Nottingham Community Safety Partnership

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Domestic Homicide Review
Executive Summary

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

Review into the death of Julie
in August 2020

Report Author: Christine Graham
June 2023

Preface

The Nottingham Community Safety Partnership (formerly the Nottingham Crime and Drugs Partnership) and the Review Panel wish at the outset, to express their deepest sympathy to Julie's family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken in an open and constructive manner, with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by the Nottingham Community Safety Partnership on receiving notification of the death of Julie in circumstances that appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Contents

Preface 2

1. The Review Process 4

2. Contributors to the Review 5

3. Review Panel Members 5

4. Domestic Homicide Review Chair and Overview Report Author 6

5. Terms of Reference 7

6. Summary Chronology 8

7. Key Issues Arising from the Review and Lessons Identified 10

8. Recommendations 12

9. Conclusions 13

1. The Review Process

1.1 This summary outlines the process undertaken by the Nottingham Community Safety Partnership (the 'CSP') Domestic Homicide Review Panel, in reviewing the death of a resident within their area, prior to her death in August 2020.

1.2 The following pseudonym's have been used in this review for the victim, perpetrator, and others (as set out below), to protect their identity and those of their families:

- The deceased in this case will be known as 'Julie'. She was a White British woman who was only 42 years old at the time of her death.
- Her partner of 25 years will be known only as 'her partner'.

1.3 Julie died at her home in August 2020. She was a woman who had experienced a difficult and traumatic life. Julie had been with her partner for 25 years, and they had five children together: two of whom had been adopted, and two who were living with other carers under a Special Guardianship Order. Their youngest child was living with the couple. Julie and her partner had both been Class A drug users (heroin and crack cocaine), and both were reported to be on a methadone programme to assist them with reducing their addiction.

1.4 In the early part of the year of her death, Julie had been sentenced to six months in prison for an offence of witness intimidation. The relationship between the couple was subject to multiple instances of domestic abuse, and after Julie's release from prison, and thus in the months prior to her death, both had been arrested for assaults upon each other. At the time of Julie's death, the couple were living apart because her partner was subject to a Domestic Violence Protection Order (DVPO), which had been imposed two weeks previously.

1.5 It was late on an evening in August 2020, when emergency services attended the address at which she was living. They found her deceased, surrounded by the debris of a variety of tablets.

1.6 An inquest was subsequently held in April 2021, at which HM Coroner came to a finding that Julie's death was as a result of 'drugs and alcohol'. She had a mixture of drugs in her system: of which the quantities of two could have been fatal in themselves. This, coupled with high levels of alcohol, was the cause of her death. It is within this context that this review is set.

1.7 The process of this review began in October 2020, when the CSP were notified by East Midlands Ambulance Service (EMAS), regarding a death that it was believed met the criteria for a Domestic Homicide Review. The Chair of the Nottingham Community Safety Partnership considered the notification and after consulting with board members, they agreed that the criteria had been met. On 10th November, the Home Office was notified about the decision to undertake the review, and an Independent Chair and Author were appointed.

1.8 All local agencies were scoped for prior contact with the victim. Nine agencies were found to have had relevant prior contact. Those agencies secured what files were available to them.

2. Contributors to the Review

2.1 Nine agencies contributed to the review by way of IMR or summary report. They were:

- Nottingham CityCare Partnership – Summary report
- Derbyshire, Lincolnshire, Nottinghamshire and Rutland Community Rehabilitation Company – IMR
- Department of Work and Pensions – Summary report
- East Midlands Ambulance Service – Summary report
- Nottingham and Nottinghamshire Clinical Commissioning Group – Summary report
- Nottingham Healthcare NHS Foundation Trust – IMR
- Nottingham University Hospital – Summary report
- Nottinghamshire Police – IMR
- Trent PTS – Summary report

2.2 The independence of the IMR authors was confirmed through the review process.

2.3 Specialist support to the review was provided by:

- Harmless, who provided support and case specific advice regarding suicide and domestic abuse.
- Juno, who provided support and advice relating to women victims of domestic abuse.
- Drugs and alcohol support services, who provided advice in relation to this area.

2.4 The review was assisted by Julie's mother, who was supported by AAFDA and engaged after the report had been drafted. The report was updated to reflect any areas of concern that they raised.

