This was a further 17 days after the receipt of information from the Hospital. Contact was made and an appointment planned for her to be seen on 15th May 2015 but Adult I then cancelled this appointment.
- 5.27 On 22nd May 2015 Adult I received a home visit from the Nottinghamshire Police Safer Neighbourhood Team (SNT) (seen as good practice by the review author) and she was provided with advice and stated that her relationship with Adult IP was definitely over and he was living back in Essex. No further interventions were deemed necessary.
- 5.28 On 29th May 2015 Adult I was seen and reviewed by her GP as she was feeling depressed. She scored 23 on a Patient Health Questionnaire which suggests major or severe depression and so a referral was made to the Crisis Resolution and Home Team (CRHT) at 7:20 pm that day. As mentioned, already there was no Domestic Abuse Alert marker set on the GP records

at this time. This meant that the GP carrying out the consultation did not know about the notification from DART unless they searched the records. There is no record that the GP discussed domestic abuse with Adult I or knew about it.

- 5.29 This CRHT team tried four times over two days to contact Adult I with contact made on 31st May 2015 and an appointment was made for the following day. Their persistence in delivering their service is recognised as good practice by the review author.
- 5.30 On 1st June 2015 Adult I was assessed at home by the Crisis Resolution and Home Treatment Team (CRHT) for her mental health and wellbeing. She was seen by a Community Psychiatric Nurse (CPN) and a Psychiatrist. This is a service by NHCFT providing 24 hours, 7 days a week assessments of people with significant mental illness to minimise the risk of a patient being admitted to Hospital and to support them to achieve recovery at home. She disclosed that she had been in a physical, controlling and verbally abusive relationship which had recently ended and that her ex-partner had stolen money from her which had contributed to her financial difficulties and caused her problems studying. She disclosed that Adult IP had on one occasion punched her in the stomach and that he restricted her access to her friends. No significant risks of self-harm were identified but some depressive symptoms due to stress, including her abusive relationship issues were noted. A plan was agreed where she was referred back to her GP, however, the details of the consultation were not immediately shared with the GP and it is not known why. It was over four weeks later on 30th June before the information was passed on.
- 5.31 On the same day 1st June 2015 Adult I attended the Sexual Health Service based at the City Hospital campus of NUH. She was routinely asked about domestic abuse and she disclosed that she was in an abusive relationship and that she had been with the same partner for 18 months. She stated that the Police had referred her to the DART and that she was managing this herself and did not want any further support. She was discharged from the Service and there is no evidence that any further questions were asked to identify neither the abuse she was suffering from nor the level of risk she was facing. There is no record of any contact with DART to further gather or share information.
- 5.32 On 8th June 2015 Adult I attended the Nottingham Urgent Care Centre (UCC) requesting emergency contraception. She received appropriate treatment. There were no indicators of domestic abuse and no further enquiries were made.
- 5.33 In early June 2015, Nottingham Trent University reviewed Adult I's NEC form where it said that she was a victim of theft and fraud in April 2015 which had caused her distress and depression as well as financial difficulties. Within her exceptional circumstances, Adult I stated that the incident had caused her to attempt to take her own life and it stated that she had been prescribed anti-depressants and had been visited by the Community Health Team. Adult I stated that the incident had been reported to the police and she provided supporting evidence including a letter from DART dated 28th April 2015 informing her that a domestic abuse incident had been reported to them by the police and provided contact details should she require additional support. The University was assured by her that the risks were being managed by the appropriate agencies and so it did not trigger any further action by them. The review author is of the opinion that the University should have checked that other agencies were managing her risks rather than take her word for it. The NEC was upheld.
- 5.34 On 25th June 2015 Adult I had a telephone conversation with her GP and she reported feeling much better and had taken her prescribed 50mg of Sertraline daily for two months. She stated that she was planning to go abroad for 5 weeks and would require an extra

supply. A Psychiatrist had recommended a reduction to 20mg daily but the GP was not aware of this at the time of this consultation as the letter with the information had not yet arrived at the GP practice.

