Nottingham Community Safety Partnership

Working in partnership to build a safer and stronger city

Summary of Learning Report

SUBJECT: RAA

Died April 2022

Dr (h.c.) Vivien Bickham MBE
Independent Domestic Homicide Review Chair and
Report Author
January 2023

Contents

The Nottingham Community Safety Partnership would like to express their sincere condolences to the surviving family members and especially to her children regarding the loss of RAA.

1. Introduction :

1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004. This Domestic Homicide Review is commissioned by Nottingham Community Safety Partnership in response to the death of RAA at the age of 29. This DHR report examines agency responses and support given to RAA prior to her being found deceased on April 2022 by her ex-partner XY and mother at her ex-partner's property, having taken an apparent overdose of prescribed medication. An inquest has not currently been completed the cause of death to be confirmed by the coroner.

1.2 RAA had a history of mental health concerns documented from adolescence into adult hood. In addition to agency involvement, the DHR will also examine

the past to identify any relevant background or trail of abuse before her death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 There is clear evidence that RAA was experiencing domestic abuse with several police reported incidents. An investigation into coercive controlling behaviour has been undertaken by Derbyshire Police this has now been concluded with no action taken.

1.4 The Nottingham Community Safety Partnership approved the circumstances of this case as fulfilling the criteria for a statutory domestic homicide review and initiated the DHR process on the 30th May 2022 by the Board. The Significant Incident Learning Process (SILP) review model was the methodology used. This involves agencies producing timelines and analytical reports of their involvement and encourages learning to be identified by the staff involved in the case and as far as possible, aims to involve members of the families affected by the incidents. Staff who had been involved, and the agency report writers, were brought together at a learning event to discuss the reports and issues and themes emerging, focusing on key episodes identified from the reports. Recall Days followed to discuss the draft of the Overview Report. The Overview and Summary reports were quality assured at the Nottingham Community Safety Partnership meeting on the 7/2/23 before submission to the Home Office Quality Assurance Panel prior to any publication.

1.5 The guidance states:
A Domestic Homicide Review (DHR) must be undertaken when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

The purpose of the DHR is to:
establish what lessons are to be learned from 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 and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated 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 (December 2016)

Confidentiality and Dissemination

1.6 The DHR was conducted in the spirit of openness and fairness that avoids hindsight bias and any bias toward any one agency or individual involved. The DHR was conducted in private. All documents and information used to inform the review were confidential. The findings of the review should remain confidential until the Nottingham Community Safety Partnership accepts the Overview Report, Executive Summary and Action Plan and it has been reviewed by the Home Office Quality Assurance Panel. To preserve confidentiality, and in accordance with the wishes of the surviving family members of the deceased, the following references have been used to represent the subjects of the review. This DHR has been anonymised in accordance with statutory guidance. The specific date of the death and the sex of any children have been removed (with anonymity further enhanced by the children being referred to as Child A, and B identifying information about their primary school being removed). Only the Chair and Review Panel members are named.

The following references as agreed with the family representative have been used in this review to protect the identities of the victim, other parties, those of their family members and the perpetrator:

RAA	deceased
XY	ex-partner
Child A	child
Child B	child
BC	RAA's mother
AZ	RAA's father

Dissemination List for the report:

The following individuals/organisations will receive a copy of this report:

- Relevant family members who wish to have a copy namely BC and AZ.
- Nottinghamshire Police and Crime Commissioner
- Domestic Abuse Commissioner
- HM Coroner
- The Chief Officer of all organisations engaged in the review
- Home Office Repository

2. The Review Process: This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.

2.1 The domestic homicide review process commenced with an initial meeting of the 13/10/22. An initial trawl for information identified 19 agencies who had significant contact with either RAA or her partner. Independent Management Reviews (IMR's) and chronologies of their contact with RAA and her partner were requested from these agencies addressing the agreed Terms of Reference and Project Plan.

