NOTTINGHAM COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Tom'

Date of death: February 2022

EXECUTIVE SUMMARY

February 2025

Chair and Author: Carol Ellwood-Clarke QPM
Support to Chair and Author: Ged McManus

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1. The Review Process

1.1 This summary outlines the process undertaken by Nottingham City Community Safety Partnership [the statutory Crime and Disorder Partnership] in reviewing the death of 'Tom', who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, perpetrator, and significant others.

Name	Relationship	Age	Ethnicity
Tom	Victim	63	White British Male
Jack	Perpetrator and the nephew of victim's partner	23	White British Male
Mary	Partner of victim and aunt of the perpetrator	53	White British Female
Significant Other			
Jim	Previous partner of Mary	63	White British Male

1.3 Tom had been in a relationship with Mary. The relationship had ended in August 2020. There had been domestic abuse within their relationship. At the time of Tom's death, they lived in a house of multiple occupancy; however, they were the only occupants – each having their own room. Mary had been in a previous relationship with Jim. There was domestic abuse within that relationship. Tom, Mary, and Jim were friends, and Jim was a regular visitor to Tom and Mary's accommodation.

1.4 Jack was the nephew of Mary. In February 2022, Tom was assaulted by Jack, who claimed that Tom had been 'bullying' Mary. The assault occurred over a sustained period of time and was 'live streamed'. Tom was conveyed to hospital and placed in intensive care. Jack was arrested and charged with an offence of grievous bodily harm and remanded into custody.

1.5 Tom did not regain consciousness from the assault and later died from his injuries. Jack was charged with the murder of Tom. A Home Office postmortem determined that the cause of death was: severe trauma, with head, chest, and spine injuries consistent with being kicked and stamped to a severe level.

1.6 In May 2023, Jack was found guilty of the murder of Tom and sentenced to a life sentence – with a minimum term of 21 years and 272 days.

1.7 The first meeting of the DHR panel was held on 20 June 2023. Thereafter five further meetings were held, and a draft report written. The meetings were held using online video facilities.

1.8 The final overview report was agreed by Nottingham Community Safety Partnership on 17 May 2024.

2. Contributors to the review

2.1 Contributors to the review/agencies submitting Independent Management Reviews (IMRs).

Agency	IMR	Chronology
Nottinghamshire Police	✓	✓
Nottingham Recovery Network	✓	✓
The Probation Service	✓	✓
East Midlands Ambulance Service	✓	✓
Juno Women's Aid	✓	✓
Adult Social Care	✓	✓
Housing Aid[1]	✓	✓
Nottingham Healthcare NHS Foundation Trust	✓	✓
Nottingham University Hospitals NHS Trust	✓	✓
Equation		✓
DHU Healthcare		✓
Children's Social Care		✓
Nottingham CityCare Partnership		✓
Crown Prosecution Service		✓
Department for Works and Pensions		✓
The Friary		✓
The YMCA		✓
Nottingham City Homes[2]		✓

2.2 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

[1] Since September 2023 known as Housing Solutions.
[2] Now known as Nottingham City Council Housing Services.

3. Review Panel Members

3.1 The Review Panel Members were:

Review Panel Members		
Name	**Job Title**	**Organisation**
Marie Bower	Head of Service: Survivors and Perpetrators	Equation
Liz Cudmore	Safeguarding Lead	East Midlands Ambulance Service
Jo Elbourn	Detective Chief Inspector	Nottinghamshire Police
Carol Ellwood-Clarke	Independent Chair and Author	
Amanda Garnett	Service Manager for Safeguarding and Public Protection	Nottinghamshire Healthcare
Louise Graham	Sexual Violence and VAWG Lead	Nottingham Community Safety Partnership
Sonya Hand	Deputy Head	Nottingham City Probation Delivery Unit
Ishbel Macleod	Designated Professional for Safeguarding Adults and Domestic Abuse and Sexual Violence Lead	Nottingham and Nottinghamshire ICB
John Matravers	Head of Safeguarding, Quality and Assurance	Children's Social Care
Ged McManus	Independent Reviewer	
Corenna Olivero-Nosakhere	Domestic Violence and Abuse Policy Lead	Community Safety Partnership Specialist
Helen Pritchett	Trustwide Service Manager for Public Protection and Safeguarding	Nottingham Healthcare NHS Foundation Trust
Rebecca Radage	Operations Manager	Nottingham Recovery Network/Clean Slate/Health Shop-Harm Reduction and Sexual Health

