Rushcliffe Borough Council

South Nottinghamshire Community Safety Partnership

Domestic Homicide Review Report Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Tara
in October 2016

Report Author: Christine Graham
October 2021

A tribute to Tara from her family

Losing a child is a parent's worst nightmare but the way in which we lost Tara makes it even harder to bear or understand. Finding the words to describe the level of loss, the deep sadness and the emptiness is exceptionally difficult.

Tara was born two weeks early. The labour was long and painful, but when I held her in my arms for the first time, I was overwhelmed with love for her. She had lots of dark hair and I lay awake, just looking at her thinking how beautiful she was.

As a toddler she could be a little Miss Mischief sometimes, she loved her nursery school and liked to play Mary in the nativity play. She wanted, from an early age for everything to be "just so", neat and tidy and was very independent. She used to regularly say "mummy I'll do it"!

She tended to keep things to herself, wanting to try and sort them out without bothering me. She was bullied twice at school, I only found out when she was in tears and when the school told me. Her independence sometimes prevented her sharing problems, even though we were incredibly close.

Tara loved and protected her brother and sister and from an early age she was demonstrating a real motherly instinct. As she grew up, she was supportive and loving to her cousins. All these caring attributes really came to the fore when she became a mum herself.

Tara did well at school and wanted to be a mid-wife. Her caring nature and love of children would have served her well in this role. She commenced a college course in Health and Social Care, and volunteered for Home Start, providing support for families with young children who were struggling to cope, again demonstrating her caring, maternal nature. She also volunteered for the Air Ambulance shop in West Bridgford. Her life was beginning again, and she got great satisfaction from helping others, often helping other mothers with both advice and practical assistance.

Thankfully we have been left her three precious children and believe me she will always live on in them. They have inherited many of their mother's qualities, her quirky sense of humour and love of music and dance. It saddens me to the core to know that she missed her daughter's first day at school and the first day at secondary school of one of her sons. There will be so many milestones in their lives that she will not be here to share with them, and this breaks my heart.

My daughter's children were her world she had always kept them spotlessly clean and well dressed. Despite what they witnessed and suffered they have grown in confidence during the period they have been living with us. The older ones are doing better than expected at secondary school and the youngest is described as a ray of sunshine by all the teachers at her school. She is always smiling and makes friends with all the children throughout the school.

Obviously, the amount of time spent with them whilst their mother was alive has helped with their transition to living with us but that also makes it difficult as it does

remind us of those many, many times we shared together. It is so sad that the memories of the last holiday we shared, one of the best two weeks ever, should be tainted by what happened on our return.

We, the family, have been handed a life sentence of unbearable grief and there are no words that come close to the impact her death and the circumstances surrounding it have had on our family. No mother, father, brother, sister or child should have to experience this.

The emotional and physical pain I feel is incredible and unimaginable, I find it difficult to talk about my grandchildren's mother, my daughter in the past tense. I feel broken. Part of me feels I cannot be happy, the pain in my stomach is constant, it is the most painful feeling I have ever felt. It's an agonising pain in my stomach, It's sleepless nights. It's mental and physical exhaustion. It's nightmares, sleeping pills and anti-depressants.

Hindsight is a torture, my daughter's death should have been preventable, and I am constantly going over things in my head, as I lie awake at night, different visions and outcomes playing over and over again. People tell me that I could not have prevented this awful tragedy, but as a mother I cannot accept this and will always think differently.

Tara wasn't just my daughter she was also my best friend; I love her so much and I will miss her forever.

Contents

1 The review process

1.1 This summary outlines the process undertaken by South Nottinghamshire Community Safety Partnership Domestic Homicide Review Panel in reviewing the homicide of Tara who was a resident in their area.

1.2 The circumstances that led to the review were that during the early hours of a Tuesday in October 2016, Tara's partner took their children to his sister's home before going to the police station where he told an officer that he thought he had killed his girlfriend. He was arrested and police went to the home.