2.2 Independence and Quality of IMRs: The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were comprehensive and enabled the Review Panel to analyse the contact with RAA, XY, and their children, and to produce the learning for this DHR. The full List of Panel Members and the Agencies contributing to the review are listed below

Agencies contributing to the review are listed below:

- Nottinghamshire and Derbyshire Police
- Juno Women's Aid
- Nottingham Muslim Women's Network
- East Midlands Ambulance Service
- Nottinghamshire Health Care Foundation NHS Trust
- NHS Nottingham ICB – Including GP information.
- Nottingham CityCare Partnership
- Nottingham City Council Children's Services
- Derbyshire Children's Services
- Housing Aid Nottingham City Council
- Derbyshire Community Health Services NHS Foundation Trust
- ELM Foundation Derbyshire
- The Arc Bolsover District Council Derbyshire
- Education – Schools in Derbyshire and Nottingham
- NHCFT & City Crisis Resolution and Home Treatment Team (CRHT)
- Neighbourhood Development
- NUH
- Adult Social Care
- Probation
- NHS 111 service

- Framework Clean Slate
- DWP
- Nottingham City Council Housing
- Erewash Borough Council

Contributors to the Review: The following agencies made contributions to this DHR:

Agency	Initial information only	Panel member	Agency Report Author
NCSP		Paula Bishop (Domestic Violence & Abuse Policy Officer)	Report for MARAC
Nottingham City Council Adult Social Care	Julie Sanderson Head of Adult Safeguarding and Quality Assurance Oliver Bolam Head of Mental Health & Whole Life Disability	Julie Sanderson Head of Adult Safeguarding and Quality Assurance **If required**	
Nottingham City Council Children's Integrated Services		John Matravers (Service Manager Safeguarding Partnerships) Jesse Keene Children's Safeguarding Board officer (when John is unable to attend)	Samantha Danyluk Head of First Response
Nottingham CityCare Partnership		Karen Turton (Named Nurse Safeguarding) Katy Swanwick (Safeguarding service manager) When Karen is unable to attend	Joanna Williams Named Nurse Safeguarding, and Katy Swanwick (Safeguarding service manager)

Agency	Initial information only	Panel member	Agency Report Author
Derbyshire Police		Darren Pope (Detective Chief Inspector, Domestic Abuse, Stalking & RASSO Lead, Public Protection)	
East Midlands Ambulance Service (EMAS)		Liz Cudmore (Child and Young Person Safeguarding Lead)	Liz Cudmore Child and Young Person Safeguarding Lead
Nottingham City Council Housing Aid		Debbie Richards (Service Manager)	Debbie Richards (Service Manager)
Juno Women's Aid		Yasmin Rehman (Chief Executive Officer) Sam Bennett Head of Quality, Compliance & Performance	Sam Bennett Head of Quality, Compliance & Performance
NHS Nottingham and Nottinghamshire Integrated Care Board		Nick Judge (Associate Designated Nurse for Safeguarding Adults) Ishbel Macleod (Designated professional for Safeguarding Adults) – attends when Nick is unable to.	Nick Judge (Associate Designated Nurse for Safeguarding Adults)
Nottingham City Homes (NCH)		William Morritt (Head of Tenancy and Estate Management)	William Morritt (Head of Tenancy and Estate Management)
Nottingham Health Care Trust (NHCFT)		Helen Pritchett (Specialist Practitioner	Sam Roberts Safeguarding Lead

Agency	Initial information only	Panel member	Agency Report Author
		Domestic Abuse and Safeguarding) Replaces Hayley Frame (Senior Safeguarding Lead) who is leaving	
NUH		Maggie Westbury Adult Safeguarding Lead	Maggie Westbury Adult Safeguarding Lead
Nottingham Muslim Women's Network		Zaynab Asghar – also expert panel member	Zaynab Asghar
Nottinghamshire Police (Public Protection)		Mark Dickson (Detective Chief Inspector – Public Protection) Luke Waller, Detective Inspector (when Mark is unable to attend)	
Police – EMSOU			Adrian Morgan Regional Review Unit (covered all police forces info).
Probation Service		Lisa Adkins-Young Deputy Head, Nottingham and Nottinghamshire	Karen Middleton MAPPA Coordinator
Child A Primary School		TS Principal JS (DSL) - (attended meetings for Principal)	JS (DSL) TS (Principal)
Derbyshire County Council		Alison Boyce (Domestic Abuse Manager, Community Safety)	