2.5 Approaches were made to invite Julie's partner to engage with the review, but he declined to assist. The review respects that position.

3. The Review Panel Members

3.1 The members of the original Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Independent Report Author	
Karen Turton	Domestic and Sexual Violence and Abuse Specialist	Nottingham CityCare Partnership
Kerry Jackson	Advance Customer Support Senior Leader	Department of Work and Pensions
Lucy Gascoigne	Head of Safeguarding	East Midlands Ambulance Service
Adrian Morgan	Review Officer	East Midlands Special Operations Unit (EMSOU) Regional Review Unit
Sarah Kessling	Strategic and Resilience Lead	Harmless

Yasmin Rehman	Chief Executive Officer	Juno Women's Aid
Nick Judge	Associate Designated Nurse Adult Safeguarding	Nottingham and Nottinghamshire Integrated Care Board
John Matravers	Strategic Lead for Safeguarding Partnerships	Nottingham City Council – Children's Services
Heather Fry	Safer Neighbourhood Housing Manager	Nottingham City Homes
Paula Bishop	Domestic Violence and Abuse Policy Lead	Nottingham Community Safety Partnership
Rebecca Graham	Operations Manager	Nottingham Recovery Network
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospitals
Helen Voce	Chief Executive Officer	Nottingham Women's Centre
Julie McGarry (replaced by Julie Gardner)	Associate Director for Safeguarding	Nottinghamshire Healthcare Foundation Trust
Clare Dean (replaced by Mark Dickson)	Chief Inspector	Nottinghamshire Police
Lisa Adkins-Young	Deputy Head	Probation Service

3.2 All members of the panel and IMR authors were independent of direct involvement with either Julie or her partner.

4. Domestic Homicide Review Chair and Overview Report Author

4.1 The Independent Chair for this review was Gary Goose. He is a former police officer who 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 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. Thereafter, he has been self-employed as a safeguarding review Independent Chair.

4.2 The Independent Overview Author for this review was Christine Graham. She 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.

4.3 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.

4.4 Neither Gary Goose nor Christine Graham is 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.

4.5 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, as well as DHR Chair Training (Two days) and refresher training, provided by AAFDA (Advocacy After Fatal Domestic Abuse). Details of ongoing professional development are available in the full overview report.

5. Terms of Reference

5.1 The Domestic Homicide Review set out to explore the following areas:

- 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.
- 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.
- Consider the efficacy of report authors' agencies' involvement in the multi-agency risk assessment conferencing (MARAC) process.
- Consider the efficacy of report authors' agencies' involvement in a multi-agency / multi-disciplinary team meetings regarding domestic abuse.
- Consider the efficacy of report authors' agencies' involvement in a multi-agency / multi-disciplinary team meetings regarding the victim's mental health.
- 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.
- Establish whether relevant single agency or inter-agency responses to concerns about the offender and the assessment of risk to him and his risk to others, were considered and appropriate.
- To what extent were the views of the victim and offender (and where relevant, significant others), appropriately considered to inform agency responses.
- Identify any areas where the working practices of agency involvement had a significant positive or negative impact on practice or the outcome.
- 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, in Nottingham City, where domestic violence is a feature.
- Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their responsibilities and duties and

- worked together to manage risk and safeguard the victim, her family, and the wider public.
- To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring / reappearing in this review: taking into account if and when these actions were implemented within the agency.

5.2 The full Terms of Reference can be found at Appendix One of the full overview report.

6. Summary Chronology

6.1 This section summarises the information known. Full details are contained within the overview report.

6.2 Julie was 42 years old when she died. The review has sought to understand Julie and life from her perspective. The review has drawn largely upon information held within agency records but is grateful to Julie's mother for the additional context that she has been able to provide to us.

6.3 This review is aware of some of the issues that Julie faced in her life, and it is clear that she suffered considerable adverse childhood experiences. Whilst the details of those experiences are known to this review, they are not repeated within this report: this is in order to protect her memory and those of her family. Whether organisations viewed Julie's life through the lens of a person affected by trauma, is an issue considered by this review.

6.4 As an adult, Julie had been with her partner for 25 years, and they had five children together: two of whom had been adopted, and two who were living with other carers under a Special Guardianship Order. The reason for the Order was recorded as parental substance misuse, chaotic lifestyle, and criminal activity. Julie and her partner had both been Class A drug users (heroin and crack cocaine), and both were reported to be on a methadone programme. The couple's youngest child was living with them.

