Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the homicide of 'Nicky' (pseudonym)

In July 2020

Report produced for West Cumbria Community Safety Partnership by

Paula Harding

Independent Chair and Author

Nicky is the youngest of my children. From a young age she had a lot of health problems. However, this made her extremely strong, and she never let her issues get in the way of her life.

Growing up she was a daddy's girl. She would always try to help him. I have a lot of fond memories of all of the children. I am proud to say they had a great childhood filled with laughter, picnics and watching their dad fishing. As a family we have always loved one another.

There were times during Nicky's life where she would be isolated and lack confidence. I think about this a lot and sometimes feel guilty. However, I now know she was a victim of domestic abuse – something which I never considered at the time.

Nicky fell pregnant with her two children in her twenties. She truly adored them and being a mam, I know how proud she was of them. A memory which sticks with me is when it was her daughter's prom, Nicky was in hospital prior due to her health issues but, still managed to go and see her in her beautiful dress and get photos. The photo of them both is still one of my favourites despite Nicky hating how she looked at the time.

Nicky was always a hard worker, often doing two jobs. She was truly the type of person that would do anything for everyone.

It has now been three years since Nicky was killed. It never gets easier, and I think about her a lot. She was taken from us in the worst way. I often try to think of the happy memories we all had but, this is sometimes difficult as it is a consistent reminder that she is no longer here.

Being part of the domestic homicide review was a difficult decision for me to make and I was apprehensive at first. However, I truly hope this is going to help at least one other family from going through the hardship and pain that we have had to endure.

Nicky's Mam

PREFACE

Members of the review panel offer their deepest sympathy to the family and all who have been affected by the homicide of the victim.

The panel would also like to extend its thanks to the victim's neighbours for calling the police and bravely providing evidence of the domestic abuse that they had witnessed, as well as providing testimony for this review.

CONTENTS

PREFACE **3**

1. INTRODUCTION **6**

1.1 Background 6

1.2. Aim and purpose of a domestic homicide review 6

1.3. Timescales 7

1.4. Confidentiality 7

2. TERMS OF REFERENCE **8**

2.1. Methodology 8

2.2. Involvement of family and others 9

2.3. Independent chair and author 9

2.4 Members of the review panel 10

2.5. Time period 11

2.6. Individual agency reports 11

2.7. Agencies without contact 12

2.8 Key Lines of Enquiry 12

2.9 Definitions 14

2.10 Parallel reviews 15

2.11 Equality and diversity 15

2.12 Dissemination 16

3. BACKGROUND INFORMATION **17**

3.1 The homicide 17

3.2 The victim’s background 17

3.3 The alleged perpetrator’s background 18

4 CHRONOLOGY **18**

5. OVERVIEW OF AGENCY INVOLVEMENT **27**

5.1 Cumbria Constabulary 27

5.2 Cumbria and Lancashire Community Rehabilitation Company 31

5.3 Primary Care - General Practice 33

5.4 Cumbria, Northumberland, Tyne and Wear NHS Trust 34

5.5 Lancashire and South Cumbria Foundation Trust 35

5.6 North Cumbria Integrated Care NHS Foundation Trust 37

5.7 Greater Manchester Mental Health NHS Foundation Trust 38

5.8 Cumbria County Council Children’s Services 39

5.9 Home Group 39

6. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS **40**

6.1 The victim’s experience of domestic abuse 40

6.2 Routine enquiry and health pathways 45

6.3 MARAC and high risk 46

6.4 The “relentless pursuit and disruption” of domestic abusers 48

6.5 Engagement with alcohol treatment services ... 52
6.6 Role of Social Landlords ... 54
6.7 Impact of the Covid-19 Pandemic ... 55
6.8 Homicide-Suicide ... 56
7.0 CONCLUSION ... 57
8. RECOMMENDATIONS ... 58
8.1 Overview & System Recommendations ... 58
8.2 Individual Agency Recommendations ... 60
9. BIBLIOGRAPHY ... 63
ACRONYMS ... 67
GLOSSARY ... 67

1. INTRODUCTION

1.1 Background

1.1.1. This review concerns the circumstances leading to death of a 43-year-old woman in July 2020. Her partner was arrested for her murder but committed suicide in prison five days later.

1.2. Aim and purpose of a domestic homicide review

1.2.1. Domestic homicide reviews came into force on the 13th of April 2011 having been established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a domestic homicide review 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 they were related or with whom they were or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

1.2.2. The purpose of a domestic homicide review is to:

" a. 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;

b. 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;

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

d. 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;

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

f. highlight good practice" (Multi-Agency Statutory Guidance 2016, para 7)

1.2.3 As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should "articulate the life through the eyes of the victim… situating the review in

the home, family and community of the victim and exploring everything with an open mind" (Multi-Agency Statutory Guidance 2016, paras 8 and 9).

1.3. Timescales

1.3.1. The homicide occurred in July 2020 and the decision to undertake a review was made by the Chair of West Cumbria Safer Communities Partnership in consultation with affected agencies.

1.3.2. The review commenced promptly with the first panel meeting being held on 14.10.2020. However, the review was delayed in its conclusion as a result of national arrangements to contain the spread of the Covid-19 pandemic and to ensure that family members could engage with the review. Nonetheless, the panel met six times.

1.3.3. The panel considered and agreed the draft Overview Report in November 2021 and family members were provided with the opportunity to provide their comments, before the final Overview Report was endorsed by the Community Safety Partnership on 06.12.22.

1.4. Confidentiality

1.4.1 This Overview Report has been anonymised in accordance with statutory guidance. In order to protect the identity of the homicide victim, her family and significant others, pseudonyms have been used. The homicide victim will be referred to by the name, Nicky[1], and the alleged perpetrator of domestic abuse, by the name Mark[2].

1.4.2 Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

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[1] The family were consulted on the use of a pseudonym and agreed that pseudonyms be chosen from names that were popular in the year that the individual was born as featured in official records, in this case Nicky and Mark
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/babynamesenglandandwalestop100babynameshistoricaldata

[2] ibid

2. Terms of Reference

2.1. Methodology

2.1.1. The review followed the methodology required by the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (HM Government, 2016a).

2.1.2. Twenty local agencies were notified of the homicide and were asked to examine their records to establish if they had provided any services to the victim or alleged perpetrator and to secure records if there had been any involvement. Seventeen agencies were found to have had relevant contact with the victim or the alleged perpetrator. Three local agencies had had no relevant contact.

2.1.3. Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author and agree the make-up of the multi-agency review panel.

2.1.4. Cumbria Constabulary provided the findings from the criminal investigation and provided details of the family who were to be invited to engage with the review.

2.1.5. The terms of reference for the review were drawn up by the Independent Chair together with the panel and incorporated both key lines of enquiry and specific questions for individual agencies where necessary. It was identified that six agencies were to provide Individual Management Reviews (IMRs) and chronologies analysing their involvement and a further ten agencies were to provide information reports due to the brevity of their involvement or by providing historic context to the scope of the review. Briefings were made available for IMR authors by the Independent Chair in order to support report authors in their task and maintain the focus on the key lines of enquiry.

2.1.6. All reports were written by authors who were independent of the delivery of services provided. Wherever possible, report authors presented their findings to the review panel in person and, where necessary, were asked to respond to further questions. The individual agency reports concluded with recommendations for improving their own agency policy and practice responses in the future and informed the multi-agency and thematic recommendations which followed.

2.1.7. The Independent Chair authored the Overview Report and each draft was discussed and endorsed by the review panel before submission to the Community Safety Partnership.

2.2. Involvement of family and others

2.2.1. Nicky's family were notified about the review in writing by the Independent Chair of the review. They were also provided with Home Office explanatory leaflets and leaflets from the support agencies including Advocacy After Fatal Domestic Abuse. They went on to be supported by the Victim Support Homicide Service. The family were given the opportunity to meet with the Independent Chair and, through their advocate, they also had the opportunity to comment on the terms of reference and were updated as the review progressed. The Chair met with the family to discuss the findings of the review and share the report prior to submission to the Home Office, and their comments have been added to the report.

2.2.2. The Chair sought engagement from Mark's family and a letter together with Home Office explanatory leaflets were delivered by hand by the police on behalf of the review. However, no response was received, and therefore the family were deemed to have declined to engage with the review.

2.2.3. The Chair wrote to Nicky's last place of work, seeking to engage with any work colleagues or friends but in the absence a reply, assumed that they declined engagement with the review.

2.2.4. The Chair met with one of Mark's neighbours, who had been a witness to distressing levels of domestic abuse and their testimony has been added to the review.

2.3. Independent chair and author

2.3.1 The Independent Chair and Author is Paula Harding. She has over thirty years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years she was the local authority strategic and commissioning lead for domestic abuse for Birmingham and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office,

Conducting a Homicide Review,[3] as well as undertaken training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

2.3.2 Beyond domestic homicide reviews, Paula Harding has had no involvement with agencies in the Cumbria area.

2.4 Members of the review panel

2.4.1 Multi-agency membership of this review panel consisted of senior managers and designated professionals from the key statutory agencies, and all were independent of the case, with the exception of Home Group[4].

2.4.2 Wider matters of diversity and vulnerability were considered when agreeing panel membership. Victim Support provided the local domestic abuse service and therefore brought particular expertise on domestic abuse and the 'victim's perspective' to the panel. Unity provided expertise on drugs and alcohol and Cumbria, Northumberland, Tyne and Wear NHS Trust provided expertise on mental health, each of which were issues particularly pertinent to this review.

2.4.3 The review panel members were:

Name	Role/Organisation
Paula Harding	Independent Chair
Alison Knight	Department for Work and Pensions, Senior Safeguarding Lead
Amanda Boardman	NHS North East and North Cumbria Integrated Care Board, GP Lead for Safeguarding
Andrew Donnelly	Cumbria Constabulary, DI North Crime and Safeguarding Team
Clare Stratford	North Cumbria Community Safety Partnership Co-ordinator
Daniel McAllister	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust, Safeguarding and Public Protection Lead
James Varah	Home Group Operations Manager

[3] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning
[4] Home Group's panel member had responsibility within his portfolio for the geographical area in which the homicide took place. However, he also carried the national lead for tenancy enforcement and this specialism was seen as integral to the review. His membership of the panel was therefore encouraged.

Janine Weatherington	Cumbria and Lancashire Community Rehabilitation Company, Senior Probation Officer Lead for Risk and Public Protection
Lisa Handley[5]	Cumbria County Council Children's Services, Service Manager Safeguarding Hub
Louise Cavanagh	Cumbria County Council, Domestic and Sexual Abuse Co-ordinator
Pat Graham	Copeland Borough Council, Chief Executive
Ruth Higgins[6]	Lancashire and South Cumbria NHS Foundation Trust, Specialist Safeguarding Practitioner
Sarah Edgar[7]	Cumbria Constabulary, Domestic Homicide Review Co-ordinator
Sarah Place	Victim Support
Sheona Duffy	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Sioux Nealings	HMP Durham, Head of Offender Management
Susan Mein	North Cumbria Integrated Care NHS Foundation Trust, Safeguarding Lead

2.5. Time period

2.5.1. The panel agreed that the review should focus on the contact that agencies had with the victim and the alleged perpetrator during the period between September 2018, when both individuals appear to have met, and the victim's death in July 2020. Information about earlier times was included for contextual information and to consider whether support had been provided to the victim when she had lost contact with her children.