Agency	Initial information only	Panel member	Agency Report Author
The Elm Foundation		Jennifer Calverley	Jadah Shah Derbyshire Domestic Abuse Helpline & Community Team Service Manager
Erewash Borough Council		Kat Thornhill (Community Safety Manager)	Leah Taylor Housing Options Team Leader
Derbyshire Children's Services		Adele Glover (Head of Child Protection and IROs)	Paula Livesey Head of service
Derbyshire Community Health Services NHS Foundation Trust	Jane Graham Safeguarding Specialist Practitioner Adults Sarah Fitzgerald Safeguarding Specialist Practitioner		
Framework - Nottingham Recovery Network (NRN) & Clean Slate		Claire McGonigle Kevin Howard Head of SHEQ (Safety, Health, Environment & Quality)	Jez Wilson Services Manager Criminal Justice Substance Misuse Service & Alcohol Recovery
DHU Healthcare CIC		Julie Tomlinson Lead Nurse – Adult Safeguarding	Julie Tomlinson Lead Nurse – Adult Safeguarding
Bolsover District Council – The Arc	Deborah Whallett **Nothing Further to contribute to the review**		Sharon Ryan Job title: Domestic Violence Officer / IDVA
Department of Working Pensions (DWP)	Kerry Jackson **Nothing Further to contribute to the review**		

Panel Members

Name	Job Title	Agency
Paula Bishop	Domestic Violence & Abuse Policy Officer	Nottingham Crime and Drug Partnership
John Matravers	Service Manager Safeguarding Partnerships	Nottingham City Council Children's Integrated Services
Karen Turton	Named Nurse Safeguarding	Nottingham CityCare Partnership
Darren Pope	Detective Chief Inspector, Domestic Abuse, Stalking & RASSO Lead, Public Protection	Derbyshire Police
Liz Cudmore	Child and Young Person Safeguarding Lead	East Midlands Ambulance Service (EMAS)
Debbie Richards	Service Manager	Nottingham City Council Housing Aid
Yasmin Rehman	Chief Executive Officer	Juno Women's Aid Specialist Agency
Nick Judge	Associate Designated Nurse for Safeguarding Adults	NHS Nottingham and Nottinghamshire Integrated Care Board
William Morritt	Head of Tenancy and Estate Management	Nottingham City Homes (NCH)
Helen Pritchett	Specialist Practitioner Domestic Abuse and Safeguarding	Nottingham Health Care Trust (NHCFT)
Maggie Westbury	Adult Safeguarding Lead	NUH
Zaynab Asghar	Expert panel member	Nottingham Muslim Women's Network
Mark Dickson	Detective Chief Inspector – Public Protection	Nottinghamshire Police (Public Protection)
Adrian Morgan	Regional Review Unit	Police – EMSOU Report Author (covered all Police forces info)
Lisa Adkins-Young	Deputy Head, Nottingham and Nottinghamshire	Probation Service
Anon	Principal and DSL	Child A's primary school
Alison Boyce	Domestic Abuse Manager, Community Safety	Derbyshire County Council
Jennifer Calverley	Helpline & Community Team Service	The Elm Foundation
Kat Thornhill	Community Safety Manager	Erewash Borough Council
Adele Glover	Head of Child Protection and IROs	Derbyshire Children's Services
Claire McGonigle Kevin Howard	Head of SHEQ (Safety, Health, Environment & Quality	Framework - Nottingham Recovery Network (NRN) & Clean Slate
Julie Tomlinson	Lead Nurse – Adult Safeguarding	DHU Healthcare CIC

2.3 **Chair of the DHR and Author of the Overview Report:** The Nottingham Community Safety Partnership appointed Vivien Bickham to Chair the review and to author the overview report. She has never previously worked in Nottinghamshire and is independent from all the agencies involved in this case, having never had

any association with the agencies or organisations involved. She has been trained in the process prescribed by the Home Office to conduct Domestic Homicide Reviews, including three-day Chairs training by AAFDA and trained in the Significant Incident Learning Process [1] . She has written Internal Management Reports (IMRs) and led internal reviews of critical incidents in the Organisations she has worked for. She has worked in the domestic abuse field for over 40 years, in various leadership and strategic roles.