1.3 When they arrived, they found Tara had been severely beaten and was dead in the house. A murder investigation was commenced.

1.4 A post-mortem was conducted and thirty-seven external injuries together with six internal injuries were recorded. These are summarised as:

- Extensive bruising to her body including bruises to her face, left breast, front of her upper abdomen, inner and outer aspects of her legs, inner and outer aspects of her arms, front and back of her left shoulder, back of her right hand and fingers and the back of her left wrist and fingers, her back and buttocks
- Abrasions to her face
- Full thickness lacerations to her forehead, top of her head, back of head and bruising underlying the scalp injuries
- A torn upper frenulum
- Five fractured ribs
- A punctured lung

1.5 The conclusion of the post-mortem was that these horrific injuries were not enough to kill her, but that the amount of cocaine in Tara's system was enough to kill her: the cause of death was recorded as cocaine toxicity. This review will return to discuss this in more detail later within this report.

1.6 Given the findings of the post-mortem, it was considered that there was not sufficient evidence to charge Tara's partner with causing her death. He was, therefore, charged with intentionally causing her grievous bodily harm. He pleaded not guilty to this charge, but at his trial in February 2018, he was found guilty. He was sentenced to 15 years imprisonment with a further licence period of three years.

1.7 Tara's family have specifically requested that her name is used. The following pseudonyms have been used for others during this review:

Tara's partner will be referred to as Adult M.
Other partners of Adult M will be referred to as Partner A, B and C.
The male with whom Tara had a historic relationship is referred to as Adult O.

1.8 On 21st February 2017, a meeting was held to determine whether a Domestic Homicide Review should be held. Investigators were concerned as the Home Office pathologist was of the view that Tara had not died as a result of homicide. A Domestic Homicide Review and a Safeguarding Adults Review (SAR) were considered but it was agreed that the criteria were not met for either. This decision was then ratified at the SAR sub-group meeting on 3rd March 2017.

1.9 On 12th September 2017, South Nottinghamshire Community Safety Partnership (CSP) received an email from AAFDA[1] asking if a Domestic Homicide Review had been commissioned in respect of Tara's death. This led to the latest amendments to the Home Office guidance being consulted, specifically that there was no longer a requirement for a homicide to have taken place in order for there to be a Domestic Homicide Review.

1.10 Enquiries were made of Nottinghamshire Police and on 18th September an outline of what had happened to Tara was sent, along with a request that the CSP consider commissioning a Domestic Homicide Review.

1.11 On 17th October 2017, the CSP agreed that a Domestic Homicide Review was required and that an Independent Chair and Report Author would be commissioned. The Home Office were also notified of the decision. The review notes that this was within one month of the notification as required within the statutory guidance. The review then commenced in December 2017.

1.12 The first panel meeting was held on 6th December 2017. The panel met on three further occasions, with the last meeting being on 4th October 2018. The report was subsequently submitted to the Home Office.

1.13 The Overview Report was considered by the Home Office Quality Assurance Panel on 11th December 2019. Following this meeting, it was suggested to the Community Safety Partnership that a new Chair and Report Author be appointed to address issues identified through the quality assurance process.

1.14 In February 2020, Gary Goose and Christine Graham were appointed to undertake this role. It was agreed that they would redraft the report rather than make amendments to the original report submitted.

1.15 The IMRs and chronologies were provided, along with the original report. The sentencing remarks of the trial, transcript of the coroner's summing up, and conclusion of the fact-finding hearing held in the Family Court, have also been used as source documents. Some further enquiries were made in order that the rewrite could be drafted.

1.16 The trial of Tara's partner was held in March 2018.

[1] Advocacy After Fatal Domestic Abuse

1.17 In July 2018, the Family Court held a Finding of Fact hearing as part of the Care Proceedings to determine the future arrangements for Tara's children.