Yasmin Rehman	Chief Executive Officer	Juno Women's Aid
Debbie Richards	Head of Housing Solutions	Housing Aid/Solutions, Nottingham City Council
Julie Stevens	Service Manager and Principal Social Worker – Adult Social Care Safeguarding and Quality Assurance	Adult Social Care
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospitals NHS Trust
Anna Wetherburn	Operational Risk Manager	Nottingham Recovery Network

3.2 The Panel Chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny.

4. Chair and Author of the Overview Report

4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors.

4.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair and Author. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not Nottinghamshire), in 2017, after 30 years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to safeguarding and family liaison. In addition, she is an Associate Trainer for SafeLives.[3]

4.3 Carol was supported in her role by Ged McManus. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Nottingham or an adjoining authority). Ged served for over 30 years in different police services in England (not Nottinghamshire). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

4.4 Between them, they have undertaken the following types of reviews: child serious case reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. They have both completed accredited training for DHR Chairs, provided by AAFDA.

4.5 Both have previously completed DHR's for Nottingham Community Safety Partnership.

[3] https://safelives.org.uk/

5. Terms of reference

5.1 These were set as -

The purpose of a DHR is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7)

5.2 **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, were your agency aware of that could have identified Tom as a victim of domestic abuse, and what was your response?
2. What knowledge did your agency have in relation to Tom, Mary, Jack, and Jim's relationship? Did this include evidence of domestic abuse, and if so, what was your response?
3. What knowledge did your agency have in relation to Jack's offending behaviour, and what was the response?

4. Was there sufficient focus on reducing the impact of Jack's offending behaviour by applying an appropriate mix of sanctions (arrest/charge) and other interventions?

5. How did your agency identify, assess, and manage the level of risk faced by Tom from Jack? What risk assessments did your agency undertake, and what was the outcome? Were risk assessments accurate and of the appropriate quality?

6. What consideration did your agency give to any mental health issues and/or substance misuse when engaging with the subjects of the review?

7. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed? Are the procedures embedded in practice, and were any gaps identified?

8. What knowledge did family, friends, and employers have around Tom, Mary, Jack, and Jim's relationship? Did this identify domestic abuse, and if so, did they know what to do with that knowledge?

9. Were there any issues in relation to capacity or resources in your agency that impacted on its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? Please consider if Covid-19 related work practices affected your response?

10. Were there any examples of outstanding or innovative practice?

11. What learning did your agency identify in this case, and how will this be embedded into practice?

12. Was the learning in this review similar to learning in previous Domestic Homicide Reviews commissioned by Nottingham Community Safety Partnership?

5.3 Timescale

The review covers the period from 1 January 2019 to February 2022. This timescale was used to capture events within the two years prior to Tom's death – to inform analysis around contemporary and current practice. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.

6. Summary Chronology

There was no contact between Tom and Jack (known to agencies) prior to the murder of Tom.

6.1 Tom

6.1.1 Tom was born in Lincolnshire and was one of six children born to his mother and father. Tom's parents' relationship ended when he was a young child, and he and three of his siblings were brought up by their father.

6.1.2 After leaving school, Tom worked for his father, as a painter, before moving away from Nottingham, where he then worked as a lorry driver. Tom met and married a woman. The marriage ended after several years, and Tom remained living away from Nottingham. Tom had no children. Tom returned to live in Nottingham around 2001/2002.