- 5.35 On 1st July 2015 the Board of Examiners met and Adult I's NEC was upheld. Adult I was awarded first sittings (retakes) in her outstanding modules with a third and final attempt in another module with attendance required in the next academic year.
- 5.36 Adult I was informed on 7th July 2015 of her requirement to retake four modules in the following academic year, with attendance. Three modules were to be taken as a first sit and one module as a second sit and a third as an exceptional sitting. Adult I was asked to confirm her intention to return to her studies in the next academic year. Adult I did not respond to this and so was withdrawn from her studies due to the lapse of time. This is five weeks after she told them she had been subject to DA. The review author feels that they should have checked the situation in regard to Adult I and confirmed her wellbeing before closing these matters.
- 5.37 On 18th August 2015, Adult I attended the UCC with a bacterial infection. She said she was still with the same partner and she was described as "otherwise well". Adult I was still taking Sertraline and she was prescribed antibiotics and advised to attend the GUM to provide swabs. She was given appropriate advice and no safeguarding concerns were seen and nothing was raised about her emotional presentation.
- 5.38 Twice in September 2015 Adult I went to see her GP suffering from a sore throat. Antibiotics were prescribed and advice given that if the symptoms got worse or persisted she should return to her GP.
- 5.39 On 6th October 2015 Adult I attended her GP practice as she was feeling low in mood. Sertraline was re-prescribed as Adult I had stopped using this a couple of months previously as she was feeling better. Adult I was advised to self-refer herself to counselling and the GP would follow this up in a month's time. Adult I reported that she was currently working and may need a sick note so that she could attend the counselling. A Patient Health Questionnaire was completed and it scored 19 which was lower than on a previous occasion. There were no discussions about her partner or any relationships at this time.
- 5.40 Towards the end of October and into early November 2015 Adult I suffered from tonsillitis and after visits to her GP she was prescribed anti-biotics.
- 5.41 On 6th November 2015 Adult I had a Job Seekers Allowance New Claim appointment at the Nottingham Station Street office. Adult I provided a Zimbabwean passport and residence permit as her Identification and completed an initial basic skills screening which identified a no skills need. She informed the Jobcentre that she had finished employment on 2nd November 2015 after working as a complaints resolution manager. A Habitual Residency Test was carried out and this confirmed that Adult I had the right to reside in the UK. A Work Search Review was booked for 18th November 2015.
- 5.42 At 06.14am on the 15th November 2015 Adult I called Nottinghamshire Police from her home address, reporting a domestic incident between herself and Adult IP. She said that she had been pushed and wanted him removing from the flat. The Police attended at 06:43 am and found that the call followed an argument between Adult I and Adult IP following a drinking session in Nottingham city centre and they were both under the influence of alcohol. A picture frame had been damaged during the argument but Adult I refused to provide any meaningful details of the incident to the Police and said that she just wanted Adult IP to leave the flat. The Police Officer recorded that Adult I had no visible injuries.

- 5.43 After Adult I had been spoken to and made no complaints she signed the officer's pocket book confirming this. Adult IP was interviewed at the scene and he stated that an argument had taken place but denied any assault. He agreed that the picture frame had been damaged and he had also received a small cut to his hand. The Officers made a decision not to arrest Adult IP based on the circumstances at the scene and Adult I's lack of co-operation. Adult IP was, however, taken from the flat to a friend's address elsewhere in Nottingham. A DASH RIC form was submitted and classified as medium risk. The review author has queried this suggesting this risk should have been escalated to high given the ongoing circumstances and that the Police perhaps were looking at these incidents in isolation. He has seen the paperwork and been given assurance by the police that they didn't look at it singularly but in fact moved the risk from standard to medium after taking into account all of the incidents.
- 5.44 On 18th November 2015 Adult I failed to attend her Work Search review and her claim was closed down as a result of this non-attendance. Her Job Seekers Allowance was paid up to and including 20th November 2015.
- 5.45 On 22nd November 2015 Adult I attended the Nottingham UCC with pain following a tonsillectomy. An examination was completed and there were no signs of infection and she was observed as alert and otherwise well. She was still taking Sertraline and was prescribed an anaesthetic throat spray and advised on analgesia and increased fluid intake and swallowing. She was advised to see her GP if her symptoms worsened.
- 5.46 On 25th November 2015 Nottinghamshire Police made contact with Adult I where she said that there had been no further issues with Adult IP. The review author recognises this proactive follow up as good practice.
- 5.47 On 2nd December 2015 a letter was sent from a Nottingham University Hospital Trust consultant to Adult I's GP advising that she had had a tonsillectomy and had been discharged back into the care of her GP.

Period in Sheffield area

- 5.48 On 13th December 2015 Nottinghamshire Police again made contact with Adult I and she confirmed that there had been no further issues with Adult IP and that she had moved back to live with her mother in Sheffield. The details of this address in Sheffield were not obtained and South Yorkshire police were not notified.
- 5.49 There is now a gap of four months where nothing is known by agencies about the lives of Adult I or IP. Adult I's family say that after moving to Sheffield she had in fact gone to London to work for a short while, but returned to Sheffield to care for her mother after she had had a stroke.
- 5.50 During the evening in April 2016 Adult IP went to his ex-partner's address in a car that had been hired to his mother. Adult IPCM would not let him in and so he left a note for the children on his car which read, "*Has had enough of this life*". He also left his wallet, some identification and some spare keys. He then bought two knives from an Asda supermarket in Colchester and drove to Sheffield. Once there he waited outside Adult I's home and when she came outside he stabbed her around 40 times and then drove off towards Manchester. He was arrested by the Police later the same day after he handed himself in at a Manchester Police Station. Adult I died later that day in Hospital and the post mortem revealed that she died from multiple stab wounds. He was charged with and pleaded guilty to murder. He has been sentenced to life imprisonment with a minimum to serve a minimum of 26 years.

6.0 Analysis

- 6.1 This analysis answers the terms of reference set by the panel, including the additional questions raised through progression of the process of the review. In order to ensure the overview report reads and flows appropriately, these are not highlighted separately but covered in the chronological order of events.