2.6. Individual agency reports

2.6.1 Individual agency reports and chronologies were requested from the following organisations:

[5] Lisa Handley was a panel member until the final meeting when she left the service
[6] replaced Helen Hargreaves
[7] replaced Angela Rush

- Cumbria and Lancashire Community Rehabilitation Company *(to incorporate whole probation response)*
- Cumbria Constabulary
- HMP Durham
- Lancashire and South Cumbria NHS Foundation Trust
- North Cumbria Integrated Care NHS Foundation Trust
- North-West Ambulance Service

2.6.2 The following agencies were asked to provide briefer information reports and chronologies to the review

- Copeland Borough Council Housing Options
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- North East and North Cumbria Integrated Care Board (for GP Practices)[8]
- Cumbria County Council Children's Services
- Cumbria Health On Call (CHOC):
- Department for Work and Pensions
- Home Group
- HM Courts and Tribunals Service
- Impact Housing to access historic records from Let Go service in respect of the victim's potential engagement with the IDVA service following a MARAC referral
- Unity (Greater Manchester Mental Health NHS Foundation Trust)
- Victim Support

2.7. Agencies without contact

2.7.1 The following agencies were contacted but confirmed that the victim or alleged perpetrator were either not known to them, or that their involvement was not relevant to this review:

- Safety Net
- Gateway Women's Centre
- Freedom Project

2.8 Key Lines of Enquiry

2.8.1 The review should address both the 'generic issues' set out in the Statutory Guidance, in Appendix 1 below, and the following specific issues identified in this particular case. Individual Management Review Authors were asked to provide a chronology and respond to the following questions, where relevant, in respect of

[8] Formerly North Cumbria Clinical Commissioning Group

their involvement in key episodes with the couple during the period specified above.

i. **Individual Practice: how effective were agencies in identifying and responding to the needs and risks faced by the victim?**
Reflective Questions. In responding can you consider:

- *A pen picture of how the individuals were known to you*
- *What knowledge your agency had about the relationship between the victim and the alleged perpetrator?*
- *What needs did your agency identify for either individual and how did your agency respond?*
- *What specific support was made available to the victim as a result of her repeat domestic abuse victimisation?*
- *What opportunities were there to engage and refer over substance misuse issues and how was substance misuse considered/responded to in the context of domestic abuse?*
- *How were decisions made and actions taken by agencies to reduce risk and prevent harm, considering, for example:*
    - *indicators of risk; how risk was assessed and managed; attention to previous history; identifying pre-existing vulnerabilities; how were the individual's attitudes to risk perceived and understood, and how did this affect decisions made or actions taken;*
    - *How substance misuse impacted upon assessment and response to risk?*
    - *Safety planning; escalation; managing risk on closure of cases?*
    - *How the alleged perpetrator's repeat presentations impacted upon his risk profile?*
    - *What actions were taken to respond to and manage* the alleged *perpetrator's domestic abuse and how effective were they in harm reduction?*
    - *Whether the alleged perpetrator's serial abuse was considered in the context of 'violence against women' and, if so, how that impacted upon the response?*
    - *If domestic abuse was not known, how might your agency have identified the existence of domestic abuse from other issues presented to you? For example, were there policies and procedures for direct or routine questioning and how well were they implemented in this case?*
    - *What barriers to engagement did agencies face and how did they seek to overcome these barriers?*
    - *How did agencies recognise and respond to issues of equality and diversity for either individual? Was there any evidence of unconscious bias in the assessments, decisions or services delivered?*
    - *How effective was record keeping?*
    - *How effective was management oversight?*
    - *Did resource issues impact upon services offered?*
    - *How the Covid-19 pandemic impacted upon agencies' responses?*

ii. Multi-Agency Practice: how effective were agencies in working together to prevent harm and to meet individuals' needs?

Reflective Questions. In responding can you consider:

- *How roles and responsibilities were understood and multi-agency protocols adhered to?*
- *Was there a shared ownership and approach?*
- *How effective was the co-ordination of services?*
- *How effective was communication, information sharing and sharing records?*
- *How effective was escalation between agencies?*

iii. Can you identify areas of good practice in this case?

iv. Improving services:

- *what lessons can be learnt to prevent harm in the future?*
- *what recommendations are you making for your organisation and how will the changes be achieved?*
- *what system-wide, multi-agency recommendations do you consider need to be made?*

2.8.2 The following agencies were also requested to consider specific additional questions:

- Cumbria Constabulary to analyse how they responded to the intelligence report received from HMP Durham on 22.06.20 regarding an acrimonious telephone conversation between the victim and alleged perpetrator
- North Cumbria Integrated Care NHS Foundation Trust to also consider their responsibilities to patients leaving A&E before treatment and how they were followed in this case

2.8.3 A briefing was provided for IMR authors in order that the key lines of enquiry could be explored fully.

2.9 Definitions

2.9.1 During the course of this review, the Domestic Abuse Act 2021 was enacted and introduced a legal definition of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

(a)physical or sexual abuse
(b)violent or threatening behaviour
(c)controlling or coercive behaviour

(d)economic abuse
(e)psychological, emotional or other abuse (s1: Domestic Abuse Act 2021)[9]

2.9.2 The Act further introduced into law that children are to be legally recognised as victims of domestic abuse by virtue of their seeing, hearing, or experiencing the effects of the abuse (s1.1: Domestic Abuse Act 2021)[10].

2.9.3 Economic abuse is defined as any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services (s.3: Domestic Abuse Act 2021).[11]

2.10 Parallel reviews

2.10.1 As Cumbria Constabulary had recent contact with the couple, the police response was subject to an investigation by the Independent Office for Police Conduct (IOPC). Their report was shared with the panel and their findings incorporated into this report.

2.10.2 Mark had been subject to statutory supervision by Cumbria and Lancashire Community Rehabilitation Company at the time of the homicide. The circumstances were therefore subject to a Serious Further Offending review and the findings from this review have also been incorporated into this domestic homicide review.

2.10.3 An inquest into both deaths has been postponed pending the finalisation of the domestic homicide review.

2.11 Equality and diversity

2.11.1 The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010[12], as well as to wider matters of vulnerability for both the victim and the alleged perpetrator.

[9] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted
[10] ibid
[11] ibid
[12] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

2.11.2 Nicky was a 43-year-old, white British woman who had experienced long-term domestic abuse from her ex-husband before this most recent relationship.

2.11.3 Mark was a white British man and aged 44 years old at the time of the homicide and his own death. He had a long history of perpetrating domestic abuse against his family and previous partners.

2.11.4 The panel therefore considered that violence against women required specific consideration. Domestic abuse and domestic homicide are considered to be, most often, gendered crimes (Stark, 2007). In the year before the victim was killed, the majority (90 per cent) of victims of domestic homicides in England and Wales were female(n=80) (ONS, 2021). The significance of sex and violence against women should, therefore, always be considered within a domestic homicide review.

2.11.5 Mental health and problematic substance use were also considered in the review as vulnerabilities for both the victim and alleged perpetrator.

2.11.6 The Review applied an intersectional framework in order to understand the lived experiences of both victim and alleged perpetrator. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their community.

2.12 Dissemination

2.12.1 The following individuals and organisations will receive copies of this review:

- The victim's family
- Agencies directly affected by this review
- West Cumbria Communities Partnership and its agencies
- Cumbria Office of the Police and Crime Commissioner
- Cumbria Domestic Abuse Partnership

3. BACKGROUND INFORMATION

3.1 The homicide

3.1.1 On an evening in July 2020[13] the police and ambulance services responded to a third-party report[14] and found Nicky at home with injuries to her face and neck. At hospital she was found to have a bleed to her brain, and she died the next day. A post-mortem revealed that she had died as a result of an acute subdural haemorrhage caused by blunt force head impacts, consistent with punches to the head.[15]

3.1.2 Mark was charged with her murder and remanded at HMP Durham where he was found deceased five days later. He is thought to have killed himself.

3.1.3 An inquest into both deaths is due to be heard following the completion of this domestic homicide review

3.2 The victim's background

3.2.1 Before meeting the alleged perpetrator, Nicky had been in a relationship for over 20 years and had two children. This relationship was characterised by high-risk domestic abuse against Nicky and led to organisations being involved in managing that risk. This included referrals to a multi-agency risk assessment conference (MARAC) and children's services. Nicky experienced mental ill-health and substance misuse and despite attempts by children's services to improve the relationship between Nicky and her children, they went to live with their paternal grandmother under an informal agreement. Nicky went on to have little contact with her children after the relationship with their father ended. After starting a relationship with Mark, Nicky mostly lost contact with her wider family.

3.2.2 Shortly before meeting Mark, Nicky was evicted from her home as a result of significant rent arrears, and she made a homeless application in which she denied any vulnerabilities or domestic violence when asked. Copeland Borough Council accepted that they had a statutory duty to help prevent homelessness for Nicky

[13] Precise date redacted
[14] A third-party report is one made by someone other than those directly involved in the incident as victim or alleged perpetrator
[15] As, at the time of writing, an inquest has not yet been undertaken, the coroner will be asked for permission to disclose this information prior to the report being made available in the public domain.

and assist her in finding alternative accommodation. They went on to assist Nicky to gain a private rented tenancy by providing a rent in advance payment to her new landlord.

3.2.3 Nicky suffered from a significant lack of confidence and the degree to which this, together with her mental ill-health and substance misuse, was caused by her long-term experiences of domestic abuse did not appear to have been explored. Her stress and anxiety were thought to contribute to eczema and alopecia, and she would wear a wig when this occurred.

3.2.4 Nicky's ex-husband continued to be abusive towards her even after the end of the relationship and threatened to kill her when he knew that she was in a new relationship.

3.3 The alleged perpetrator's background

3.3.1 The alleged perpetrator had been violent since a child and had an extensive background of criminality over the last 25 years. This included domestic abuse against his parents and previous partners and as well as other areas of criminality including assaults and public order incidents, burglaries, criminal damage and drugs offences. Two of his previous partners were taken to MARAC as a result of the high threat of harm that he posed to them.

3.3.2 Much of his offending was accompanied by problematic alcohol use and attempts had been made by the Liaison and Diversion Service, known at the time as the Criminal Justice Liaison Team, to encourage his engagement with alcohol treatment. During 2018, the local Unity drug and alcohol service worked collaboratively with the Liaison and Diversion Service to try to maintain Mark's engagement with alcohol treatment and an alcohol detoxification programme was planned. However, he disengaged from treatment before it could begin and was discharged shortly before starting his relationship with Nicky.

4 CHRONOLOGY

4.1 The relationship between Nicky and Mark was thought to have begun in the autumn of 2018 when both were receiving mental health services and when Nicky would have been particularly vulnerable, particularly as she was still facing the high risk of serious harm from her ex-husband.

4.2 In September 2018, shortly after the breakdown of her marriage and her children ceasing to live with her, Nicky was brought to the hospital Emergency Department

by a work colleague. This was her only attendance at the Emergency Department, and she disclosed feeling suicidal, was in poor physical health and was socially isolated. An assessment was undertaken by Emergency Department staff in co-operation with the Mental Health Liaison Team although there was no indication that routine enquiry of domestic abuse was undertaken during this assessment. Her mental health concerns were followed up by the community mental health team who undertook a further assessment during which she disclosed the ongoing domestic abuse from her ex-husband and the involvement of the police. Thereafter, mental health services had difficulty engaging with her as she was often not present when home visits were arranged, but they persisted and, after one month, an exit care plan was completed, and she was discharged back to the care of her GP. The GP noted the helpfully detailed discharge letter that was received.

4.3 The mental health service was not aware that Nicky had commenced a relationship with Mark who had also been referred to the Trust by the police during that time. Indeed, Mark had said that he was living alone. Nicky had disclosed her history of substance misuse to mental health services but did not report any current problems. However, during their assessment of Mark, he disclosed his long-term problematic alcohol misuse and recognised that it was affecting his mood. Nonetheless, he declined a referral to alcohol services at this time. Mark disclosed low mood as a result of losing contact with his children, but an assessment concluded that there was no ongoing role for secondary mental health services, and he was discharged back to the care of his GP.

4.4 In December 2018, Mark was convicted of harassment against his previous partner having left over 130 messages and repeatedly calling her in recent months against her expressed wishes. He received a two-year Community Order which included the requirements to undertake the Building Better Relationships[16] domestic abuse programme and 160 hours of unpaid work.

4.5 Despite a restraining order having been put in place, he continued to call and text his ex-partner over the following two weeks and was charged with breach of the restraining order for which he received a suspended sentence five months later. In the intervening time, Mark breached another restraining order which had been granted following an assault on a female family member.

4.6 The nature of Mark's previous domestic abuse of his previous partner meant that by January 2019, he was treated by police in West Cumbria as one of the top 10 domestic abuse alleged perpetrators and considered at MARAC. MARAC agencies

[16] Building Better Relationships is a nationally accredited groupwork programme within Probation Services designed to reduce reoffending by adult males convicted of violence against an intimate partner

were made aware that his ex-partner had reported hundreds of incidents of contact and harassment toward her and that there was a non-molestation order in place against him in this regard. However, at the time, no agency appeared to be aware of his relationship with Nicky and he later told Unity that he was single.

4.7 Mark was supervised by probation services from this time and was initially required to report to them weekly. He was considered to be at medium risk of causing serious harm to his ex-partner, children and known adults. The probation officer undertook a risk assessment and risk management plan, both of which missed significant information and key monitoring tasks were not undertaken. Mark stated that he was not in a relationship and no home visits were undertaken to monitor his home circumstances. Likewise, no enquiries were undertaken with the police to check whether any domestic abuse had been reported.

4.8 At the end of January 2019, Nicky approached her GP with concerns that her medication for depression was not working and she was experiencing thoughts of self-harm. Her medication was reviewed over the next few months and her eczema was worsening and so she was being treated by the Dermatology Clinic.