6.1.3 Tom's family described him as a hard worker, who was always sociable – the life and soul of the party – and as a family, they had a great relationship. Tom was generous and funny – he loved singing, dancing, and partying. Tom was a happy man and lovely with his nephews and nieces, who called him 'stupid Uncle Tom' because he would be silly with them and entertain them.

6.1.4 Tom had been known to criminal justice agencies since 1974. Tom was a perpetrator and victim of domestic abuse. Tom had three convictions for domestic abuse, which related to assaults on Mary.

6.1.5 Between 2015 and 2021, Tom was arrested on 11 occasions for assaulting Mary. These offences were not prosecuted.

6.2 Jack

6.2.1 Jack had been known to Children's Social Care since 2012. Concerns had been raised regarding Jack's alcohol use and the ability to focus on Jack's wellbeing, which was linked to neglect. Due to the concerns raised, there was period of involvement by Children's Social Care: this was managed at Child in Need level and Common Assessment Framework, with the case being closed after identified risks were reduced.

6.2.2 Jack had been known to criminal justice agencies since 2015.

6.3 Mary

6.3.1 The Review Panel had little information about Mary. Tom's family believed that Mary had two adult children, with whom she did not have any contact.

6.3.2 Nottingham Recovery Network provided the review with the following information that Mary had provided to them during engagement with their service:

'Mary reported she had started drinking alcohol at the age of 11 and classed herself as a social drinker at weekends until 10 years ago when her father passed away, she ended a 26-year relationship, and she lost her job. Within a few months of this her alcohol use escalated to daily drinking of 3 litres of cider and 9 bottles wine daily. Mary's brother died 2 years ago. Mary acknowledged at the time of presentation all her current social group were all heavy drinkers. Mary had periods of homelessness and sofa surfing after this. Mary has two daughters and a grandchild'.

6.3.3 Mary has been known to criminal justice agencies since 1998. Mary was a perpetrator and victim of domestic abuse.

6.3.4 In 2015 and 2021, Mary was arrested for assaulting Tom. These offences were not prosecuted.

6.4 Jim

6.4.1 Jim was a friend of Tom and Mary's. Jim had known Tom for over 30 years, after they had started working together in the flooring/tiling business. Jim met Mary through Tom and they had previously been in a relationship. Jim would see Tom and Mary about 3 or 4 times a day.

6.4.2 Jim told the Chair that he had previously had a drug/alcohol addiction and had previously been in detox.

6.5 Tom, Mary, and Jim's relationship

6.5.1 Tom and Mary had been in a relationship since 2012. Tom and Mary's relationship was not stable and was described in agency records, and by Tom's family, as being 'on and off'. The relationship was understood to have ended in August 2020; however, they continued to live in the same home in multiple occupancy (HMO), where they shared communal facilities, but each had their own bedroom.

6.5.2 Tom and Mary led a transient lifestyle. They were known to consume alcohol, often to excess, and were often seen drinking alcohol with other people described as 'street drinkers'. Tom and Mary would often allow people who were homeless into their home to consume alcohol.

6.5.3 Tom and Mary's contact with the police tended to occur whilst they were under the influence of alcohol. It was during these times that domestic abuse occurred and was reported to the police.

6.5.4 Tom, Mary, and Jim reported to the police that they had been assaulted by each other. A breakdown of the allegations is provided below:

- Tom was the victim of 22 assaults by Mary.
- Tom was the victim of 9 assaults by Jim.
- Mary was the victim of 20 assaults by Tom.
- Mary was the victim of 18 assaults by Jim.

Alcohol was a feature in every call made to the police. The nature of the assaults included hair pulling, slapping, throwing paint, punching, being hit with a plastic bottle, throat grabbing, and strangulation. The allegations made were often withdrawn upon the arrival of the police, and when the police recontacted the identified victim, they were informed that they could not recall the incident, or that the victim no longer supported a prosecution.

Events within the Terms of Reference

During the review's time frame, there were 172 contacts with the police. These are not repeated in chronological order here. The Review Panel determined that only those of relevance would be documented below.