Incidents relating to Adult I and IP in Essex Area

- 6.2 Essex Police Officers attended two incidents of domestic abuse involving Adult IP and his previous partner Adult IPCM, with their children present, which were both graded as standard. On each occasion the victim, Adult IPCM, requested that Adult IP be removed from her home and on both occasions the officers did this, once under arrest and once to convey him to his mother's address. This was in line with the procedures for Essex police at the time.
- 6.3 A DV/1 and DASH risk assessment were correctly completed on each occasion and gave due consideration to the children being present, who had witnessed the incidents. On the first occasion they considered a notification to Social Care as appropriate and on the second occasion they made a formal referral to the Local Primary Care Trust, in addition to a further notification to Social Care. Supervision was also appropriately completed. This is seen as good practice by Essex Police. Appropriate signposting information was provided to Adult IPCM regarding local domestic abuse services.
- 6.4 On the 5th July 2014 Adult I was a vulnerable young adult who attended Colchester Accident and Emergency Department at Colchester Hospital University Foundation NHS Trust (CHUFT) in a highly emotional state following an overdose. She disclosed to staff that this was following an argument with her boyfriend. Arguments between couples within national domestic abuse guidance are identified as a risk factor for domestic abuse as is an overdose as well. The staff were unaware of any history of domestic abuse regarding Adult I and they failed to explore the reason for her overdose and did not exclude domestic violence. Staff also failed to alert Adult I's GP regarding her admission to Hospital as no GP details were ever obtained or recorded during her stay in Hospital. Routine enquiries regarding domestic abuse need to be embedded in staff's practice to ensure that the safeguarding of patients that could be subjected to domestic abuse occurs.
- 6.5 The Hospital Staff in the Colchester Accident and Emergency Department did offer Adult I the opportunity to speak with staff within the Mental Health Crisis Team which Adult I refused. The Staff then failed to explore with her why this was, or to seek any alternative support resources for her. Adult I was discharged home to the same address as her boyfriend, without any exploration as to whether home was a safe environment or whether she could be at further risk. Staff need to be aware of the safeguarding of patients on discharge from the care of the Hospital.
- 6.6 During this attendance there were missed opportunities that should have alerted those staff within Colchester Hospital University Foundation NHS Trust who were involved in the treatment of Adult I. Staff failed to recognise her vulnerability and failed to explore life events with her. Staff didn't follow safeguarding guidance and procedure and significant information about her was not shared by them with other organisations. The GP was not notified of this hospital attendance.
- 6.7 Colchester Hospital University Foundation NHS Trust did not receive any notifications or alerts from external organisations such as Essex Police. Adult IP was known to both services and so it is recommended that Colchester Hospital University Foundation NHS Trust liaise with Essex Police to develop a robust procedure for information sharing. Any information

should then be shared within the organisation as appropriate including alerts on the patient information system (Portal) regarding the risk to an individual.

- 6.8 The review author understands that Colchester Hospital University Foundation NHS Trust (CHUFT) has made significant progress in increasing awareness amongst staff regarding domestic abuse over the last 12 months by introducing a referral system to the Essex Domestic Abuse Partnership, increasing training compliance and revising the domestic abuse policy. This is seen by the review author as good progress.

Nottinghamshire Area (University period)

- 6.9 DASH risk assessments were received by Nottingham CC Adult Social Care on two occasions 30th December 2014 and 28th April 2015 and the same Social Worker dealt with them. A specialist DART team sits within Children and Family Services and part of their role is to screen and triage all referrals focussing primarily on high and medium risk referrals. All adult referrals are worked on by the designated Adults Worker. If there are any concerns for a child this would also be referred on to Children Social Care. The service required with this referral was regarded as needing a minimal intervention, but did have a quick response. Procedures were followed and on each occasion a letter was sent to Adult I and no contact by telephone was made as it was deemed to be an unsafe number and “questionable” whether to use it. The Social Worker (SW) has advised the review why the contact number was ‘questionable’ and is based on the Police DASH forms and the two incidents recorded having two different mobile numbers for Adult I plus two different addresses were cited. The SW felt the mobile numbers were written unclearly as the first referral had the end number as just 2 small circles above each other, not joining. The second referral had the fourth number as an 8 or a 9 again unclear as they had been written on top of each other. The SW confirmed as she was left with unclear numbers she decided it would be more appropriate to send Adult I an information letter. The SW had identified the suspect’s home address was not the same as Adult I therefore she risk assessed that communication via letter would be the safest communication. A copy of the letter that was sent to Adult I is detailed below.

“Dear Adult I, The DART is a team of professionals which include Police/Health/Social Care/Family and Community Teams which look at all domestic abuse referrals. Information was received from Nottinghamshire Police regards to a reported domestic abuse incident, which was forwarded to us. If in the future, should you require support/advice in relation to Domestic Abuse or are concerned about the safety and welfare of children, you can access this from your local Children's Centre/Sure Start centre, Adult Social Care on 0300 300 00 00 or by calling the Women's Aid Helpline on 9476490. If you would like to discuss the contents of this letter, please do not hesitate to contact the DART (9150494), so a member of the team can help. Yours sincerely Adult Social Worker Domestic Abuse Referral Team”

- 6.10 The Social Worker dealing with the referrals was sensitive around the safety of Adult I. The review author has had clarification that the letter is an introductory letter. On each occasion Adult I apparently failed to respond to the letter and follow up took place with a referral to the GP. The review author fully accepts that as Adult I had capacity so this was her choice.
- 6.11 No in depth assessments took place of Adult I by any agency and in the vulnerable adult’s section her physical disability was marked stating that she had a spinal disorder (scoliosis). There appears to have been no consideration of this physical disability and no contact was made via telephone to discuss this further and establish any needs Adult I may have had. The contact was through sending a letter. Feedback to the review author by the family is that Adult I was not in their view adversely affected by her scoliosis other than through pain, which was self-treated by over the counter pain relief.

