



## Domestic Homicide Review

Overview Report

Stacey

Died: June 2021

Mark Dalton  
Independent Domestic Homicide Review Chair  
and Report Author

October 2022 (revised August/October 2023)

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## 1. INTRODUCTION - PEN PICTURE OF STACEY

Stacey's mother shared information about what Stacey was like as a person. Stacey had a bubbly personality and enjoyed bingo and other socialising, although her outgoing personality and socialising became severely restricted by her partner Mr B. She was good at crafts and a talented cake maker – to the point where she was considering this as a small business from home.

Her children were the centre of her world, and much of her behaviour and reactions around Mr B can be interpreted as her attempts to protect and shield them from his behaviour.

She remained close to her mother and her ex-partner – the father of her two oldest children. These were two people who tried to provide emotional and financial support.

Stacey's family have agreed that she will be known by her real name in this report.

## INTRODUCTION – DOMESTIC HOMICIDE REVIEW

1.1 This Domestic Homicide Review is concerned with the murder of Stacey by her long-term partner Mr B. Throughout the report, they will be referred to by these names.

1.2 Stacey and Mr B had been in a relationship for 16 years. They had been separated since April 2021 at which time Mr B left the family home and moved into his mother's address.

1.3 Both Mr B and Stacey have children from previous relationships. They also had their own two children who lived with them throughout the period under review and who were at home and witnessed the final fatal assault. It is important to recognise that their children are also the victims of domestic abuse,<sup>1</sup> they had been subjected to a level of coercive and controlling behaviour by Mr B and lived with the daily threat of escalating violence and witnessed his aggressive and abusive behaviour towards their mother.

1.4 There were frequent arguments about money, Mr B was employed as a security guard in a supermarket. Stacey did not have a job and was financially dependent on Mr B and some statutory benefits. There is evidence that Mr B did not want Stacey to work and have a level of independence. He used his control of the finances to

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<sup>1</sup> [The Domestic Abuse Act 2021](#) recognises that children are also victims of Domestic Abuse

make it difficult for Stacey to socialise with her friends. His behaviour can be defined as economic abuse according to the Domestic Abuse Act 2021<sup>2</sup>.

1.5 There had been repeated arguments about the breakdown of their relationship and over belongings in the house. Several times during the period under review Mr B moved out of the family home and moved in with his parents who lived about a mile away.

1.6 On previous occasions Stacey and Mr B would affect reconciliation and he would move back to the family home. In the weeks before the final fatal assault the situation had changed; Mr B believed that Stacey had started a new relationship and he would not accept that their relationship was over. The nature of his abuse changed, and several incidents of harassment and stalking were reported to the Police.

1.7 There are reports of domestic abuse between Mr B and Stacey. Mr B is also known for domestic abuse of a previous partner.

1.8 Mr B had been treated for his mental health and impulsive overdose attempts; his more recent suicide attempts would seem to be partly a reaction to Stacey finally ending their relationship.<sup>3</sup> Mr B has a diagnosis of an Adjustment Disorder<sup>4</sup> and had been detained under Section 2 of the Mental Health Act 1983<sup>5</sup> because of threats to harm himself.

1.9 The frequency and severity of the incidents escalated during the final months of their relationship. On the day of the final assault, the Police were called in the early hours of the morning by a neighbour stating that "Mr B and Stacey were in the back garden and that there was blood everywhere." Stacey suffered a sustained attack from Mr B, including being stabbed multiple times and strangled. Mr B had purchased the knife used in the fatal assault earlier that day from his place of work.

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<sup>2</sup> [Domestic Abuse Act 2021](#) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—(a)acquire, use or maintain money or other property, or (b)obtain goods or services.

<sup>3</sup> [Men, suicide, and family and interpersonal violence: A mixed methods exploratory study](#). Research suggests that the use of violence and suicidal behaviour was also a deliberate and calculated response by which some men sought to maintain influence or control over women.

<sup>4</sup> The clinical literature defines adjustment disorders as transient states of distress and emotional disturbance, which arise in the course of adapting to a significant life change, stressful life event, serious physical illness, or possibility of serious illness.

<sup>5</sup> To be detained under Section 2 Mental Health 1983 an individual must meet the following criteria: -a) they must be suffering from a mental disorder of a nature and/or degree which warrants their detention in hospital for assessment, or assessment followed by treatment for a limited period. b) their detention under Section 2 is justified in the interests of their own health, safety or for the protection of others.

1.10 Stacey died of her injuries in hospital two weeks after this fatal assault. Mr B was convicted of Stacey's murder and sentenced to 29 years in prison.

1.11 Nottingham Crime and Drugs Partnership know that Stacey was a much-loved mother, daughter, sister and friend. The Partnership would like to express its sincere condolences to Stacey's parents and children.

## 2. THE REVIEW PROCESS

2.1 The Chair of the Nottingham Crime & Drugs Partnership was notified by letter dated 04/06/2021 from Nottinghamshire Police, of a death resulting from domestic violence. The circumstances of the death fall within Section 9 of the Domestic Violence Crime & Victims Act 2004<sup>6</sup> which required consideration of conducting a Domestic Homicide Review. A DHR Notification form, setting out the circumstances leading to the death, was submitted and this outlined Nottinghamshire Police's initial briefing and provided additional information about the case.

2.2 The Nottingham Crime & Drugs Partnership Chair considered the notification, following a recommendation made by the Nottingham City Adults Safeguarding Partnership Board Serious Case Review (NCASPB SCR) subgroup.

2.3 This review was the first in Nottinghamshire to be undertaken following the passing of the Domestic Abuse Act 2021. For the purposes of this Review, domestic abuse is defined as:

Domestic abuse is any single incident, course of conduct or pattern of abusive behaviour between individuals aged 16 or over who are "personally connected" to each other as a result of being, or having been, intimate partners or family members, regardless of gender or sexuality. Children who see, hear or experience the effects of the abuse and are related to either of the parties are also considered victims of domestic abuse. Behaviour is "abusive" if it consists of any of the following: physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; or psychological, emotional or other abuse. This includes incidences where the abusive party directs their behaviour at another person (e.g., a child). Economic abuse means any behaviour that has a substantial adverse effect on someone's ability to acquire, use or maintain money or other property, or obtain goods or services.<sup>7</sup>

2.4 Of particular relevance to this case is the inclusion of economic abuse into the statutory definition of domestic abuse and the recognition of children and young people as victims of domestic abuse in their own right.

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<sup>6</sup> [Domestic Violence, Crime and Victims Act 2004, Section 9](#)

<sup>7</sup> [For the full legal definition of domestic abuse, see Part 1 of the Domestic Abuse Act.](#)

2.5 The CDP Chair agreed to appoint Mark Dalton as independent chair in July 2021, for the DHR Review Panel, and to author the Overview report.

## TIMESCALES

2.3 The scoping period covered by the review will cover events from June 2020 until June 2021 when significant domestic violence was identified between the subjects of this Review. Agencies were also asked to review their contact with Mr B and Stacey before this time to provide information about Mr B's previous history of domestic abuse, mental health and suicide/self-harm attempts.

## 3. TERMS OF REFERENCE

### **Matters for Authors of Independent Management Reviews (IMRs):**

3.1 When reviewing the following points, IMR Authors should where possible, identify any areas where the working practices of agency involvement had a significant positive or negative impact on practice or the outcome.

3.2 To identify all incidents and events relevant to the named persons and identify whether practitioners and agencies responded in accordance with agreed processes and procedures at the time of those incidents.

3.4 To establish whether practitioners and agencies involved followed appropriate inter-agency and multi-agency procedures in response to the victim's and/or offender's needs.

3.5 Consider the efficacy of IMR Authors' agencies' involvement in Multi-Agency /Multi-disciplinary Team meetings regarding children and domestic abuse.

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

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

3.8 To what extent were the views of the victim and offender (and where relevant, significant others), appropriately considered to inform agency responses?

3.9 To what extent did Covid-19, Lockdown and potential isolation impact the victim and/or offender accessing support, e.g., for domestic abuse or mental ill health services.

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

3.11 Establish whether there are lessons to be learned from the case about how local practitioners and agencies carried out their responsibilities and duties and worked together to manage risk and safeguard the victim, her family and the wider public.

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

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

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

### **Ownership of IMR's**

3.15 Identify the purpose of the IMRs and who owns them.

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

### **Matters for the Review Panel to Consider**

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

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

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

3.20 If the Coroner has an interest in this DHR, the CDP lead officer, the Independent DHR Chair and Author will agree the process with the coroner for a copy of the Home Office approved DHR Overview Report as part of the inquest disclosure bundle. The CDP and DHR Authors will inform the coroner of any delays with the process such as criminal proceedings. The DHR Author may be called as a witness at the Coroner's Inquest where the Home Office approved DHR Overview Report has been submitted.

3.21 The Overview Report can only be submitted to the coroner once it has been approved as adequate by the Home Office. Where an Inquest is taking place and the coroner has requested a copy of the DHR Overview Report which has not been approved by the Home Office, the DHR Author and Coroner will consider the best way to proceed to prevent delays. Where a DHR has criminal proceedings, the agency information submitted for this should suffice and to prevent further delays to the Coroner's Inquest, the DHR Overview report may not be requested as part of the disclosure bundle.

3.22 The Home Office understand the need for the Coroner's Inquest to avoid unnecessary delays and will aim to have the Overview Report considered by the DHR Quality Assurance Panel as soon as possible. To assist with this, the CDP will inform the Home Office of any Coroner requests and timescales to help with forward planning.

3.23 The coroner will support DHRs where relevant, by sharing disclosure bundle documents with the DHR Author and inviting them to attend the Inquest hearing or share the findings from the Inquest (this is in line with Home Office DHR Guidance).

### **Previous DHR recommendations and actions**

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

## **4. CONFIDENTIALITY**

4.1 The findings of this DHR are confidential until approved for publication by the Home Office Quality Assurance Panel. In the interim, information has been available only to participating officers/professionals and their line managers.

4.2 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide and any identifying details of the children have been removed. The author of the Overview Report and Review Panel members are named.

4.3 The following names have been used in this review: the victim is referred to as Stacey after consultation with her family. The perpetrator is referred to throughout as Mr B.

## 5. METHODOLOGY

5.1 This review has been undertaken using the Significant Incident Learning Process (SILP) methodology. This approach combines the information obtained through individual management reports with face-to-face learning events for practitioners and managers where key themes are discussed. The intention is to understand decisions, actions and behaviours in the context of day-to-day real-life pressures and factors. The views and opinions of all parties are actively sought and included as part of the final analysis.

## 6. FAMILY INVOLVEMENT

6.1 Stacey's mother was informed a Domestic Homicide Review was being undertaken at the beginning of the process and that it would not proceed until after the conclusion of the criminal trial. Family members were supported by a Police Family Liaison Officer and Victim Support during the trial. Stacey's mother also informed the Overview Report author that the children were not allowed any access to counselling before the commencement of the trial in October 2021 because they were potential witnesses. (See section 16.21 below).