6.6 2019

6.6.1 At the beginning of year, Tom was living in accommodation provided by the YMCA. Mary was living in separate YMCA accommodation.

6.6.2 On 10 May, Tom presented as homeless after being evicted from his accommodation. By the end of May, Tom had been referred to the Independent Living Support (ILS) service for support. Tom's application proceeded – in accordance with legislation and policy – over the following weeks.

6.6.3 Throughout June, Mary had contact with Juno Women's Aid due to domestic abuse that had been assessed as high risk. The perpetrator was Jim. The case was referred to MARAC. An IDVA continued to seek engagement with Mary over the following months, including a move out of the area. The case was closed in November 2019.

6.6.4 During September, Mary contacted the Police on several occasions and reported incidents of domestic abuse, which had been perpetrated by Tom and Jim.

6.6.5 On 13 September, Tom appeared at court and was sentenced for an offence of assault by beating on Mary. A restraining order was not awarded because Mary had resumed her relationship with Tom, and they were living in the same household. Probation completed a Short Format Report (SFR) to assist the court with sentencing. Tom was assessed as posing a medium risk of serious harm to Mary.

6.6.6 At the beginning of October, at an appointment with his keyworker at Nottingham Recovery Network, Tom discussed his alcohol use, accommodation, finances, health, and previous drug use. Tom told his keyworker that he had a co-dependent relationship with Mary, and that Mary was also in a relationship with a long-standing friend he had known for over 25 years. The Review Panel determined that this was Jim.

6.6.7 On 11 November, Tom told his probation practitioner that he had been given notice to vacate his accommodation.

6.6.8 On 23 November, Mary contacted the police and stated that Tom had assaulted her and threatened to kill her. Tom was arrested. No further action was taken. The incident was shared with Probation and discussed with Tom on 11 December.

6.6.9 On 29 December, Tom contacted the police and reported that he and Mary had been assaulted by Jim. Tom described Mary as his partner. Jim was arrested. Jim was charged with assault; however, the case was later discontinued. Mary attended at hospital with a head injury sustained in the incident on 29 December. Medical staff were not aware that Mary had been a victim of domestic abuse.

6.7 2020

6.7.1 By the end of January, Tom had been issued with a warning letter by Probation for failure to attend appointments with Nottingham Recovery Network. Tom told the probation practitioner that he had been served an eviction notice.

6.7.2 On 17 February, Tom was issued with a final warning letter by Probation – after he had failed to attend five appointments in the past four weeks with Nottingham Recovery Network – due to noncompliance in the treatment element of work. Tom continued to miss appointments, and a further final warning letter was issued on 27 March.

6.7.3 On 27 February, Tom contacted the police and reported a domestic incident with Mary and Jim, during which Mary had smeared paint on Tom. Tom did not support a complaint. Mary and Jim were issued with notices under Section 35 Crime and Policing Act 2014.[4] This prevented them from returning to Tom's address. Later that day, Mary was taken into custody for failing to adhere to the Section 35 notice.

6.7.4 On 12 March, Tom's Alcohol Treatment Requirement terminated.

6.7.5 By April, Tom was engaging with Nottingham Recovery Network on a voluntary basis. Contact between Tom and his probation practitioner had moved to telephone contact due to the Covid-19 pandemic. Tom reported an increased consumption of alcohol.

6.7.6 On 8 April, Tom contacted the police and stated that he had been assaulted by Mary. Tom stated that he did not want to make a complaint. Mary was taken to an alternative address. Later on 8 April, Mary contacted the police and reported that Tom had assaulted her. Mary stated that she did not want to make a complaint. A crime of assault was recorded. Details of this incident were shared with Adult Social Care. Over the following month, Adult Social Care attempted to contact Mary. This was unsuccessful, and the case was closed on 11 May.

6.7.7 On 13 April, Tom contacted the police and reported that he had been assaulted by Mary. Tom did not provide further details of the assault. A

[4] https://www.legislation.gov.uk/ukpga/2014/12/part/3/enacted

crime was recorded. The incident was emailed to the Neighbourhood Policing Team to work with the landlord around housing.