- 6.12 As already stated a mobile number was available to the Social Worker as well as an email address and as Adult IP lived in a different county it is unclear why further steps were not taken to consult with Adult I by alternative methods of correspondence, rather than rely on a letter that was never replied to. Furthermore, the telephone number for Adult Social Care provided on the letter that was sent out to Adult I is incorrect and should read 0300 300 3333 with Option 2. This contact number provided has been called and it connects to the Cambridgeshire ICT service. Therefore, if Adult I had wanted to contact Adult Social Care, she would have been unsuccessful. She may well have tried but that fact will never now be known.
- 6.13 The DASH RIC had been completed and graded as medium, with 7 “yes” ticks. Question 13 asks: Is the abuse happening more often? This was ticked “no”, but the written narrative states that it is, “constant every week”. Furthermore, question 14 asks: Is the abuse getting worse? Again “no is ticked”, but the written narrative states “constant and persistent”. Question 18 asks: Has....ever attempted to strangle, choke, suffocate, drown you? Again, “no was ticked”, but the narrative reads “grabbed IP by the throat before, but she could breathe, let go after 1 minute”. There are three very clear discrepancies here which may just be human error. As it stood an extra 3 ticks would have made 10 which is still a medium classification. It is accepted by the review author that this would be more significant and have been more impactful if those missed ticks had turned the medium to high, which of course it wouldn’t have. There is indication that professional judgement had been applied as well as the counting of the ‘ticks’, as it should have been standard risk on the basis of the incident alone and was raised to medium because of the previous history.
- 6.14 Whilst under the care of staff from Nottinghamshire Healthcare Foundation NHS Trust (NHCFT) following her overdose Adult I disclosed to the Mental Health Liaison Nurse (MHLN) historic and ongoing domestic abuse and disclosed that the Police had been involved previously (this disclosure was when Adult I was seen in the Emergency Department). There is no evidence that staff explored this with her to ascertain what kind of abuse had been perpetrated upon her. NHCFT have a detailed Domestic Violence and Abuse policy which provides guidance to staff but this was not followed on this occasion. The DASH RIC should have been used to assess her level of risk so that decisions could be made around whether information could or should be shared. The fact that she had attended with a mental health problem that she indicated was linked to the situation she was in, should have prompted staff to make more enquiries. Attendance with a mental health issue should always alert staff to their potential vulnerability and therefore should consider whether any safeguarding is required. After Adult I’s attendances in April and June 2015, at the Nottingham University Hospitals NHS Trust, Emergency Department, opportunities were missed to make clinical enquiries and to share relevant information with the appropriate agencies. She was seen by two different nurses and one doctor at her April and June attendance and each one documented their involvement but none ever identified any safeguarding concerns other than mental health. It would appear that because Adult I had disclosed abuse but had said that the Police were already involved then the staff felt that they did not need to make any further enquiry or referral and accepted this on face value. All staff needs to be inquisitive, without being intrusive, to safeguard vulnerable adults, this is now reinforced within safeguarding and DA training which has been developed and enhanced over the last 2-3 years within the Trust.
- 6.15 There was then a 37 day gap between Adult I’s discharge from Hospital on 22nd April 2015 and being seen by the CRHT following the referral from her GP. This is not down to the CRHT because as soon as the GP referred it to them, they acted on the information. The referral to the CRHT was not part of the initial discharge plan and this does not appear to have any detrimental impact on her care. The delay in notifying the GP of the outcome of the

assessment by the hospital though not causing an issue in this case, this is not seen by the review author as good practice. The CRHT were though very persistent and efficient in arranging the assessment once notified.

- 6.16 The assessment by the CRHT was clear, appropriate and comprehensive. A plan was agreed with her which included further contact with her GP, contact with her course tutor and accessing local counselling support services. There was, however, no real consideration or discussion around the clearly identified domestic abuse issues and a potential referral for safeguarding by the completion of a DASH RIC assessment form. If a DASH RIC was not considered appropriate, then the reasons should have been recorded. Record keeping should happen and continued emphasis of this in training would assist with this. Assumptions were made that things were in place and therefore there was no need for further involvement or follow up, which should have happened.
- 6.17 Adult I registered as originally recommended by the MHLN the counselling services at Base 51 (An independent counselling service), there is however no record of any counselling actually taking place.
- 6.18 During her attendance at the Genito-Urinary Medicine (GUM) Department at Nottingham University Hospital, Adult I answered the standard question concerning domestic abuse and it was documented that she was experiencing domestic abuse but that this was being dealt with and she wished for no further support. There was an opportunity to complete a DASH RIC and this is seen as a missed opportunity.
- 6.19 When reviewing Adult I's two attendances at Nottingham University Hospitals NHS Trust, there is evidence that it needs to be made more explicit during training, that staff should still engage the patient in the risk assessment process, wherever possible and refer to other agencies as appropriate, even when the patient states that they are already in receipt of domestic abuse services. The review author has been advised that the current training programme at Nottingham University Hospital includes ensuring that staff members feel that they have the necessary skills to make effective safeguarding enquiries when domestic abuse is disclosed or when there is a concern.
- 6.20 The process in place within the GP practice for the receipt, review and recording of DART referrals is not formalised and the roles and responsibilities in relation to its receipt are not clearly defined. After receipt the risk should be reviewed and actions agreed. The standards were not met and a process that should take 2 days at most, took 17 days. The DART referral also includes the level of risk and on this occasion the police had assessed it as medium risk. The GP changed it to low risk based on the limited information available and may have missed the medium risk marker. Adult I's overdose and the DART referral were viewed in isolation and events occurring in her life were not linked.
- 6.21 The Alert marker and level of risk should be inputted onto the GP electronic record but there is no defined period of time within the practice for this. In this case it was activated in June 2015 some two months after the DART referral was received. The lead GP did not instigate the Domestic Abuse marker upon receipt of the DART referral as he perceived it to be a "theft" and not Domestic abuse. It was when the Practice received the report from the CRHT which identifies the physical, emotional and psychological abuse that the marker was added to the Adult I's record.
- 6.22 Information received by the GP practice in relation to the domestic abuse Adult I was suffering was not recorded or acted upon appropriately. Adult I's physical and mental health needs were addressed but the causative factor was not identified. This may have led to a missed opportunity to offer specialist support and advice from the IRIS project. The revised

notification template (that is now in place) from the DART to GP's will make this situation much better. The review author has now seen this template and agrees it is clear.