2.4 The Significant Incident Learning Process (SILP) is a learning model which engages practitioners in case reviews, focusing on why those involved acted in a certain way. It follows a systems methodology, SILP reviews also highlight what is working well and patterns of good practice.

2.5 The Review Panel met a total of five times, with the first meeting on the 12th Oct 2022. There were further meetings in October and December 2022 and with recall events to revise the draft report in January and February 2023. Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment on a final draft and signing off the final report by the Safeguarding Board on the 7th February 2023. The Chair wishes to thank everyone who contributed their time, patience and cooperation.

2.6 The Review Panel expresses its sympathy to the family of RAA dealing with their loss in such tragic circumstances.

3. Scope and Terms of Reference of the Review:

At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from the beginning of 2020 to the date of the suicide. This date was chosen because of significant incidents relating to RAA's deteriorating mental health and the refusal of XY to agree to a divorce. XY's alleged suicidal ideation as an alleged manipulative tactic of coercion impacting on RAA's mental health.

Equality and Diversity

3.1 The nine protected characteristics identified in the Equality Act 2010[2] were assessed for relevance to the DHR. The characteristics of Age, Disability, Race, Religion or belief, and Sex, were discussed by the DHR, and the potential vulnerabilities of mental health and domestic abuse were recognised by agencies working with RAA.

[1] https://www.reviewconsulting.co.uk/silp-reviews/

[2] The Equality Act 2010 sets out nine protected characteristics and discrimination is recognised when at least one of these characteristics determines the way in which a person is treated. The nine characteristics that are protected are: Age, Disability, Gender reassignment, Marriage or Civil Partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation.

3.2 At the first meeting of the Review Panel, it was identified that the protected characteristic of Sex required specific consideration. RAA was female, her partner male. An analysis of domestic abuse reveals gendered victimisation with females representing the majority of victims and males representing the majority of perpetrators[3].

3.3 The Review Panel also identified the following protected characteristics as requiring specific consideration:

- RAA's enduring mental health would meet the criteria for disability,
- Age (there was a 10 -year age gap between RAA and XY),
- Race (RAA was mixed heritage Asian other, and described being a victim of racism in her teens and XY was of Bangladeshi origin),
- Spiritual and cultural belief (RAA believed she was in an Islamic marriage which may have added cultural belief and pressure around honour and marriage with XY believed to have been of the Muslim faith)

3.4 **Scope of the Review**

The scope of the review was agreed from 27/01/2020 to date of death in April 2022 (This represents the period from when agencies became involved in reported RAA's deteriorating mental health). Additionally, at the start of the DHR, it was established that RAA had moved between the counties of Nottinghamshire and Derbyshire. The Domestic Abuse Manager for the Community Safety Partnership in Derbyshire was invited to join the Review Panel, as were specific agencies as required. There are 3 episodes identified within the review that were analysed:

Episode 1 - 27/1/20 RAA and XY were known to have a history of DA with a previous High-risk referral to MARAC and Children's Services in 2015.

Episode 2 - 17/6/20 Incidents in relation to RAA's deteriorating mental health and refusal of XY to agree to a divorce. XY's alleged suicidal Ideation as an alleged manipulative tactic of coercion impacting on RAA's mental health.

Episode 3 - 5/11/21 Escalating deterioration in RAA's mental health exasperated by longstanding relationship breakdown and alleged concerns from 'family' if RAA left XY.

Key Lines of Inquiry addressed throughout the report: The Review Panel considered the statutory guidance and identified the following case specific issues:

- The communication, procedures, and discussions, which took place within and between agencies across county borders.
- The opportunity for agencies to identify and assess domestic abuse risk.
- RAA's access to specialist mental health agencies with an understanding of domestic abuse.
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

[3] https://theconversation.com/why-gender-cant-be-ignored-when-dealing-with-domestic-violence-74137

The Review Panel benefited from the involvement of two organisations that specifically had contact with RAA around culture and honour-based abuse:

Juno Women's Aid

Nottingham Muslim Women's Network

The vital contribution of both agencies acted as a critical friend and provided comment and feedback on the report during drafting. The Chair and Review Panel are grateful for their time and input. Their contribution is a reminder of the importance of being able to access local community expertise and knowledge in the course of a DHR.

