Nottingham Crime & Drugs Partnership

Working together to reduce Crime, Disorder and the misuse of Drugs

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A domestic homicide review into the death of Mr A (Operation Hickwall)

Executive Summary

A report for the Nottingham Crime and Drugs Partnership

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Executive Summary

The review process

This summary outlines the process undertaken by the Nottingham Crime and Drugs partnership Domestic Homicide Review panel in reviewing the murder of Mr A.

Mr A was in a relationship with Ms B. Ms B had previously been in a relationship with Mr C. Both Mr A and Mr C were violent towards Ms B. Mr C was subsequently convicted of the murder of Mr A. Ms B was found guilty of perverting the course of justice. Both Ms B and Mr C were imprisoned.

Agencies who participated in this Review and were commissioned to prepare Individual Management Reviews:

- *Nottinghamshire and Leicestershire Police (joint IMR)*
- *Nottingham University Hospitals NHS Trust*
- *East Midlands Ambulance Service*
- *Nottinghamshire Health Care Trust*
- *NHS Nottingham City Clinical Commissioning Group*
- *Nottinghamshire Probation Trust*
- *Women's Aid Integrated Services*
- *Women's Aid Integrated Services - MARAC*
- *Framework Housing Association*
- *Leicester Partnership NHS Trust*
- *Leicester City GP practice*
- *University Hospitals of Leicester*
- *SAFE*
- *Leicester City Safeguarding Adults Board*
- *Leicester City Council Children's Services*
- *Leicester City Council Housing Services*
- *HMP Nottingham*

Agencies were asked to give chronological accounts of their contact with the victim prior to his death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report was asked to consider whether internal procedures were followed; and draw conclusions and recommendations.

Analysis

A number have themes have arisen from the overview of this case. These can be summarised in the following headings:

- *The management of perpetrators of abuse*
- *Engagement of service users*
- *The role of General Practitioners in the context of a multiagency approach to domestic abuse*

- *Violence as a method of communication*

In addition, several cross authority issues have arisen from this DHR, including information sharing, engagement with services, oversight and coordination. All of these issues pertain to Ms B however and as such have little bearing on the outcome for Mr A.

Five years prior to the murder Mr A was not managed via MAPPA (Multiagency Public Protection Arrangements) processes adequately and there were missed opportunities for Mr C to be referred to MAPPA although it is unlikely that he would have met the criteria for MAPPA management.

It has been raised within this review that the MARAC (Multiagency Risk Assessment Conference) should have a more dynamic role in the management of perpetrators of domestic abuse such as Mr C. The most significant factor is that the MARAC is not a statutory function (unlike MAPPA) and actions for agencies are not always progressed in a meaningful way. Activity has been undertaken in an attempt to resolve this issue locally.

Another significant factor is that of the effectiveness of bail conditions imposed upon offenders in cases of domestic abuse. Mr C was repeatedly given court bail despite breaching the bail conditions not to contact Ms B over and over again. The Local Criminal Justice Board (LCJB) is working to address this matter with the courts and representations are made regarding specific cases however the decisions regarding granting bail remain that of the magistrates.

Towards the beginning of the scoping period, Mr C completed the Integrated Domestic Abuse Programme (IDAP). The report completed at the end of the programme indicated that there were still significant areas of work required to address his attitudes towards women and risk of ongoing domestic abuse to partners. As Mr C was no longer being supervised by probation, there were no means to facilitate this work.

In addition, when known to the Probation Service later in the scoping period, Mr C only superficially engaged with his Offender Manager and sought to control what was discussed during sessions. Given Mr C's attitude towards women, it is unlikely that he would have a respectful relationship with a female Offender Manager. Changes within the case work supervision model now allow for reflective supervision and encourages exploration of the emotional impact of work upon the Offender Manager and will enable identification of when an Offender Manager is potentially losing focus of a case. In addition, action is to be taken to ensure that mandatory staff training and supervision must recognise the emotional impact, and potential conflictual and disempowering nature of the interactions in domestic abuse work.

The learning in respect of engagement of service users is predominantly in relation to events concerning Ms B. It is evident that Ms B was at high risk of serious domestic abuse. The DHR Panel has considered that she was also a victim in this case. Despite the high risk of abuse and her extreme

vulnerability she was a very difficult person to effectively support and she frequently failed to engage with agencies. Her movement between two cities made engaging with her even more difficult for agencies.

The histories of the three adults are characterised by violence within their social circles, family, neighbours and relationships. In the case of Mr C in particular, his violence was in discriminate and he refused to consider nonviolent methods of communications. Mr A and Mr C's high number of attendances at the Emergency Department and their GP due to assaults by unknown perpetrators gives an indication of the circles within which they mixed where alcohol misuse; antisocial behaviour and violence would appear to be a way of life.

The role of GPs in cases of domestic abuse is an important factor in this case. The GPs for perpetrators are provided with information from MARAC but it is not clear what is expected of the GP upon receipt of this information. The GP for Ms B did not receive any MARAC information. The review has found that GPs can find themselves in a difficult position when dealing with perpetrators as patients as GPs are dependent on the patient's account of events and occasional information from other agencies. It is unusual for patients to portray themselves as perpetrators. The GPs primary concern is for the patient, and establishing and maintaining a therapeutic relationship is the usual strategy used to help them to do this. Openly challenging a patient's story, asking intrusive questions and failing to respect their confidentiality are things that may damage the therapeutic relationship and make the task of helping the patient in the future much harder. The constraints of data protection and confidentiality are significant issues of concern for GPs when sharing information.