6.7.8 On 5 May, Mary contacted the police. She stated that Tom had tried to choke her, and she said that he was going to kill her. Later that day, Mary contacted the police and reported an incident with the landlord, who had been banging on the door trying to evict her.

6.7.9 On 18 June, Tom told his probation practitioner that he had ongoing issues with accommodation, his relationship with Mary was strained, and that he was drinking three times more due to boredom. The probation practitioner agreed to refer him to the housing team for support.

6.7.10 On 10 July, Mary reported to the police that she had been assaulted by Tom. Tom was arrested. A crime of assault was recorded, Mary declined to provide a statement. Tom admitted to pulling Mary's hair in self-defence after Mary had attacked him. Tom was released without charge. Details of the incident were shared with Adult Social Care, who were unable to contact Mary, and the incident was closed. The incident was shared with Probation.

6.7.11 On 12 September, Tom's order terminated.

6.7.12 On 19 October, Mary contacted the police and reported that she had been assaulted by Tom. Tom was arrested. Mary declined to make a statement. A crime of assault was recorded. Tom denied assaulting Mary and was released without charge.

6.7.13 On 31 December, Mary attended Nottingham Recovery Network for alcohol assessment. During this appointment, efforts were made to secure a refuge space due to domestic abuse concerns. As no spaces were available, a referral was made to Housing Aid. Initial contact was made with Mary via Nottingham Recovery Network, and a telephone assessment was started. A break in the assessment was requested by Mary. Attempts to re-establish contact with Mary were unsuccessful, and the case was closed in April 2021.

6.8 2021

6.8.1 On 13 February, Tom contacted the police and reported that he had been assaulted by Mary. Mary was arrested. Tom declined to make a statement and stated that he would not support a prosecution. A crime of assault was recorded. Mary was released without charge.

6.8.2 Whilst in custody, Mary was seen by the Liaison and Diversion Service. Mary was referred to a range of services including Changing Lives, the Wellbeing Hub, and Adult Social Care regarding housing concerns. Mary did not respond to any contact from Changing Lives.

6.8.3 On 30 March, Tom was arrested by the police after Mary reported that she had been assaulted by Tom three days earlier. Mary declined to support a prosecution. Tom was released without charge. A crime of assault was recorded.

6.8.4 On 25 April, Tom was assaulted by Jim. Mary had been present during the incident. A crime of assault was recorded. Tom provided a witness statement. Jim denied assaulting Tom and stated that he had intervened to stop Tom and Mary arguing. Jim was released without charge.

6.8.5 On 23 June, the police prepared a case summary of events to be shared with agencies in support of a civil action being taken by the landlord.

6.8.6 On 5 July, Tom and Mary reported to the police that they had been assaulted by Jim. Jim was arrested. A crime of assault was recorded. Jim was released on bail, with conditions not to contact Tom and Mary. The case was referred to the Crown Prosecution Service for a charging decision. Tom and Mary were not supportive of a prosecution. No further action was advised by the Crown Prosecution Service.

6.8.7 On 31 July, Tom and Mary were staying in a hotel in Skegness, Lincolnshire. Mary contacted Lincolnshire Police and reported that she had been assaulted by Tom. When the police arrived at the hotel, Mary stated that she had not been assaulted. Mary was taken to another hotel.

6.8.8 During the early hours of 1 August, Lincolnshire Police received several calls from the hotel regarding Mary's behaviour. Mary was taken to the train station by the police.

6.8.9 During August, Housing Aid had contact with Mary. She had asked for support due to the current situation with her accommodation, which was described as being in disrepair and having no electricity. Following initial contact, all further attempts at contact were unsuccessful and the case was closed.

6.8.10 On 17 October, Tom contacted the police and reported that Mary had assaulted him. Tom had no visible injuries, and he told the police that he did not want to make a complaint. Mary was taken to an alternative address. A crime of common assault was recorded. No action was taken against Mary.

6.8.11 On 22 November, Nottingham Health and Care Point, received a referral from the ambulance service for Tom. The referral detailed concerns regarding the state of Tom's accommodation. A Health and Social Care Officer made contact with Tom, who stated that he wanted Mary to be his carer. Mary was described as Tom's ex-partner. Mary told the Health and Social Care Officer that she did not want to be Tom's carer. Tom declined social care support. An environmental health and safer places referral was completed.

6.8.12 On 1 December, Nottingham Health and Care Point received a further referral from the ambulance service. This referral cited the same concerns as those raised on 22 November. Enquiries were undertaken by the Adult Safeguarding Team Social Worker which did not identify any safeguarding concerns, and the referral was closed.

6.9 2022

The below information was gathered as part of the homicide investigation.

6.9.1 On 9 February, Jack went to Tom and Mary's address. Jack assaulted Tom over a sustained period of time. The assault was live streamed. Mary was present during the assault.

6.9.2 On 10 February, the police were informed of the assault and attended at the address. Tom was taken to hospital and placed into intensive care. Jack was arrested for the offence of grievous bodily harm. Jack was charged and remanded into custody.

6.9.3 Staff at Nottingham University Hospital completed a DASH, which was graded as high and sent to MARAC. A referral was sent to Equation's High Risk Domestic Violence and Abuse Service. Contact with Tom was not able to take place due to him being sedated and ventilated on the adult intensive care unit. The case was listed to be heard at MARAC at a later date.

6.9.4 At a later date in February, Tom died. Jack was charged with Tom's murder. The police made a policy decision that Mary was a witness to the incident. The MARAC had not been heard at the time of Tom's death.

7. Key issues arising from the review.

7.1 Multi agency response to continuous reported incidents of domestic abuse, including the identification of primary victim and perpetrator of domestic abuse.

7.2 Professionals responses to domestic abuse where alcohol and co-dependency are present.

7.3 Opportunities for professionals to discuss and seek consent for referrals to support services for survivors of domestic abuse, and intervention options for perpetrators.

7.4 Compliance to current MARAC referral processes.

8. Conclusion

8.1 Tom died following a long and sustained assault perpetrated by Jack.

8.2 Jack was the nephew of Mary, with whom Tom had previously been in an intimate relationship. Tom and Mary lived in the same household.

8.3 As part of their victim impact statement, Tom's family stated: 'I can't accept what had happened to Tom – how unfair it is and how unnecessary. I don't know how to explain Tom's death to my youngest children who still ask when they will get to see their 'stupid uncle Tom'.

8.4 Tom had had a long-term relationship with Mary. Whilst the relationship was understood to have ended in August 2020, the Review Panel saw information that they did, at times, continue to describe themselves as being in a relationship.

8.5 Within Tom and Mary's relationship was another male, Jim. He was a long-term friend of Tom's, and a previous partner of Mary's. Together, all three of them had relationships that centred around friendship and alcohol consumption. At times, there was violence within their relationships – with incidents of abuse, including physical abuse being reported to the police. Where criminal offences had been identified, these did not always result in a criminal investigation and conviction, due to the lack of evidence and support from the identified victim.

8.6 Tom, Mary, and Jim were identified as victims and perpetrators of domestic abuse. The exact identification of the primary victim and perpetrator of domestic abuse was often difficult for professionals to establish.

8.7 Tom did not provide consent for information to be shared with partner agencies, including support agencies for domestic abuse and alcohol consumption.

8.8 The frequency of the incidents of domestic abuse were not discussed within a multi-agency forum; therefore, the domestic abuse continued to occur.

8.9 The review acknowledged the difficulty for agencies that respond to incidents of domestic abuse, especially where those involved have additional and often complex needs, and who decline support from agencies.

8.10 The Review Panel identified areas of learning, for all agencies, on responding to cases where there is a potential escalation in terms of frequency of incidents and contact with agencies.