3.5 In addition agencies were asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

3.6 **Specific terms of reference set for this review which agencies were required to address in their agency reports.**

3.6.1 Identify examples of good practice, both single and multi-agency.

3.6.2 Analyse the quality of risk assessments undertaken. Were links between mental health, domestic abuse and suicidal ideation identified at any risk assessment? Have there been changes in the service since 2020, particularly policies and training?

3.6.3 Whether risk was or was not identified, where can practitioners within your agency receive advice or support if they suspect domestic abuse? Was this taken up in this case? If this is available would the advice extend to consultation or referral across agencies?

3.6.4 Is their evidence of whether any identified risk had been assessed as reaching the threshold for inter-agency information sharing especially around suicidal ideation linked to Domestic Abuse?

3.6.5 What evidence is there of communication and information sharing between agencies? How could information sharing, and communication have been improved during the scoping period both within and between agencies? Did the cross-boundary context impact on information sharing and if so, how?

3.6.6 Were referral pathways followed according to local policies? If not, what was the reason this did not happen? Are these pathways different now?

3.6.7 What role if any, did the Covid pandemic and restrictions at the time impact on access to services for RAA and family members?

3.6.8 Were agencies aware of any complexities of family dynamics or circumstances that would impact on RAA or family members accessing support?

3.6.9 Was consideration given of the link between domestic abuse and suicide because of cultural practices, concepts of honour and shame, and/or community barriers that may have prevented RAA seeking help?

4. Review Summary

4.1 Background Information

The victim will be referred to in this report as RAA. RAA was at the time of her death estranged from ex-partner who will be referred to as XY. She had 2 children, child A and child B. The eldest child A was a surviving twin, and the loss of the other twin is believed to have had an impact on RAA's mental health[4]. RAA was supported by her biological mother referred to as BC and her biological father referred to as AZ. Her biological parents were divorced however they have a good relationship, both having offered support as required throughout RAA's life. RAA also had close relationships with her half-sister and 2 biological brothers.

4.2 RAA is described as an adoring mother to her two children, kind, putting everybody first, family orientated. Although she came across as strong this was often a front as she didn't like to burden others. She is described that she often would only let you know what she wanted you to know and hold things back as she didn't want to burden her family. She would ask her mum and dad for assistance, including financial help, when necessary, although she is said to have not wanted anything.

4.3 She was known to Mental Health, Police, Children's Services and Domestic Abuse services with sporadic engagement at various crisis points. It is noted from information supplied reference to a traumatic event of an alleged rape and RAA's experience of going through the court process at 13 years of age. The rape occurred when RAA was aged 10, during this time there were concerns of some alcohol use and self-harming as part of her coping strategy with the traumatic events. Research evidences the impact of adverse childhood experiences[5] with almost half of children and young people living in the UK having experienced one or more forms of adversity. ACEs are shown to impact on a child's development, their relationships with others, and increase the risk of engaging in health-harming behaviours and experiencing poorer mental and physical health outcomes in adulthood. RAA's life experience would suggest from the examples given by family she was more than four times more likely to have concerns around mental health because of her life experience based on the research. RAA also would meet the criteria for an individual who has been exposed to complex trauma. This is defined as someone who has either experienced repeated instances of the same type of trauma (e.g. domestic abuse) over a period of time or experienced multiple types of trauma (van der Kolk, McFarlane, & Weisaeth, 1996). Expert consensus is that people who have complex trauma will typically require more intensive and extensive treatment as well as possible adaptations to standard treatment. It is significant that throughout reports there is no direct mention regarding the impact of rape trauma on RAA, minimal reference to loss of the other twin at birth with her pregnancy with child A, all with the potential impact of complex

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8747442/

[5] https://www.youngminds.org.uk/professional/resources/understanding-trauma-and adversity/#:~:text=Trauma%20isn%E2%80%99t%20a%20mental%20health%20condition%20in%20itself%2C,compulsive%20disorder%20%28OCD%29%2C%20eating%20disorders%20and%20self-harming%20behaviours.

post-traumatic stress disorder[6]. It has been established that mental health conditions including enduring suicidality have an established patten with intimate partner violence.[7] In the Domestic Homicide Reviews 2020-2021 report aggravating factors were recorded in 61% of the reviews. Of these, coercive control was the largest and financial control second. In RAA's case we see both factors highlighted by agencies and family members.