4.9 During the same period, between the end of January and May 2019, Mark self-referred to Unity Drug and Alcohol Service twice and he was referred by the Court Liaison and Diversion Service once more whilst in police custody. The Liaison and Diversion Service undertook an assessment which revealed his poor physical health and his reports of increasing alcohol misuse, financial problems, rent arrears and depression and he agreed a plan to support his engagement with the relevant services. Their records featured his reports that he could not have contact with his children, ex-partner or mother, but the service was unable to explore this with him due to the ongoing police investigation. He also advised that his doctor was treating him for depression but that he had not disclosed the extent of his alcohol use which may have been inhibiting the therapeutic benefits of the medication he was prescribed. Thereafter, they were unable to engage with him further once he was out of custody.

4.10 Between February and March 2019, Mark attended the hospital Emergency Department four times, reporting falls, a fight and an assault as variously responsible for the injuries which included, at different times, a minor head injury and fractured facial bones. The police and medical staff shared information, particularly as Emergency Department staff had been unable to gain clarity over whether one injury was as a result of a fall or an assault. On the later occasion, Mark disclosed having broken a restraining order and held in custody but also that he lived alone. The hospital were not aware of him having a partner who may be at risk.

4.11 With Unity, Mark only attended one appointment in May 2019, at which point he was drinking six litres of cider daily and had poor physical health. A detailed history and risk assessment was taken and showed that he was being supervised by probation; had restraining orders in respect of his ex-partner and mother and was on numerous medications as a result of having had his pancreas removed. Thereafter he engaged well with the first two sessions of a group programme before his disengagement. A discharge letter was sent to his GP.

4.12 During these months, Mark contacted the out-of-hours primary care services following a fall downstairs and attended the Emergency Department of the hospital on a further five occasions in respect of a further fall downstairs and an assault which broke his nose. He generally left before treatment and the GP was notified on each occasion.

4.13 Between June and July 2019, Mark attended his GP Practice whilst low in mood and with worsening health due to high intake of alcohol and liver disease. The GP discussed reducing alcohol intake and was aware that Unity was involved with alcohol treatment at this time. As the months progressed, the GP Practice witnessed his behaviour varying from being verbally abusive to reflecting on his suicidal thoughts. The GP went on to screen for suicidal intent in future consultations and treated his worsening physical health.

4.14 In October 2019, Mark attended the Emergency Department again with low back pain and bruised ribs which he accounted for by an alcohol related fall. He was discharged with painkillers and the GP notified. Over coming months, he regularly attended various departments of the hospital including Urology, Gastroenterology and Opthamology[17].

4.15 The first call to the police concerning Mark's domestic abuse towards Nicky came in December 2019 when a neighbour called saying that Nicky had been screaming for about half an hour "No. Don't. Get off me". The neighbours went on to say that the screaming happened every night.

4.16 When the police arrived, there was no sign of a disturbance or distress and officers spoke to Nicky and Mark separately, each giving the same account that Nicky was in bed and that Mark was having an argument on the phone to someone else. They both said that their neighbours were likely to be making up the complaints to aggravate them. Police officers visited the neighbours to gather

[17] Gastroenterology is the branch of medicine focused on the digestive system and its disorders. Urology, also known as genitourinary surgery, is the branch of medicine that focuses on surgical and medical diseases of the urinary-tract system and the reproductive organs. Ophthalmology is a surgical subspecialty within medicine that deals with the diagnosis and treatment of eye disorders.

their accounts but did not obtain statements and their accounts were not documented

4.17 Later that month, on Christmas Day, Mark requested an ambulance for Nicky explaining that he found her on the floor with slurred speech and that she had remained in this unresponsive state for a couple of hours without change. She was taken by ambulance to the local Emergency Department with Mark and, whilst concerns over alcohol intake were noted, she advised that she had not been drinking any more than usual. She left the hospital before treatment and before enquiries could be made of potential risks. The GP was notified that she had attended and had declined treatment.

4.18 In mid-March 2020, Mark was admitted to the Intensive Care Unit following a diabetes related seizure and discharged after two days. At the Emergency Department, Nicky was listed as his partner and next of kin but as the Emergency Department did not have access to a patient's full medical records, previous history of domestic abuse for either party would not have been available. Mark reported that he had stopped drinking seven weeks earlier.

4.19 Later that month, a neighbour heard Nicky screaming things like "leave me alone, get off me, leave me alone, you're hurting, I'm never on my own how can I be sleeping behind your back". The neighbour threatened to phone the police and the screaming stopped.

4.20 A national lockdown period began at the end of March 2020 to manage the Covid-19 pandemic. Probation's supervision of Mark was held remotely after this.

4.21 At the end of May 2020, Cumbria Police received a third-party report stating that there was a female inside the address screaming and it was getting worse. Caller added the female had been screaming on and off for two days, but it had become particularly bad that day.

4.22 Officers spoke with Nicky who stated that the argument was with her with ex-partner on the phone over their daughter and there has been no argument with Mark. Officers noticed that Nicky had a lump on her forehead, and she said she got this from a wallpapering accident. She was asked if she felt safe at the address and was aware to call 999 if she needed help. She declined to respond to an assessment of her risk.

4.23 On the following day, Mark was treated in hospital for self-harm: he had slashed his arm with a razor. Nicky attended with him, and he was assessed by mental health services where he disclosed a verbal argument with Nicky, which he said had led to police involvement, and disclosed previous convictions for domestic abuse against an ex-partner and mother. Mark declined to be seen on his own and hospital staff did not take the opportunity to talk independently to Nicky

regarding this incident or her role as a potential carer. In respect of Mark's long history of alcohol misuse, he declined a referral to addiction services and was offered harm reduction advice in relation to his alcohol use.

4.24 The Emergency Department provided the GP with a discharge letter detailing Mark's argument with his partner Nicky, the suspended prison sentence and the breach of the non-molestation order. It is not known whether this discharge letter was brought to the attention of the safeguarding lead in the practice or merely filed on his record.

4.25 In June 2020, police received reports that neighbours had witnessed Mark kicking Nicky and punching her at least four times in the ribs. They went on to state that the couple had been arguing for the last four weeks. The arguments reportedly often lasted for hours, and things could be heard being thrown against the wall. They also reported having heard, a week earlier in the middle of the night, Nicky shouting "GET OFF ME, YOU'RE HURTING ME" before shouting out of the window for help.

4.26 Although Nicky denied that there had been any domestic abuse, as a result of the evidence from witnesses and the Body Worn Video recordings of the attending officers, Mark was arrested on suspicion of assault.

4.27 Officers discussed safeguarding options with Nicky including the Domestic Violence Disclosure Scheme, Domestic Violence Protection Orders and restraining orders. At one point Nicky briefly said 'I DON'T DESERVE IT' but very quickly corrected herself. Officers sought Nicky's engagement with undertaking a Domestic Abuse Stalking and Harassment (DASH) risk assessment, but Nicky continued to state that nothing had happened. Nonetheless, the risk was assessed as high.

4.28 Whilst in custody, Mark stated that he suffered from depression for which he was on medication. He also said that he had had a couple of pints but was not dependent upon alcohol or drugs. Nevertheless, both the Custody Sergeant and the Healthcare Professional who attended him, offered to refer him to substance misuse services in the form of Liaison and Diversion and Unity, but he declined both offers.

4.29 As his period in custody continued, Mark was taken to hospital because his blood sugars were low. Whilst at hospital he vomited and showed signs of withdrawing from alcohol. Hospital staff informed the police of a management plan for the patient's withdrawal from alcohol whilst in police custody. Once stable, he was charged with 'assault by beating' and on 3rd June, remanded in custody in HMP Durham where his mental health was checked by triage service on arrival.

Referral to MARAC

4.30 In response to this incident, Nicky was referred to the Multi-Agency Risk Assessment Conference (MARAC) and the police made a referral to the Independent Domestic Advisors (IDVA) at Victim Support. However, the contact details were not provided. The Police advised Victim Support that the mobile number that they had listed for Nicky was not recognised and that that they would be sending a police officer to visit her. Although police officers tried a couple of times, they were unable to locate Nicky before the MARAC

4.31 MARAC agencies committed to offer Nicky re-housing and to refer the matter to the Domestic Violence Disclosure Scheme (DVDS) Panel who approved a disclosure to Nicky about her partner's offending background.

4.32 When the safeguarding police officer visited Nicky, she continued to deny domestic violence but confirmed that they argued, blaming herself as she always wanted to have the last word. She told the officer that she had known Mark since she was young and had been in a relationship with him for 14 months by this time but admitted that she did not know his full history.

4.33 Nicky spoke about Mark having had a problem with alcohol in the past but that he had stopped drinking for six months before lockdown when things were fine between them. However, he had started drinking again when lockdown commenced and that she had been drinking too. She felt that she could stop drinking at any time, but that Mark had a drink problem, and she would like him to receive professional help.

4.34 Nicky went on to talk about Mark's very low moods and self-harm. She described how they had both suffered bereavements of close relatives and how she had suffered depression also, for which she currently received medication from her GP but in the past had been under the care of the mental health Crisis Team. She spoke about how she was happy for MARK to come home when he is released and that their relationship was going to continue.

Continuing abuse from prison

4.35 Whilst in prison, Mark was subject to a triage assessment by mental health services and no secondary mental health needs were identified.

4.36 On 10th June, Nicky submitted a request to locate Mark in prison as she wanted to send him some money. At the time there were no known communication restrictions on MARK applicable to this request, but HMP Durham staff monitored their communications, nonetheless.

4.37 On 17th June, they observed that Mark contacted the victim several times per day, during which he mostly shouted and argued with her. Staff considered his behaviour to be abusive and controlling and thought that Nicky was frightened of him. On the same day they recorded that Mark admitted to a friend that he had head-butted the victim and, later on, he told the victim that he had two razor blades in his cell and he was checked for self-harm. It was not possible to decipher the next statement which he was shouting[18]. However, Nicky was heard to say that she felt like "doing away with herself … [and that she was] … sick and had enough." The content of each of these calls together with his account of headbutting Nicky was considered by the prison's Security Department on the following day and the Prison Governor authorised the sharing of the information with the police's Force Intelligence Bureau and Public Protection Units on the next working day. However, this was followed by internal delays within the police in getting the information to the relevant safeguarding team, by which time the victim had already been visited as agreed at MARAC.

4.38 During the visit in July, the safeguarding police officer who had been allocated as a single point of contact to Nicky, disclosed Mark's previous history of domestic abuse against family members and previous partners. Nicky responded saying that she was already aware of "most of" this history but continued to deny being assaulted and declined to provide a statement. She revealed that she had been speaking with Mark by telephone whilst in prison but gave no indication that these calls had been abusive.

4.39 In response, the officer provided general safeguarding advice and offered Nicky a mobile phone that automatically connects victims of domestic abuse to the police and enables the police to track the phone if it is a silent call, which Nicky declined.

4.40 The officer went on to discuss drug and alcohol misuse and Nicky said that she wanted them both to remain alcohol free after Mark's period in prison. She was offered a referral to Unity substance misuse services, which she declined but was advised that she could self-refer. As the officer had not yet received the information regarding the abusive nature of the calls, this was not discussed with the victim.

Assault on release from prison

4.41 Mark was sentenced to 60 days in prison for his assault of Nicky, but due to the 40 days already served on remand, he was released immediately[19]. The prison administrator rang probation to check his reporting requirements, making

[18] Mark was visited by prison officers to discuss potential threat of self-harm which Mark denied

[19] Because of arrangements to manage the Covid pandemic, sentencing was held by video conference between the court and the offender in prison

arrangements for him to attend the following morning, and notified the police Public Protection Unit and his Offender Manager of his release by email. This unexpected release meant that no arrangements had been put in place to manage the threat that he posed to Nicky.

4.42 On his release, Mark met Nicky in Carlisle city centre and went on to assault her in the street. A witness called the police and officers spoke with Nicky and Mark separately, each activating their Body Worn Videos to record their interactions. Nicky was observed to have injuries above her left eye in the form of a bump on her forehead and a cut above her eyebrow. Despite probing questions, Nicky denied being assaulted, explaining that the injuries had been accidental from tripping over her bag and from a prior wallpapering accident.

4.43 Mark was described as loud and incoherent and, although officers were communicating separately to each individual, they remained in close proximity with each other. Mark continued to shout over to Nicky and question,"… *have I pushed you*?" to which Nicky shouted back "… *no, I fell over the bag*".

4.44 The officers were contacted to check whether additional resources were required to attend and assist with the initial investigation, but this was declined. Initially the officers left the couple as they felt that they did not have sufficient evidence to take action. However, concerns shared with the Duty Inspector, enabled them to locate the couple shortly afterwards and Mark was arrested for common assault on the strength of a witness's verbal account. Mark was noted to be under the influence of alcohol and was aggressive towards police staff when he was taken to a custody cell.