6.2 The Overview Report author and the Domestic Violence and Abuse Policy Lead met with Stacey's mother, her ex-partner, a family friend and a case worker from Victim Support in April 2022. They shared their memories of Stacey and their reflections on the relationship between her and Mr B over the years. They also spoke of the deteriorating situation between Stacey and Mr B and missed opportunities to protect Stacey. They still have many unanswered questions about the Police response in the light of escalating threats by Mr B.

6.3 Mr B was informed that the Review was being undertaken by letter. He had been described in court at his trial as narcissistic and lacking remorse. The details of the offence and that he entered a plea of diminished responsibility caused the DHR Panel concern that he would not be able to engage honestly with the DHR process because he did not accept responsibility for the incident.

6.4 At the time this Review was undertaken all Panel Meetings were virtual meetings held online. After the initial meeting, it was mutually agreed that ongoing contact between the family and the DHR Panel would be either face-to-face through contact with the Overview author and the Domestic Violence and Abuse Policy Lead or by telephone.

6.5 The possibility of including the opinions of the children in the review was discussed with their maternal grandmother who was their legal guardian. She explained that the children were still traumatised and faced many challenges on a daily basis. Their father's trial had been extensively reported in the local media. Her opinion was that it would be too difficult and distressing for the children to engage with the review process on any level.

6.6 The family's experience of the investigation of the murder, the process of the trial and the aftermath provide insights which are not captured in the management reports from agencies. Their reflections are honest and provide an important adjunct to the responses from the various agencies to Stacey's death. The caseworker from Victim Support remained involved to assist and advocate for Stacey's mother and the children.

6.7 Stacey's mother and a family friend had a second meeting with the Overview Report author and Abuse Policy Lead in September 2022. They have read the final draft of the report and their comments and amendments have been included.

6.8 On behalf of the Crime and Drugs Partnership, we extend our deepest sympathy and regret for their loss and thank them for their involvement in this review.

## 7. CONTRIBUTORS TO THE REVIEW

**East Midlands Ambulance Service**

**Nottinghamshire Healthcare Foundation Trust**

**Nottinghamshire Police**

**Greater Nottingham Clinical Commissioning Group (GP services)** – summary report.

**Nottingham University Hospitals NHS Trust** – summary report.

**Nottingham and Nottinghamshire CCGs (for GP services)** – summary report.

**CityCare** - summary report.

**DWP** – summary report.

7.1 Agencies produced an Independent Management Report using the agreed template and systematically addressed the questions stated in the Terms of Reference. For agencies with minimal contact or contact outside the scoping period, a summary report was requested. All agencies contributed to producing an integrated chronology that recorded events from 2002 until 2021.

### 7.2 Review Panel Members

Mark Dalton	Review Consulting	Independent Reviewer and Chair of Panel
Julia Greig	Review Consulting	Independent Reviewer

Emma Wilson	East Midlands Ambulance Service	Adult Safeguarding Lead
Bennjoseph Vaughan/Olwen Edwards	Equation (Equation is a Nottingham-based specialist charity that works with domestic abuse, sexual violence and gender inequality.)	Head of Services
Karen Turton	Nottingham CityCare Partnership (Community Health Services provider)	Specialist Health Practitioner Domestic and Sexual Violence and Abuse
Nick Judge	NHS Nottingham and Nottinghamshire CCG	Associate Designated Nurse Safeguarding Adults.
Ishbel Macleod	NHS Nottingham City and Nottinghamshire CCG	Designated Safeguarding Professional for Adults
Yasmin Rahmen	Juno Women's Aid	Chief Executive Officer
Mark Dickson	Nottinghamshire Police	Detective Chief Inspector
Paula Bishop	Nottingham Crime and Drugs Partnership (CDP)	Domestic Violence and Abuse Policy Lead
Maggie Westbury	Nottingham University Hospitals (NUH)	Domestic Abuse Nurse Specialist
Heather Fry	Nottingham City Homes (NCH)	Safer Neighbourhood Housing Manager
Helen Pritchett	Nottingham Healthcare Foundation Trust	Safeguarding Lead
Jane Lewis	Nottingham Crime and Drugs Partnership	Community Safety Strategy Manager

7.3 Mark Dalton was formally commissioned to undertake this review on 12<sup>th</sup> July 2022. The Panel met on 5 occasions; to agree on the terms of reference, to receive an update on the criminal proceedings, to review the Individual Management Reviews and to comment on drafts of the Overview Report.

7.4 The Panel met on the following dates: 06/10/2021, 02/03/2022, 22/03/2022, 04/05/2022 and 24/05/2022. An initial presentation to the Crime and Drugs

Partnership Board highlighting the key issues and drawing the Board's attention to the main findings took place on 5<sup>th</sup> December 2022. The Crime and Drugs Partnership Board accepted the report and endorsed its recommendations.

7.5 The report was submitted to the Home Office on the 12<sup>th</sup> October 2022 and considered by the Quality Assurance Panel on the 29<sup>th</sup> March 2023 and feedback was received on 15<sup>th</sup> May 2023. The Overview Report was resubmitted to the Home Office on 15<sup>th</sup> August 2023. Further changes were requested before publication and the report was again submitted to the Home Office for approval in October 2023.

## 8. AUTHOR OF THE OVERVIEW REPORT

8.1 The Nottingham Crime and Drugs Partnership appointed Mark Dalton to chair the review and to author the Overview Report. He is an independent registered social worker and an experienced SILP (Significant Incident Learning Process) reviewer. He has extensive social work experience in the statutory and voluntary sectors and has undertaken DHRs for other Community Safety Partnerships. He has completed the Home Office approved course for Domestic Homicide Review Authors and over the years undertaken further training with Community Safety Partnerships, the Social Care Institute for Excellence, and Review Consulting. He is independent of all the agencies involved in this case and the Nottingham Crime and Drugs partnership. He has previously undertaken Adult Safeguarding Reviews for the Nottinghamshire Safeguarding Adults Board and a previous Domestic Homicide Review for Nottingham Crime and Drugs Partnership.

8.2 Julia Greig is an experienced social work manager and Independent Reviewing Officer. She has undertaken the Home Office online training for authors of Domestic Homicide Reviews and training in the SILP methodology. She is currently undertaking Safeguarding Adult Reviews and Domestic Homicide Reviews in other local authority areas. She is independent of all the agencies in Nottingham.

## 9. PARALLEL PROCEEDINGS

9.1 The criminal trial of Mr B was concluded in January 2022, he pled guilty to manslaughter on the grounds of diminished responsibility but was convicted of murder and sentenced to 29 years imprisonment before consideration of parole.

9.2 An Independent Office for Police Conduct (IOPC) investigation has concluded, and the final report shared with Stacey's mother. Its findings have not been shared with the Overview Report author or panel members for this DHR.

9.3 The coroner has also requested to be kept updated on the progress and findings of this review.

## 10. EQUALITY AND DIVERSITY

10.1 The nine protected characteristics identified in the Equality Act 2010<sup>8</sup> were assessed for relevance to the DHR. The subjects of this review are both white British citizens, Ms A was in her late 30s and Mr B was approximately four years older. No discriminatory issues were identified by the Panel that affected the services offered to Mr B or Stacey.

10.2 Research of Domestic Homicide Reviews shows that the murder of a female victim by a male perpetrator is the most common form of domestic homicide.<sup>9</sup> this research also noted that 60% of perpetrators had mental health issues, with depression and suicidal thoughts being one-third of these.

10.3 Although deprivation is not a protected characteristic recognised under the Equality Act, Mr B's and Stacey's financial circumstances were relevant to the domestic abuse perpetrated in this relationship. The lack of money caused arguments and on occasion serious violence between Stacey and Mr B. Also, the lack of any independent financial means meant that Stacey stayed in the relationship because she was fearful that she would not be able to provide for herself and her children.

## 11. DISSEMINATION

11.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Nottingham Crime and Drugs Partnership for approval and thereafter will be sent to the Home Office for quality assurance.

11.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with Multi-Agency Risk Assessment Conference (MARAC) partners, and the Executive Summary will be published on the [Nottingham Crime and Drugs Partnership](#) website. There will be a range of dissemination events to share learning.

11.3 The recommendations will be owned by the Nottingham Crime and Drugs Partnership which will be responsible for monitoring the recommendations and reporting on progress.

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<sup>8</sup> The Equality Act 2010 sets out nine protected characteristics and discrimination is recognised when at least one of these characteristics determines the way in which a person is treated. The nine characteristics that are protected are: Age, Disability, Gender reassignment, Marriage or Civil Partnership, Pregnancy and Maternity, Race, Religion or Belief, Sex and Sexual orientation.

<sup>9</sup> [Analysis of domestic homicide reviews](#) this research found that 77% of victims were female and 89% of perpetrators were male. Analysing the relationships between the victims and perpetrators shows that for 68% of the victims the perpetrator was a partner or ex-partner. Within these relationships 29% were partners who had separated or were separating from the perpetrator.

## 12. PREVIOUS CASE REVIEW LEARNING LOCALLY

12.1 This is the seventh DHR commissioned locally. The Review Panel considered the learning and recommendations from other reviews in the analysis and the development of recommendations for this DHR. Re-occurring themes such as the need to develop professional curiosity (See section 16.9 below) build on previous learning from both local and national reviews.

12.2 Published DHRs can be found at [Nottingham Crime and Drugs Partnership](#)

## 13. BACKGROUND INFORMATION

13.1 Before this relationship, they both had previous partners and other children from these relationships. Information contained in the Police IMR shows that Mr B had also been violent towards his ex-partner before he began the relationship with Stacey.

13.2 Stacey and Mr B had been in a relationship for 16 years, they had 2 children together who are in their teenage years.

13.3 Police records from as far back as 2005 show that this relationship had episodes of violence; the Police were called to twelve separate altercations. These incidents ranged from theft to criminal damage and assault. Some of these occurred in the city centre with physical assaults perpetrated by both Stacey and Mr B. However, five incidents occurred either at the home address or at Stacey's mother's property. The Police response did not always identify these incidents as domestic abuse related, DASH forms were completed on four occasions and identified both Mr B and Stacey as victims. On several occasions, either Stacey or Mr B would withdraw their complaint the following day. None of these incidents resulted in a referral to the MARAC or any other agency.

13.4 A further significant event occurred in August 2011 when Stacey contacted the Police to report an argument with Mr B who would not let her go out drinking with her friends because they could not afford it. By the time the Police attended Mr B had left for work, Stacey disclosed that during the argument he had made threats to slit her throat if she left him and took the children. This was a significant incident, it was recorded as a non-crime medium-risk domestic violence incident, the children were present and DASH forms were completed. Both Mr B and Stacey requested contact from the Domestic Violence Team and referrals are made to Children Social Services and support networks for domestic abuse survivors. Stacey was given contact information for helplines for victim support and lawyers against domestic abuse. The DASH form requested that contact be made with Mr B to advise him on services which may be able to support him. There is no Police record to indicate if this happened or what services he may have been referred to.