- 6.23 The GP practice did not have robust procedures in place to ensure that information is shared in an efficient way. Critical information was not known by the GP dealing with Adult I. The GP practice did make appropriate referrals to the Mental Health Team but the late arrival of information from the Community Psychiatrist hindered the GP in assessing and formulating a plan.
- 6.24 The review author feels that staff at Nottingham Trent University lacked professional curiosity. There was at least one occasion when Adult I had informed them that she was subject to DA, that they should have made sure someone was dealing with the abuse. They also should have followed up the fact that Adult I never returned to University as planned.
- 6.25 As a medium risk case Adult I should have been managed by the Nottinghamshire Police Safer Neighbourhood Team covering the area of her home address. There is no record of a follow up visit by the SNT to discuss any intervention plans or referrals to other agencies. It is not clear why this was not carried out. After this first referral, it was completed on the following two occasions appropriately.
- 6.26 Nottinghamshire Police Domestic Abuse Procedures state that if a victim has moved out of Nottinghamshire the officer with that information must ensure that the new force and command unit are informed. The new address should be provided and the new force appraised of circumstances of the abuse and risk category of the victim. This was not completed. At the time of this incident this information should have been recorded on the Case Administration and Tracker System (CATS), it would now be recorded on the NICHE system which is a more user friendly system and provides a shared IT platform for the five East Midlands police forces to record crime, intelligence, and custody and case information.
- 6.27 Nottinghamshire Police Officers included the details of Adult IP's three children on the DASH RIC even though they were not present during the incidents and was believed to be in Essex. This is good practice but it did not include sufficient detail about them. There was a failure to follow up information concerning the children of Adult IP and two areas have been identified where improvements could be made. The first is the need for officers completing the DASH RIC to show more professional curiosity in establishing the full details and home address of any children and to conduct further research if necessary. The second area is to consider referrals to other Police Forces and Children's Social Care Departments when the children of perpetrators live in other policing areas. It would seem appropriate for any such referrals to be made by the multi-agency Domestic Abuse Referral Team (DART) due to their contacts and knowledge of safeguarding procedures.
- 6.28 This was also the third occasion in November 2015 that Nottinghamshire Police had been involved with Adult I as a victim and Adult IP as a perpetrator. The risk remained medium and as mentioned earlier in this report the review author questions whether this should have been escalated to high as it was a third occasion in 11 months, as it appeared to the review author that they were looking at each incident in isolation, rather than holistically. The author has seen the paperwork and been given assurance by the police that they didn't look at it singularly but in fact moved the risk from standard to medium after taking into account all of the incidents. This referral was also not shared with the DART, who would then have had the opportunity as a specialist service to maybe put the ongoing abuse together in a more holistically way. It is fully accepted also by the review author that Adult I had refused to give consent so the referral could not be shared – unless they had identified

clear safeguarding concerns or used professional judgement to raise it to a high risk referral where consent was not required.

- 6.29 Throughout Adult I's interaction with the various agencies there was on occasions a lack of professional curiosity which was needed to be proactive, rather than reactive as demonstrated here. There were times when escalation should have been considered and broader safeguarding was not always considered. Adult I was vulnerable (through being a victim of DA) and in need of help and protection. No one agency ever took ownership of Adult I's case and therefore there was a lack of coordination of risk. At times her case was dealt with by simply following process without further thought for the wider picture of what life was like for her.

7.0 Family perspective

- 7.1 It is crucial that overview reports for DHR's obtain the views of family and friends. This report has benefited from this perspective. The review author is very grateful to the FLO and the officer in the case from South Yorkshire Police, who facilitated obtaining the views of Adult I's mother, uncle and brother for this review report.
- 7.2 As already mentioned earlier in this report, the family didn't want Adult I's own name being used, and were happy for the review panel to use Adult I to refer to her in this way. They also stated that the scoliosis wasn't in their view a major disability for Adult I and when causing her pain, was self-treated by use of over the counter pain relief.
- 7.3 Adult I's mother describes Adult I as the most genuine and caring person, who was full of life and love. The family talk of their devastation of life without Adult I. They describe Adult I as someone who united their family, a most wonderful woman who had a wonderful future ahead of her.
- 7.4 Adult IM did not know exactly when (but it was approximately two years earlier), or where in Nottingham her daughter met Adult IP. Adult IM knew after a while that he came from Colchester where his mum lived and that he had three children but didn't know if he was divorced or not. Adult IM had first met him two years ago when he went to a wedding with them. Adult IM never saw him again after this.
- 7.5 Adult I had told her mother that that he was a kind of violent person and that on two occasions she had reported him to the police, but each time he had begged her to drop charges. Also Adult IM knew when Adult IP used £800 after stealing Adult I's card. Adult IM understood that her daughter had asked for police protection for Adult IP to keep away from her. Adult IM thought and told Adult I that the relationship was toxic and had even phoned Adult IP's mother to get him to leave her daughter alone.
- 7.6 Adult IM thought they had split up, but found out from Adult I in October 2015, that they were back together and were involved in counselling, but not sure where or who with and if it was actually happening. Adult I had found out that Adult IP was also seeing someone else and tried to finish their relationship, but he followed her when she went to live and work in London.
- 7.7 Adult I came home to live in Sheffield to care for Adult IM after she had a stroke. Adult IM actually witnessed the homicide as it took place in the street outside her house. The trauma of this coupled with the loss of her daughter has caused her untold psychological and emotional trauma, which Adult IM is sure she will never recover from.