4.45 A domestic abuse report was completed grading the risk as 'standard', despite officers knowing by this time that Mark had assaulted Nicky previously and that she had faced high risk. Moreover, there was no indication that Nicky was approached to complete the DASH.

4.46 Witness statements were not taken at the time as, in the absence of the deployment of additional officers being requested, officers were not able to both manage the couple and seek out witnesses. When officers tried to obtain witness statements from the onlookers the next day, they were unsuccessful. Thereafter, Nicky was contacted by phone and asked if she would provide a statement regarding the incident, but she declined. Nicky was advised that Mark was to be bailed for 28 days with conditions not to contact or approach her and that an officer would visit her in person to discuss the case. At the time, she said that she was at Mark's house but would return home and officers attempted to visit her at various addresses on six occasions over the next 24 hours, making enquiries of neighbours and making numerous attempts to contact her by phone.

4.47 Although attempts had been made to obtain other evidence by virtue of CCTV footage, which was not conclusive, and through interviewing the alleged perpetrator, who denied the assault, there was insufficient evidence at this stage to charge Mark and remand in custody and he was given bail for 28 days whilst further evidence was explored. It was noted that had witness statements been obtained, then Mark would have likely been charged and remanded for this offence. It was also noted that had risk been assessed in accordance with the known history then safeguarding information would have been shared with other agencies.

4.48 Later that night, Nicky suffered the fatal assault.

5. OVERVIEW OF AGENCY INVOLVEMENT

5.0 This section considers the Individual Management Review and Information Reports completed by individual agencies and the outcomes of discussions with the review panel concerning improvements to services in the future.

Criminal Justice Agencies

5.1 Cumbria Constabulary

5.1.1 In many respects, the police response to domestic abuse in this case was positive. In June 2020, they made a positive arrest despite the victim minimising the harm caused and declining to offer evidence. MARAC actions were undertaken systematically and enhanced through the deployment of a specially trained safeguarding officer as a single point of contact. The availability of a single point of contact was seen as good practice: a means to establish trust and positive engagement with high-risk domestic abuse victims as well as signposting them to appropriate support agencies, assisting in safety planning and escalating risk when necessary. In addition, officers went to some lengths to make contact with Nicky after she had been assaulted in the days before her death. However, the Police reflected upon several missed opportunities.

Abusive calls from prison

5.1.2 In respect of the abusive calls that Mark made to Nicky whilst he was in prison for assaulting her, there was a missed opportunity by the police to discuss these with the victim and take enforcement action against the alleged perpetrator. Indeed, it

was reflected that the evidence from the prison, even without a victim statement, may have been sufficient for the police to present to the Crown Prosecution Service for charging advice.

5.1.3 The source of the missed opportunity fell upon the delays in the information from the prison being accessed by the right team in the police. A process is now in place that requires Cumbria Police intelligence systems to be cleared on a daily basis, therefore minimising any matters of risk being sat in generic email inboxes for a period of time without being reviewed and appropriate action taken. Contact details have also been shared with the prison service to ensure notifications can be directed to the correct respondent.

5.1.4 Thereafter, the safeguarding team went on to make a decision not to revisit the victim to put the specific issue to her as they thought they had given her opportunity to disclose these calls had she wanted to when they last visited her but she had declined assistance and minimised the abuse. This theme of how officers responded to the victim’s minimisation of the abuse features in a number of interactions with the victim. As a result, the Constabulary have recognised that cases involving victim-minimised harm behaviours should be clearly recognised as possessing inherent risk and has committed to strengthen understanding of staff across the organisation, from the Control Room through to the MARAC Chair and Inspector ranks.

Identifying previous history

5.1.5 In respect of the assault in the city centre, it was not known why the attending officers did not check Mark’s history, even after he disclosed that he had been released from custody earlier in the day. The information was available to officers, but they appeared to be assessing risk based on only the incident before them. In order to assist future responses, Cumbria Constabulary have committed to make key information about high-risk victims and alleged perpetrators more prominent on their intelligence systems.

5.1.6 As a result, any officers responding should be able to recognise additional safeguarding elements within the early attendance at an incident and subsequent case management. Understanding the significance of previous history will be examined further in the thematic section which follows.

Evidence gathering

5.1.7 Again, in relation to this incident, the police reflected upon an apparent level of indecisiveness by officers about what to do in relation to gathering evidence to allow an arrest. Had additional patrols been requested and allocated, this may have enabled witness statements to have been secured in early evidence and a greater likelihood of the ability to charge and remand Mark rather than release him on bail whilst those enquiries continued.

5.1.8 The separation and questioning of the couple during this incident was also considered and there was the possibility that failing to prevent Mark from communicating with Nicky may have prevented Nicky from having confidence in disclosing the assault.

5.1.9 As well as actions to strengthen officer's responses to victim-minimised harm, the Constabulary have committed to strengthen awareness of the need for adequality resourcing victim-minimised harm incidents and maximise the gathering of early evidence, particularly where the victim may decline making a statement.

5.1.10 In terms of the evidence gathering in the earliest report by neighbours of the domestic abuse in the household, it was noted that police officers visited the neighbours to gather their accounts. This was particularly significant as the victim and her partner were minimising the abuse and suggesting that the neighbours' reports were malicious. However, statements were not obtained, and accounts were not subsequently documented. As a result, the Constabulary has made a recommendation that an accurate auditable record of witness accounts should be made, whether by witness statement or by the account being recorded in officer's pocket notebook or digital device detailing their activities.

Risk

5.1.11 The DASH assessment of the domestic abuse report stated that Nicky would not disclose the assault that had been witnessed by others. However, the body-worn recordings did not show that any approach had been made to the victim concerning the DASH assessment.

5.1.12 Thereafter, the standard risk assessment was not reassessed by the investigation team on the following day and there was no supervisory oversight of this decision until the grading was reassessed by the Public Protection Unit some days later, by which time the victim had been killed. If it had been correctly graded as a high-risk safeguarding referral, then it would have been reviewed and brought to the attention of all relevant partners very quickly. The Constabulary has therefore

committed to strengthen the appreciation and understanding of risk and DASH across the organisation.

5.1.13 Within the force, it has been observed that there had been an erosion of the quality of supervision in such cases. The need for oversight from a supervisor before any handover of such cases used to be mandatory but this is no longer the practice. As a result, the practice of police inspectors monitoring handover has been resumed.

5.1.14 Moreover, the Constabulary has recognised that the tracing and completion of enquires between responding police officers and custody investigation teams needed a digital overhaul which accurately depicts the process and stage of the investigation and details safeguarding and approaches to risk. This has since been changed and a new process adopted to improve investigative standards.

5.1.15 In terms of the granting of bail, the Constabulary has recognised that there should be a sustained and critical evaluation by bail decision makers of the decision to bail and not continue enquiries. The evaluation should also explore the risks posed to victims where an alleged perpetrator is released, and a victim has not been located. Actions to address these are featured in their action plan.

Operation DART

5.1.16 At the time of the victim's homicide, the Constabulary had just commenced a significant programme of development around domestic abuse. Operation DART (Domestic Abuse Reduction Tactics) requires that all high-risk domestic abuse cases be dealt with by a detective in the Safeguarding team. The victim is allocated a single point of contact to build rapport and offer an advanced level of service. The alleged perpetrator is also targeted in respect of other potential offences, such as drugs and driving, in order to reduce further domestic abuse, and consideration is given to engagement through the Integrated Offender Management and other pro-active programmes for managing violent offenders.

5.1.17 However, in view of the multiplicity of concerns around the police response in this case, it has been recommended that Cumbria Constabulary provide assurance to the Community Safety Partnership around the outcomes of their improvement programme and internal communications activity in each of the features of this review including: compliance with DASH; positive action; risk assessment; supervision; bail and responding to intelligence reports and responding to victim minimisation and engagement. This recommendation features in the multi-agency recommendations which follow.

5.1.18 Since this time, Cumbria Constabulary have been working with the College of Policing and SafeLives to roll out the *Domestic Abuse Matters* programme across

its workforce. *Domestic Abuse Matters* is a bespoke cultural change programme for police officers which has been designed to transform the response to domestic abuse, ensuring the voice of the victim is placed at the centre, and controlling and coercive behaviour is better understood. The programme is designed to have long-term impact: changing and challenging the attitudes, culture and behaviour of the police when responding to domestic abuse. In this way, the Constabulary's adoption of the programme was seen to be good practice.

5.2 Cumbria and Lancashire Community Rehabilitation Company

5.2.1 The Community Rehabilitation Company (CRC) reflected upon their response to Mark and noted a number of shortcomings in their supervision of him from December 2018 onwards. In particular, they found that the initial risk assessment and risk management plan were missing key information concerning his offending behaviour and analysis of motivations, trigger factors and how risk would be effectively managed in the community. Thereafter, the probation officer did not undertake key tasks including police intelligence checks to monitor any domestic abuse offending; a home visit to monitor his home circumstances; monitoring his developing relationships or undertaking structured interventions to address his offending.

5.2.2 The probation officer focussed on Mark's ill health more than on his offender management, despite ill-health not being part of his plan. As a result, Mark had not been required to undertake unpaid work or undertake the Building Better Relationships domestic abuse programme in the 19 months of probation supervision before his death despite these being requirements of his community order. In view of the nature of the offence and subsequent order, a Women's Safety Worker should also have been allocated to his ex-partner. As well as providing support, the Women's Safety Worker would have been able to provide additional monitoring of his abuse and harassment. Indeed, his case was considered at MARAC as a result of the level of his harassment against his ex-partner

5.2.3 Initially Mark was engaging with the substance misuse services of Unity, but his engagement was not monitored, and no re-referral was made when he disengaged as the probation officer was under a misapprehension that such a referral needed Mark's consent.

5.2.4 Line management oversight was reliant upon the probation officer requesting it and, not having done so, oversight was limited in its effectiveness. More generally,

the Senior Probation Officer did attempt to address the officer's practice, involving the Practice Development Unit, but practice did not improve sufficiently. Additional internal monitoring has since been put in place to resolve this over-reliance upon officers to raise issues of concern with their supervisors.

5.2.5 In the final months before the homicide, arrangements to manage the Covid-19 pandemic meant that a remote model of working was introduced as an option for probation services. Thereafter, the probation officer undertook monthly telephone calls but there was no recorded rationale for the decision in this case. A possible impact was that the risk management and sentence plans did not reflect the circumstances.

5.2.6 When Mark's abuse of Nicky was heard at MARAC, the probation officer was not pro-active in following up concerns independently. They could reasonably have contacted a Women's Safety Worker, the IDVA or have direct contact with Nicky herself. Mark's sentencing to custody for the assault of Nicky provided further opportunity for this pro-activity.

5.2.7 The CRC were required to provide assurance to Her Majesty's Prison and Probation Service (HMPPS) that they were managing domestic abuse alleged perpetrators to a sufficient standard. In response, the CRC undertook two domestic abuse thematic quality audits focusing on 150 domestic abuse cases involving every probation officer with a qualifying case. This audit has had independent scrutiny provided by HMPPS and good practice and lessons learning have been disseminated and embedded throughout the organisation.

5.2.8 Aside from the matters of individual learning for the probation officer involved, the CRC also committed to:

- developing a criminal justice pathway within substance misuse services through which to address the issues over self-referral and information sharing between probation and substance misuse services.
- Strengthening management oversight of staff in order to ensure adherence to policy and practice standards in assessments, planning, implementation and review of interventions in the future.

5.2.9 During the course of this review, the National Probation Service and Community Rehabilitation Companies were unified and returned to public control under the new Probation Service. The review has recommended that learning from this review, together with outstanding recommendations and actions for probation services, be adopted by the new organisational model in the region.

Health and Social Care Agencies

5.3 Primary Care - General Practice

5.3.1 Although registered at the same practice, Nicky and Mark were not registered at the same address. They always attended appointments at the surgery alone and clinicians were not aware that they were in a relationship. After the homicide, it transpired that non-clinical staff had been aware of the relationship because of their knowledge of the community, and this has led to a recommendation being to reinforce the need for all practice staff to raise concerns with their safeguarding lead or senior member of staff.

5.3.2 In respect of the victim, Nicky saw her GP periodically for depression and for a severe form of eczema for which she was referred to a specialist Dermatology consultant. Despite both conditions being potential indicators of domestic abuse, targeted routine enquiry was not undertaken. The review was made aware that there has been much activity in rolling-out routine enquiry in primary care but that this has been disrupted by the remote arrangements that have had to be put in place to address the Covid-19 pandemic and so a recommendation has been made to further promote with GPs the need for targeted routine enquiry about domestic abuse when indicators are present and to strengthen the disclosure pathway.