13.5 In 2013 there was an incident that resulted in the couple agreeing to separate where Mr B threatened suicide if he had to leave his children. This led to referrals to the Mental Health Department at Nottingham University Hospital. There were no disclosures from Mr B or any information shared with the hospital that indicated there may be domestic abuse in the relationship. It was a characteristic of Mr B's portrayal of his problems that these were couched in terms of relationship difficulties and fear that his relationship was ending. It does not appear from the records that domestic abuse was considered as a factor in these relationship difficulties.

13.6 In summary, there is evidence that the relationship between Stacey and Mr B was intermittently violent, sometimes reaching a pitch, (or possibly because it was in public), that the Police became aware of and intervened.

13.7 The perception of family members is that Mr B was intimidating and oppressive, but not physically violent as far as they are aware. They noticed gradual changes in Stacey where she became less outgoing and more compliant with Mr B's demands that she remained at home. This relative isolation also included making it difficult and uncomfortable for her to maintain contact with her older children, her mother and her friends. With the benefit of hindsight, it is easy to recognise a pattern of coercive control in Mr B's behaviour towards Stacey. Whilst outsiders may have recognised this, for Stacey's part, she believed she was keeping the peace and doing her best to preserve her relationship.

13.8 A thorough review of agency records show that Stacey had minimal contact with health services between 2013 and when the relationship with Mr B became violent in 2021 and she was fatally assaulted by Mr B. She did not disclose problems with her relationship to any other agency.

13.9 Mr B had significant involvement with health agencies; in the period under review, these were all in the context of relationship problems and fear of the relationship with Stacey ending. These were expressed as problems of low mood, thoughts of suicide and deliberate self-harm. He was prescribed medication for depression and given information to self-refer to counselling therapies. He would use the prescribed medication to overdose when the relationship reached a crisis point. At no time was there any disclosure of domestic abuse or violence. Medical records show a reference to Mr B being detained following an argument with Stacey, but the subsequent assessment states that this was as a place of safety rather than due to criminal behaviour. Therefore, there was nothing to prompt further exploration of the incident by his GP.

#### 14. TIMELINE OF SIGNIFICANT EVENTS – JUNE 2020 – JUNE 2021

**14.1 June 2020.** In early June 2020, the Police were involved on consecutive days, initially, they were contacted by Stacey who reported that Mr B was being verbally aggressive and refusing to leave the family home. The context of this argument seems to have been Stacey's discovery that Mr B was having an affair. She also

informed the Police he had mental health issues and was not taking his medication. They were spoken to separately and Mr B said he intended to leave and was moving to his mother's address. There had been a verbal argument only and no offences were disclosed.

14.2 The following day Mr B contacted the Police complaining that Stacey had contacted him and was threatening to damage his property. Mr B alleged that Stacey was "controlling" but had not been violent. A DASH/PPN<sup>10</sup> assessment was completed for Mr B which assessed the incident as standard risk. There was no reference to the children, even though it was reported that they were present at the time.

14.3 Mr B moved out of the family home to stay with his parents and after a brief time away, he moved back into the family home.

**14.4 July 2020.** Mr B telephoned his GP having taken an overdose of painkillers and tranquillizers. The GP shared concerns with the Crisis Resolution Home Treatment Team (CRHT) who contacted Mr B. Mr B stated that he had taken the overdose following an argument with Stacey and he had ongoing relationship difficulties. The possibility of domestic abuse was not discussed, and the focus was on developing a safety plan for Mr B. Further advice and the option of attending talking therapies were discussed but these were rejected by Mr B. There was no further contact from the CRHT.

14.5 It was 10 months before the Police were contacted again, and significantly this was through a third party rather than directly by either Mr B or Stacey. Family members were asked directly about the state of their relationship in the second half of 2020 and early 2021, in the absence of any agency records. Stacey's mother's opinion is that the relationship had not improved, and Mr B continued to be domineering and controlling. One of the effects of this had been to make Stacey feel that there was no point in contacting the Police because they would not believe her and there was nothing they would do anyway.

**14.6 April 2021.** The Police received a third-party referral from a friend of Stacey's who overheard Mr B shouting at the children whilst on the phone with Stacey. The Police attended and found an unhappy situation with Stacey again saying she no longer wanted Mr B to live there. Again, the plan was that he would move to his

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<sup>10</sup> The Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification, Assessment and Management Model was implemented across all Police services in the UK from March 2009, it is a standardised questionnaire which can be used to define the level of risk of domestic violence or abuse. Risk is defined as either high, medium or standard.

A Police Protection Notice (PPN) is to provide temporary protection for a person. The notices operate like a temporary Protection Order.

In Nottinghamshire, the DASH Form was replaced by the Domestic Abuse Public Protection Notice (DAPPN/PPN) in 2018

mother's address about a mile and a half away. Mr B had threatened suicide if he could not remain in the family home. The Police spoke to him about this, and he asserted that the comment had been made in the heat of the moment and he had no intention of killing himself. It became known following the homicide enquiry that Mr B had sent text messages to Stacey threatening suicide and saying goodbye to the children. Stacey did not reply to any of these messages.

14.7 The impact of the rows at home was also experienced by their children. Changes in the children's presentation and demeanour were noticed at school and one of the children disclosed that they were concerned about Mr B shouting at their mother and they were also concerned for the safety of their sibling and themselves. After consultation with the designated safeguarding officer in the school, a plan was put in place to support the children in school and ensure there was an opportunity for discussions or disclosure. The safeguarding plan within the school was to work with the child who had disclosed and encourage them to agree to talk to a specialist service.

14.8 The Police gave Stacey advice on obtaining a Non-Molestation Order. There is evidence that she took this advice on board and was in the process of obtaining an Order a few weeks later. After she was killed the address and contact details of a women's refuge were found in her possessions.

14.9 The Police recorded this incident as domestic abuse and assessed it as a standard risk. Stacey also disclosed that Mr B was being treated for depression but was not taking his medication. She also stated that he was controlling and would not let her see her friends. It would seem that the Police missed this disclosure of what was, in effect coercive and controlling behaviour and therefore a crime.

**14.10 May 2021.** In early May, a work colleague of Mr B called the Police as they were concerned about his welfare because he had posted messages on Facebook implying that he intended to end his own life. The call was received in the late evening and within an hour the Police had spoken to Mr B at his mother's address. He reassured the Police that he had been venting his feelings and was not serious about killing himself.

14.11 However, later the same evening the Ambulance Service were called because Mr B had taken an overdose of prescribed medication and alcohol. Mr B was refusing to engage with the ambulance crew, so the out-of-hours Doctor was informed. Police assistance was not required at that time.

14.12 The situation changed 3 hours later – in the early morning of the following day an approved Mental Health professional requested assistance from the ambulance service and Police in detaining Mr B under Section 2 of the Mental Health Act. The Police attended and Mr B was transported via ambulance to hospital.

14.13 When Mr B was admitted to a Mental Health inpatient ward, he informed staff that he was going through a challenging time in his relationship with his partner and she was asking to end the relationship. He also disclosed that a neighbour had called the Police due to “bickering” and he had been advised to leave the property and was now staying with his parents.

14.14 Mr B was discharged from hospital two days later. The diagnosis was that he was suffering from an Adjustment Disorder following the end of his relationship. Mr B's mother attended the discharge meeting and raised concerns that he was still a risk to himself and that he could be irrational at times. A three-day follow-up appointment was arranged with the Crisis Resolution Home Treatment Team (CRHT) to assess if there were any further support needs. The follow-up meeting took place and Mr B was briefly seen, he agreed to book a further appointment, but failed to do so and attempts to contact him were unsuccessful.

14.15 One of the children again spoke to their tutor at school about the poor situation at home. On this occasion, the school contacted Stacey to ask if she required any further support and would agree to a referral being made to services that could offer her support with domestic abuse. At this time Stacey was unable to accept the offer because she was fearful of the consequences if she did.

**14.16 13<sup>th</sup> and 19<sup>th</sup> May** In these 6 days there was an escalating pattern of harassment, stalking, and use of threats (including sending intimate phone images of Stacey to her mother, this incident was recorded as an offence of disclosing private sexual images), and criminal damage displayed by Mr B towards Stacey.

14.17 Some of these incidents revolved around Mr B wanting to remove his property from Stacey's home. However, these incidents were not solely about property; Mr B displayed a level of aggression and harassing behaviour (banging on windows, entering the garden by the back fence, and shouting abuse) despite being warned to keep away from the address. At this time Mr B was living close by and was able to visit the family home, harass Stacey, and be gone by the time the Police arrived.

14.18 The Police responded to Stacey on 8 separate occasions before the final fatal assault. Initially, the Police interventions calmed the situation down and they offered to become involved to allow Mr B to collect his property from the family home. However, it became apparent that Mr B would not cooperate with these arrangements and his behaviour became more aggressive.

14.19 Mr B was arrested on 15<sup>th</sup> May for the offences of disclosing private sexual images, harassment and criminal damage. He was released on conditional bail with the bail conditions that he had no contact with Stacey directly or indirectly, to stay away from the family home and not to contact Stacey's mother.

14.20 In the early hours of the morning on the day before the fatal assault Stacey contacted the Police as she saw that Mr B had entered her garden on her CCTV, by the time the Police arrived he had left. Due to other demands on the Police resources that night no attempt was made to arrest Mr B for breach of bail conditions.

14.21 A PPN/DASH form was completed and identified this as a medium risk. Stacey told the Police that she had recently started a new relationship and believed Mr B had found out about this. Research and DHRs on similar situations have found that the commencement of a new relationship by one of the partners can be a trigger for abuse in all its forms (harassment, physical abuse and coercive behaviour) to escalate.

14.22 The following day, again in the early hours of the morning Stacey called the Police reporting that Mr B was in her rear garden in breach of his bail conditions. The Police responded promptly and searched the garden but failed to find Mr B and assumed he had left the property before they arrived. Although it would seem he was in fact hiding in the garden. The Police looked for Mr B at his mother's address to arrest him for the offence of stalking but could not find him.

14.23 Twenty minutes after the Police had visited Mr B's parents' home looking to arrest him, Stacey's neighbour made a 999 call as she was witnessing Mr B attacking Stacey in the garden with a knife. Their children also witnessed the assault from their bedroom windows. When the Police arrived, Stacey was fatally injured but still alive. Mr B was arrested for attempted murder. The Police officers provided first aid before the ambulance crew took over.

14.24 Stacey was taken to hospital with multiple stab wounds where she died of her injuries 2 weeks later. Mr B was subsequently charged with murder.