7.8 The family can think of no recommendations for agencies that they felt could be implemented as learning from the death of Adult I. They do not know how much Adult I would have interacted with agencies anyway.

8.0 Conclusions- Learning Lessons

8.1 In December 2016 the Home Office published 'Key findings from analysis of Domestic Homicide reviews'³ within this it identifies a series of common learning themes from all of the reviews that they examined. 1) Record Keeping 2) Risk Assessment 3) Communication/Information sharing between agencies 4) Identification and understanding of Domestic Abuse 5) Organisational policy 6) Competence, Knowledge and Skills 7) Multi-Agency work 8) Referrals 9) Training 10) Public Awareness. A number of these themes have also been identified from the analysis of this DHR into the homicide of Adult I.

Learning Themes Adult I

- **Domestic Abuse incidents being dealt with as individual incidents**
- **Lack of professional curiosity- including believing another agency was doing something**
- **Record keeping and information sharing**
- **Self-Harm and mental health concerns as indicators of DA**
- **Lack of prevention action for perpetrator**
- **Working with student/transient populations**

8.2 This review has identified that improvements should be made in relation to information sharing. In the circumstances though, these oversights, would not have prevented the tragic death of Adult I in Sheffield in April 2016. The review author is also of the belief that this tragic death could not have been predicted.

8.3 There were a number of occasions when agencies demonstrated good practice. Examples of this are the actions and persistence of the Crisis Resolution and Home Treatment Team (CRHT) for her mental health and wellbeing. (This is a service offered by NHCFT providing 24 hours, 7 days a week assessments of people with significant mental illness to minimise the risk of a patient being admitted to Hospital and to support them to achieve recovery at home.) This service is not in place in all areas of the country and is seen as a real benefit. Another example of good practice is the involvement of the Nottinghamshire Safer Neighbourhood teams in keeping contact with victims of DA. The actions by the taxi driver in Nottingham on 21st December 2014, is also seen as good practice when he phoned the police.

8.4 There were a number of occasions when individuals dealt with the domestic abuse that Adult I was reporting by treating them as individual incidents. This is despite the fact that on one occasion Adult I told professionals that domestic abuse was happening constantly. The victim centred approach and trying to see how life is like from that victim's perspective is important in order to get the whole picture.

8.5 There is a large body of research (including Lord Laming 2009 in his Progress report) that shows that professionals need to show more curiosity in dealing with safeguarding issues. There is no doubt in Adult I's case that this lack of professional curiosity is evident. There is

³ Home Office (2016) 'Domestic Homicide Reviews KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS' HM Government

further research in particular in domestic abuse cases that professionals shouldn't accept that others are doing the safeguarding when this may not be the case. This acceptance that others were doing something when they were not in Adult I's case is also evident, by a number of agencies including NTU.

- 8.6 The initial response to the incidents by Nottinghamshire Police was in keeping with their policies and procedures. Positive action was taken on each occasion with prosecutions being considered where appropriate. Unfortunately, the reluctance of Adult I to pursue a complaint together with the lack of corroboration prevented further action being taken. They could have shared information with Essex as Adult IP lived there and this is where his three children were residing. If this had have been done then Essex police may have shared the complaints raised by Adult IPCM. If there had been consent to share they could have shared information with the DART in relation to the third reported (to them) incident of DA. They could also then have shared with Sheffield when they found out that Adult I had moved there. The review author did pose the question to the police panel member as to what training takes place and what is the understanding of consent that officers have when looking to tick the box on the DASH RIC. The review author has had sight of the information on the DASH RIC form outlining what consent means, and agrees this is very thorough and informative.
- 8.7 Opportunities were missed by staff at Nottingham University Hospitals NHS Trust to make clinical enquiries into Adult I's circumstances and to share relevant information with other appropriate agencies. Staff felt that no further involvement was required by them as Adult I had disclosed that the police were involved. As already mentioned previously, professionals should not take for granted other agency involvement.
- 8.8 CHUFT staff failed to alert Adult I's GP regarding her attendance at Hospital as no GP details were obtained or recorded during her admission. Staff also failed to explore the reasons for her overdose and overlooked the domestic abuse she was suffering. There were missed opportunities that should have alerted staff to her vulnerability and they failed to follow safeguarding guidance and procedure.
- 8.9 There were also missed opportunities with NHCFT staff that failed to address Adult I's domestic abuse disclosures and failed to share information with external agencies in a timely way.
- 8.10 Adult I's GP practice does not have robust procedures in place to ensure that specific information is shared in an efficient and effective way. This contributed to the GP not having critical information about the domestic abuse she had suffered when she was struggling with her mental health and sending a referral to IRIS. The new notification template that has now been implemented should definitely make a difference here.
- 8.11 The service provided by Nottingham CC Adult Social Care was in line with their processes in place at the time and their response was quick. The letter sent was appropriate but incorrect contact information was provided meaning Adult I would have been unable to make contact if she so wished. The logging and recording of information is vital, as is the sending out of correct information to victims of DA.
- 8.12 Adult I on two occasions made an attempt to self-harm by the taking of tablets, but also the drinking of toilet cleaner. There is also mention within her conversations with health professionals in particular the GP practice of her having a low mood and being depressed. The review author feels that not enough was done to try and persuade her to engage with interventions to get to the root of her problems which may have been her disability but were more likely due to the constant (her words) domestic abuse she was suffering.