5.3.3 The GP was aware when commencing Nicky on anti-depressants in October 2018, that her mental health deterioration had arisen as a result of her relationship breakdown and loss of her children, but no consideration appeared to have been given to the need for further support for her. The Integrated Care Board recognised that it was unlikely that primary care practitioners would be aware of services that might be available to address the impact of the loss of one's children and welcomed the contributions from panel members about the nature of such services which were circulated across primary care.

5.3.4 Beyond these consultations, the GP Practice received a notification from the Emergency Department where Nicky had left before treatment on Christmas Day 2019, but as they were alerted to nothing of concern, no follow-up was undertaken, and the notifications were filed on the patient record. The Practice was also notified in June 2020 that Nicky was being discussed at MARAC and added a clinical note to the patient record as requested. No further information

was received and the relationship of primary care to the MARAC is considered further in the thematic section which follows.

5.3.5 The Practice were aware that Mark was being supported in respect of his alcohol use by Unity until August 2019 but reflected that the Practice could strengthen its working relationship with substance misuse services and this issue is raised further in the thematic section which follows.

5.4 Cumbria, Northumberland, Tyne and Wear NHS Trust

5.4.1 Although the Trust did not provide mental health services in North Cumbria at the time that both individuals accessed support for mental health services in 2018, they have since taken over the mental health portfolio for the area as well as holding the historic records. The Cumbria Partnership Foundation Trust, who provided mental health services at the time, had limited contact with both individuals although assessments were made on each occasion when they were referred to their service and concluded that there was no ongoing role for secondary mental health services.

5.4.2 In respect of the assessment of Nicky in 2018, Nicky had disclosed ongoing harassment and domestic abuse from her ex-partner. It was recognised that this was a contributor to her mental ill-health and although they were aware that the police were involved in the domestic abuse, the service did not appear to consider supporting her referral to domestic abuse services. A recommendation has therefore been made for them to promote the need to enable engagement with domestic abuse services, even when the police may be involved.

5.4.3 When Mark was referred to their services again in May 2020. However, the mental health service did not take the opportunity to talk with Nicky on her own after disclosures of his history of domestic abuse against his ex-partner and mother, and current police involvement following his argument with Nicky. Likewise, it was not clear that practitioners were aware of how to respond to disclosures of historic domestic abuse and how those might apply to the current experiences. Although the mental health service was not aware, their assessment of Mark was undertaken at the same time as reports were being made to the police by third parties about his abuse of Nicky.

5.4.4 The Trust has recognised in its recommendations that:

- there is a need to ensure professionals routinely enquire about domestic abuse when there are indicators of concern
- staff need to understand their role when hearing disclosures of domestic abuse from perpetrators and consider their 'Think Family' responsibilities to family and carers
- staff need to consider history of domestic abuse and how this impacts on presenting risks at the time of initial assessments and future appointments.

5.4.5 In other regards, their assertive efforts to engage the victim in assessment were recognised as good practice as was the level of detail provided to the GP upon discharge.

5.5 Lancashire and South Cumbria Foundation Trust

5.5.1 The Liaison and Diversion Service, previously known as the Criminal Justice Liaison team in West Cumbria, operates exclusively within Police Custody Suites, Magistrates Courts and Crown Court with time limited, community based, assertive support. Rather than provide mental health treatment or interventions, the service acts as a bridge to treatment: as a point of referral and assertive follow up to ensure those involved can access, and are supported to attend, treatment and rehabilitation appointments.

5.5.2 The service had originally assessed and supported Mark when he was in custody in June 2018 following an assault on his mother. At this time, they supported him in attending GP appointments for a review of his mental health; in accessing financial assistance for his debts; in accessing emergency payments for his utilities and in attending appointments with alcohol services. Indeed, during this earlier period, the service worked closely with Unity alcohol services to enable his attendance with an initial plan for inpatient detoxification. There were indicators that Mark relied heavily upon the Service at this time and may not have sought to re-engage with alcohol services without this support. However, despite their efforts, they were unable to engage Mark beyond the custody suite for the same range of services needed when he was in custody the next year.

5.5.3 There was no indication that the alleged perpetrator's alcohol use was considered within the context of domestic abuse, for which he had taken into custody. Due to the nature of their service, they were prevented from exploring this further during

the ongoing investigation. Indeed, the service would not discuss the circumstances for a person's arrest and subsequent detention on custody in accordance with the Police and Criminal Evidence Act 1984 and the prevention of a first disclosure. However, the standard risk assessment undertaken in February 2019 lacked reference to domestic abuse. The service therefore identified the need to ensure that all staff are clear in their responsibility to complete the Trust safeguarding module for all clients in order to support 'think family' practice and routine enquiry into domestic abuse.

5.5.4 As well as the nature of records that should be held concerning the alleged offending and it was agreed to revisit the information governance around this, particularly where these suspected offences are relevant to considering risk.

5.5.5 It was noted that staff were trained in domestic abuse; have a designated domestic abuse 'champion' for support and connecting to specialist services and the service participates actively in MARAC, although the alleged perpetrator was not open to their services when the MARAC took place.

5.5.6 There was good evidence of assertive engagement with Mark in the earlier period as well as seeking relevant information from mental health services to aid assessments. There were particularly good levels of communication between the Liaison and Diversion Service and Unity. The alleged perpetrator's GP was advised of assessments, achieved outcomes or non-engagement on discharge. However, the alleged perpetrator's probation officer was not advised of discharge from the service. Liaison with other agencies, especially those that specifically address offending behaviours such as courts and probation services was identified as a recommendation for the service.

5.5.7 The Trust shared with the review how the supervision of safeguarding had been strengthened in the intervening time but reflected on the need to consider whether additional mandatory safeguarding training specifically on domestic abuse may be necessary beyond that which is currently offered.

5.5.8 Reflecting upon their approach, the Trust recognised that its processes were focussed upon their responses to victims of domestic abuse. However, as an offender focussed service, they also needed to have clear expectations of staff when working with suspected perpetrators of domestic abuse and have commissioned a specialist perpetrator programme agency to help determine these expectations and provide training for staff, which was seen as good practice.

5.6 North Cumbria Integrated Care NHS Foundation Trust

5.6.1 This Integrated Care Trust was created in 2019 and incorporated the former North Cumbria University Hospitals NHS Trust whose hospitals were attended by both the victim and alleged perpetrator at various times.

5.6.2 Nicky was only seen by the hospital on three occasions prior to the final assault that she endured: once as an outpatient at the dermatology clinic and twice at A&E. On the first attendance at A&E she was feeling suicidal, and this led to the mental health pathway above. However, her next attendance on Christmas Day in 2019 had been generated by Mark calling for an ambulance because Nicky had been unresponsive. Whilst it was recognised that this may have been an opportunity for staff to enquire about Nicky's lived experience and concerns about her alcohol use had been noted, she left the department before being fully reviewed and a discharge letter was sent to the GP. The Trust has committed to undertake a review of the pathway and follow-up for patients who leave A&E prior to completing treatment.

5.6.3 In contrast, Mark had considerably more contact with the hospital as he had several health conditions related to, or impacted by, his problematic alcohol use and he was known to a number of different departments in the hospital. He had nine attendances at A&E during the period under review. Four of these were related to him either having a fall or a fight; one in relation to an alcohol related fall and two attendances related to mental ill-health.

5.6.4 The Trust reflected that problematic alcohol use was well documented for Mark, and he was signposted to Unity for alcohol treatment by the Gastroenterology Outpatient Department. However, there were missed opportunities from A&E and the Maxillofacial and Urology Clinics to refer him to Unity for support and the need for practitioners to encourage engagement with specialist substance misuse services features within the Trust's recommendations.

5.6.5 The Trust was not aware of the two individuals being in a relationship until receiving a MARAC notification in June 2020 and neither party returned to hospital after that time, until the fatal incident. However, the Trust found little evidence of routine enquiry around domestic abuse taking place either in outpatient or A&E settings. Although steps had already been taken to improve selective enquiry in A&E, leading to an increase in referrals to MARAC, the Trust has committed to continue mandatory training with all staff on domestic abuse and substance misuse with particular focus on routine enquiry and referral to specialist support services. They have also committed to continue to improve

awareness and responses to domestic abuse through the improvement plan, to include increased use of DASH and MARAC referrals and the 'think family' Screening tool. This new Screening tool is being used in A&E to enable staff to routinely enquire about family and support networks, thereby identifying patients or dependents who may be at risk whilst they are in hospital or on discharge.

5.7 Greater Manchester Mental Health NHS Foundation Trust

5.7.1 The Trust provides Unity Drug and Alcohol Recovery Service across Cumbria (hereinafter referred to as Unity) and, since 2018, Mark had self-referred to Unity on two occasions and been referred by the Court Liaison and Diversion team, two more times.

5.7.2 Mark had been invited to engage in a range of interventions including: 1:1 sessions; a pre-detox group in order to prepare for assisted withdrawal in the community and a motivational group. Despite it being indicated that Mark may be suitable for alcohol de-toxification, he never engaged fully with the service, which resulted in Unity not being able to deliver any meaningful treatment around his substance misuse.

5.7.3 Unity is a member of the MARAC, but at the time of the MARAC referrals, he was not open to their services. However, a detailed history was undertaken on the last occasion when the service became aware of restraining orders taken out to protect his ex-partner and mother from him and a comprehensive risk assessment was completed.

5.7.4 Unity had shown flexibility in engagement with Mark during his earliest referral whereby they delayed discharging him from services whilst the Court Liaison and Diversion team sought to encourage his attendance. Beyond this, it was noted that the service is limited in its ability to be more pro-active in engagement as their treatment contract had no capacity for assertive outreach.

5.7.5 Although the GP was notified on each occasion when Mark was discharged from services, probation services were not notified when he disengaged and this features in the recommendations for strengthening pathways between services in the thematic section below.

5.8 Cumbria County Council Children's Services

5.8.1 Although the period when Nicky lost contact with her children was outside of the main scope of this review, Children's Services reflected that insufficient support appears to have been provided to her at that time. The Service recognised that Nicky had been a victim of considerable domestic abuse from her ex-husband and father of her children and considered that mothers experiencing domestic abuse need to receive appropriate support. Indeed, Nicky's family reflected that she needed support at that time.

5.8.2 As a result, Children's Services have made a recommendation for themselves to ensure that victims of domestic abuse are enabled to access specialist domestic abuse support services as well as receive support within their own models of working.

Housing Agencies

5.9 Home Group

5.9.1 Nicky had been a tenant of Home Group, a regulated social landlord, before she was evicted for £3000 rent arrears earlier in 2018, before she had met Mark. Home Group were able to demonstrate to the review that they had made many attempts to prevent the eviction and signpost Nicky to sources of support.

5.9.2 Mark had also been a tenant of Home Group. During the 17 years of his tenancy, he had presented no difficulties in his tenancy beyond low level rent arrears until June 2020 when the police alerted them to his assault of Nicky. Although they were aware that Mark had been involved with the Police on occasions as Mark had contacted them to let them know that he may be going to prison, the landlord was not aware of the extent of the offences involved before this assault, nor about the extent of his substance and alcohol misuse. As they were represented at MARACs by their domestic abuse champion, they were aware of that Mark's abuse of a former partner had been considered there.

5.9.3 The Housing Manager reviewed the circumstances and advised the police that they would take tenancy enforcement action against Mark due to the incident once the criminal proceedings had been concluded. The Housing Manager continued to monitor this and sought confirmation that Nicky had been referred to sources of support and assistance. These were considered to be good practice responses and in line with their policies and procedures. It was also recognised

that Home Group had a good track record of using their powers as social landlords to take civil action against perpetrators of domestic abuse.

5.9.4 The fact that the landlord had not been made aware of previous domestic abuse in this couple's relationship, and the role of a social landlord in support, safety planning, re-housing and enforcement not previously drawn upon, will be considered in the thematic section which follows. Nonetheless, Home Group have committed to strengthen their procedures, through their National Safeguarding Panel, to ensure that when domestic abuse is reported or suspected, that these incidents are reviewed by a senior manager. They have also committed to strengthen their procedures to ensure that MARAC cases have senior manager oversight.

6. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

6.0 Following on from the analysis of individual agencies responses, this section explores the thematic, multi-agency and system analysis that arises from the circumstances leading to Nicky's homicide.

6.1 The victim's experience of domestic abuse

6.1.1 A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Multi-Agency Statutory Guidance, 2016). Before considering how agencies responded collectively at the time, the review seeks to consider what is now known about the Nicky's experience of abuse that may have been underlying any barriers she may have faced in seeking help.