1.18 An inquest was held by the coroner and concluded in December 2018.

1.19 These reports have all been used to draw on when writing this report. Particular attention is paid to the Care Proceedings as in this case the judge heard live evidence from witnesses and therefore this evidence and thus the findings have been tested.

1.20 Tara's family were considered as integral stakeholders to the revisiting of this review. Unfortunately, arrangements made to meet the family coincided with the COVID-19 lockdown. In June 2020, an online meeting was held, and the review progressed in light of this meeting.

1.21 The family had a copy of the draft report to consider in their own time with the support of their AAFDA advocate. The Chair and Report Author met with Tara's family in order to discuss their feedback. Additional enquiries and revisions were made in light of these discussions. The final version was largely agreed by Tara's family. Any areas of continued disagreement are noted within this report.

1.22 Following a process of further panel meetings and CSP scrutiny, this report is now resubmitted to the Home Office.

2 Contributors to the Review

2.1 Individual Management Reviews and chronologies were then commissioned from:

- Children's Social Care – Nottinghamshire County Council
- Greater Nottingham Clinical Commissioning Group – on behalf of GP
- Metropolitan Housing
- NHS Nottingham North and East Clinical Commissioning Group – on behalf of GP
- Nottinghamshire Healthcare NHS Trust
- Nottinghamshire Police
- Women's Aid Integrated Services

2.2 The original review confirmed the IMRs were completed by author's independent of any prior direct involvement in this case.

3 The Review Panel Members

3.1 The members of the original Review Panel were:

Name	Organisation
Tony Webster	EMSOU
Rhonda Christian	NHS Nottingham CCG

Jean Gregory	NHS Nottinghamshire North and East CCG
Claire Sampson	Nottinghamshire County Council – Children's Services
Tony Shardlow	Nottinghamshire County Council – Community Safety
Julie Gardner	Nottinghamshire Healthcare NHS Trust
Leigh Sanders (replaced by Rob Severn)	Nottinghamshire Police
David Banks	Rushcliffe Borough Council
Jennifer Allison	Women's Aid Integrated Services
Rebecca Smith	Women's Aid Integrated Services

3.2 Given the time that had elapsed, a number of the panel members had moved on or retired. Therefore, a new panel was convened to consider the redrafted report. The members of this panel were:

Name	**Organisation**
Stuart Prior	EMSOU
Chris Bull	Metropolitan Thames Valley Housing
Nick Judge	NHS Nottingham CCG
Claire Sampson	Nottinghamshire County Council – Children's Services
Hannah Hogg	Nottinghamshire Healthcare NHS Trust
Clare Dean	Nottinghamshire Police
Geoff Carpenter	Rushcliffe Borough Council
Rebecca Smith	Women's Aid Integrated Services

3.3 Tara's mother and stepfather had requested to meet the Review Panel, but this had not occurred. On 25th September 2020, they met with this newly convened Review Panel, supported by their AAFDA advocate.

4 Domestic Homicide Review Chair and Overview Report Author

4.1 The Report Author did not feel it was appropriate or professional to add information about the previous Chair.

4.2 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high- profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011, Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility as well as substance misuse and housing services. Gary concluded his employment with the local

authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

4.3 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

4.4 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim ;and, reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England and Adult Care Reviews.

4.5 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[2]

4.6 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports. Appendix Two sets out the ongoing professional development of the Chair and Report Author.

5 Summary Chronology

5.1 Tara and Adult M became a couple when she was 15 and he was 20 (2003). Tara had her first baby when she was just 16 years old. The couple continued in an 'on-off' relationship up until the time that she died. There was a particularly lengthy separation between 2005 and 2012, when Tara became pregnant, but they remained in contact during this time.

5.2 Tara's family described how Tara was never her usual bubbly self when she was with Adult M. They said that because of his influence she never lived up

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

to her full potential. Her friends said that she had always been bright, bubbly and friendly but this all changed when she met Adult M. She became withdrawn, private and was 'up and down' in mood especially on the frequent occasions that she and Adult M had fallen out.