- 8.13 Nothing had been done in either Essex or Nottingham to consider any interventions in relation to the offender. Including the two previous incidents with IPCM, and there were three known about occasions with Nottinghamshire police for Adult I. There was also the occasion when Adult I was in hospital in Colchester, which was as a result of an argument with Adult IP. Alcohol as a trigger was also mentioned on a few of these occasions and a pattern is clearly in place here of Adult IP as a consistent perpetrator of DA. An education programme may have been of use in preventing him committing DA in the future. It is not clear what offender programmes are in place in Essex. The only programme available in Nottingham City is the 'Building Better Relationships programme' for offenders accessing Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC) or National Probation Service (NPS) – Nottinghamshire.
- 8.14 It is acknowledged that the victim and perpetrator are of a Black ethnicity and both were migrants to the UK, however there has been no issues in relation to this, identified from the information provided to the author, by either agencies or the family. It has already been explored in this report about Adult I's disability, and how this impacted on her life taking into account the fact her family felt it wasn't a major issue. It is however, highlighted by the review author that there is a large age difference (almost 15yrs) between Adult I and Adult IP, this may have contributed to his power and control over her. The review author would like to also highlight that Domestic Homicide and domestic abuse in particular, is predominately a gender crime, with women by far making up the majority of victims, and by far the vast majority of perpetrators are male. A detailed breakdown of homicides reveals substantial gendered differences. Female victims tend to be killed by partners/ex-partners. In England and Wales 46% of all females killed in 2013/2014 were killed by partner or ex-partner, compared to just 7% of male victims. (Payton J et al 2017). This information the review author feels, demonstrates the power the perpetrator felt he had over Adult I, and that it needs to be recognised as a gender crime as well.

9.0 Recommendations

- 9.1 Individual agencies have made a series of recommendations within their IMR's, which they need to ensure they implement. The process involved including the work of the DHR panel to compile this overview report has also raised a number of recommendations that the overview report author believes will help to protect victims of Domestic Abuse in the future.

Recommendation 1

The Sheffield First Safer and Sustainable Communities Partnership (SFSSCP) should request that the community safety partnership that covers the Colchester hospital areas seeks assurance from them that they are implementing their action plan and disseminating learning from this review. This CSP should also ensure the same applies for Essex police.

Recommendation 2

The Sheffield First Safer and Sustainable Communities Partnership (SFSSCP) should request that the relevant community safety partnerships within Nottinghamshire seek assurance from the agencies below that they are implementing their action plan and disseminating learning from this review and specifically request:

- i) Nottingham University Hospitals NHS Trust that they are delivering clear domestic abuse training to its staff so that a clinical enquiry is carried out when a patient discloses domestic abuse. This training must make it clear that even if there is already an agency involved then a DASH RIC should still be completed and the relevant referrals made.

- ii) Nottingham City Council Adult Social Care should ensure that the standard letter for general DART use outlines the correct contact number and the available resources that are deemed safe and appropriate. This can always be amended according to need, risk and safety aspects. There is in place a clear protocol for record keeping which would cover when phone calls will be deemed unsafe. The records need to document why unsafe and clear rationale for this. An audit of records should assure the CSP that the recording policy is being adhered to.
- iii) NCCCG should work with GP practices to develop a protocol that can be used by them when processing and recording DART referrals.
- iv) Nottinghamshire Police ensures that where children are recorded on the DASH RIC, Officers should be reminded of the need to obtain their full details including a current address wherever possible. This may require further enquiries and research by the Officer submitting the DASH RIC. This includes the requirement to consider safeguarding referrals for children recorded on the DASH RIC irrespective of the policing area in which they currently reside. Nottinghamshire Police Officers should be reminded that if a victim has moved out of Nottinghamshire the person with that information must ensure that the new Policing Area and Command Unit are informed. The new address should be provided and the Policing Area appraised of the abuse and risk category of the victim.
- v) Nottingham Trent University is making sure that their staff use professional curiosity when a student informs them that they are subject to DA and checks other agencies are actually dealing with the abuse. Particularly if a student subsequently drops out of their course / is unable to be contacted.

Recommendation 3

In order to help to disseminate learning the SFSSCP should write to the Home Office to ask them for guidance on what good practice is currently happening across the UK in relation to intervention programmes that are delivered to perpetrators. In this case it is felt that a programme could have been a preventative factor however guidance is needed on commissioning such a programme and how to achieve the maximum effect. The SFSSCP should share findings with the other CSP's involved in this DHR.