6.5 Domestic abuse appears to have been a regular feature of their lives together. Historically, reports were made by both against each other. 10 incidents of domestic abuse concerning the couple, were reported to Nottinghamshire Police between 2012 and 2017. These concerned allegations of assaults and verbal arguments between the pair, with both recorded as victims and perpetrators. Both parties declined to pursue prosecutions and although arrests were made at various times, none of the incidents resulted in court appearances.

6.6 Julie disclosed to services that she had been using illicit substances (specifically heroin and crack cocaine) intravenously for approximately 17 years, which she said she had funded by prostitution. She said that she had stopped using illicit substances in 2009, when she was initially prescribed methadone followed by Subutex. Before her death, she said that she had been drug-free for 10 years, and that she had been free of all substitute medication for two years.

6.7 She had been diagnosed, at the age of 17, with a personality disorder, elements of bipolar, schizophrenia, and depression and anxiety. She had been diagnosed in 2009 with post-traumatic stress disorder. She was, at the time of her death, being prescribed two forms of anti-psychotic medication to manage this, which she said helped with her anger

management issues. Julie also suffered with carpal tunnel syndrome, making it difficult for her to grip with either hand. She had surgery that had been unsuccessful.

6.8 During one of her conversations with a professional, Julie identified herself as a highly strung individual, easily agitated, and was conscious that she had to keep this in to avoid conflict.

6.9 During 2018, Julie and her partner became involved in a criminal investigation in relation to threats made to another woman known to Julie. As a result of the interactions, Julie was arrested for witness intimidation, and her partner was convicted of carrying a knife in public. Julie's case continued through 2019, and in December, she was, in turn, convicted. In January 2020, she was sentenced to six months' imprisonment.

6.10 In a pre-sentence review for the offence, she referred to her own child as being her purpose for life and recognised that the child would be affected if she received a custodial sentence. We know from what Julie said to agencies towards the end of her life, that her children were important to her, and she feared that her youngest child would also be taken into care in the way that her older four had been.

6.11 Julie spent three months in prison: being released in early April. She was subject to standard licence conditions and went to live with her partner. She was subject to Post-Sentence Supervision for one year. The Offender Manager (OM) visited her at home shortly following her release. The OM could not enter the house due to COVID-19 restrictions, and she was then supervised by telephone.

6.12 Within days of her release, Julie told her Offender Manager of arguments with her partner and that she had left the address. A few days later, she called the police. Julie said that her partner had punched her in the right eye, hit her with a broom handle, and tried to strangle her on the floor. She was observed to have a slight bruise to her eyelid and reddening in the area. Her partner was present and was arrested. Julie provided a witness statement and details for a DASH[1] risk assessment form and Domestic Abuse Public Protection Notification (DAPPN), and she said that she was willing to support a prosecution. She said, in her statement, that whilst she was in prison, her partner had said that he did not wish her to return home on her release, and he had been abusive to her since her release. She said that she was frightened of being a victim of further violence, was being isolated from her friends, and had suicidal thoughts. Her partner was interviewed and denied the offence: he said that he had been a victim of an assault by Julie. He showed officers a bruise on his arm that he said had been caused by Julie.

6.13 There was no independent evidence to support Julie's complaint, and it was referred to the Crown Prosecution Service, who decided that no further action would be taken. Julie was updated on the phone, and a follow-up letter was sent offering further assistance if requested. Although Julie provided details for the DASH and DAPPN, she declined the information to be shared with partner agencies. She said that this was because she had lost access to four of her children, and she thought it would impact on her child if Children's Social Care became aware.

6.14 In early May, the OM completed the OASys (offender assessment) and highlighted that Julie was a risk of harm to the public, specifically those in conflict with her or her partner and child, due to previous substance misuse and witnessing domestic abuse. Additional information suggested that they were living separately at this time.

[1] Domestic Abuse, Stalking and Honour Based Violence

6.15 By the end of May, the couple were living back together again.

6.16 During June and July, Julie was having input from Nottingham Women's Centre on the Healthy Relationships programme and was having monthly contact with her OM. Her life, at this time, seemed stable.