Vulnerability

6.1.2 Whilst the review focussed on the period after Nicky and Mark had formed a relationship, the context for Nicky at this time was nonetheless considered. Nicky's 20-year relationship had broken down shortly before Nicky and Mark met and we have seen that this relationship was characterised by high-risk domestic abuse, and she had experienced violence throughout this relationship. Nicky had gone on to suffer from problematic alcohol use, anxiety and anxiety related conditions in her attempts to cope with her abuse and this impacted seriously upon her ability to care for her children. A crisis in 2016 meant that her children

went to live with their paternal grandmother and Children's Services became involved, working with the extended family, to ensure that Nicky could retain meaningful contact with her children.

6.1.3 It was evident that much work had gone into trying to repair the bonds between mother and children by Children's Services with a view to mother and children being reunited. However, by the end of 2017, Nicky's relationship with her children had deteriorated to the point that she was not having direct contact with either of them. Children's assessments recognised that Nicky was trying to engage with Children's Services but was "unable to exercise her parental responsibility due to the level of control by father" and appeared "defeated". Recognising the impact of the domestic abuse, thereafter social workers sought unsuccessfully to engage with Nicky to strengthen her confidence and self-esteem and autonomy. However, her ex-partner, the children's father, continued to abuse her and the risk led to her being considered at MARAC after the relationship had ended.

6.1.4 By the time Nicky was beginning a relationship with Mark, she had therefore experienced significant and high-risk domestic abuse for most of her adult life; suffered from mental ill-health and problematic alcohol use and lost her children. We have seen that Nicky's family reflected that she needed a lot of support at this time, but she was a very private person and would have found it hard to talk about her experiences and how she was feeling. Nonetheless, her vulnerability and need for specialist support to help her to recover from her experiences was evident and Children's Services offered to refer her to a range of specialist services without success.

6.1.5 Since this time the County Council has employed Health and Well-Being Coaches (HAWCs) whose role includes assertive engagement. Had they been in place at the time, they would have had the capacity to visit Nicky, spend time, build trust and enable effective referral to domestic abuse services and alcohol services with whom this recovery could begin. The review heard that Cumbria's Health and Well-Being Coaches work in a person-centred way: encouraging and coaching individuals to draw upon their personal resources and resources to become more independent and resilient and engage with your local communities and social networks. Their assertive outreach role is ideally placed to enable domestic abuse victims to access specialist domestic abuse services rather than merely be referred or signposted to them. Indeed, the panel were made aware that the Health and Well-being Coaches work very closely with the specialist domestic abuse service.

6.1.6 In the absence of this level of support, Nicky sought help from her GP who, whilst knowing about the breakdown of the abusive relationship and loss of her children, and how this will have impacted upon her mental health, was unfamiliar with the

help that may be available to her and prescribed anti-depressants without any corresponding therapeutic interventions or referrals to specialist services.

Learning Point: Vulnerability

Victims of long-term abuse need specialist domestic abuse services to help them to recover from the abuse and not leave them vulnerable to predatory abusers. Making the first step to engage with domestic abuse services will often be difficult, or unsafe, for victims. All agencies need to know what services are available and how to enable access to them through clear pathways and procedures.

Physical violence

6.1.7 Thereafter, from the third-party reports to the police and the contribution to the review from a neighbour, it is possible to piece together a picture of Nicky 's experiences of physical violence from Mark. Neighbours had witnessed her being beaten and kicked and shouting out of the window for help, including shouting, "He is killing me". They reported hearing shouting, things being thrown against the wall and arguments that would continue for hours and which had escalated and been more constant in the months before her homicide. They had heard Nicky scream for her assailant to get off her as he was hurting her and heard her pleading with him to let her get dressed so that she could go out. Third parties went on to report witnessing Mark's violent assault of Nicky in the street following his release from prison and to hear his disclosure of having head-butted the victim. In this way, third-party reports can be seen to provide vital evidence to support the protection of domestic abuse victims. When evidence from third parties was taken in June 2020, the police were able to arrest the perpetrator.

Learning Point: Third Party Evidence

Evidence from third parties in respect of domestic abuse is vital. It can take responsibility away from the abused, who for so many reasons, may not be able, or feel able, to provide a statement themselves. Had witness statements been taken from third parties, the alleged perpetrator would likely have been held on remand for assault at the time of the homicide.

6.1.8 Neighbours had also borne witness to Mark's history of domestic abuse against women; witnessing long-term abuse of his mother, abuse of his ex-partner and he had reportedly also subjected one female neighbour to demands of money with menaces.

6.1.9 The Home Office noted that as well as third party statements, there are many other sources of evidence, in the absence of engagement with the victim, that all agencies should be aware of. They highlighted the need to be relentless in securing evidence from, for example: CCTV, 999 calls, hearsay, medical evidence and digital communications.

Coercive control

6.1.10 Prison surveillance bore witness to Mark's coercive control of Nicky during his telephone conversations with her repeatedly over the day in June and that Nicky appeared frightened of him. This proactive surveillance by HMP Durham was recognised as good practice and provided evidence of coercive control that was not available through other sources.

Difficulty disclosing the abuse

6.1.11 From Nicky's own disclosures of her relationship with Mark, we know very little as agencies appeared unable to meaningfully engage with her. It was telling that agencies appeared to be more aware of Mark's domestic abuse of other women, as a result of his previous prosecutions and breaches of orders, than of his abuse of Nicky.

6.1.12 In common with many abused women, Nicky often denied experiencing domestic abuse, minimised the abuse or blamed herself, saying that she had to have the last word and by implication, had provoked Mark. The difficulty that victims often have disclosing abuse to professionals will often involve a complex array of practical and emotional considerations, not least the real risk that they may face when they make a disclosure and seek help. Whilst the review was unable to establish the full extent of Mark's abuse of Nicky, or the extent of the impact that it had upon her, it is well researched that experiencing coercive control erodes self-confidence and a victim's sense of self. This was indeed evident for Nicky in her previous long term abusive relationship.

6.1.13 A domestic abuser will often distort a victim's understanding, where, isolated from other's views, a victim will often take on the abuser's perception that she was responsible for the abuse. Combined with fear of exceptionally violent men, it is not surprising that victims will often minimise or deny the abuse or not feel confident that agencies can keep them safe if the abuse was disclosed (Stark, 2007). We have seen how the police have committed to strengthen their understanding of victim-minimisation risk across the organisation. However, it was to their credit that they identified the high risk of serious harm that Nicky

faced, referred her to MARAC and sought to engage with her by disclosing Mark's previous violence against women.

Trauma and Gender Informed Practice

6.1.14 In these ways, the panel considered that Nicky's traumatic history of domestic abuse, accompanied by mental ill-health and substance misuse and the loss of the care of her children will have contributed to her vulnerability as well as influencing her trust and confidence in agencies to support and protect her.

6.1.15 There is a growing body of research which explores the needs of women with mental health and substance misuse issues experiencing domestic abuse and the need for gender and trauma-informed practice to enable their recovery (Alcohol Concern & AVA,2016; AVA and Agenda, 2017, 2019); Department of Health and Social Care & Agenda, 2018). In this context, trauma-informed practice for women acknowledges that mental ill-health and substance misuse are legitimate responses to life events. However, it was not evident that any agency had been able to meaningfully engage with Nicky and engage her in addressing the trauma that she was continuing to experience.

Learning Point: Domestic abuse, mental health and substance misuse
The victim experienced male violence and abuse throughout most of her adult life and her substance misuse and mental ill-health should be seen as legitimate responses to this long-standing trauma. Domestic abuse victims often do not recognise the link between their own experiences of trauma and the difficulties that they have with mental health and substance misuse and so practitioners need to enable victims to understand what is happening to them (AVA, 2018)

Recommendation 1: Gender and trauma-informed services
Safer Cumbria Domestic Abuse Partnership Board to promote gender and trauma-informed practice in response to victims of domestic abuse experiencing multiple needs including adverse childhood experiences and mental health, alcohol and substance misuse. Safer Cumbria Domestic Abuse Partnership Board to seek assurance from all affiliated agencies that gender and trauma-informed practice is embedded in their practice response to domestic abuse.

6.2 Routine enquiry and health pathways

6.2.1 We have seen that Nicky sought medical help for anxiety, as well as anxiety related illnesses such as eczema and alopecia, to the extent that she would wear a wig when it occurred. She reported her isolation and suicidal thoughts to the Emergency Department and mental health services in September 2018; reported depression, self-harm and eczema to her GP in January 2019 and was taken to the Emergency Department with slurred speech during the Christmas period in 2019, suffering a fall and pains in leg and ribs the next day when reporting to the out-of-hours-GP. Although the opportunity for routine enquiry was not always present, indicators of domestic abuse were missed in most of these settings.

6.2.2 The review recognised that health professionals have a privileged position in identifying potential domestic abuse. The National Institute for Health and Clinical Excellence provides a list of evidence-based indicators of abuse including symptoms of depression, anxiety, suicidal tendencies or self-harming, alcohol or other substance misuse (NICE,2016), each of which were experienced by Nicky. These indicators recognise the evidence: women's experience of domestic abuse has been found to be a cause of depression, anxiety and broader mental illness (Feder et al, 2006, Rose et al, 2011; Department of Health, 2017; Department of Health and Social Care, 2018). Likewise, women who have experienced domestic abuse have been found to be three times more likely to be substance dependent than those who have not (Rees et.al., 2011). The misuse of alcohol, as a means to cope with violence and abuse and to self-medicate the trauma, is also well documented (Department of Health, 2017:73).

6.2.3 Nicky's disclosures of mental health and substance misuse concerns would therefore have been expected to generate appropriate and sensitive routine enquiry about domestic abuse and we have seen that the primary care, hospital and mental health services have each made recommendations for themselves to strengthen routine enquiry. The review considered that the Community Safety Partnership would nonetheless benefit from seeing the impact of these developments in the round in order to be able to assess their strategic impact on Cumbria's health pathways for domestic abuse. This was seen to be particularly the case where the co-existence of mental health, substance misuse and domestic abuse occurs, recognising the challenges that the intersection of these issues can bring in engaging with domestic abuse victims.

Recommendation 2: Selective and routine enquiry on domestic abuse in health settings

West Cumbria Community Safety Partnership should seek assurance and evidence that primary care, Emergency Department, mental health and substance misuse services in their area have implemented policies, pathways and staff training that have resulted in effective, selective, routine enquiry in domestic abuse, particularly where mental health and substance misuse are also involved.

6.3 MARAC and high risk

6.3.1 The effective running of a MARAC is a crucial element of the local, co-ordinated community response to domestic abuse (STADV, 2013). Whilst in a relationship with Nicky, Mark had been discussed at MARAC on two occasions. On the first occasion, in January 2019, his stalking and harassment of his ex-partner was considered, including consideration of his 130 messages to her and breaches of court orders protecting his ex-partner. Despite the level of multi-agency scrutiny through the MARAC, Mark's relationship was not known by any agency at that time.

6.3.2 Thereafter, Mark's abuse of Nicky was considered at West Cumbria MARAC in June 2020. It was attended by a broad range of agencies and his prior stalking was rightly taken seriously. Indeed, a recent study has found that stalking was featured in 94% of the 358 domestic violence related deaths that were analysed but was often not understood by agencies as a key indicator of serious harm. (Monkton-Smith et al., 2017).

6.3.3 However, there was a missed opportunity to make an effective referral to the Independent Domestic Violence Advisor. Victim Support had received the referral and were updated about the police visit to the victim but were advised that the victim's phone was not accessible. Despite their approaches to the police, their engagement with the victim was not enabled and it appeared that the police were satisfied that the victim had been visited by their own officer and provided with the advice that was necessary.

Learning Point: The Role of Independent Domestic Violence Advisor (IDVA)
Research has shown that the IDVA enables victims to "become more confident in their knowledge of services and legal rights and in their dealings with the criminal justice system… [and]…equip women with awareness of their entitlements…. In practice this is far more than knowledge of material/practical options, since many victim- survivors have to move through recognising and naming violence, reframing perpetrators' behaviour and understanding how abuse has narrowed their space for action before they can consider and act on these options." (Coy and Kelly, 2010:3)

Evaluation findings consistently suggest that it is IDVA interventions that have the most impact on enhancing the safety of domestic abuse victims (Coy and Kelly, 2010; Coy and Kelly, 2010, Howarth, Stimpson, Barron et al, 2009, Robinson, 2009; Taylor-Dunn,2016)

Recommendation 3: Enabling access to Independent Domestic Violence Advisors
Cumbria Community Safety Partnership should seek evidence and assurance that agencies are consistently enabling high risk victim engagement with the Independent Domestic Violence Advisors in addition to their own services.