## 15. SUMMARY

15.1 There is an escalating pattern of abusive behaviour displayed by Mr B from April 2021 onwards. This seems to be about the time that Stacey decided to end the relationship for good. This is an important and notable change; their relationship had been characterised by episodes of violence and aggression interspersed with periods where it seemed to settle (in the sense that there were no calls to the Police), although Stacey's mother has confirmed that Mr B had convinced Stacey that the Police could not help her. Stacey's family never considered it a good relationship.

15.2 Mr B had a history of mental health problems which were exacerbated by his erratic use of medication combined with alcohol abuse. He had threatened suicide on at least 3 occasions and had used this as an emotional threat to Stacey of what he might do if she ended their relationship. Mr B had disclosed to his GP that he was having relationship difficulties but made no disclosure of abuse or violence.

15.3 Although Stacey had made passing comments to professionals that her relationship was not a good one, she was not offered, nor did she seek help from any of the agencies in Nottingham that support women living with domestic abuse.

15.4 Mr B was offered therapeutic help with his mental health problems but declined any help apart from medication.

## 16. ISSUES ARISING FROM THE REVIEW

16.1 Mr B and Stacey were engaged in very few of the statutory and voluntary services in Nottingham, the notable exceptions are the Police and to a lesser extent Mental Health Services, but even these agencies did not have a full picture of the extent of the domestic abuse and did not effectively share information. It is also notable that there was only limited consideration of the impact of domestic abuse on their children.

16.2 When responding to Mr B's mental health crises there was a failure to fully explore the antecedents of this; they were invariably a response to an argument with Stacey and being confronted with an ultimatum. These were euphemistically described as "relationship difficulties" and on one occasion minimised as "bickering." The "bickering" had been overheard by a neighbour who was sufficiently concerned to call the Police, and the relationship difficulties had led to Mr B moving out of the family home.

16.3 The IMR from the Nottinghamshire Healthcare Foundation Trust acknowledges there are further lessons for practitioners regarding professional curiosity. To a large extent, Mr B's description of the problems in his relationship was taken at face value. Further exploration around the "relationship difficulties" could have helped identify that this was not a case of relationship difficulties but a domestic abusive relationship. This recognition would have led to further risk assessments being undertaken and liaison with the Police.

16.4 Stacey was not contacted by the in-patient Ward treating Mr B. Because there was no plan for him to return to the family home, the Ward would only speak to his next of kin. In the case of Mr B, the next of kin was recorded as his mother because the plan was to discharge him to her home. Given this scenario and having accepted Mr B's account of his relationship with Stacey, the Ward believed they would need Mr B's consent to contact her. If domestic abuse had been considered there would have been an opportunity to share information with the Police and the potential for challenging Mr B's account of the incident which would have changed the risk assessment.

16.5 The connection between domestic abuse and the prospect of a relationship ending was seemingly overlooked. There is a wealth of information that the risk of

losing a partner can significantly raise the risk of domestic abuse.<sup>11</sup> it would be expected that professional curiosity would be exercised to explore the relationship problems further in accordance with the “Think Family” approach of the Foundation Trust.

16.6 Mental Health services in Nottingham adopt a Think Family approach<sup>12</sup>, this means that the implications for family members and especially children should be assessed as part of the ongoing risk. The lack of information being shared between agencies enabled Mr B to minimise the impact of his behaviour on his partner and children. Mr B informed the Crisis Team that the Police had been called due to “bickering.” Further exploration of this, and cross-checking with the Police would have led to a more accurate assessment of risk.

16.7 It is important to place Mr B's involvement with Mental Health services in the correct context. Mr B's diagnosis of an adjustment disorder does not mean that he suffers from a long-term serious mental illness. An adjustment disorder is a transitory state of mind describing someone struggling to adapt to change in circumstances. Treatment usually takes the form of counselling or psychological therapy. It did not affect Mr B's cognitive ability nor the responsibility for the deliberate and planned attack on Stacey.

16.8 The traumatic impact on the Police Officers who attended the incident on 19<sup>th</sup> May should also be recognised. As a result of attending the incident, one Officer resigned from the Police force and the second remained on light duties such was the trauma of attending the event. Not only is this a stark reminder of the reality of attending incidents of domestic abuse, but also a reminder that all staff working with domestic abuse will need supervision and support.

### Professional Curiosity

16.9 The Independent Management Reviews from both the Police and the Nottinghamshire Healthcare Foundation Trust highlighted a lack of professional curiosity at certain key times. The concept of professional curiosity has existed for over 20 years and the lack of it has become a commonplace finding in Safeguarding and Domestic Homicide Reviews. It may be that while it is a phrase with a common-sense definition, this definition is not the same across all agencies and the expectations of how frontline practitioners demonstrate this is variable.

16.10 It is important therefore to establish a shared definition of professional curiosity and its meaning across a multi-agency audience. Expectations of competence in

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<sup>11</sup> [NICE Domestic Violence and Abuse - Risk Factors](#)

<sup>12</sup> The ‘Think Family’ approach encourages adult's and children's services to work closely together and take a whole family approach to ensure better outcomes for children and adults from families with complex needs. See [Nottingham and Nottinghamshire Multi-Agency Safeguarding Vulnerable Adults Guidance](#) p7.

this area vary between agencies; one expects the Police, with their training in investigation to be more practised than other professionals. However, this Review demonstrates that it is equally important for GPs, Social Workers and Mental Health Professionals to have skills in challenging and probing information.

16.11 The need for professional curiosity may become more apparent when reviewing actions with the benefit of hindsight, than it seemed in the here and now when dealing with a person who may be aggressive or agitated, and there are immediate practical issues that have to be dealt with.

16.12 It is clear from the records that Stacey did not disclose domestic abuse to any professional other than the Police Officers who responded to her 999 calls. Their actions were protective and focused on detecting crime, but also episodic and the Police did not notice an escalation in the frequency and seriousness of Mr B's abuse of Stacey. A further important aspect was his disregard for the Police and his bail conditions.

16.13 Professional curiosity is not in itself a safeguarding measure, there is a need for a theoretical understanding of the nature of domestic abuse to make questions relevant and help with analysing the responses. For example, questioning and interview techniques need to be combined with knowledge of a relevant conceptual framework such as Monckton Smith's 8-Stage Timeline. (See section 17 below).

16.14 When Lord Laming first discussed the concept of "respectful uncertainty"<sup>13</sup>, and the need for social workers to corroborate and triangulate information they received from service users, he also suggested there was a clear role for supervisors in assessing the veracity of information and opinions of frontline workers, this is a recognised function of supervision.

16.15 For the Police Officers responding to Stacey – usually late at night or in the early hours of the morning as part of a busy shift – the opportunity to reflect on information would have been more limited. However, there are ways of addressing this problem through the handover of information between shifts and reviewing calls which require a follow-up.

16.16 The Nottingham City Safeguarding Adults Board, in common with several other boards across the country, has produced a Multi-Agency briefing on professional curiosity (Appendix A). This is a checklist of good practices with links to further guidance, initiatives such as this need to be supported by training for practitioners and supervisors.

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<sup>13</sup> [The Victoria Climbié Inquiry](#) p205

## Services for Men in the Community

16.17 It is extremely unlikely that Mr B would have agreed to become involved with any community-based service which attempted to work therapeutically with his need for control in relationships.

16.18 However, his needs were known by members of his family and colleagues at work who were concerned about him and the possibility he may self-harm. One of his work colleagues was sufficiently concerned about Mr B's suicide threats to contact the Police.

16.19 This Review has contacted the supermarket where Mr B worked (as he was employed through a facilities company, they were not his direct employer) to consider the scope for raising awareness of Domestic Abuse among employees and responding to signs of distress in the workplace.

16.20 The supermarket chain has responded and outlined a range of initiatives to raise awareness and support for employees including membership of the Employers Initiative on Domestic Abuse<sup>14</sup>, and access to online resources on Domestic Abuse through their intranet site which includes signposts to support both victims and perpetrators. There is an Employee Assistance Programme and a Domestic Abuse Colleague guide to help Line Managers understand Domestic Abuse and recognise the signs, these resources were in place at the time Mr B was employed at the store. In October 2022 they ran a "Let's Talk about Domestic Abuse" campaign with the aim of raising awareness in the workplace.

## Indicators of Domestic Abuse

16.21 Nottinghamshire Police are early adopters for the Domestic Violence Disclosure Scheme (DVDS) Right to Know/Right to Ask scheme<sup>15</sup> and apply criteria to these disclosures balancing out the safeguarding needs and proportionality.

16.22 Nottinghamshire Police do not automatically provide DVDS to all domestically abusive relationships and consider the disclosure following set criteria. Whilst, in hindsight, disclosure may seem obvious, the Police are still required to be proportionate with disclosure.

16.23 The Police position, in this case, was that, given that the previous abusive relationship ended 16 years before they became aware of the escalating abuse between Stacey and Mr B, it was not usual to report on incidents which had occurred so long ago. A DVDS (Domestic Violence Disclosure Scheme) was considered but the criteria were not met.

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<sup>14</sup> [Employers Initiative on Domestic Abuse](#)

<sup>15</sup> [Domestic Violence Disclosure Scheme](#)

16.24 There are significant indicators in Mr B's behaviour that his suicide attempts were prompted by his failure to control and dominate Stacey.

16.25 The context of the suicide attempts were all following arguments with Stacey, and to some extent arguments that he had "lost" because the Police had been called. These are indicators of coercive control in his behaviour towards Stacey, with an escalation in violence when she would not be intimidated.

16.26 The pattern of his continued harassment by visiting the house in the middle of the night meets the accepted definition of stalking behaviour<sup>16</sup>. While the Police attended Stacey's house on numerous occasions and identified Mr B's behaviour as harassment, they did not identify the crime of stalking.

16.27 There were two consequences of the failure to report Mr B for the crime of stalking. Firstly, this meant that he was not referred to a monthly "Stalking Clinic" (this is a regular meeting between Police and other partner agencies which shares intelligence and can arrange support for victims and perpetrators).

16.28 Secondly, and more importantly, research has shown that the frequency, persistence and escalation of stalking behaviour is significant as a potential indicator of risk or threat of serious violence. The chronology of events shows that throughout April and May Mr B was visiting the family home in the middle of the night or early hours of the morning with impunity, on at least one occasion he followed his children on the school bus. Despite repeated contact with the Police and the imposition of bail conditions his stalking behaviour increased.

### Impact of Abuse on Children

16.29 The impact on children living with domestic abuse is now widely recognised.<sup>17</sup> Under the Domestic Violence Act, children are recognised as victims of domestic abuse in their own right rather than witnesses. It is accepted that children may be psychologically damaged by living in a hostile environment even when they are not directly subject to abuse.

16.30 The impact of domestic abuse on the children was not recognised by the Police when they attended the home and recorded that the children were present during incidents between Stacey and Mr B in June 2020 and April 2021. Neither of these incidents led to any further action regarding the children. Referral to Children's Social Care was not made until a week before the fatal incident.

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<sup>16</sup> [Exploring the Relationship between Stalking and Homicide](#) defined stalking as having 2 key consistent aspects: presence of obsession and fixation, and surveillance or tracking activities.

<sup>17</sup> [Protecting children from domestic abuse](#) . See also Nottinghamshire Safeguarding Children Partnership (NSCP) and the Nottingham City Safeguarding Children Partnership (NCSCP) Interagency Safeguarding Children Procedures [Domestic Abuse](#)

16.31 There were no explicit complaints from Stacey about Mr B's behaviour towards the children, however, he had been overheard shouting at the children during a telephone call between Stacey and the Police and it was alleged that he shouted a great deal at the children. In addition, Stacey had informed the Police that they were not attending school and one of her children put a cupboard against his bedroom door when they went to bed because they were scared of Mr B's behaviour. It was also alleged that after he moved out of the family home, he had followed them to the school bus which had upset them.

16.32 On two occasions, within weeks of each other one of the children had disclosed their concern about the relationship between their parents and concern for their own safety and that of their sibling. The school had identified the situation as domestic abuse and as a result, was monitoring the children and ensuring there was an opportunity for them to talk about the situation at home. They also contacted Stacey to offer her support in identifying services that could help her, however, it would seem she was too fearful of the consequences to engage with these services.

16.33 In the opinion of their grandmother the children were emotionally abused by living in the oppressive environment and tension of domestic abuse. The children were subdued and withdrawn at home and tended to "live in their bedrooms" to avoid arguments between their parents as much as they possibly could. It should also be noted that the first concerns about the impact of domestic abuse on these children are recorded in their first years at primary school when they witnessed a violent argument between their parents and missed school as a result of being upset.

16.34 The grandmother was aware that one of the children had mentioned the situation at home at their school but was unaware of the school's offer to Stacey to help her identify services that could help her. Once Stacey had declined this offer there was little the school could do other than provide a safe forum for the children to talk about the situation at home. The school has safeguarding policies in place and dedicated safeguarding staff who would have made a referral to Children's Services if they believed the children were at risk of significant harm.

16.35 The fact that the school suspected problems at home (which were never confirmed by the children or by Stacey) only became apparent when a draft of the review was shared with Stacey's mother. The full extent of the impact on the children of living with domestic abuse is still being explored through counselling.

16.36 All agencies need to recognise that a victim of abuse may be unable to accept an offer of support for a variety of reasons; they may be fearful of the consequences if the perpetrator becomes aware they have accessed support, they may lack the confidence to make that initial contact or minimise the impact of the abuse as an attempt at self-preservation. A failure to engage should not be interpreted as a sign that the situation has improved for the victim lacks the

motivation to change. It is important therefore that all agencies do not have a default position of equating a failure to engage as evidence that the problem is not serious.

16.37 The decision to prevent the children from receiving counselling before the beginning of the trial was unnecessary. While this may be understood as an initial response, following the death of their mother this decision should have been reviewed. There is CPS guidance on the provision of pre-trial therapy for children<sup>18</sup> which would have provided sufficient protection for the criminal case whilst allowing the children to receive therapeutic support at a crucial time.

### Male Roles and Masculinity

16.38 This review raises the question of whether Mr B's abusive behaviour within his relationship with Stacey (and previous partners) had been bolstered by his choice of employment. At the time of the offence, he worked as a security guard in a local supermarket and before this, he had worked as a door attendant in Nottingham's pubs and nightclubs.

16.39 Besides anti-social hours and long shifts, these jobs have inherent stressors which may have had a significant impact on a person suffering from an Adjustment Disorder and rejecting any therapeutic support. Mr B's jobs also potentially gave him an unearned authority and a uniform which put him in a position of power over others.

16.40 This Review questions whether there is a connection between his behaviour in his employment and whether this extended into his personal and family relationships. There seems to be little oversight or supervision for people in the role of a security guard; in Mr B's case, he was not employed directly by the supermarket but through a facilities company. Therefore, his actual employer is even further removed from having any oversight of his welfare.

### Coercive Control

16.41 From the information provided by her mother it seems probable that Stacey often did not perceive Mr B's behaviour as amounting to domestic abuse because he stopped short of physical violence. Although controlling and coercive behaviour in an intimate family relationship was introduced as an offence in 2015<sup>19</sup>, there may

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<sup>18</sup> [Provision of Therapy for Child Witnesses Prior to a Criminal Trial](#) this guidance was originally written for child witnesses in sexual offences cases; however, it is widely applicable to any child or vulnerable witness. The CPS has also updated its guidance on the provision of [Pre-trial Therapy](#).

<sup>19</sup> Section 76 of the Serious Crime Act 2015 introduced the offence of controlling or coercive behaviour in an intimate or family relationship to recognise that victims can experience extreme psychological and emotional abuse that can have severe impacts, whether or not accompanied by physical abuse.

still be some barriers to identifying it as a pattern of abuse particularly if the victim is kept isolated by their abuser.

16.42 There are indicators of coercive control in the IMRs from the Police and Mental Health Services. The information from family members, in particular, Stacey's mother shows the powerful corrosive impact that living with this kind of abuse has on an individual's personality. In Stacey's case, she believed herself to be dependent on Mr B and incapable of surviving alone.

16.43 Mr B's control extended into all areas of Stacey's life and affected her self-esteem, social relationships and the parenting of their children. Stacey did not work, although she had the potential and had enjoyed a work experience placement arranged through the DWP. However, Mr B did not want Stacey to work; a situation which allowed him to have maximum financial control. He also controlled what she ate and used her weight gain to further undermine her self-confidence. The children were only allowed to shower twice a week and they were not allowed to put the heating on. Agencies were not aware of this information at the time; it became known through discussions between family members and the Overview Report author.

16.44 Mr B was jealous of Stacey's relationships with anyone else, including her mother and her first partner, the father of her two older children. Mr B had made threats towards him and threatened to burn down his house. He had also put used needles and syringes through the letterbox and did the same to Stacey's mother (these incidents were not reported at the time). The sending of intimate photos of Stacey to her mother is a further example of his attempt to shame and embarrass her and damage the relationship between mother and daughter.

16.45 Mr B's suicide attempts and threats to self-harm were also a form of emotional manipulation, it is significant that these attempts always followed a serious argument with Stacey.

16.46 There is no doubt that living with this behaviour for so many years and simultaneously trying to placate her abuser and protect her family, particularly her children, placed Stacey under enormous strain.

#### [Arrest by Voluntary Attendance at a Police Station](#)

16.47 In mid-May the situation between Stacey and Mr B had deteriorated irretrievably. Stacey had reported Mr B to the Police for damaging her property and verbally abusing her. The Police took a witness statement and had evidence of harassment and criminal damage. Whilst in the process of making this complaint Stacey was informed by her mother that Mr B had sent explicit images of her. This was recorded as a crime of malicious communication through disclosing private

sexual images. A few hours later Mr B was again at the property moving his belongings which had been placed outside and demanding more property.

16.48 The Police found Mr B a few streets away and seized his mobile phone and warned him to attend a Police station for a voluntary interview. This was contrary to the wishes of the investigating officer who wanted Mr B arrested as soon as he was found for the “revenge porn” offences (i.e., the images he had sent to Stacey’s mother). Mr B’s mobile phone was not returned to him and was disposed of by the Police after his trial.

16.49 Although Police officers have the discretion to make arrangements for suspects to attend a Police station for an interview, it was not appropriate in this situation because it gave Mr B the opportunity to dispose of evidence and construct an argument justifying his behaviour. Also, given his evident lack of compliance with warnings and advice given previously by the Police to leave Stacey alone, this less assertive approach may have reinforced his attitude that he could behave with impunity towards the Police.

16.50 While any comment on the impact of Mr B’s subsequent actions is speculative, his subsequent behaviour would bear out the view that he paid little regard to sanctions, including bail conditions that were imposed upon him, and he continued to intimidate and harass Stacey.

16.51 Stacey’s mother has also made a telling and relevant observation concerning the decision not to arrest Mr B for breach of bail. She believes, and there is some evidence to support this, that the failure of the Police to arrest Mr B for breach of bail conditions added to his sense of invulnerability and being either above or beyond the law. Equally, she ascertains that the failure of the Police to act reinforced Stacey’s feelings of helplessness and confirmed what Mr B had told her – that the Police would not help her.

16.52 If Mr B had been arrested at the first opportunity this would have been an opportunity to clarify the offences he had committed, which included the serious offence of stalking, secure the evidence of disclosing private sexual images as well as the offences of criminal damage.

16.53 The review understands that the practice of using voluntary attendance instead of arrest in domestic abuse cases has been challenged internally within Nottinghamshire Police as its use seems to be at odds with the Police’s commitment to take positive action in these cases.

#### Use of DASH assessments

16.54 DASH (Domestic Abuse, Stalking and Harassment and Honour-based violence) assessments were completed on five occasions in the period under review (including

the final fatal assault). DASH assessments are graded as high, medium or standard risk based on the answers given to a series of questions with some latitude for professional judgment on the part of the person completing the review.

16.55 DASH assessments can be completed by professionals from any agency but are most frequently used by the Police when they are called to domestic abuse incidents. In the Police, the completion of the DASH generates a task for the Domestic Abuse Risk Assessors (DASU) who will review and complete the risk assessment of the case, share information with partner agencies and assign interventions according to the risk level. Cases assessed as High Risk are immediately referred to the MARAC (Multi-Agency Risk Assessment Conference)<sup>20</sup>. With Medium Risk cases, there is an offer to arrange specialist support and further referrals may be made if children are involved or the victim is a vulnerable adult. Standard Risk cases are offered information to local support services including a 24-hour Domestic Abuse Helpline.

16.56 Incidents are not considered in isolation, and therefore several medium-risk incidents occurring in a short period may also result in a referral to MARAC. The Police have reviewed the assessments made in this case as part of their Independent Management Review and accepted that they are accurate based on information available at the time.

16.57 In the 14 years before the period under review, DASH assessments were completed for either Stacey or Mr B on five occasions, the last one being in October 2013. Of these, three were recorded as Standard Risk, one recorded as Medium Risk (Stacey informing the Police she was frightened of Mr B) and one recorded as High Risk (Mr B threatening to harm himself).

16.58 In the period under review five DASH assessments were completed. In June 2020, Mr B was the subject of the assessment following a complaint by him to the Police alleging that Stacey had threatened to destroy his property. The DASH forms assessed Mr B as a standard risk.

16.59 Stacey was the subject of the four remaining DASH assessments. In April 2021, the Police completed DASH forms identifying Stacey as a standard risk after a friend reported concerns about Mr B shouting at his children. Stacey confirmed to the Police that this had been a verbal argument and that no violence or damage to property had occurred. However, analysis of the Police Protection Notices (PPN) indicates that evidence of coercive and controlling behaviour was not identified and recorded as it should have been.

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<sup>20</sup> A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local Police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. The primary focus of the MARAC is to safeguard the adult victim and any children affected by abuse.