Appendix A

Individual Agency Recommendations

Colchester Hospital University NHS Foundation Trust

- 1) All staff to be made aware of the recommendations within the IMR and the DHR when published.
- 2) Specific training is undertaken on recognising and safeguarding patients who may be victims or perpetrators of domestic abuse in identified high risk areas on admission to CHUFT. This must include A&E, EAU and Maternity.
- 3) Urgent review of the documentation in ED and EAU should be undertaken to ensure routine domestic abuse enquiry on admission. This routine enquiry should mirror the process already established within Maternity services at CHUFT where domestic abuse information is routinely and explicitly obtained from the patient.
- 4) Staff must ensure that GP details are routinely checked and documented on admission to CHUFT.
- 5) CHUFT liaises with Essex Police and MARAC to develop a robust procedure for information sharing. Any information should then be shared within the organisation as appropriate including central alerts on the patient information system (Portal) regarding the risk to an individual.
- 6) Victims or perpetrators who disclose domestic abuse should be offered the opportunity to speak to a member of staff from EDAAP currently based within CHUFT.

Essex Police

No recommendations made

East Anglia Ambulance Trust

No recommendations made due to minimal involvement

Nottinghamshire Police

- 1) Where children are recorded on the DASH form, officers should be reminded of the need to obtain their full details including a current address wherever possible. This may require further enquiries and research by the officer submitting the DASH form.
- 2) DASU staff are reminded of the requirement to consider safeguarding referrals for children recorded on the DASH form irrespective of the policing area in which they currently reside.
- 3) Officers should be reminded that if a victim has moved out of Nottinghamshire the officer with that information must ensure that the new force and command unit are informed. The new address should be provided and the new force apprised of circumstances of the abuse and risk category of the victim.

Nottingham Trent University

- 1) When a student states that other agencies are dealing with issues such as those raised in this case either in the Notification of Exceptional Circumstances procedure or via any other contact with the University that our Student Support Services teams do check wherever possible on the information provided that this indeed has been referred to the appropriate agencies to investigate.

Nottingham University Hospitals NHS Trust

- 1) Domestic abuse training to be explicit that clinical enquiry must be carried out when a patient discloses domestic abuse
- 2) Domestic abuse training to be explicit that even if there is already an agency involved that a DASH risk assessment should be completed and relevant referrals made
- 3) Additional training to be delivered to GUM staff to include nursing assistants.

Nottinghamshire Healthcare NHS Foundation Trust

- 1) There is a clear need to re-enforce record keeping and assessments following contacts with clients evidenced within this review.

Nottingham City Care Partnership

- 1) City Care Urgent Care Centre will continue to implement clinical enquiry around domestic abuse and will continue to be vigilant to signs of domestic abuse during all contacts with service users.

Nottingham City CCG/ GP Practice

- 1) The GP practice to develop a protocol for the processing and recording of DART referrals in conjunction with the CCG within a view to this being shared across all City GP practices.
- 2) The GP Practice to change its policy on redacting third part information from DART referrals in line with National IG good practice Guidelines.
- 3) The Nottingham City CCG to issue guidance on the recording of third party information on clinical records to all GP practices in the city.
- 4) GP practice to develop a clear protocol in relation to the contacting of students following the disclosure of deliberate overdose/self-harm
- 5) Nottingham City CCG to issue information to GP Practices to remind them of the links between mental health, domestic violence and suicide.

Nottingham City Council Adult Social Care

- 1) Standard letter for general DART use outlining correct contact number and resources if deemed safe and appropriate. This can be amended according to need, risk and safety aspects.
- 2) Explanation should be provided as to why contact is not made via telephone and if the safety of speaking via the telephone is questionable, then evidence of this must be documented.

Due to minimal or no involvement neither Shelter nor the DWP had any recommendations that need to be made. This same applies for South Yorkshire Police whose involvement commenced with the murder of Adult I.

Glossary

CCG	Clinical Commissioning Group
CHUFT	Colchester Hospital University NHS Foundation Trust
CPN	Community Psychiatric Nurse
CRHT	Crisis resolution and home treatment
DACT	Domestic Abuse Coordination Team
DART	Domestic abuse referral team
DASH RIC	Domestic Abuse Stalking Harassment and Honour based violence. Risk identification checklist
DHR	Domestic Homicide Review
GUM	Genito-urinary medicine
IAPT	Improving access to psychological therapies
IRIS	Identification and referral to improve safety
MHLN	Mental Health Liaison Nurse
NEC	Notification extenuating circumstances
NHCFT	Nottinghamshire Healthcare NHS Foundation Trust
NUH	Nottingham University Hospitals NHS Trust
SFSSCP	SHEFFIELD FIRST SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP
SNT	Safer neighbourhood team
QPM	Queen Police Medal
UCC	Urgent Care Centre



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Domestic Abuse Co-ordination Team
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27 October 2017

Dear Ms Higgins,

Thank you for submitting the Domestic Homicide Review (DHR) report for Sheffield (Adult 1) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20 September 2017. I apologise for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a good review which is easy to follow.

There were, however, some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The Panel felt equality and diversity have not been sufficiently explored as they are particularly relevant to this case. For example, the subjects of the review were migrants, the victim had a disability and perhaps the age gap between the victim and perpetrator could also have been examined;
- Further clarification on the independence of the chair to help assure a reader that there is no conflict of interest. For example, information on when he retired and the force in which he was employed would be helpful;



- The Panel noted that the report contains sensitive information about the perpetrator's previous partner and their children. It is not clear in the report whether they were invited to participate or if their consent was sought to share information;
- The Panel noted the absence of domestic abuse specialists or any voluntary sector agencies on the review panel;
- You may wish to enhance anonymisation by removing precise dates of birth and death and dates of incidents.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel