Nottingham Crime & Drugs Partnership

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

A Domestic Homicide Review into the Death of Ms MA (Operation Hoplite)

Executive Summary

A report for the Nottingham Crime and Drugs Partnership

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Introduction

1.1. The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the *Domestic Violence Crime and Victims Act 2004* which came into force on 13th April 2011.

1.2. Multi-agency statutory guidance for the conduct of DHRs has been issued under Section 9 (3) of the *Domestic Violence Crime & Victims Act 2004*. Section 4 of the Act places a duty on any person or body named within that section (4) to have regard to the guidance issued by the Secretary of State. The guidance states that the purpose of a DHR is to:

- Establish what lessons are to be learned from a 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 policies and procedures as appropriate, and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3. The Chair of the Nottingham Crime & Drugs Partnership was notified of the death of Ms MA by letter dated 10th February 2015. The circumstances of the death fall within Section 9 of the *Domestic Violence Crime & Victims Act 2004* which required consideration of conducting a DHR. The decision was made to conduct a DHR and an Independent Chair and Independent Author were appointed.

Contributors

1.4. Agencies participating in the Review and commissioned to prepare Individual Management Reviews were:

- **Nottingham City Children's Services**
- **Nottinghamshire Police**
- **National Probation Service**
- **Nottinghamshire Healthcare NHS Foundation Trust jointly with Nottinghamshire County Council Adult Services**
- **NHS England**
- **Gedling Homes**

- **HMP Ranby**
- **HMP Nottingham**

2. **The Facts**

2.1. Ms MA was stabbed and killed by Mr HL on or after Friday 30th January 2015 and her body was discovered at her home on Wednesday 4th February 2015. Ms MA was 47 years of age.

2.2. Ms MA was a friend of Mr HL's mother and this is how Ms MA initially met Mr HL. Ms MA and Mr HL had been in a relationship which was believed to have ended at the time of her death. There was a significant age difference between Ms MA and Mr HL.

2.3. The relationship was not known to any agency and nor was it known to most of the friends or the daughter of Ms MA. There are no agency reports of or evidence to suggest that there were incidents of domestic abuse within the relationship.

2.4. The post mortem revealed three deep stab injuries to the abdomen and although it concluded that there was no single cause of death, it concluded that taken together the injuries would eventually result in death.

2.5. Mr HL was subsequently sentenced to life imprisonment (to serve a minimum of 21 years) for the murder of Ms MA.

3. **Summary of Key Events**

3.1. The Police were contacted on 28th December 2007, and Mr HL was arrested for actual bodily harm having punched his 16 year old girlfriend to the face causing her nose to bleed. Mr HL, who was 17 at the time, was also arrested for common assault on a Police Officer who was attempting to arrest him. Mr HL was arrested and interviewed and admitted both assaults during a tape recorded interview.

3.2. Mr HL's girlfriend would not make a complaint and refused to attend court. On 14th February 2008, Mr HL attended court and was found not guilty as no evidence was offered. However the following day he attended court again and pleaded guilty to the common assault against the Police Officer and was made subject to an Action Plan Order for 3 months.

3.3. Mr HL did not engage with the Youth Offending Team as part of the Action Plan Order and failed to attend a number of appointments. As a result of this failure to engage, Mr HL returned to court for a breach of the order and a new Action Plan Order was made. Again Mr HL was in breach of the requirements due to a lack of engagement and at court on 9th May 2008 the case was adjourned pending the completion of a psychological assessment.

3.4. On 22nd May 2008, Mr HL was arrested for disorderly behaviour towards Police Officers despite being warned to stop. On 24th May 2008, he was again arrested for being drunk and disorderly. He was charged and bailed to attend the Youth Court on both occasions.

3.5. Mr HL failed to attend court on 13th June 2008 and a warrant was issued for his arrest. He was arrested on 17th June 2008.

3.6. On 2nd July 2008, when Mr HL was a few weeks away from being 18 years of age, an independent psychological assessment was completed by a Clinical Psychologist as part of the ongoing criminal proceedings. The report concluded that Mr HL was intellectually bright and articulate with insight into the nature, extent and origins of his difficulties, which when motivated he was able to effect change.

3.7. On 17th July 2008, Mr HL was sentenced at court to a further 3 month Action Plan Order as a result of the offences committed on 22nd and 24th May 2008 and the breach of his previous order. As part of the Action Plan Order, Mr HL was seen by the Children and Adolescent Mental Health Service (CAMHS). He stated that he was trying to manage his alcohol use and disclosed historical cannabis use. It was agreed that he would engage with cognitive behavioural therapy. Although Mr HL did attend the majority of the CBT sessions arranged by CAMHS, he failed to engage with the Youth Offending Team substance misuse worker.

3.8. An allegation of assault was made against Mr HL on 12th September 2008 where it was stated that he assaulted a friend whilst in drink causing black eyes. The victim refused to make a statement and no further action was taken.

3.9. Following expiry of the Action Plan Order, Mr HL was referred to Compass, young people's drug and alcohol services, for ongoing support with his alcohol use.

3.10. On 17th June 2009, Mr HL visited the GP with his mother. As a result of this attendance, the GP referred Mr HL to the Health in Mind, Psychological Health and Wellbeing Service due to Mr HL experiencing considerable problems with anxiety. The service stated that as Mr HL was moving to a county address he would need to be referred by the GP to the County Mental Health Team as he would benefit from cognitive behavioural therapy. It was stated that Mr HL had no idea or intention of suicide, self-harm or harm to others.

3.11. On 9th May 2010, Mr HL was arrested having assaulted his adult sister. Mr HL was 19 years of age. Mr HL's sister refused to make an official complaint however Mr HL admitted the offence and was given a police caution for common assault.

3.12. On 11th July 2010, Mr HL's mother wrote to the GP and reported that her son was experiencing serious social and emotional issues, had been threatened at knifepoint in his own home by local gangs, and was now rarely leaving the house. The letter stated that Mr HL had no self-confidence, was suffering with paranoia and had developed obsessive behaviours to help him cope. The following day Mr HL was seen by the GP where he was prescribed Propranolol. Mr HL was seen again by the GP on 29th July 2010 where he was referred to the Community Mental Health Team. The prescription for Propranolol was increased.

3.13. On 13th October 2010, the Community Mental Health Team wrote to the GP to state that Mr HL did not meet the criteria for their service. Suggestions were made for referrals to support services, in particular for employment support, as this was felt to have potential to improve Mr HL's confidence and social skills. It was recorded that Mr HL's self-imposed isolation had resulted in his loss of social skills and ability to act confidently amongst his peers. There was no suicidal intention, no symptoms of depression or thoughts of deliberate self-harm. The GP made appropriate referrals for Mr HL.

3.14. Mr HL was arrested by the police on 3rd November 2010 following an unprovoked knife attack on a 15 year old friend. They had been watching a film in his bedroom when he stabbed the friend 7 times with a 5 inch kitchen knife, requiring 37 stitches. Mr HL was under the influence of alcohol at the time of the assault. Mr HL admitted the offence, was charged with causing Grievous Bodily Harm with intent and remanded into custody.

3.15. On 11th February 2011, at 20 years of age, Mr HL pleaded guilty to GBH with intent and was sentenced to 3 years in a Young Offenders Institution (YOI).

3.16. On 4th May 2012, aged 21 years, Mr HL was released to Approved Premises on licence.

3.17. On 11th May 2012, Mr HL attended an appointment with a Consultant Forensic Psychiatrist, accompanied by his Offender Manager. The report that was written as a result of this appointment indicated that Mr HL represented an ongoing risk of serious violent offences and that his risk of offending would increase should he return to drink or drug use and perhaps when faced with transitions or losses.

3.18. Mr HL also attended appointments with Double Impact (substance misuse and mental health services) regarding his alcohol use and an Employment and Training assessment where it was decided that he was to apply to attend college.

3.19. On 12th June 2012, Mr HL failed to return to the Approved Premises by the time of curfew, and was recalled to prison.

3.20. On 13th August 2012, Mr HL was released back to the Approved Premises subject to the same licence conditions. Support from mental health and alcohol services, as well as Employment and Training was re-established.

3.21. Mr HL failed to return to the Approved Premises on 24th August 2012 and was again recalled to prison. However he was unlawfully at large until 13th September 2012 when he handed himself in to the police and was transferred to HMP Doncaster.

3.22. Whilst at HMP Doncaster, Mr HL was seen on a number of occasions by a Consultant Psychiatrist. His diagnosis was of an adjustment disorder with anxiety and depressive symptoms.

3.23. On 22nd November 2013, at sentence end, Mr HL was released from prison. He was 23 years of age. Having concluded his sentence, there were no conditions or licence requirements for Mr HL to adhere to therefore Mr HL was not subject to any statutory provisions when released into the community.

3.24. Mr HL, now 24 years of age, was arrested on 8th June 2014 on suspicion of harassment and stalking. Mr HL was given police bail with conditions not to contact the woman in question or attend her local area. The CPS subsequently determined that there was insufficient evidence to support a realistic prospect of conviction.

3.25. On 8th December 2014, the mother of Mr HL reported him missing to the police. She stated that he had been drinking, had split from his girlfriend (Adult A) and had talked about killing himself. Within the missing person report there was reference to Ms MA being a previous partner and the possibility that Mr HL had gone to visit her. Unsuccessful attempts were made to contact Ms MA to see whether she had any information regarding Mr HL's whereabouts. This is the only reference to Ms MA with regards to Mr HL within all of the agency records.

3.26. Mr HL returned home later that evening and, following a police referral, was seen by a mental health nurse who identified that his low mood was due to the relationship with his girlfriend (Adult A) ending. Mr HL was advised to see his GP the next day. He stated that he had no intention of self-harm. The PCSO who visited the family made a referral to the Multi-agency Safeguarding Hub on 17th December 2014.

3.27. Upon receipt of the C51, the MASH determined that Mr HL had a 'care need' rather than a 'safeguarding concern' and the form was forwarded to Adult Social Care for them to progress.

3.28. On 27th January 2015, the PCSO visited as a result of the contact made on 26th January 2015. Following this visit the PCSO made a referral to the Vulnerable Persons Panel in respect of Mr HL. The referral was not heard by the Vulnerable Person Panel which is held monthly as Mr HL was arrested prior to the next panel taking place.

3.29. On 29th January 2015, a Social Worker from the Mental Health Team – Social Care visited the family home. The mother of Mr HL informed the Social Worker of her concerns regarding Mr HL's behaviour. A discussion took place regarding a referral for Mr HL to the Community Mental Health Team.

3.30. On 2nd February 2015, the mother of Mr HL contacted the Mental Health Team – Social Care to state that Mr HL had gone missing on Friday (30th January 2015) and on Saturday (31st January 2015) he had sent her messages stating that he needed help and to come to get him, which she did by borrowing a neighbour's car. The worker stated that she was going to be making a referral for Mr HL to obtain independent accommodation but his mother felt that he was not ready for independent living. It was agreed that the referral would not be made and that the mother would ensure that Mr HL attended the GP appointment in order to be referred to the Community Mental Health Team.

3.31. On 4th February 2015, the death of Ms MA was reported to the police.

3.32. Mr HL was subsequently arrested and charged. He was 24 years of age at the time of the murder.

4. **Family Perspectives**

4.1. Ms MA was described as a creative, bright and spontaneous woman who loved to travel and to write. She had written scripts, plays, short films and books, and used to work as a TV extra. According to her daughter, Ms MA was a very strong woman who was driven and had raised her daughter to be the same. Ms MA did not care what others thought of her, “She knew what she wanted and believed you can do something if you put your mind to it, like with her books, all she did was write”. Ms MA’s daughter shared that her mother held very strong views regarding domestic abuse, violence in general, drugs and alcohol, racism and homophobia. Ms MA was described as a ‘spiritual’ woman who believed in the afterlife and past life regression. She would often dye her hair bright colours and wear alternative ‘gothic’ clothing.

4.2. Neither Ms MA’s daughter nor Ms MA’s closest friends were aware of the relationship between her and Mr HL. Her daughter only became aware of the relationship after her mother’s death.

5. Analysis

5.1. This review has established that there was no professional knowledge of the relationship between Ms MA and Mr HL prior to the domestic homicide. There were no indicators or evidence of domestic abuse being a factor within their relationship at all. Very little is known about Ms MA and even less is known about the nature of her relationship with Mr HL. Although there were, at various points, concerns regarding the risk of harm that Mr HL might pose to himself or others, at no point was Ms MA known to be at risk of harm from him, or from anyone else for that matter.

5.2. As a result, this review has focused upon Mr HL and the agency involvement with him, with particular regard to risk management.

5.3. A number of themes/areas of learning have arisen from the review of this case. These can be summarised in the following headings:

- Lack of engagement
- Continuity of support
- Risk management
- Information sharing and recording
- Domestic abuse and the role of the Youth Court
- The use of DASH RIC

Lack of Engagement

5.4. This review has indicated that Mr HL had a troubled early life. However a significant feature throughout was his lack of engagement with support services.

5.5. Mr HL had capacity to make choices and as such, his degree of cooperation with support services was well within his control. Although there is evidence of some psychological difficulties, Mr HL's level of functioning and lifestyle was not so inhibited or troubled to preclude him from engaging with services, and nor was he diagnosed with a mental illness that would prevent him from working with the professionals who were attempting to support him. Mr HL never met the criteria to be compelled to engage with services (apart from when being a condition of his licence) – engagement had to be his choice. It is significant that Mr HL's difficulties and in particular his propensity for violence appeared to be linked to alcohol misuse and this is the area where he repeatedly failed to engage with support offered, including prior to final release from prison.

5.6. **Finding:** Even when appropriate interventions are put in place; outside of statutory provisions, these can only be effective if the subject chooses to engage and wishes to make, and sustain, changes. A recommendation has not been made from this finding as it is being

addressed by the Domestic and Sexual Violence and Abuse Safeguarding Working Group who are looking at non enagement of vulnerable people with capacity.

Continuity of Support

5.7. The review has established that there were occasions where the continuity of support for Mr HL was compromised, in the main due to Mr HL moving addresses or custodial establishments.

5.8. Although appropriate support was put in place once released into the community on licence, this too was disrupted by his recall to prison on two occasions.

Finding: Where possible, there is a need for planning for continuity of support services, at points of transition or movement. A recommendation has not been made from this finding but this report is shared with agencies who will be tasked to note the findings as well as recommendations and incorporate them into their core business.

Risk Management

5.9. Mr HL was managed by Multiagency Public Protection Arrangements (MAPPA) at Category 2 (serious violent, terrorist or other sexual offender sentenced to 12 months or more in custody)**,** Level 2 MAPPA management following sentencing for s18 wounding with intent.

5.10. Levels of management are determined as being:

- Level 1: ordinary agency management – risks posed can be managed by the agency responsible for the supervision or case management of the offender

- Level 2: cases where the offender is assessed as posing a high or very high risk of harm; or the risk is lower but the case requires active involvement and coordination of interventions from other agencies to manage the presenting risks of serious harm, or the case has previously been managed at level 3, or multi-agency management adds value to the lead agency's management of the risk of serious harm posed.

- Level 3: cases where the management issues require senior representation from the Responsible Authority and duty to cooperate agencies. This may be when there is a perceived need to commit significant resources at short notice or where there is a high likelihood of media scrutiny or public interest

in the case and a need to ensure public confidence in the criminal justice system.

5.11. At the MAPPA meeting held on 9th May 2012, the level was reduced to Level 1. This was appropriate given that relevant agencies were working with Mr HL and there was a risk management plan in place. In addition, he was to remain on licence until 2013.

5.12. The 2012 MAPPA statutory guidance states that when a MAPPA offender is recalled to prison, his or her MAPPA management level must be reviewed before release. The Offender Manager did complete the OASys final risk assessment two weeks prior to Mr HL's release, which includes specific questions with regard to MAPPA management. Mr HL was assessed as high risk of harm to the public.

5.13. When Mr HL was released from prison at sentence end, and therefore no longer subject to a licence, he was no longer a MAPPA Category 2 offender. Had consideration been given for MAPPA management upon release from prison, it would have to have been as a Category 3 offender[1].

5.14. All Category 1 and 2 offenders managed at Level 2 or 3 who are coming to the end of their notification requirements or period of statutory supervision must be reviewed and should be considered for registration as a Category 3 offender. However, Mr HL did not meet this threshold for statutory consideration at category 3 having only been managed at Level 1 prior to sentence end.

5.15. The National Offender Management Service MAPPA Level 1 Best Practice Guidance also published in 2012, states that:

Good practice ordinary agency management will, however, include information-sharing at least between the police and the probation service, especially for high risk of serious harm offenders.

5.16. In the case of Mr HL it may have been advantageous for there to have been discussion between the Police and the Probation Service prior to his release, despite there not being a statutory requirement to do so, especially given the OASys final risk assessment determining that he was a high risk offender. Locally, a pilot scheme between NPS and the Police is being established which will ensure that communication occurs. Offender Managers now inform the Police Intelligence Team

[1] 3.1. The MAPPA statutory guidance states that Category 3 offenders are other dangerous offenders who do not meet the criteria for either category 1 or 2 but who are considered by the Responsible Authority to pose a risk of serious harm to the public which requires active multi-agency management.

3.2. To register a category 3 offender, the responsible authority must establish that the person has committed an offence which indicates that he or she is capable of causing serious harm to the public and reasonably consider that the offender may cause serious harm to the public which requires a multi-agency approach at level 2 or 3 to manage the risks.

of all releases at sentence end date (SED) of offenders who continue to pose an ongoing risk of harm and in particular all High Risk/Very High Risk of Harm offenders. The Intelligence Team will then disseminate the information to the local police teams including front line staff in the relevant area so they are aware of their release.

5.17. In addition, the Community Rehabilitation Company (CRC) for Derbyshire, Leicestershire, Nottinghamshire and Rutland, which came in to operation in June 2014 is now responsible for delivering resettlement services to all prisoners in resettlement prisons. In the final 12 weeks before release a pre-release plan will be made. The plan will look at practical resettlement needs, and one of support as opposed to risk management. In preparation for release, the resettlement team can collate any relevant appointments; assist attendance at appointments and signpost to specialist services. Although this would have been of benefit to Mr HL in terms of support at sentence end, and might have assisted in ensuring ongoing mental health support, it would have required his engagement and cooperation.

5.18. It is evident that concerns regarding Mr HL were becoming apparent in late 2014/early 2015. As a result discussions took place between agencies at round robin meetings hosted by the Housing provider (Gedling Homes) and appropriate referrals were made to the Multiagency Safeguarding Hub and to the Vulnerable Persons Panel. Mental Health Team – Social Care.

5.19. The concerns however were predominately that of Mr HL's mental health and potential risk that he posed to himself rather than a risk to others. There was no indication that he posed a risk to his girlfriend Adult A or indeed to Ms MA. There was opportunity to assess any risk posed to his mother given her reports of being scared of her son but this did not occur (see section re DASH RIC below).

5.20. The panel has considered whether the possession of a samurai sword in January 2015 should have triggered a referral to MAPPA. The panel has found that the actions of the PCSO, in that a referral was made to the Vulnerable Persons Panel, plus the fact that the round robin meetings were considering all of the issues, was sufficient. Mr HL would not have met the criteria for MAPPA management at this stage, and there would have been little added value given the multi-agency liaison already in place.

Finding: The risk posed by Mr HL was managed in accordance with locally agreed processes and national MAPPA guidance. Recent local initiatives will strengthen information sharing for offenders who are released from prison at sentence end. As noted in the Changes to Practice section, pg.18 and the pilot is being monitored.

Information Sharing and Recording

5.21. The review has established that there was much evidence of information sharing and communication between professionals. There were examples of innovative practice such as the round robin meetings and going forward the new initiatives being developed between National Probation Service and the police at sentence end. However there were also instances where communication and recording practices could have been improved.

5.22. It is significant that the forensic psychiatric report completed in 2012 was not evident in the GP or probation records. The loss of the Nottinghamshire Healthcare NHS Foundation Trust clinical notes for Mr HL makes it impossible to establish who the report was sent to, although normal practice would be for it to be sent to the referrer, in this case probation and the GP. The significance of this apparent omission is that the report determined an ongoing risk of harm, and identified triggers. The report findings and the identified triggers should and could have informed future risk management although it has been established by this review that the probation risk assessments identified risk appropriately.

5.23. Another example of a lapse in appropriate information sharing is that the GP did not receive minutes of the MAPPA meetings held in respect of Mr HL to which they were invited.

5.24. The review has considered much evidence of the mother of Mr HL making contact with agencies on his behalf or to express concerns about Mr HL and seek support. This is challenging in terms of consent to disclose information but may also have prevented a true understanding of Mr HL, given the influence of the accounts given by his mother.

5.25. The review has also established that there were opportunities to add flags or warning markers to the records of Mr HL, especially in relation to his mental health, both within police and GP systems.

Finding: Agencies must ensure that there is an audit trail in place for the distribution of reports/minutes and that relevant warning markers are added to records. A recommendation has not been made from this finding but this report is shared with agencies who will be tasked to note the findings as well as recommendations and incorporate them into their core business.

Domestic Abuse and the Role of the Youth Court

5.26. In 2007, Mr HL was a young person who harmed his 16 year old girlfriend when he himself was 17 years of age. The statutory definition of domestic abuse at the time excluded 16 and 17 year olds.

5.27. This was changed in 2013 to the following:

any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

5.28. In response, locally a care pathway for young people in intimate violent relationships has been developed.

5.29. Due to his age, Mr HL attended the Youth Court in respect of this incident, as would be the case today. However perpetrators aged 18 and over are dealt with locally by the Specialist Domestic Violence Court. The Youth Court does not have a domestic abuse specialism, or the expertise with regard to support pathways.

Finding: Perpetrators of domestic abuse aged 16 and 17 should be responded to with the criminal justice system with the same degree of specialist knowledge in respect of domestic abuse as those aged 18 and over.

The use of DASH RIC

5.30. The Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification Checklist is the multi-agency risk assessment tool used locally in cases of reported domestic abuse. This is well embedded, particularly within the police. However, it is less commonly used in cases of reported stalking and harassment, especially when the individuals are not in a relationship. The DASH RIC could have been utilised following the reports of alleged stalking perpetrated by Mr HL.

5.31. The mother of Mr HL indicated that she was scared of Mr HL to the PCSO and to Adult Social Care. It would have been good practice to have completed a DASH RIC in order to determine the level of risk to which she was potentially exposed.

Findings: Practitioners should utilise the DASH RIC in cases of reported stalking and harassment.

When family members are reporting being fearful of someone they live with, the DASH RIC will help identify and determine the level of risk.

Good Practice

5.32. The review has considered that the actions of the Mental Health Team – Social Care are to be commended in terms of their swift response to the families increasing need.

5.33. The development of the round robin meetings as a forum to share information and concerns is also identified as an example of good interagency practice.

6. **Conclusions**

6.1. All of the agency information pertains to Mr HL and it is here that most of the learning from the case has arisen.

6.2. The significant difficulty within the case is how agencies can realistically identify and manage unpredictable and random acts of violence committed by a person with capacity[2]. Mr HL has a history of unprovoked violent attacks against people known to him, often when under the influence of alcohol. Due to this history, the focus of this review has been upon risk management.

6.3. Two psychiatric assessments of Mr HL were completed as part of the criminal proceedings following Ms MA's death. Copies were requested to inform this review, however Mr HL refused to give consent for their release for either this review or to agencies aiming to support him.. When sentencing Mr HL, the Judge referred to one of the assessments which diagnosed Mr HL with an antisocial personality disorder. It is evident that Mr HL has demonstrated personality traits that would pose a significant challenge to agencies in terms of engagement and reduction of risk, especially a risk to the general public.

6.4. There are clear and established processes in place to manage risks posed to an identified individual or individuals. The challenge here is how to manage a more generic and unpredictable risk. In order to formulate a robust risk assessment the following factors must be established: the nature of the risk; who is at risk and in what circumstances. These factors were not easily identifiable in the case of Mr HL. It is evident that Mr HL himself maintained responsibility to manage the risk that he posed.

6.5. It is the DHR panel view that agency responses, as outlined through this review, were proportionate and appropriate, and emerging concerns were being considered within the right processes, although there were instances where practice could have been improved. The DHR panel has found that agency responses could not have impacted upon or prevented the death of Ms MA. The relationship between Mr HL and Ms MA was not known, even to some of those friends and family close to them. The risk that Mr HL posed to Ms MA was unknown to agencies and his actions towards her could not have been predicted.

[2] Under mental health legislation

7. Changes to Practice

- The role of GPs in the MAPPA process is now much improved, GP representation is better and the MAPPA coordinator now has established means to liaise securely with all GP practices in the area.

- Locally, a pilot scheme between the National Probation Service and the police is being established which will ensure that communication occurs at sentence end for high risk offenders. Offender Managers must now inform the police intelligence team of all releases at sentence end date (SED) of offenders who continue to pose an ongoing risk of harm and in particular all High Risk/Very High Risk of Harm offenders. The Intelligence Team will then disseminate the information to the local police teams in the relevant area so they are aware of their release.

- Over recent months there has been a national review undertaken around MAPPA eligibility. Whilst this work is still in progress it has been agreed that there will be an updating and additional guidance for the management of offenders at level 1 and for those being considered for category 3.

- A separate national piece of work is also underway reviewing recall processes with a view to ensuring that more recalled offenders are released prior to licence end albeit for a short period to allow a period of supervision with a view to helping them reintegrate. Additional guidance on this and training will be provided from April 2016 onwards.

- The Community Rehabilitation Company (CRC) is now responsible for delivering resettlement services to all prisoners in resettlement prisons. In the final 12 weeks before release a pre-release plan will be made. The plan will look at practical resettlement needs, and one of support as opposed to risk management. In preparation for release, the resettlement team can collate any relevant appointments; assist attendance at appointments and signpost to specialist services.

- The new Protocol on the Appropriate Handling of Stalking Offences, which has been jointly drafted and agreed by the CPS and ACPO, focuses strongly on the needs of stalking victims. The protocol also instructs prosecutors to apply, where possible, for restraining orders on both conviction and acquittal in order to protect the ongoing safety and security of victims. Restraining orders on acquittal can be an added protection for victims in situations where the likelihood of abuse may be 'beyond the balance of probabilities', a lower standard of proof than that usually required in criminal convictions of 'beyond reasonable doubt'.

8. **Recommendations**

8.1. Each agency retains responsibility for the implementation of actions arising from their IMR. In addition, the Crime and Drugs Partnership Domestic Homicide Review Assurance, Learning and Implementation Group provides scrutiny and quality assurance of these agency actions.

8.2. Given the changes in practice identified above and the fact that some findings did not result in an identified need for a recommendation, the recommendations arising from this review are few in number, and although they will improve practice going forward, their implementation would not have altered the outcome in this case. The recommendations are for Nottingham as this is where Ms MA resided. However Mr HL resided in a different Local Authority area and as a result of this, this report and its findings will be shared with the relevant community safety partnership boards for them to consider the recommendations locally.

8.3. The recommendations arising from this review are as follows:

a. Agencies will provide assurance that practitioners have an awareness of the DASH RIC and the S-DASH[3], as well as how and in what circumstances they should be used.

b. Agencies should ensure a refresh of the training regarding the DASH RIC and consider its use for familial domestic violence and abuse, including parents.

c. Young persons who harm aged 16 and 17 should be responded to with the criminal justice system with the same degree of specialist knowledge in respect of domestic abuse as those aged 18 and over.

d. Agencies should also ensure that they have appropriate information sharing policies in place that make reference to third party information.

[3] S-DASH (2009) Risk Identification Checklist For Use in Stalking and Harassment Cases