16.60 The remaining DASH assessments were completed in the week before the final fatal assault. The substance of the second complaint was a threat by Mr B to damage Stacey's property - specifically to "smash up the house." The DASH assessment recorded this as medium risk. However, at the time, the Police did not perceive that the threat to damage Stacey's property constituted a crime, and this incident should have been recorded and investigated as the offence of a threat to commit criminal damage. Stacey had also made disclosures which suggested that offences of stalking/harassment had been committed, and this was a missed opportunity to record this as a crime of stalking and possibly revise the DASH assessment.

16.61 The third DASH assessment followed a further threat by Mr B of harassment and damage to Stacey's property. In the course of making her witness statement, Stacey was notified by her mother that Mr B had sent explicit private images of Stacey to her. This was recorded as a crime of malicious communications and the DASH was recorded as medium risk.

16.62 The penultimate DASH assessment was completed the day before Stacey was murdered. Stacey had seen Mr B in her garden in the early hours of the morning in breach of his bail conditions. She had recently installed CCTV due to the ongoing harassment. The DASH assessment recorded this as medium risk. Unfortunately, further action was superseded by the final fatal assault which happened a few hours later.

16.63 It may be the case that the incidents happened too closely together for the significance of the escalating pattern to become apparent to the Police. Factors such as the decision to end the relationship, harassment, stalking (including following the children to the school bus), threatening messages and malicious communication and breach of bail conditions are all indicators of heightened risk.

16.64 It is significant that the only high-risk DASH assessment that was ever made was in relation to Mr B being at risk of harming himself. The assessments of the risks to Stacey were either medium or standard and do not seem to have considered the escalating pattern of harassment and the frequency of incidents. This may be a flaw in the DASH assessment tool and it requires updating, alternatively, there may be a training issue for the Police and other agencies who use DASH.

## 17. ANALYSIS

17.1 A fundamental finding of this report is that practitioners needed to demonstrate more effective professional curiosity. To do so frontline staff need an understanding of domestic abuse in general, but also further knowledge about the pattern of abusive relationships.

17.2 Indicators of the risk of further violence were apparent in Mr B's behaviour; the level of coercive control he had over Stacey and the increasing stalking and harassment as well as jealousy over the perceived new relationship and the inability to accept that his relationship was over were precursors of escalating violence. They were not the signs and symptoms of a person struggling to come to terms with the end of the relationship.

17.3 Monckton-Smith's 8-Stage Timeline<sup>21</sup> has been widely recognised as a useful analysis of the stages that many intimate partner abusive relationships go through. When we consider what is known about Mr B and Stacey's relationship alongside the 8 Stage Model the significance of particular events becomes more apparent, in particular, the heightened risk as Mr B's behaviour escalated could usefully have influenced charging and bail conditions and may also have led to Stacey being supported to obtain legal protection against Mr B.

17.4 The 8 stages identified by Monckton-Smith are sequential, but they will also overlap, as with any framework which attempts to describe human behaviour. The power of this model is that it militates against seeing incidents of domestic abuse in isolation, and suggests they are part of a continuum of behaviour and may also continue from one abusive relationship to the next.

17.5 The adoption of this model has implications both for the practice and supervision of practitioners working with domestic abuse. There is a need for improved communication between agencies and knowledge of legal provisions such as Clare's Law<sup>22</sup> and Domestic Abuse Prevention Notices<sup>23</sup>.

17.6 The 8 stages, with notes showing the relevant information shared as part of this Review, are as follows:

## **1. A pre-relationship history of stalking or abuse by the perpetrator.**

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<sup>21</sup> Professor Jane Monckton-Smith's work has been published in academic literature [Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide, Violence Against Women](#) and in her book "In Control, Dangerous Relationships and how they end in murder" 2021.

<sup>22</sup> The Domestic Violence Disclosure Scheme – commonly known as Clare's Law, is a process which allows the Police to share information about the background of a potentially violent partner with a person they are in a relationship with. The usual route for sharing information would be following a request from an individual to the Police to disclose information about the offending history of the person they were in a relationship with, this is known as the "right to ask." There is also a second pathway known as the "right to know" where the Police can take the initiative to disclose information to warn an individual about a potential threat.

<sup>23</sup> The purpose of the DVPO is to protect victims of domestic violence where there is insufficient evidence to charge a perpetrator and provide protection to victims via bail conditions.

*In 2002 a previous partner had called the Police to report that although she had left Mr B, he was trying to get into her parent's house (where she was living) with a knife. He was charged with harassment and pleaded guilty to possessing a bladed article in a public place and received a 12-month conditional discharge.*

**2. The romance develops quickly into a serious relationship.**

*Mr B and Stacey's oldest child was born soon after their relationship started. Having a child together is an obvious sign of the relationship becoming more serious.*

**3. The relationship becoming dominated by coercive control.**

*In 2011 Stacey contacted the Police and reported that during an argument Mr B had made threats to slit her throat if she left him and took the children. She said Mr B was saying they had no money and could not afford for her to go out drinking with her friends.*

*Finances remain a perpetual worry and are the basis for numerous arguments, in 2011 Mr B was arrested for attempting to pervert the course of justice whilst working as a door attendant.*

**4. A trigger to threaten the perpetrator's control – for example, the relationship ends, or the perpetrator gets into financial difficulty.**

*In 2013 there was the first record of Mr B threatening suicide following an argument with Stacey, she reported that she was frightened of Mr B and what he might do because she felt he was unstable and required a mental health assessment.*

**5. Escalation – an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide.**

*Between April 2021 and May 2021, there is a clear escalation in Mr B's abusive behaviour towards Stacey. The Police are called on a total of 8 occasions – sometimes on consecutive days. It is clear that Mr B is not paying any regard to the legal sanctions that have been imposed.*

*In one night, Mr B called Stacey 53 times and also sent sexually explicit photos of her to her mother.*

**6. The perpetrator has a change in thinking – choosing to move on, either through revenge or by homicide.**

*Stacey and Mr B separated in June 2020 after she discovered he had an affair with a work colleague. They both admitted their relationship was difficult after this and Stacey finally ended the relationship in April 2021.*

*Stacey began a new relationship in March 2021 and believed Mr B had found out about this in May 2021. Stacey's new relationship may have been a trigger for Mr B that his relationship with her was finally over.*

*Mr B took the third overdose in July 2020 allegedly following an argument with Stacey.*

**7. Planning – the perpetrator might buy weapons or seek opportunities to get the victim alone.**

*On the day before Mr B murdered Stacey CCTV recordings at his place of work show him purchasing a kitchen knife and practising stabbing a desk. He had also previously tried to cover the CCTV camera Stacey had set up.*

**8. Homicide – the perpetrator kills his or her partner and possibly hurts others such as the victim’s children.**

*Stacey was murdered in the garden of her home whilst her children were inside. Mr B did not attempt to flee the scene and had to be forcibly restrained by the Police to end his assault. His behaviour at the murder scene formed part of his defence of diminished responsibility.*

17.7 If we consider Mr B's behaviour as part of a pattern rather than separate episodes, then there is an understanding that there were potential opportunities to respond to him which may have prevented the fatal assault. An awareness of the 8-Stage Model may have provided the framework for exercising a more focused professional curiosity.

## 18. GOOD PRACTICE

18.1 These comments are made in the context of the limited amount of professional contact that agencies had with Mr B and Stacey.

18.2 It should be recognised that the Police log shows that they responded promptly to almost all of Stacey's calls for assistance. Lack of resources meant that on a few occasions, they were unable to assist Mr B in collecting his belongings immediately and he had to make an appointment with them to do this. However, this had no bearing on his subsequent behaviour.

18.3 Mental health services both at the hospital and in the community attempted to provide support to Mr B following his overdoses. Attempts were made to engage him in therapeutic services; the recognised treatment for adjustment disorders, but these were unsuccessful as he refused support.

18.4 Information from the Domestic Abuse Referral Team (DART) indicates that information was effectively shared across agencies that were relevant to supporting the children in 2013 and following Stacey's death.

## 19. LESSONS TO BE LEARNED

19.1 There is a need for a collective understanding of professional curiosity that is underpinned by theoretical knowledge of domestic abuse, an awareness of services for victims and perpetrators and a greater understanding of the legal options available.

19.2 The impact of living with domestic abuse on the children was for the most part overlooked and only recognised too late. An element of exercising professional curiosity is attempting to corroborate and validate information; in this case, an earlier referral to the DART (Domestic Abuse Referral Team) and Children's Social Care may have provided an opportunity to intervene to support the children.

19.3 This issue is being addressed through Police training plans across the force, especially for front-line officers. The office is responsible for managing the process of sharing information with partners are devising a training plan to deliver this message and the importance of identifying vulnerability regarding children in Domestic Abusive households.

19.4 At a senior level, agencies need to recognise the complexity and strain this work can place on individual practitioners and support their frontline staff and supervisors with support that recognises the personal impact this work can have.

19.5 The completion of the DASH/PPN should be recognised as part of the investigation and not seen only as a referral form for other services. It is also crucial that the DASH assessment is completed correctly, and all relevant risk factors are included; in this case, the escalation in threatening and harassing behaviour was overlooked and the evidence of stalking was missed.

19.6 The Mental Health assessment and diagnosis appear to have been made without any lateral checks and corroborative information from other agencies. The assessment of Mr B's relationship difficulties was based on his version of events which minimised the impact of his behaviour on Stacey and ignored any consideration of the children. The suggestion made by the consultant on the ward round that Relate counselling might be appropriate, suggests that the indicators of domestic abuse were not recognised.

19.7 The failure of the Police to arrest Mr B in the days before the final assault and the failure to locate him when he was hiding in the garden immediately before the fatal assault must be regarded as a missed opportunity. It is the family's firm belief that Stacey broke with her usual pattern of behaviour and went into the back garden based on the false reassurance that Mr B was not there whereas it would seem he was actually hiding.

19.8 Support services for perpetrators, victims, family and friends are available in Nottingham. It is important that up-to-date and accessible information is available on the range of services on offer and that frontline staff have access to this.

19.9 The family have also made several telling observations about their treatment in the immediate aftermath of Mr B's assault on Stacey. Firstly, they note that it was one of the children who first contacted their grandmother from the Police station to tell them they were being looked after by the Police after Mr B had attacked their mother.

19.10 A Police Officer then spoke to their grandmother and confirmed that there had been an incident, but refused to give any details, and while she confirmed that Stacey was in hospital, refused to say in which hospital she was being treated. The Police Officer then asked her to collect the children from the Police station. She was unable to do this, and they were returned to her home still in their pyjamas. When Stacey's mother arrived at work her colleagues had already heard about the incident on local radio, whilst no names were given, the location strongly suggested that Stacey was the likely victim.

19.11 The family strongly maintain that their treatment in the initial period following the fatal incident should have been better; firstly, the delay in contacting the grandmother to care for the children caused unnecessary distress. Secondly the reluctance of the Police Officer to share any useful information, even the address of the hospital added to the worry the grandmother felt for her daughter and grandchildren.