5.3 A full chronology of events and a summary of information known by family, friends and agencies is contained within the overview report. Findings of Fact from the Family Court hearing is also included in the chronology. The chronology includes some incidents outside the scope of the review that are relevant to the review, particularly in helping us to understand the 'on-off' nature of the relationship between Tara and Adult M.

5.4 In 2005 Tara's grandmother and uncle attended her home and found her upset. Tara told her grandmother that Adult M had kicked her in the stomach when she was pregnant and holding her child. She was worried that she would lose the baby. In September however, Tara gave birth to her second child. Adult M says that they separated a week later and remained separated until 2012. However, Tara's family maintain that the relationship was 'on-off' throughout this time.

5.5 There were a number of incidents that Tara's family cite as assaults or threats by Male M during this time (2006, 2007, 2008). Some of those were reported to the police, some were not. Tara's children certainly were present during some of those incidents. Information was shared between agencies and court proceedings were instigated in relation to child contact.

5.6 The view recorded by Children's Social Care in relation to the children was that Tara was taking steps to protect them and that because the couple were separated, there was no requirement for any further action by them.

5.7 An indication of the level of difficulty that existed between the couple during this time is that 'arranged' handovers of the children for access were to take place outside the police station, although it appears that this did not always take place.

5.8 During 2011 Male M was involved in a further abusive relationship with another partner that required police involvement. No prosecution ensued. The police were also called by Tara following an incident when Male M refused to return the children to her, citing her as under the influence of alcohol at the time as the reason. The children were returned the following day, but it illustrative of the continued breakdown of any relationship between the two.

5.9 During 2012 Adult M came back into Tara's life and a form of relationship began again. Tara fell pregnant again.

5.10 According to her family, Adult M beat up Tara over the course of an hour by punching her in her side and kicking her, causing bruising to the left side of her body.

5.11 In July 2013, Tara gave birth to her third child.

5.12 The following year Tara reported a verbal altercation with her partner, Adult M, at her home address. When officers arrived, Adult M was confrontational with them. He was removed to a friend's address to prevent a breach of the peace. The children were all present at the address and DASH risk assessments were completed with Tara. It was classified as a domestic incident where there had been a verbal argument. The level of risk was classified as MEDIUM and the assessment was submitted to the Domestic Abuse Support Unit (DASU). The risk assessor submitted the DASH report to the Multi-Agency Safeguarding Hub (MASH) after endorsing the risk assessment. A MASH domestic abuse meeting was held, and it was agreed that:

- A MASH enquiry would take place to gather all the relevant information regarding the children
- The MEDIUM risk assessment would remain in place
- Children's Social Care (CSC) would make contact with Tara
- The information held by the police would be shared with CSC

5.13 The CSC assessment concluded that the current and historic domestic abuse did not meet the threshold for continued CSC involvement.

5.14 During 2015, Adult M began a relationship with another woman and moved in with her in April. Moving back with Tara later in the same year.

5.15 At some point in 2016, another woman became pregnant by Adult M: she told Tara that Adult M intended to leave the family to be with her.

5.16 Between June and October 2016. The family say that the children were exposed to an escalation in Adult M's controlling and abusive behaviour towards Tara. During this time, there were repeated arguments about Tara's relationship with Adult O. These arguments were heard by the children, who were required to spend long periods upstairs. Adult M assaulted Tara to such an extent that he caused fractures to her ribs. Photos found on Tara's camera showed bruising to Tara's neck consistent with hands being held around her throat.

5.17 During July, a friend saw Tara at the swimming pool and described that she 'appeared to be very anxious and out of character', rushing the children away to get changed and home. Her friend saw her again later in July, when she appeared anxious.