6.17 In late July, Julie's partner contacted the police to complain that he had been assaulted by her at their home address. He said that Julie had thrown an ornament at him, causing a cut to his chin. He also had scratch marks on his face. Both had been drinking. Julie was arrested; however, her partner declined to make a statement, allow officers to photograph his injuries, or share information with partner agencies. Julie was arrested and subsequently released without charge. She was seen by support services whilst in custody, and appropriate referrals were made to Children's Social Care because their child was in the house at the time.

6.18 In early August, Julie contacted the police and reported that her partner had been verbally abusive and violent towards her for the past two weeks, and she now wanted him removed from the home address, as he was not on the tenancy agreement. She said that she had been assaulted by him on either 30th or 31st July, and that he had been abusive towards her since that date. He had kicked her legs, and she showed the officers bruising that was still visible on her upper leg. Their child was not present at the time of the visit by officers but was at a friend's address. Julie's partner was arrested on suspicion of assault. Julie made a statement, and her injuries were photographed. Her partner denied the assault.

6.19 As a result of the lack evidence available at the time, no proceedings were instituted; however, a Domestic Violence Prevention Notice (DVPN) was authorised by a Superintendent and served on Julie's partner. The conditions imposed were that he must leave the home address, not go within 100 metres of the address, and not contact or harass Julie. The DVPN was authorised for 48 hours, pending an application to the Magistrates Court for a Domestic Violence Prevention Order (DVPO). Two days later, Nottingham Magistrates Court imposed a DVPO upon her partner, with similar conditions.

6.20 Following this incident, Julie was contacted by CSC, and it is clear that she was struggling on her own looking after the young child. In mid-August, she was served with a notice of around £1400 rent arrears.

6.21 Just before the end of August, Julie self-referred to Trent PTS and disclosed issues of 'mental health, loss and trying to deal with my past'. She indicated yes to couple's therapy.

6.22 The following day, she was found deceased.

7 Key Issues Arising from this Review and Lessons Identified

7.1 This review has identified a number of areas where lessons can be learned from the scrutiny of this case. These are set out below.

7.2 Firstly, whether a trail of abuse is evidence in this case, and what can we learn from the way in which agencies responded to any reports of such abuse.

7.3 It is clear that abuse existed within this relationship for many years. The first record being when Julie attended hospital over 20 years ago, having been assaulted, and disclosed that the perpetrator was her partner. Further disclosures were made during her pregnancy in 2012, following a routine enquiry by staff; and a further 10 reports to the police thereafter.

7.4 Whilst many of the reports are abuse towards Julie, there are also reports made by Julie's partner, in which he disclosed attacks upon him.

7.5 As a result of the abuse, child protection plans were put in place for the children.

7.6 We have looked at the way agencies responded to such reports. Whether appropriate support was offered and whether safeguarding actions were put into place.

7.7 It appears that services recognised the abuse. Appropriate referrals were made in the majority of cases, and where there was a lack of professional curiosity identified through the review, we evidence changes in practice to ensure no repeat for others.

7.8 Importantly, appropriate referrals were made to protect the children, who may have been victims by witnessing the abuse.

7.9 It is clear that in most cases, there were evidential difficulties in the police progressing matters to court; however, there is evidence that consideration was given to evidence-led prosecutions in cases where neither party would support a prosecution. The use of a DVPN followed by DVPO, as an effort to protect Julie, was a positive action by the police and the courts.

7.10 Some organisations have identified areas for improvement. For example, the Urgent Care Centre that Julie attended – self-reporting a dog bite – were unable to view the Safeguarding Information Notice (SIN): this would have alerted them to the multiple issues of domestic abuse within her relationship. Knowledge of this would have prompted greater professional curiosity as to the cause of the injury. This has resulted in a recommendation.

7.11 That routine questioning around domestic abuse was not always applied across different health settings. Whilst there was good practice noted within the emergency department, it was not always replicated elsewhere. This has not resulted in a recommendation, as discussions during the review, assured the panel that work was continuing in this aspect.

7.12 It was also clear that some professionals do not always feel empowered to have multi-agency discussions when individuals they remain concerned about, do not meet the threshold for existing safeguarding processes. This has resulted in a recommendation.

7.13 That the significance of a report to professionals of prior strangulation was not recognised for the specific indicator that it is. The review welcomes the work being done by Nottinghamshire Police in this respect but still feels a recommendation is appropriate.