19.12 The family have also raised concerns about the process which led to Mr B being taken to the same hospital as Stacey (there is a routine check after people have been tasered). Mr B walked past members of Stacey's family, with Police Officers but not in handcuffs in a hospital waiting area at a time when they had no information about how serious her injuries were. To be confronted by the perpetrator at a time like this was enormously distressing for them and they have requested that measures are put in place to ensure that no other family is ever in this position in the future.

19.13 Finally, Stacey's mother and children are still waiting for her personal belongings to be returned by the Police six months after they were initially requested. These items include Stacey's mobile phone, tablet and laptop computer. These possessions have an emotional value for the family and knowing where they are and being able to keep them safe are important matters for them.

## 20. CONCLUSION

20.1 Stacey's murder followed a period of escalating abusive behaviour by Mr B, it is not known when he decided to murder her, but it was planned and deliberate.

20.2 the Police and Mental Health services did not have any meaningful contact with Stacey or Mr B. These agencies have analysed the information available to them at the time and recognise that there were indicators of heightened risk that were

not acted on. They recognise that there were opportunities to take preventative action and have instituted training and awareness raising to improve the response to similar cases in the future.

## 21. RECOMMENDATIONS

### Recommendation from Stacey's family

Stacey's family believe that there should be a national campaign supported by the Home Office to provide more information on television about domestic abuse and in particular, coercive control to raise public awareness and tell victims where they can get support.

### Nottingham Crime and Drugs Partnership<sup>24</sup>

1. Nottingham Crime and Drugs partnership should liaise with the Safeguarding Adults Board and Children Safeguarding Partnership Board, to ensure that the policy and training about professional curiosity are consistent across all partnership agencies.
2. Nottingham Crime and Drug partnership should work with the Police and the commissioned training provider (Equation) to ensure that training on Monckton Smith's 8-Stage Model is made available to partner agencies. The purpose of this is to support professional curiosity as part of the investigation and risk assessment in cases of adult and child abuse as well as domestic abuse.
3. Supervisors and first-line managers of services and agencies who contributed to this Domestic Homicide Review, where there is direct contact with service users should be asked to provide evidence to the Nottingham Crime and Drug Partnership Domestic Homicide Review Assurance, Learning and Implementation Group (DHR ALIG)<sup>25</sup> that supervision is used to discuss and reflect on the quality and outcome of risk assessments.
4. Nottingham Crime and Drugs Partnership should use commissioning processes to review how the training provider (Equation) works with businesses and commercial organisations in partnership with the Nottingham Business Improvement District (BID) to raise awareness about indicators of domestic abuse and mental health.

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<sup>24</sup> Nottingham Crime and Drugs Partnership is a statutory partnership under the Crime and Disorder Act 1998. It is a multi-agency organisation that plays a key strategic role in coordinating and monitoring domestic abuse services across the city and county. It is also responsible for tackling crime and substance misuse.

<sup>25</sup> Domestic Homicide Review Assurance, Learning and Implementation Group (DHR ALIG) looks at the systemwide and partner learning from the local DHR's.

5. The Nottingham Crime and Drugs Partnership should collaborate with partners including the Business Improvement District and the Police and Crime Commissioner to look at innovative ways to raise awareness of businesses and workers in the night-time economy (NTE) of the signs and indicators of domestic abuse.

6. The Nottingham Crime and Drugs Partnership should collaborate with the Police, Children's Social Care and other agencies to ensure that victims of abuse, particularly child victims of abuse are offered pre-trial therapy. The Partnership should seek assurance that pre-trial therapy is not delayed on account of an ongoing Police investigation or prosecution.

7. Future Domestic Homicide Reviews should ensure that appropriate enquiries are made at schools/colleges. Individual management reviews should be requested from schools. Representation from schools on future DHR Panels should be considered.

The following organisations made specific recommendations for their agency:

#### [Nottinghamshire Police](#)

a) Nottinghamshire Police communicate to staff that the completion of the PPN (Police Protection Notice) is part of the investigative process and that professional curiosity should be exercised when disclosures are made during this risk assessment process.

b) Nottinghamshire Police to focus on improving arrest rates and reducing the use of voluntary attendance for suspects in domestic abuse investigations. Chief Officers to provide clear guidance regarding positive action and the expectation of arrest over voluntary attendance.

c) Nottinghamshire Police have a Police Officer, 'SPOC,' dedicated to stalking crimes and, collaborating with partner agencies, holds a monthly "stalking clinic." This should be recognised as good practice and disseminated to other areas.

#### [Nottinghamshire Healthcare Foundation Trust](#)

d) Training and awareness-raising regarding professional curiosity to be more focused on an understanding of what this term means and its practical application.

e) For all inpatient units to be reminded of the Think Family approach to patients. This will include collating all demographic details regarding the patient's children or children they have contact with so the risks towards them can be fully assessed.

Training materials and Information briefings used within the Healthcare Foundation Trust regarding understanding family relationships to be updated and focused on adult services.

f) Mandatory DVA training to include information on factors that may increase the risk of serious harm from domestic abuse and the risk of referring to Relate

g) Increase awareness of the Police's role in domestic abuse and routes of communication with Police officers

## Appendix A

## 7 Minute Briefing

### Professional Curiosity

#### What is professional curiosity?

Professional curiosity is the ability to explore and understand what is happening with a family or adult. It is about not accepting a situation as it appears, especially if it does not 'feel' right. It requires practitioners to act upon their safeguarding responsibilities

rather than passively make assumptions or take matters at face value. A curious professional will enquire deeply by looking, listening and proactively questioning and challenging all those involved

#### Why professional curiosity is important?

A lack of professional curiosity is identified regularly by children and adult learning reviews when examining practice in which a child or adult has been harmed. Developing and maintaining a sense of professional curiosity is vital if practitioners are to work together to keep children and adults safe

#### Barriers to professional curiosity

- Not recognising 'disguised compliance'
- Being too optimistic about a case despite evidence of escalating risks
- Responding to each situation discretely rather than cumulatively
- 'Normalising' actions rather than recognising them for the risks they present
- Deferring to the view of a senior colleague who may not be familiar with the case
- Not recognising your own confirmation bias
- Ignoring information that refutes your view
- Having a 'gut feeling' that something is not right, but no evidence to act
- Allowing individuals to disrupt meetings so that difficult topics do not get discussed

#### Useful skills for being professionally curious

- Adopt a 'Think Family' approach
- Understand an individual's past to inform your assessment of the future
- Triangulate information from a range of practitioners and others
- Acknowledge your own values and personal bias can affect judgement
- Be respectfully nosy
- Use risk assessment tools alongside professional judgement
- Consider different theories and research to understand a situation
- Be open-minded and not take everything at face value
- Think the unthinkable; believe the unbelievable
- Consider how to articulate 'intuition' into an evidenced, professional view
- Review records, verify 'facts' and record accurately
- Pay as much attention to how people look and behave as to what they say
- Hold a multiagency meeting if you need support
- Take responsibility for the safeguarding role you play in the individual's life
- Have empathy for the lived experience of the individual
- Always try to see the person alone
- Be alert to those who prevent you from engaging with the individual

## Having difficult conversations

Raising subjects that are difficult to discuss, even amongst other practitioners, can be daunting, but effective safeguarding means addressing concerns and disagreements as well as challenging the views of others, despite knowing this could raise hostility. Practitioners need to be brave and hold these difficult conversations. So...

- Plan the conversation in advance
- Keep the agenda focused on the issues you need to discuss
- Focus on the needs of the service user
- Be non-confrontational, do not blame and stick to the facts
- Have evidence to back up what you say
- Ensure decision-making is justifiable and transparent
- Show empathy and compassion whilst being real and honest
- Acknowledge 'gut feelings' whilst seeking evidence to underpin those feelings
- Maintain a degree of healthy scepticism
- Recognise disguised compliance
- Apply professional judgement

## Top tips

Keep these top tips in mind when having difficult conversations

- Look, Listen, Ask, Check out
- Test out your professional hypothesis
- Do not be afraid to ask the obvious question and share concerns with others
- A 'fresh pair of eyes' on a case can help
- Focus on the need, voice and 'lived experience' of the individual
- Be confident in your own judgement
- Share your view with other practitioners, even if it differs from theirs

## Managers can develop practitioners' professional curiosity by:

- Playing 'devil's advocate' and challenging staff to think again about cases
- Presenting alternative hypotheses about what could be happening
- Setting up group supervision to stimulate debate and learning between team colleagues
- Presenting cases from the perspective of others involved
- Asking practitioners to show the evidence and 'working out' of their decisions
- Restricting caseload numbers and complexity
- Recognising when a practitioner is tired
- Recognising when a case could benefit from a fresh pair of eyes
- Not closing cases too quick

## More information

[www.researchinpractice.org.uk](http://www.researchinpractice.org.uk)

Nottingham City Safeguarding Adults Board

 [safeguarding.partnerships@nottinghamcity.gov.uk](mailto:safeguarding.partnerships@nottinghamcity.gov.uk)

## **Appendix B**

### **DHR Chaffinch Overview Report Action Plan – October 2022**

DHR Chaffinch is a homicide between ex-partners. Female victim is stabbed multiple times and strangled by her male ex-partner. There was an escalating pattern of abusive behaviour displayed by the offender to the victim from April 2021 onwards. The offender had previous history of domestic abuse, mental health and suicide/self-harm attempts.

This action plan is a live document and subject to change as outcomes are delivered.