5.18 At the end of July, Tara's mother and stepfather saw her and Adult M at a local pub having a drink. After a brief chat, they sat at separate tables because Adult M did not like dogs (and they had their dog with them). Whilst returning from the toilets to the garden where they were sitting, Tara's mother was met by Tara going in the opposite direction. Tara put her arm around her mum and said, 'love you mum'.

5.19 In early August, Tara telephoned her mother and was hysterical saying that Adult M was going to take the children away. Her mother could hear Adult M in the background shouting, 'what are you feeling fucking sorry for. It's me you should be sorry for'. They say Adult M assaulted Tara and caused bruising to her: this was witnessed by the children.

5.20 On 1st August, Adult M's mother reported him as a missing person. She said he had last been seen on 27th July. He was recorded as a missing person on COMPACT[3] and enquiries were made to locate him. Within the report, it was recorded that Adult M was seeing a female and her boyfriend was seeking him out, with this being a potential reason for him being missing. After a number of further telephone calls he was later found to be at Tara's address. He said that he had been sleeping rough in his car for a few days. Tara's family are clear that he had been living at Tara's address since September 2015 and although he parked his car away from the house so that he could not be traced, he had not been sleeping rough.

5.21 Tara's mother contacted the police on 2nd August to report that she was concerned for the safety of Tara and her children from Adult M. She said that Tara had been acting out of character recently and she may be in a bad domestic situation. Officers visited the address and carried out a welfare check on Tara. She was found to be safe and well and reported no domestic incidents or abuse[4]. The children were not seen during this visit and her mother was updated.

5.22 Adult M told Tara's mother that Tara was depressed and that she just wanted him and did not want to see other people. Tara's mother was surprised as she saw no sign of depression when they had met a couple of days earlier so told Adult M to take Tara to the GP if she was depressed. He responded that he would 'sort her out'.

5.23 On a day, most likely to be at the end of September, Adult M assaulted Tara to such an extent that he caused serious injury to her arm. Medical assistance was not sought, and her arm was treated with a 'cast' purchased from the internet: it remained painful until the date she died.

5.24 In October, Tara was seen by her grandmother crouched on the bed on all fours (on her hands and knees), with the left side of her face down on the pillow. She told her grandmother she had an ear infection, and she was too weak to go to the doctors. Her grandmother told Adult M that Tara needed to see a doctor and gave him a telephone number. There is no evidence that he took her for medical treatment.

[3] This is the Nottinghamshire Police Missing Person investigation and recording system. It records persons reported missing, assessment of risk and the investigative actions/tasks undertaken during the investigation.

[4] The officer who attended was spoken to by the original Chair and although he had very little recollection of the incident due to the passage of time, he has said that, under the circumstances he would have spoken to Tara alone. He said that if he had any concerns at all for the children, he would have put the appropriate safeguarding measures in place and put in a referral to CSC.

5.25 From 22nd – 24th October, the children were present in the family home when Adult M committed a sustained assault on Tara. They heard shouting, Tara screaming, and Tara being assaulted by Adult M.

5.26 On 25th October Tara died at her home.

6 Key issues arising from the review

6.1 Tara and her partner had what many have described as an 'on-off' relationship. He moved out of the family home on numerous occasions throughout the years that they were together. He had relationships with other women throughout the time of their relationship. The judge in sentencing said, 'What is beyond question is that Tara's relationship with you was bad for her'.

6.2 Tara was a teenager who was very sensitive and wanted to please people and do her best. She had a place at college to study childcare and was described as not being 'worldly wise'. She had not been in touch with her birth father for a number of years and it is possible that she craved attention from a man. The review has been told that she wanted a 'happy ever after' relationship with a mother and father for her children

6.3 Adult M was seeing one of Tara's friends and he then got involved with Tara[5]. Tara did not tell her mother about the relationship initially and this secrecy was very out of character for Tara. This secrecy may have been a key part of his initial grooming of Tara[6].