7.14 Whilst there does appear to have been a change in Julie's views (after her release from prison) to the abuse that she had historically suffered – making her more likely to report the abuse – it is difficult to identify why that change in attitude occurred. We would hope it is down to some of the rehabilitative work done during her time in prison. However, there is no single record that follows a detainee through the prison estate. This makes it difficult for those working with detainees within the prison, and upon release, to have a full appreciation

of rehabilitation work carried out during their stay and can affect continuing rehabilitation. A recommendation is made in respect of this.

7.15 We have also looked specifically at Julie's vulnerability and whether organisations recognised the trauma that she suffered in early life and adjusted their response accordingly. It is clear that this is developing work. The impact of Julie's children being taken into care is something that is not lost upon us.

7.16 Finally, we have looked in depth at the link between domestic abuse and suicide. We have looked at the suicide prevention work being undertaken locally. Furthermore, we have made a recommendation in relation to the commitment of agencies, locally, to this important area of work.

8 Recommendations

8.1 **Nottingham CityCare Partnership**

8.1.1 That Nottingham CityCare Partnership explores with the Integrated Care Board (ICB) and GP practice, the most appropriate way to ensure that any Safeguarding Information Notice (SIN) is easily visible to other services.

8.2 **Nottinghamshire Healthcare Foundation Trust**

8.2.1 That the NHCFT Safeguarding Team seeks assurance from senior colleagues in the Liaison and Diversion Service, that the referral mechanism is robust and allows for the appropriate assessment and care planning of patients in a timely manner.

8.2.2 That the NHCFT Safeguarding Team liaises with colleagues in the Information Assurance Team, to gain further understanding around the duplication of electronic files and the risk that this poses. A method of mitigating the associated risks should be explored.

8.3 **Nottinghamshire Police**

8.3.1 That consideration is given to ensuring that DASH risk assessments in which strangulation is a factor, are rated as high: regardless of the other answers given.

8.4 **Her Majesty's Prison and Probation Service (HMPPS)**

8.4.1 That the service explores the feasibility of one single record for a prisoner that follows them from prison to prison and records all the course and interventions with which they have engaged.

8.5 **Nottingham Community Safety Partnership**

8.5.1 That the work commenced in the previous DHR, in relation to awareness training for frontline staff on the impact of self-harm and suicide, be continued across the partnership.

8.5.2 That the area continues its work to develop the ethos of multi-agency working for service users, including those who do not necessarily reach thresholds for existing safeguarding forums but who are known across services and about whom professionals have concerns about their safety. Specifically empowering professionals to have multi-agency discussions in those cases.

8.6 All agencies represented on the DHR Panel

8.6.1 That all agencies represented on the DHR panel commit to the Suicide Prevention Stakeholder Network.

9 Conclusions

9.1 This has been a particularly sad case to review. It is based upon the death of a mother of five children. Even though all but one of those children were not within her care, they have still lost their mother.

9.2 Julie lost her life because of a drugs overdose. HM Coroner has not found sufficient evidence to enable them to conclude that she intended to take her own life. It is clear, however, that she was in emotional turmoil at the time of her death.

9.3 She and her partner had been in a long-term relationship that was consistent in ongoing reports of bidirectional domestic abuse. This, together with her complexities of previous trauma, drug and alcohol use – probably to cope with that previous trauma – meant that Julie was a vulnerable woman.

9.4 She had spent a period in prison during the months leading up to her death. Upon release, she seemed to want to make a change in her life and start again. Unfortunately, she and her partner rekindled their relationship, and reports of domestic abuse between them started once again. Both were arrested at different times in the months immediately prior to her death. At the time she died, her partner was subject of a Domestic Violence Protection Notice.

9.5 It seems likely, having reviewed what was known by all agencies in this case and having attended the inquest in this case, that Julie's multiple and compound issues, including the ongoing abusive relationship, had left her feeling at her lowest and that a combination of drugs were taken to null the pain. Unfortunately, that combination was fatal.

9.6 We have looked at this review through the lens of domestic abuse and its connection with suicide. Although suicide has not been proven in this case, many aspects of the 'cry of pain', made by Julie, are relevant.

9.7 There had been significant prior agency involvement with Julie, and we have identified a number of areas where we feel lessons should be learned from this case. We note and welcome the work that is ongoing in Nottingham to make others safer. We make a total of eight recommendations that we feel will support that work.