9. Learning

9.1 The DHR panel identified the following learning. Each point is preceded by a narrative which seeks to set the context within which the learning sits. Where learning leads to an action a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
There was an opportunity for Mary and Jim to have been informed about the provision of a voluntary domestic abuse and violence project, to which, with their consent, they could have been referred. The programme, known as YCP, includes a support service for survivors of domestic abuse, alongside the intervention for perpetrators to monitor/manage risk and ensure survivor safety and wellbeing.
Lesson
Awareness of the role, remit, and referral process of YCP allows professionals to discuss with perpetrators of abuse, a service which can work with them to address their domestic abuse behaviour.

Learning 2 [Panel recommendation 2]
Narrative
The review identified that the volume of domestic abuse cases had increased exponentially, which impacted on cases being referred to MARAC. In addition, the threshold criteria to refer cases to MARAC was not being adhered to by agencies, and single-agency processes had been implemented for MARAC referrals where the risk had not been deemed as high.
Lesson
Understanding the current volume of domestic abuse cases, risk level, and – where that risk is high – the number of referrals to MARAC, will then inform if the current threshold criteria is valid or needs to be reviewed.

Learning 3 [Panel recommendation 3]
Narrative
The case identified that the domestic abuse continued over an extended period of time, and despite incidents of abuse being reported to the police and action being taken, including through criminal justice routes, the domestic abuse continued to occur and be reported to agencies. The

implementation of The Prevention Hub will respond to cases of domestic abuse and utilise a partnership orientated problem-solving method.
Lesson
Understanding the role of The Prevention Hub in responding to repeated cases of domestic abuse, particularly where there is escalation in terms of frequency. Furthermore, agency contact will inform Nottingham Community Safety Partnership on the partnership approach to repeated cases of domestic abuse and seek to identify any gaps in the multi-agency working arrangements.

9.2 Agencies Learning

9.2.1 Nottinghamshire Police

- To ensure processes are in place to identify and investigate cases of domestic abuse flagged in partner agency DASH referrals.
- Feedback on responses to police officers regarding the identification of domestic abuse and completion of DAPPNs.

Action taken to address this learning –

- Tactical advice around the use of civil orders is added to all prisoners received into custody for domestic abuse offences.
- Nottinghamshire Police have revamped the DAPPN training, which will be delivered across the Force over the next 12 months.
- Nottinghamshire Police have a bespoke webpage dedicated to the use of DVPN/O – including when to consider them, how to complete them, and other operational advice. During the standard working week, there is also a dedicated SPOC to answer any queries relating to DVPN/O use.
- As part of the Prevention Hub, further training and advice around the use of all civil orders is planned to be delivered by the end of the 2023/24 financial year.
- A full systematic review of DASU and MARAC is planned for 2024 – this will include an escalation process for repeat domestic abuse cases.

9.2.2 The Probation Service

- Review of domestic abuse incidents to highlight any potential emerging risks.
- Home visits.

Action taken to address this learning –

- Since this case, the DLNR CRC and NPS have merged to form part of East Midlands Probation Service, and policies have changed.
- Home visits to cases with domestic abuse concerns are mandatory, and a clear and established process of obtaining information around domestic abuse from the police is embedded into practice.
- It is now mandatory for all cases to have a safeguarding and domestic abuse check at the start of supervision and a home visit within the first three months in a case that is medium risk and has domestic abuse concerns.
- It is now expected and embedded into practice that information regarding further offending is followed up with the police and other relevant agencies and that offence-focussed work is undertaken on all areas of risk to assess all areas of concern.

9.2.3 <u>East Midlands Ambulance Service</u>

- Promotion of future EMAS 'Learning from Events' session, around documentation and completion of Patient Referral Forms (PRFs), to include EMAS Safeguarding Team – so that learning around comprehensive documentation can be disseminated Trust wide and documentation requirements for domestic abuse referrals can be reiterated.