6.4 She became pregnant, four months into the relationship, when she was 15 and Adult M was 20. Tara only disclosed the relationship and pregnancy to her mother when her mother recognised the signs and confronted her. Tara was treated by her GP, midwife and the local hospital for the pregnancy. Because Tara came from a supportive family and she was going to, initially, live with them, there was no referral made to Children's Social Care. It is important that we remember that she was a child and he was an adult.

6.5 The role of drugs, namely cocaine and alcohol, in this review is very important as the pathologist's finding was that Tara died of cocaine toxicity. The review seeks, in no way, to question the finding of the pathologist that the amount of cocaine found in Tara's blood stream was sufficient to kill her.

6.6 However, the evidence presented to the inquest, the Family Court hearing, and statements made to the police, does leave a number of unanswered questions about how she ingested the cocaine that led to her death. The fact that she was severely beaten by Adult M before her death is not in question.

6.7 The abuse she suffered at the hands of Adult M had gone on for so long that the whole family, including the children, were used to covering up the

[5] The review is aware that he continued to encourage relationships and interest with teenage girls for a number of years, into his thirties.
[6] How He Gets Into Her Head: The Mind of the Male Intimate Abuser, Hennessey, Atrium, 2012, p42

problems and they all knew the things to avoid saying and doing that would upset Adult M.

6.8 The judge, in his sentencing remarks, said that there was evidence that Adult M 'domineered, controlled and bullied Tara' and that to him this was 'crystal clear'.

6.9 Tara's child described Adult M as being 'controlling', saying that his father 'wanted things done his way' and did not 'allow his mother to do things on her own'. The person who interviewed the children for the Care Proceedings considered that it was clear that Tara's child attributed the entire responsibility for the arguments to his father.

6.10 Her friends described how Adult M did not like Tara to go out without him. When he was working as a barman, he would insist that she went there to be with him. When she arrived, he would flirt with another woman behind the bar, just to embarrass or belittle Tara.

6.11 Tara would not say a bad word against Adult M and explained away her bruising and withdrawn state to her family, friends and children. In contrast, he blamed her for everything. In evidence to the Family Court, he contended that she was responsible for his numerous infidelities as she had driven him to this by not making herself available to him.

6.12 Tara's family all described her being more withdrawn when she was with Adult M (when the couple were together) to the extent that they considered Adult M to be very controlling of her.

6.13 We know that Adult M had, on at least one occasion, been through Tara's phone to search for material that she might be hiding from him. This was how he found out about the relationship that Tara had with Adult O.

6.14 Tara's family have made the review aware that he did not acknowledge Tara in his social media profile. There was nothing in this profile and activity to suggest that he and Tara were together.

6.15 The previous report contained a recommendation that the Community Safety Partnership worked to raise awareness of coercive and controlling behaviour. In particular, the emphasis should be given to recognising what constitutes coercive control, providing practical advice to anyone who has a suspicion that either they or someone they know may be a victim of controlling or coercive behaviour, including the signs that they should look out for and where a victim can go for help.

6.16 Since the completion of that report, the Community Safety Partnership has commissioned training, delivered by Equation, that sets out the offence of controlling and coercive behaviour and helps practitioners to identify the signs that they should look for. The training was delivered to the three local authorities in the South Nottinghamshire area. All staff receive adult

safeguarding training every two years, and this has been updated to include coercive control.

6.17 It is clear that Tara was frightened of Adult M, he took away her autonomy and fighting spirit, he used her when it suited him, isolated her, involved the children, subjected her to economic abuse and was verbally and physicaly abusive.

6.18 A number of agencies were aware of the relationship between Tara and Adult M, and some of the risk that was posed. The true level of risk was not identified however; a combination of taking reports at 'face value' (in particular when a victim minimises an offenders actions), a belief that the couple had separated thus the risk was lower, a lack of 'consent' from the victim resulting in agencies not feeling able to speak to others, in particular family members, who may have been able to add valuable and independent information, all led to this position.