Another factor in this review is the role of GPs when patients lead chaotic, transient lifestyles and are difficult to engage. GPs are notified of attendances at hospital, outpatient reviews and discharges from health services. In many respects this leads agencies to view the GP as the holder of all information pertaining to a case and therefore best placed to understand the issues. However whether the GP themselves have capacity to read all of the information they are sent, or indeed know what to do with it, is unlikely and as such this questions whether the information sharing is purposeful or actually just adding to a 'central storage record'.

<u>Findings</u>

- *Category 3 MAPPA referrals in cases of high or very high risk of serious harm through domestic abuse need to be given active consideration by Offender Managers. Locally good practice guidance is being issued to this effect and a quality assurance mechanism has been requested at a national level*
- *Developments in the MARAC operating protocol including the role of the MARAC steering group to chase actions and implications for not doing so are now established yet need to be embedded. The role of*

MARAC in making recommendations for referrals to MAPPA needs to be reinforced and mainstreamed within MARAC agendas.

- *Issues of power and control must be explicitly considered when allocating cases within probation services and as part of ongoing management oversight of the case.*
- *A nominated police officer in cases of high risk repeat domestic abuse would enable an overview of the situation to be formed and a consistency in approach.*
- *Engagement of GPs in the MARAC process needs to be purposeful and clear with regard to expectation.*
- *In the case of Ms B, MARACs were held in 2 different cities and at times when she was moving between the two. There was opportunity for improved information sharing and joining up of MARAC processes which would have mitigated against duplication of work and could have improved coordination between all of the services in contact with Ms B.*
- *Nottingham would appear to be in a strong position with regard to the management of domestic abuse within health services and it would be useful for Leicester agencies to establish whether any learning can be gained from the good practice in Nottingham.*
- *A process for coordinating and supporting vulnerable people who have capacity yet continue to make poor choices is an identified gap and forms the most significant recommendation arising from this review.*

<u>Conclusions</u>

Although it is known that domestic abuse can affect men, domestic abuse was not a factor in the death of Mr A. However, there is considerable learning to be gained in this case in relation to the services engaging with Ms B.

Ms B was a survivor of domestic abuse and experienced domestic abuse from both Mr A and Mr C. It has been suggested by the DHR panel that Ms B was also a potential homicide victim and assurances have been sought regarding the current provision of support services to Ms B.

A significant amount of agency information pertains to Ms B and Mr C and it is here that most of the learning from the case has arisen. It is the DHR panel view that agency responses would not have impacted upon or prevented or predicted the death of Mr A. However there is a sense that agencies either were not aware of how dangerous Mr C was, or interventions were not in accordance with his level of risk. That said, his actions towards Mr A could not have been predicted and the risk that he posed to Ms B was known to agencies and managed within a multiagency arena.

Referral to MAPPA, specifically in respect of Mr C, has been a significant topic of exploration within the DHR. It is evident that safeguards with regard to referrals for possible category 3 offenders are required within the Probation Service and that the MARAC could act as a further safety net in consideration of potential referrals to MAPPA. It is evident however that Mr C was not viewed as posing a specific risk to Mr A by any of the agencies involved with the 3 adults.

In addition, the impact of power and control exerted by Mr C towards those professionals seeking to challenge his behaviour, and including his Offender Manager, meant that work to address his offending was largely ineffective.

The volume of incidents involving Ms B is considerable. It is clear that she was not easy to engage despite services attempting to secure her safety. The number of police officers involved is a factor that has been identified in the DHR, with the resulting repeated risk assessments completed within a short time frame. The benefit of a nominated officer to have oversight of high risk cases forms a recommendation of this review.

Despite the complexity of this review, spanning agencies from two different cities, there has been opportunity to learn from the services provided within each city and identify good practice. In addition, there has been opportunity to explore how arrangements can be improved, particular when survivors of domestic abuse are transient.

There is considerable learning in respect of engaging the most difficult to engage. Both the survivor (Ms B) and the victim (Mr A) had vulnerabilities and met the criteria for the being a vulnerable adult in the wider sense (as opposed to meeting the criteria for accessing adult safeguarding) which could have been better understood and therefore better responded to. It is recognised that vulnerable people who have capacity may continue to make choices that present risk, however the professional response when working with these individuals should be to assess the risk from such choices and advise accordingly.

A process for coordinating and supporting vulnerable people who have capacity yet continue to make poor choices is an identified gap and forms the most significant recommendation arising from this review.

<u>Recommendations</u>

(a) That the report is formally shared with the Safer Leicester Partnership and for Leicester agencies to consider the learning to be gained from Nottingham in respect of domestic abuse strategy and service provision.

(b) That the NCSAPB considers the learning to be gained from Leicester's Vulnerable Adult Risk Management process and considers an appropriate response for Nottingham to manage and support its most vulnerable individuals in line with the Opportunity Nottingham pathway for people with multiple and complex needs.

(c) That steps are taken within Nottinghamshire Police to allocate one specialist domestic abuse police officer to victims deemed to be at high risk of domestic abuse.

(d) That actions arising from MARAC continue to be monitored with clear escalation procedures for noncompliance of agencies with MARAC actions.

(e) That robust process is established for MARAC arrangements when survivors are transient and move across boundaries and that steps are taken to fully engage GPs in MARAC processes.

(f) That the consideration of referrals to MAPPA is routinely embedded within MARAC meetings.

(g) Guidance should be issued within The National Probation Service to ensure active consideration of a MAPPA category referral 3 for all non-mandatory MAPPA cases assessed of presenting a High or Very High Risk of Serious Harm of Domestic abuse. A request has been made that this guidance is issued nationally.

(h) That when allocating domestic abuse cases to Probation and CRC Offender Managers, recognition is given to the dynamics of power and control which exist in all such cases. A request has been made that this guidance is issued nationally.