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence: <ul style="list-style-type: none"> <li>• Key milestones achieved in enacting recommendation</li> <li>• Outcome</li> </ul> Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?	RAG
1	Stacey's family believe that there should be a national campaign supported by the Home Office to provide more information on television about domestic abuse and in particular, coercive control to raise public awareness and tell victims where they can get support.	Recommendation from Stacey's family to the Home Office	National	Home Office to review	Home Office			Home office to provide response to this recommendation.	Red
2	Nottingham Crime and Drugs partnership should liaise with the Safeguarding Adults Board and Children Safeguarding Partnership Board, to ensure that the policy and training about professional curiosity are consistent across all partnership agencies.	Professional curiosity is an issue identified in reviews across children, adults and DHRs.	Local	Professional Curiosity 7 Minute briefing circulated  Animation clip on Professional Curiosity to be developed	CDP	Jan 2023	Mar 2023	Professional Curiosity 7 minute briefing developed by Adult Safeguarding with consultation from DHR ALIG members and circulated to all agencies in Nottingham City on 8/11/2021  7-minute briefing 2-page professional c	Green

3	Nottingham Crime and Drug partnership should work with the police and the commissioned training provider (Equation) to ensure that training on Monckton Smith's 8 Stage Model is made available to partner agencies. The purpose of this is to support professional curiosity as part of the investigation and risk assessment in cases of adult and child abuse as well as domestic abuse.	This review highlighted the 8 stages that could be identified in this review to assist with agencies understanding the need for professional curiosity.	local	Seminar and bitesize clips to be made available.	CDP	July 2023	Apr 2023	<p>Police have received training by Jane Monckton Smith on 8 stages of Homicide.</p> <p>Seminar being developed with Equation and Author of this review to look at learning including 8 stages of homicide.</p> <p>Links Jane Monckton-Smith YouTube clips on 8 stages of Homicide to be circulated to agencies, made available on Equations website and expanded on in training sessions where it is already highlighted.</p> <p>8 stages of homicide clip on Equations website and presented at seminar on 18/4/23. Also included in Equations domestic abuse awareness training.</p>	Green
4	Supervisors and first-line managers of services and agencies who contributed to this Domestic Homicide Review, where there is direct contact with service users should be asked to provide evidence to the Nottingham Crime and Drug partnership Domestic Homicide Review Assurance, Learning and Implementation Group (DHR ALIG) <sup>1</sup> that supervision is used to discuss and reflect on the quality and outcome of risk assessments.	Assurance that questions are being asked and support to staff from supervisors / managers in doing this.	Local	All agencies to provide assurance to the CDP that this is now standard practice in supervisions	CDP	Dec 2023	Ongoing	Audit evidence will be requested as part of the Impact and Audit Statement submissions once the action plan is complete.	red

<sup>1</sup> Domestic Homicide Review Assurance, Learning and Implementation Group (DHR ALIG) looks at the systemwide and partner learning from the local DHR's

5	Nottingham Crime and Drugs Partnership should utilise commissioning processes to review how the training provider (Equation) works with businesses and commercial organisations in partnership with the Nottingham Business Improvement District (BID) to raise awareness about indicators of domestic abuse and mental health.	Assist with employers and colleagues understanding about the possible indicators regarding an employees mental health or that they are experiencing / perpetrating domestic abuse.	local	Seek funding to deliver training	CDP and Equation	Dec 2023	Ongoing	Business case being drafted to obtain funding from OPCC to facilitate work with the Night Time Economy and Local Businesses.	Amber
6	The Nottingham Crime and Drugs Partnership should collaborate with partners including the Business Improvement District and the Police and Crime Commissioner to look at innovative ways to raise awareness of businesses and workers in the night-time economy (NTE) of the signs and indicators of domestic abuse.	Assist with employers identifying that an employee may experiencing / perpetrating domestic abuse.	local	Seek funding to deliver training	CDP and Equation	Dec 2023	Ongoing	Business case being drafted to obtain funding from OPCC to facilitate work with the Night Time Economy and Local Businesses.	Amber

## DHR Chaffinch IMR Agency Actions

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence <ul style="list-style-type: none"> <li>• Key milestones achieved in enacting recommendation</li> <li>• Outcome</li> </ul>	RAG
<b>Nottingham Healthcare Foundation Trust (NHCFT)</b>							
1.1	Training for staff on professional curiosity.	This will enhance the information that has been made available to staff already as part of the safeguarding team's newsletter. Including asking further questions around intimate relationships and Think Family.	Staff Training		<b>March 2022</b>	<p>Link practitioners event in March 2022 included a session on professional curiosity. The purpose of the link practitioners network is to ensure that learning is disseminated to teams</p> <p>Spotlight on Safeguarding is a Trustwide communication on safeguarding, which is produced quarterly. The Spring 2021 edition contains a 'Spotlight on Professional Curiosity' article. This publication is shared widely across the Trust</p>	Green
1.2	For all inpatient units to be reminded of the Think Family approach to patients. This will include collating all demographic details regarding patient's children or children they have contact with so the risks towards them can be fully assessed.	The safeguarding needs of the children were not recognised as they did not live in the same house as them	Training and development of guidance and tools		<b>June 2022</b>	<p>A new safeguarding adults template has been launched across the trust. This provides guidance for staff when safeguarding and domestic abuse issues are identified. Including prompts to 'Think Family'.</p> <p>A safeguarding Childrens template is being developed</p> <p>Risk assessments include space for any children that a service user has regular contact with to be identified.</p> <p>Service to send out briefing to all staff to remind them to ask more questions about non-resident children.</p>	Green
1.3	For all inpatient units to ensure patient contact details are accurate and up to date	The inaccuracies in Mr X's address and contact details made it more difficult for CRHT to make contact and see in the community			<b>June 2022</b>	This will be highlighted at the quality and risk meetings within adult mental health, ensuring the importance is highlighted with all teams	Green
1.4	A briefing on escalation risks in domestic abuse cases. This links to concerns regarding the recent separation and Ms A attempting to end the relationship.	The inaccuracies in Mr X's address and contact details made it more difficult for CRHT to make contact and see in the community	Learning to relevant teams		<b>June 2022</b>	<p>Link practitioners session held in June 2022 included a presentation on the 8 stages of domestic homicide. With the aim of supporting staff to recognise when abuse is escalating</p> <p>18.8.22 Equation Courses regularly circulated through learning and development for staff attendance regarding DVA risk assessment.</p> <p>A short briefing on DASHric and MARAC has been available to teams since August 2018.</p> <p>NHCT does have a Perpetrator toolkit which is available via our intranet site.</p> <p>NHCT has a training package on domestic abuse, it also has an e learning package on domestic abuse.</p>	Green

1.5	Better multi-agency communication with the police	Improve agency response to domestic abuse	Staff Training		June 2022	<p>A full-time Partnership Police officer has been employed by the Trust. They are based at Highbury Hospital and Sherwood Oaks and will support in tackling crime across the hospitals. Links between the officer and the safeguarding team are being developed.</p> <p>Meeting planned with PPU officers and safeguarding to consider how to improve information sharing and escalation of concerns</p>	Green
1.6	For the process around 7 day opt in letters from CRHT to be reviewed by the Service.	Improve partnership working with police colleagues	Improve communication and information sharing		June 2022	The process has been reviewed and service users are now able to self refer so there is no longer a need for a 7 day opt-in	Green
1.7	For a briefing to be circulated to staff regarding the difference between relationship difficulties and domestic abuse and to not recommend Relate relationship counselling for any cases where there is identified domestic abuse.	Improve agency understanding and response to domestic abuse	Staff briefings		August 2022	<p>Session planned for link practitioners in January 2023 on recognising the difference between relationship difficulties and domestic abuse</p> <p>Brief session being developed regarding the difference between relationship difficulties and domestic abuse which can be used by teams to start discussions around this theme, with facilitated support offered if required</p>	Green
<b>Notts Police</b>							
2.1	Nottinghamshire Police communicate to staff that the completion of the PPN is part of the investigative process and that professional curiosity should be exercised when disclosures are made during this risk assessment process.	Improve performance and better identification of risk			1 <sup>st</sup> August 2022	<p>Nottinghamshire Police have extensively communicated the need for professional curiosity and awareness to vulnerability across the force. To drive this awareness a vulnerability education campaign has been launched internally called "Know It, Spot It, Stop It" which aims to highlight all areas of vulnerability and drive staff to take positive actions when dealing with vulnerable people. These actions include use of PPN and where necessary arresting suspects as opposed to use of voluntary attendance (where grounds allow).</p> <p>Between April 2022 and to date 194 new members of staff have received bespoke vulnerability training which includes the need for being professionally curious. Additional communications have been released internally again prompting the use of proactive measures to support victims including submitting PPN's, use of BWV to support Evidence Led Prosecutions (where the victim does not wish to provide statement), and early arrest of suspects.</p> <p>Staffing in the DASU and MASH have been reviewed and secondary safeguards put in place to ensure that PPN's are not missed and are correctly assessed. This includes a Detective Sergeant reviewing relevant incidents on a daily basis and ensuring a PPN was submitted and correctly completed. Where a PPN is not submitted or incorrectly completed the officer responsible, and their supervisor are contacted and provided direct feedback.</p>	Green

2.2	<p>Nottinghamshire Police to focus on improving arrest rates and reducing the use of voluntary attendance for suspects in domestic abuse investigations. Chief Officers to provide clear guidance regarding positive action and the expectation of arrest over voluntary attendance.</p>	<p>Improve positive outcomes and improve practice.</p>			<p><b>1<sup>st</sup> August 2022</b></p>	<p>As per the above a lot of work has been undertaken to ensure that all frontline officers know that the use of proactive measures are required when dealing with a victim of domestic abuse. Part of this work includes reinforcing the arrest of suspects as opposed to use of voluntary attendance where grounds allow. This is a key part of the "Stop it" phase of the Know it, Spot it, Stop it training as referenced above. Further communications have been released to all staff enforcing this message, including communications from Assistant Chief Constable (ACC) Rob Griffin, and additional guidance on S.24 of PACE (grounds for arrest). This approach has seen an increase in DA  Related arrests:  August 2021 – 36.92% arrests  June 2022 – 45.37%</p> <p>90% of High-Risk DA offences resulted in suspects being arrested.</p>	<p>Green</p>
2.3	<p>Nottinghamshire Police have a Police Officer, 'SPOC', dedicated to stalking crimes and, working together with partner agencies, hold a monthly "stalking clinic". This is not happening elsewhere in the region and should be recognised as good practice.</p>				<p><b>1<sup>st</sup> August 2022</b></p>	<p>Nottinghamshire police have implemented the Stalking Clinic as a pioneering project. This scheme has been very successful and has been shared with the region for consideration elsewhere.</p> <p>The stalking clinic is operating well and plans are in place for expanding its capability by integrating an "Orders team" within the unit. This team will work closely with the clinic to ensure that all opportunities are used to implement civil orders to improve suspect management and safeguard the victim.</p>	<p>Green</p>

## Appendix C



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31<sup>st</sup> October 2023

Dear Sharon,

Thank you for resubmitting the report (Stacey) for Nottingham Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in October 2023.

The QA Panel felt the review is sympathetic to the victim and tries to understand her mindset. The pen picture provided by Stacey's mother is very warm and provides an insight into Stacey as a daughter, sister, mother, friend, and a person.

They felt the report featured a good level of family engagement and it is clear the family were able to make a recommendation in the report on improving the public's awareness of domestic abuse, particularly coercive control during prime-time television viewing to raise awareness. There is constant reference throughout the report in relation to the impact of abuse for the children which is commended.

The Panel noted that the action plan is well populated and single agency recommendations complete. There is violence against women and girls (VAWG) sector representation on the panel which is good practice. Finally, the panel felt that there is a good use of Jane Monckton Smith's homicide timeline, using examples to show how it fits the case.

The Home Office noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to [DHREnquiries@homeoffice.gov.uk](mailto:DHREnquiries@homeoffice.gov.uk). This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at [DHR@domesticabusecommissioner.independent.gov.uk](mailto:DHR@domesticabusecommissioner.independent.gov.uk)

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,



**Lynne Abrams**

Chair of the Home Office DHR Quality Assurance Panel