Action taken to address this learning –

- A 'Learning from Events' session is planned around completion of PRFs and documentation.
- EMAS has launched a pathway to refer into drug and alcohol support services across the East Midlands counties covered by EMAS. Consent is required to make the referrals unless a service user has required life-saving intervention, such as administration of naloxone or airway management due to overdose. This has been well received and is now an established referral pathway. Therefore, in future attendances to service users with alcohol dependency issues, there is now an option for crews to discuss alcohol use and raise a referral if consent is gained.

9.2.4 <u>Juno Women's Aid</u>

- Opportunities to attempt one-to-one contact and engagement with Mary.
- The referral to R2C that was not processed in line with policies and procedures. This service supports complex cases, often engagement is sporadic and at the point of crisis.

- Recruitment and retention of staff.

Action taken to address this learning –

- Juno Women's Aid has created service manuals for all services. This is service-specific guidance for staff covering processes – from referral into service stage to case closures. These are available to existing and new staff at induction stage to support practice, re-enforce policy, and to embed learning.
- Juno Women's Aid has overhauled their approach to recruitment of staff, which is delivering positive results, and has introduced a one-week corporate induction followed by three weeks in-service induction. In addition, a revised learning and development plan has been implemented for the whole organisation that ensures staff receive ongoing training to address a range of topics, including supporting survivors with multiple and complex needs, case note recording, etc. so that survivors can be assured that staff understand, can respond to differing needs, and are not reliant on specific specialist services, e.g., R2C alone.

9.2.5 Nottingham Healthcare NHS Foundation Trust

- Wider consideration and exploration of perpetrator behaviour and support is required by the Liaison and Diversion Service.

Action taken to address this learning –

- The Liaison and Diversion Service will receive perpetrator training from the Your Choice Project.

10. RECOMMENDATIONS

10.1 Panel and Agency Recommendations

10.1.1 Panel Recommendations

Number	Recommendation
1	That Equation shares the learning from this review in relation to the role of, and referral processes to, Your Choice Project. This should also include the options available to agencies on how they could disseminate the learning further within their agency by: 1. Inviting the YCP to attend internal meetings or learning events to provide an overview of their service. 2. That professionals can attend online webinars that are held on the role of YCP. That professionals can attend Equation's Challenging Domestic Violence Abuse training.
2	That Nottingham Community Safety Partnership shares the learning around the MARAC process (identified within this report) with the MARAC review currently being undertaken. This can take place by sharing the relevant sections and analysis (within the report) with the review process.
3	That Nottinghamshire Police provide a report/presentation to Nottingham Community Safety Partnership that details how The Prevention Hub responds to repeated cases of domestic abuse, where there has been an escalation in frequency and agency contact, which are not being addressed through other processes, such as MARAC and criminal justice intervention. The report/presentation should detail: 1. How cases are identified. 2. How agencies are working together to respond to such cases. 3. How the outcomes of cases are measured. Upon receipt of the report/presentation, Nottingham Community Safety Partnership should then seek to consider if there remains any gap in the multi-agency response to such cases.

10.1.2 Agency Recommendations

Nottinghamshire Police

To ensure processes are in place to identify and investigate cases of domestic abuse flagged in partner agency DASH referrals.

Feedback on responses to police officers regarding the identification of domestic abuse and completion of DAPPNs.

The Probation Service

Review of domestic abuse incidents to highlight any potential emerging risks.

Home visits

East Midland Ambulance Service

Promotion of future EMAS 'Learning from Events' session, around documentation and completion of PRFs, to include EMAS Safeguarding Team – so that learning around comprehensive documentation can be disseminated Trust wide and documentation requirements for domestic abuse referrals can be reiterated.

Juno Women's Aid

Opportunities to attempt one-to-one contact and engagement.

The referral to R2C that was not processed in line with policies and procedures. This service supports complex cases, often engagement is sporadic and at the point of crisis.

Nottingham Healthcare NHS Foundation Trust

Wider consideration and exploration of perpetrator behaviour and support is required by the Liaison and Diversion Service.