6.3.4 As Mark was held on remand, and his coercive control of Nicky known to be a feature of his abuse, it was considered that the MARAC could have anticipated that he would make contact with Nicky by telephone from the prison. Although the prison service monitored his telephone contact and acted once concerns were observed, the MARAC action plan should have considered actions to prevent his communications with the victim whilst on remand.

Recommendation 4: Preventing a perpetrator's contact from prison with high-risk victims of domestic abuse
In MARAC cases where the offender is held on remand, the police should alert the prison service to prevent, or if not possible, to proactively monitor telephone contact between the perpetrator and the victim.

6.3.5 The need for disclosure of Mark's previous history of abuse was raised and heard at the Domestic Violence Disclosure Scheme (DVDS) Panel promptly and authorised on the following day. It was noted that the promptness of this action had been enhanced because the frequency of DVDS meetings had been extended from 3-weekly to weekly shortly before Nicky's homicide.

6.3.6 In the intervening time, Cumbria has also moved from monthly to weekly, virtual MARAC meetings covering the whole of the Cumbria area, ensuring a timely multi-agency response to high-risk victims. The feedback from agencies has been

positive in this regard and multi-agency training continues to be provided to strengthen the process.

6.4 The "relentless pursuit and disruption" of domestic abusers

6.4.1 At the time of writing, Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services, has recently reported on the police response to violence against women and girls in which it makes a recommendation for the need for the "relentless pursuit and disruption" of adult perpetrators (HMICFRS, 2021).

6.4.2 We have seen that Mark had a long history of domestic abuse and violence against women, including violence against previous partners and a female family member. His harassment of his previous partner led him to become one of the 'Top 10' domestic abuse alleged perpetrators for the police locally in 2019. Cumbria Constabulary had clearly been applying a perpetrator strategy in the pursuit and disruption of high-risk domestic abusers and the review heard how further developments in this management of high-risk abusers have been undertaken since by way of Operation Domestic Abuse Reduction Tactics (DART).

Previous history and serial domestic abusers

6.4.3 Aside from consideration for a disclosure to the victim, it was not evident to the review that Mark's previous high-risk history of stalking and harassment, breach of restraining order and breach of suspended sentence, in respect of his previous partner influenced how agencies responded to his current relationship with Nicky. For the police, this history did not lead to his being consistently assessed as high risk in relation to Nicky. For probation services, his history should have been known from the time of the MARAC for his ex-partner in January 2019, but this information did not lead to professional curiosity about current relationships. His denial to probation of being in a current relationship was taken at face value, without police checks or a home visit which would have been expected practice.

6.4.4 Research into domestic homicide reviews has found that in the majority of intimate partner homicides, the perpetrator had a history of violence (Home Office, 2016). Indeed, evidence from the history of violence in the murder of Clare Wood generated the need for the Domestic Violence Disclosure Scheme, which provides victims with information about their partner's violent past. We have seen that following her case being heard at MARAC, Nicky received such a disclosure under this scheme. Indeed, Cumbria Constabulary is known to have been one of the best performing police forces in its application of the scheme (BBC, 2018)

6.4.5 However, despite this understanding that a perpetrator's previous violence against women should influence their new partner's understanding of the risk that they face, the same understanding does not always appear to permeate into the risk assessments by professionals. The review therefore considered whether previous high-risk history should influence risk assessments in current relationships and whether Mark should have been considered a high-risk perpetrator from the earliest report of abuse in this relationship to the police in December 2019. At the time, the incident appears to have been considered in isolation from the abuser's history. Common sense and practice-based evidence from practitioners would suggest that it should: that a perpetrator would likely use the same methods of power and control in whichever relationship he was in. To not do so implies that there is something about the victims of domestic abuse, or their perpetrator's relationship with them, that makes them change his behaviour and that could run the risk of straying dangerously into notions of victim blaming. Nonetheless, there remains a dearth of research about the serial perpetration of domestic abuse and how that influences future assessments of risk (Robinson, 2017)

6.4.6 The College of Policing defines a serial perpetrator as someone who has been reported to the police as having committed or threatened domestic abuse against two or more victims current or former intimate partners and family members" (College of Policing, 2015). This compares to a repeat offender who commits or threatens abuse against the same victim. It has been estimated that 25,000 serial abusers are known to British police at any one time (Association of Chief Police Officers, 2009) but because estimates rely on official data, the true number is likely to be much higher. The little evidence that is available, suggests that a significantly greater proportion of serial domestic abusers were rated as a high risk to others, but it is recognised that further research is needed before being able to draw firm conclusions (Robinson, 2017).

Learning Point: History of Violence
A perpetrator's history of violence must inform future assessments of risk and information sharing where appropriate

Recommendation 5: Perpetrator's History of Violence
West Cumbria Community Safety Partnership should seek assurance from criminal justice agencies that they are able to accurately record and access records on an abuser's previous violent history and apply this to current risk assessments and responses

Recommendation 6: Serial domestic abusers

In the development of the national domestic perpetrator strategy, the Home Office considers commissioning research into whether a high-risk domestic abuser will be a high-threat domestic abuser to future partners and by virtue of their serial offending, are worthy of enhanced intervention, management and opportunities for change.

Anticipating release from prison

6.4.7 It was evident that agencies had been caught off guard when Mark was released immediately upon conviction in July 2020 for the assault of Nicky, having served time on remand.

6.4.8 This unexpected release had the effect of leaving agencies without warning and all the arrangements that would have been expected to have been put in place to manage a high threat from a domestic abuse perpetrator were not in place. Specifically, it was noted that this would have included the formulation of a multi-agency perpetrator target plan, led by the police.

6.4.9 We have seen how arrangements for managing email communications between the prison and the police have been strengthened and will hereinafter be managed robustly out-of-hours. The review also heard how a new computerised system was being installed in the prison which could automatically communicate with the probation system, *Delius*, and hence be able to automatically contact the probation offender manager without delay. However, in both instances, it was recognised that phone calls would still be required to deal with the immediacy of a threat.

Learning Point: Managing offenders subject to immediate release

Practitioners need to ensure that there is not an overreliance on information sharing through email. Picking up the phone will usually also be needed to address immediate concerns over the threat from a domestic abuse perpetrator.

6.4.10 The panel were alerted to the increasing numbers of prisoners subject to immediate release following convictions and after serving a period on remand in this way, as a result of the pressures arising from the Covid-19 pandemic.

Recommendation 7: Managing offenders subject to immediate release

The Ministry of Justice to consider how those offenders who are subject to immediate release after serving a period on remand, are flagged for risk management, considered and their management resourced.

Cumbria's management of domestic abuse perpetrators

6.4.11 In these ways, we can recognise that there were significant deficits in the criminal justice system's management of Mark in relation to both his domestic abuse offending as well as his court-mandated supervision. There also remained a lack of confidence about how 'out of area' referrals would be managed.

6.4.12 The relevant agencies have each committed to provide assurance to the Community Safety Partnership concerning their improvement in these regards and significant arrangements have been put into place to tactically manage perpetrators of domestic abuse in Cumbria since this time through the Operation Domestic Abuse Reduction Tactics (DART). In this context, the review was alerted to work at the governmental level towards a domestic abuse perpetrator strategy (Home Office 2021) which it is envisaged will provide the evidence, guidance and resources to strengthen Cumbria's approach further.

Recommendation 8: Manging Perpetrators and Harm Reduction

The Community Safety Partnership to ensure that the evidence provided by criminal justice agencies in response to this review collectively demonstrates a robust multi-agency response to domestic abuse perpetrators and demonstrates effective harm reduction outcomes, particularly in regard:

- compliance with DASH
- positive action
- risk assessment
- supervision
- bail and responding to intelligence reports
- responding to victim minimisation and engagement
- 'Out of area' incidents
- Prison release

6.5 Engagement with alcohol treatment services

6.5.1 We have seen that Nicky experienced long-term problems with alcohol use and that these may well have been a consequence of the long-term abuse that she had experienced. Indeed, problematic alcohol use was a long-term concern for both Nicky and Mark and attempts were made to refer both parties to alcohol treatment services at various times. Shortly before her homicide, Nicky briefly discussed these problems with the domestic abuse officer, feeling that she was able to give up drinking whereas she felt that Mark needed professional support to do so.

6.5.2 The review heard that problematic alcohol use is a common feature of both domestic abuse and domestic homicide. In the largest study of domestic homicide in England and Wales to date (n=141), Chantler et al. (2020) found that 48 per cent of homicides involved perpetrators who experienced alcohol problems. Despite this high level of co-occurrence between alcohol and the perpetration of domestic abuse, there is no evidence to suggest that alcohol consumption is a cause of a perpetrator's behaviour (Raaf, 2012). This is an important point as Nicky told the domestic abuse officer that Mark's alcohol misuse was the cause of his abusive behaviour towards her. She reported that his behaviour had improved when he was not drinking but his abuse had deteriorated again during the Covid pandemic lockdown when his drinking re-commenced.

Learning Point: Alcohol misuse may co-occur but is not a cause of domestic abuse

It is not uncommon for victims of domestic abuse to see their partner's drinking as a cause of their abuse and many abusers will have used their drinking as an excuse for their behaviour. Practitioners need to be dispelling these myths in order to hold perpetrators responsible for their abuse.

6.5.3 Although Mark had been abstinent for a period, it was evident that he was unable to sustain this abstinence. In earlier presentations during 2018, there was evidence that Mark had been supported and enabled to attend appointments through the assertive outreach being undertaken by Lancashire and South Cumbria Foundation Trust. However, despite Mark engaging in subsequent assessments whilst in custody, Liaison and Diversion were unable to contact him thereafter, despite several attempts and a referral to Unity was made, and he was notified by letter.

6.5.4 Given the challenge of enabling Mark's engagement with alcohol treatment in the community, the panel considered the opportunities to enable his engagement whilst he was in prison. It was evident that Unity had tried without success to engage him here also.

6.5.5 Notwithstanding the attempts that were made to engage Mark in alcohol treatment, the panel recognised that every opportunity for engagement should be utilised. The panel were advised that alcohol treatment services had been recommissioned since this time and were now being provided by Recovery Steps Cumbria and that actions to strengthen the relationship between primary care and alcohol treatment services were being made. At the time of writing, Recovery Steps was collaborating with the Integrated Care Board, to develop robust addictions pathways for primary care.

6.5.6 The review heard how shared care arrangements had been put in place between Recovery Steps Cumbria and GP Practices across the county enabling services to be provided locally and provide additional opportunities for providing timely and supportive advice, especially for people with whom practitioner may otherwise struggle to engage. At the time of writing, Recovery Steps Cumbria was collaborating with North-East and North Cumbria Integrated Care Board to develop robust addictions pathways for primary care and to provide training for clinicians to develop their skills and knowledge in working with patients with alcohol concerns.

Recommendation 9: Alcohol/substance misuse and primary care pathway.
North Cumbria Integrated Care Board and Recovery Steps Cumbria to develop and embed pathways and relationships between primary care and alcohol treatment services in the area. Pathways to ensure that clinicians in primary care have access to clear and concise guidance for assessing and managing patients with alcohol concerns and have access to locally agreed information to enable them to make effective decisions, together with patients, at the point of care, particularly for those with whom practitioners would otherwise struggle to engage.

6.5.7 Moreover, given that Probation Services were not notified that Mark had been discharged from alcohol treatment, it was considered that the pathway between these services needed to be reviewed and the recent commissioning of a new provider of drug and alcohol services in the area provided a timely opportunity for this to happen. The review heard that as the review progressed, this pathway was put in place and was subject to regular review.

Recommendation 10: Alcohol/substance misuse and probation pathway. Probation Service and Recovery Steps Cumbria to provide assurance to the Community Safety Partnership on the effectiveness of the criminal justice pathway between alcohol treatment and probation services and is able to address the issues over self-referral and information sharing

6.6 Role of Social Landlords

6.6.1 Both Nicky and Mark had been tenants of the social landlord, Home Group. Nicky had been evicted from her tenancy a few years earlier and Mark had been a tenant at the time of the homicide. It was clear that when they were notified about Mark's assault of Nicky in June 2018, that the social landlord was ready to take action against the perpetrator as their tenant as well as to ensure that victim, who was not their tenant at the time, was provided with support. Whilst the Home Group was represented at the MARAC meeting concerning Mark's abuse of his former partner, they had not been made aware of any previous abuse of the victim.