6.19 Each agency believed that they acted appropriately in all the circumstances. Culminatively however, the systems in place failed to protect Tara from a severe assault at the hands of Adult M. There were missed opportunities. There has been change in practice in some areas of work that would make a difference now. This review believes that the recommendations made by this review will make the future safer for others.

7 Lessons Identified

7.1 Nottinghamshire Police

7.1.1 There were grounds for changing the interventions offered to those victims assessed as being at MEDIUM risk. The additional interventions that are being offered are noted.

7.2 Children's Social Care

7.2.1 If contact details are given for support agencies, this should be recorded in the notes.

7.3 South Nottinghamshire Community Safety Partnership

7.3.1 The review has reinforced the understanding among professionals that coercive and controlling behaviour is the most hidden and, therefore, difficult to identify aspect of domestic abuse, but its effects are no less for a victim. Adult M stripped away Tara's freedom to choose for herself how she lived her life.

8 Recommendations from the review

8.1 South Nottinghamshire Community Safety Partnership

8.1.1 That the Community Safety Partnership ensures that training on coercive control is provided to all new staff in the local authority and that the provision of the training is extended to cover all agencies within the Community Safety Partnership[7].

8.2 Nottinghamshire Police

8.2.1 That Nottinghamshire Police provides reassurance to the CSP that evidence led prosecutions are now considered more robustly in all domestic abuse cases.

8.3 Nottinghamshire County Council – Children's Social Care

8.3.1 That CSC ensures that social work teams have up-to-date information to give to families in respect of support services for victims of domestic abuse.

8.3.2 Given the time since the IMR was written, that CSC provides reassurance to the CSP that this is now routine and provide an explanation about how this reassurance has been arrived at. That CSC are more persistent in contacting agencies if parents refuse as part of an initial assessment or where the concerns are significant enough for this to be done without consent. The review acknowledges that CSC works with parents to understand the importance of sharing information with their consent to support the protection of their children.

8.4 National Government

8.4.1 That the Government considers adopting the "Ask and Act" Policy that is in place in Wales.

8.4.2 That the Department for Education develops an effective, national campaign to change the view of CSC's role in supporting victims of domestic abuse. Also, that resources and training are provided to social workers to assist when carrying out these assessments.

9 Conclusion

9.1 The facts formally recorded in this case show that Tara died as a result of a drugs overdose. However, that masks the reality of her life. The evidence contained within this review makes it clear that she suffered domestic abuse at the hands of her long-term partner. That abuse consisted of significant levels of violence and was controlling and coercive in its many forms. Immediately before her death, Tara was subjected to an extremely violent assault by her partner. Although the medical evidence was unable to conclude that the assault contributed to her death, the injuries were so severe that, upon conviction for grievous bodily harm, the perpetrator received a sentence of 15 years' imprisonment. The post-mortem found that there were defensive wounds on each of Tara's arms. Tara's family can, hopefully, take some

[7]The review notes that this has already begun to be delivered.

comfort in knowing that, despite the horrific attack upon her by Adult M, she put up a fight.

9.2 Tara suffered varying types of domestic abuse over several years. She undoubtedly did what she thought was best to try and protect herself and her young family. That included, at times, minimising the level of violence with her friends and family and 'putting up' with the other abuse to which she was subjected. None of this was her fault and this review has sought to understand those actions in order to help other victims make themselves safer. A better level of understanding of what motivates those who continue to suffer appalling abuse can only help us all improve our response and services for others. The review has sought to always keep to the fore the fact that when fear and control is present, the word of a victim or a perpetrator cannot always be taken as the truth.

9.3 Tara's mother and stepfather spoke eloquently and passionately to this review. All those who heard their experience were moved to learn from this case to try and better protect others who suffer in a similar way to Tara. We believe the recommendations from this review will help others. The review extends its sympathies to Tara's family.