6.6.2 The review also heard how Copeland Borough Council, who managed Nicky's earlier homeless application and assisted her in securing alternative accommodation, had developed its response to victims of domestic abuse in the intervening period. The Council described how it now has a dedicated team around domestic abuse within its Home Options Team, who provide wrap around support services and safe accommodation with sanctuary home security measures. They also work very closely with the newly opened women's centre, Women out West, to support vulnerable women and provide an integrated response to women's homelessness.

6.6.3 It was therefore recognised that social housing providers have an important role to play in the co-ordinated community response to domestic abuse including: the early identification of domestic abuse; enabling safety planning and support to victims; finding alternative accommodation and taking enforcement action against perpetrators. It was also recognised that the different elements of this role may not always be understood by other agencies and that this has often led to their not being involved as core responders to domestic abuse.

Learning Point: Involving Social Housing Providers

Social housing providers have an important role to play in the co-ordinated community response to domestic abuse including: the early identification of domestic abuse; enabling safety planning and support to victims; finding alternative accommodation and taking enforcement action against perpetrators.

6.6.4 The review was alerted to the large number of social landlords in the local area and the challenges that arose from including them within MARAC and securing a consistent approach to domestic abuse across them. The review was also cognisant of social housing's role in earlier intervention in domestic abuse before it reached the threshold of high-risk, and the national developments involved in the Domestic Abuse Housing Alliance[20] to secure a whole housing approach to domestic abuse.

Recommendation 11: Social housing response to domestic abuse

West Cumbria Community Safety Partnership to secure the consistent participation of social housing providers in their area through multi-agency pathways in domestic abuse across areas of high risk and earlier intervention.

6.7 Impact of the Covid-19 Pandemic

6.7.1 The homicide took place during restrictions on movement and social interaction imposed during the Covid-19 pandemic. The impact of the Covid-19 restrictions on women's safety has been well illustrated by research and practice (ONS, 2020). Nationally, domestic abuse services experienced increased demand, including a 65 per cent increase in calls to the National Domestic Abuse Helpline (ibid).[21]

6.7.2 Indeed, Nicky considered that Mark's abusive behaviour had deteriorated during the pandemic. Over 50 per cent of women contacting the Women's Aid helpline during this time disclosed experiencing heightened domestic abuse since the restrictions started and, crucially, 58 per cent felt that they had no-one that they could turn to for help as a result of these restrictions (ONS,2020). It was therefore reassuring to see that the safeguarding police officer, who was Nicky's single point of contact within the police, went to see her in person following the MARAC recognising the high risk that she faced.

[20] More information on the Domestic Abuse Housing Alliance can be found at https://www.dahalliance.org.uk/

[21] For the period April-June 2020

6.7.3 We have seen that Cumbria Constabulary, undertook a range of initiatives to strengthen their response to domestic abuse including, Operation Domestic Abuse Reduction Tactics (DART) and increasing MARAC meetings to weekly as described above. However, in order to mitigate the impact of Covid-19 upon domestic abuse victims, they have also been running, in partnership with local agencies, the following pro-active campaigns and operations during this time:

- Domestic abuse web chat surgeries as a way of enabling potential victims to communicate with Police and partners
- Instagram promotion
- Promotion of support services online
- Invested in perpetrator support
- Ran Domestic Abuse Covid Recovery Response in relation to repeat victims
- Ran a Domestic Abuse Christmas operation
- Operation Encompass, engaging schools

6.8 Homicide-Suicide

6.8.1 Although taking place sometime after the homicide, the review considered the relationship between Mark's later suicide whilst in prison and the homicide. The phenomenon of homicide-suicide has been subject to research in its own right and could provide a greater understanding of the nature of the homicide in question.

6.8.2 Definitions of homicide-suicide generally refer to the suicide taking place within one week and often within 24 hours of the homicide (Campinelli and Thomas 2002; Hannah et al., 1998). Whilst the suspected suicide of Mark does not fall strictly within this definition, it is noteworthy that research in this area has often distinguished between those suicides which appear to be as a result of remorse for the act of killing and those "for whom a settled intention to commit suicide frees the perpetrator to plan and carry out the homicide(s) in the sure knowledge that the only person he is answerable to is himself" (Gregory, 148). Although the review was aware that the perpetrator had a history of self-harm and threats of self-harm, it was unable to establish in this case whether the apparent suicide was related to the homicide in either of these ways. It is envisaged that the forthcoming inquest may be able to shed more light upon this particular case.

7.0 CONCLUSION

7.1 This review has considered agency responses to a highly vulnerable woman who had experienced high risk domestic abuse for most of her adult life and suffered the consequences of abuse in terms of problematic alcohol use and the loss of her children.

7.2 She went on to experience domestic abuse from a prolific, high-risk perpetrator of domestic abuse who eventually killed her. Whilst agencies faced several challenges and provided examples of good practice in their responses, opportunities to identify indicators of domestic abuse were missed in health settings, opportunities to engage the individuals in alcohol and substance misuse treatment were missed and the criminal justice management of this high-risk perpetrator fell far short of expectations. However, it was reassuring to see that the agencies represented in this review have already responded swiftly in undertaking positive actions to strengthen their multi-agency approach to managing high risk perpetrators of domestic abuse.

8. RECOMMENDATIONS

8.1 Overview & System Recommendations

Recommendation 1: Gender and trauma-informed services

Safer Cumbria Domestic Abuse Partnership Board to promote gender and trauma-informed practice in response to victims of domestic abuse experiencing multiple needs including adverse childhood experiences and mental health, alcohol and substance misuse.

Safer Cumbria Domestic Abuse Partnership Board to seek assurance from all affiliated agencies that gender and trauma-informed practice is embedded in their practice response to domestic abuse.

Recommendation 2: Selective and routine enquiry on domestic abuse in health settings

West Cumbria Community Safety Partnership should seek assurance and evidence that primary care, Emergency Department, mental health and substance misuse services in their area have implemented policies, pathways and staff training that have resulted in effective, selective, routine enquiry in domestic abuse, particularly where mental health and substance misuse are also involved.

Recommendation 3: Enabling access to Independent Domestic Violence Advisors

Cumbria Community Safety Partnership should seek evidence and assurance that agencies are consistently enabling high risk victim engagement with the Independent Domestic Violence Advisors in addition to their own services.

Recommendation 4: Preventing a perpetrator's contact from prison with high-risk victims of domestic abuse

In MARAC cases where the offender is held on remand, the police should alert the prison service to prevent, or if not possible, to proactively monitor telephone contact between the perpetrator and the victim.

Recommendation 5: Perpetrator's History of Violence

West Cumbria Community Safety Partnership should seek assurance from criminal justice agencies that they are able to accurately record and access records on an abuser's previous violent history and apply this to current risk assessments and responses

Recommendation 6: Serial domestic abusers

In the development of the national domestic perpetrator strategy, the Home Office considers commissioning research into whether a high-risk domestic abuser will be a high-threat domestic abuser to future partners and by virtue of their serial offending, are worthy of enhanced intervention, management and opportunities for change.

Recommendation 7: Managing offenders subject to immediate release

The Ministry of Justice to consider how those offenders who are subject to immediate release after serving a period on remand, are flagged for risk management, considered and their management resourced.

Recommendation 8: Manging Perpetrators and Harm Reduction

West Cumbria Community Safety Partnership to ensure that the evidence provided by criminal justice agencies in response to this review collectively demonstrates a robust multi-agency response to domestic abuse perpetrators and demonstrates effective harm reduction outcomes, particularly in regard:

- compliance with DASH
- positive action
- risk assessment
- supervision
- bail and responding to intelligence reports
- responding to victim minimisation and engagement
- ‘Out of area’ incidents
- Prison release

Recommendation 9: Alcohol/substance misuse and primary care pathway.

North Cumbria Integrated Care Board and Recovery Steps Cumbria to develop and embed pathways and relationships between primary care and alcohol treatment services in the area. Pathways to ensure that clinicians in primary care have access to clear and concise guidance for assessing and managing patients with alcohol concerns and have access to locally agreed information to enable them to make effective decisions, together with patients, at the point of care, particularly for those with whom practitioners would otherwise struggle to engage.

Recommendation 10: Alcohol/substance misuse and probation pathway.
Probation Service and Recovery Steps Cumbria to provide assurance to the Community Safety Partnership on the effectiveness of the criminal justice pathway between alcohol treatment and probation services and is able to address the issues over self-referral and information sharing

Recommendation 11: Social housing response to domestic abuse

West Cumbria Community Safety Partnership to secure the consistent participation of social housing providers in their area through multi-agency pathways in domestic abuse across areas of high risk and earlier intervention.

8.2 Individual Agency Recommendations

Cumbria County Council Children's Services

- Mothers experiencing domestic abuse are enabled to access specialist domestic abuse support

Probation Service regarding the former Cumbria and Lancashire Community Rehabilitation Company

- Under the parallel Serious Further Incident review, the CRC were required to provide assurance to Her Majesty's Prison and Probation Service (HMPPS) that they were managing domestic abuse alleged perpetrators to a sufficient standard. The Probation Service to provide this evidence to the Community Safety Partnership

- To develop a criminal justice pathway within substance misuse services through which to address the issues over self-referral and information sharing between probation and substance misuse services.

- To strengthen management oversight of staff in order to ensure adherence to policy and practice standards in assessments, planning, implementation and review of interventions in the future.

Cumbria, Northumberland, Tyne and Wear NHS Trust

- To ensure professionals routinely enquire about domestic abuse when there are indicators of concern and staff need to understand their role when receiving disclosures of domestic abuse from perpetrators.
- To ensure staff consider history of domestic abuse and how this impacts on presenting risks at the time of initial assessments and future appointments.
- To promote the need to enable engagement with domestic abuse services, even when the police may be involved.

Home Group

- To review Home Group's internal procedure and ensure that the best practice highlighted above is captured and implemented. Mainly, that when DV and DA instances are reported or there are suspicions of DV/DA these incidents are reviewed by a Senior Manager (Operations Manager level).
- For Home Group to review their local procedures around outcomes and discussions at MARAC. Specifically focusing on; what visibility to Senior Managers have; What visibility do local Housing Managers have; How does the feedback process occur; What oversight and input do Senior Managers have.

Lancashire and South Cumbria Foundation Trust

- Liaison with other agencies, especially those that may be specifically addressing offending behaviours (such as the courts, probation services) assists in the wider understanding of the perpetrators' risks and actions that other services have implemented to address these. The requirement to notify partner agencies when an individual is discharged from the Liaison and Diversion service will be incorporated into the service wide Standard Operating Procedure (SOP) and introduced as standard practice.
- Communication with partner agencies including GPs should be strengthened by providing awareness about the Liaison and Diversion service to ensure an understanding of the service scope of practice. This will be achieved by sending a letter to GP's and partner agencies describing the Liaison and Diversion service.
- Information sharing and recording processes for MARAC for all LSCFT services to be consistent across all LSCFT localities.

- Current LSCFT processes regarding domestic abuse are correctly victim focussed, however, it is not clear regarding the expectations of staff when working with suspected perpetrators of domestic violence. This would be especially useful for Liaison and Diversion who are an offender focussed service.

North Cumbria Clinical Commissioning Group

- To further promote with GPs the need for targeted routine enquiry about domestic abuse when indicators are present and to strengthen the disclosure pathway

North Cumbria Integrated Care NHS Foundation Trust

- to continue to improve awareness and responses to domestic abuse through the A&E and Domestic Abuse Improvement Plan, to include increased use of DASH and MARAC referrals and the 'think family' Screening tool
- Domestic abuse and substance misuse to continue to be included in mandatory training updates for all staff, with particular focus on routine enquiry and referral to support services.
- To complete a review to be completed of current pathway and follow up for patients who leave A&E prior to completing treatment.

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ACRONYMS

AAFDA: Advocacy After Fatal Domestic Abuse
ACES: Adverse Childhood Experiences
A&E: Accident and Emergency
CRC: Community Rehabilitation Company
DNA: Did Not Attend
GP: General Practitioner
HMP: Her Majesty's Prison
HMPPS: Her Majesty's Prison and Probation Service
IDVA: Independent Domestic Violence Advisor
IMR: Individual Management Review
LSCFT: Lancashire and South Cumbria NHS Foundation Trust
MARAC: Multi-Agency Risk Assessment Conference
MASH: Multi-Agency Safeguarding Hub
MoJ: Ministry of Justice
NIHR: National Institute for Health Research
REPROVIDE: Reaching Everyone Programme of Research on Violence In Diverse Domestic Environments (University of Bristol)
SARA: Spousal Assault Risk Assessment

GLOSSARY

Building Better Relationships is a nationally accredited groupwork programme within Probation Services designed to reduce reoffending by adult males convicted of violence against an intimate partner