4.4 Her accommodation was primarily rented housing, both with her ex-partner and links to her family who lived close by. She is described as also spending time at a friend's property known as B in Nottingham. The Review Panel and Chair were unable to gain any further information about B. RAA did access safe temporary accommodation and was actively bidding for a safe secure property away from her ex-partner and near to the support of her family during episode 2 & 3.

4.5 RAA is known to have had a close relationship with the GP who was very supportive and was aware of domestic abuse. Her GP had regular reviews and the surgery was aware of her situation with her file flagged for domestic abuse, which is best practice. Her medication was in line with guidelines for her condition and the GP consulted with psychiatric services again best practice.

Consideration of XY in the review

4.6 RAA's ex-partner at the time of her death, was approached through agencies working with him to participate in this review. No response was received. As a result, there is no information directly from XY in this DHR. RAA is known to be XY's second wife. There is indication that XY had a history of domestic disturbances with his previous partner. Social Care records indicate XY was exposed to domestic abuse as a child. Witnessing domestic abuse[8] as a child can have a long-term impact on intimate relationships in adult hood and is seen as an indication of an adverse childhood experience in itself. There was a ten-year age gap between RAA and XY, age differences[9] can indicate a 'power imbalance' in relationships, with the older person using their knowledge and life experience to influence the younger person with their values and beliefs. XY has a recorded history of criminality with his most recent conviction in 2021. Information given by RAA was that XY had connections with agencies which RAA felt made her unsafe. This would indicate the level of coercive control through 'gas lighting'[10] and 'power imbalance'[11] XY had over RAA and would influence her help seeking process. There was some intelligence to corroborate this perception. It is not known what employment XY had at any point, it is known he had a joint claim with RAA via DWP for related benefits.

[6] https://enlivenarticles.com/ptsd-in-adults-from-childhood/

[7] https://doi.org/10.1136/bmj.o2890 (Published 01 December 2022)
Cite this as: BMJ 2022;379:o2890

[8] https://safelives.org.uk/practice_blog/living-domestic-abuse-ace-adverse-childhood-experience

[9] https://www.brook.org.uk/your-life/power-imbalances-in-relationships/

[10] https://www.thehotline.org/resources/what-is-gaslighting/

[11] https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-018-0675-0Unequalpower relations and partner violence against women

4.7 Factors highlighted in other reviews[12] include perpetrators of domestic abuse as having a vulnerability with mental ill health being the most common, followed by problem alcohol use and illicit drug use. All indicators of XY's lived experience factors in his abusive relationship with RAA. Perpetrators of abuse also commonly suffer mental health issues, with depression and suicidal thoughts together being present in one third of those involved in fatal domestic homicides, with over 60% of perpetrators where information was given were recorded as having a previous offending history.

4.8 Although XY was in contact with some agencies, for example, Police, Social Services, and child A's Primary School, in essence he is relatively absent. XY, although contacted did not participate in this DHR, which has limited the amount of information available about him and his experiences. However, it also reflects how the focus tended to be on either RAA and XY jointly (e.g. as part of the child protection or child in need plans) or on child A (e.g. in relation to contact with child A's Primary School).

4.9 The only agencies that specifically had contact with XY in relation to domestic abuse were the Police and Social Services, in response to reports relating to his behaviour. Continuing the theme of XY's relative absence, it is of note that the Police and Social Services focused their risk assessments on RAA's mental health with actions focused on her capacity rather than the impact of his behaviour.

Analysis

4.10 Taking account of the current government definition of domestic abuse[13] the information provided by agencies and family, it is clear that RAA was the victim of domestic abuse by XY.

4.11 Tragically, it will never be possible to know the full extent of RAA's experiences. However, as a minimum it appears RAA experienced the following:

- Physical abuse: Assaults by XY, including strangulation whilst she was pregnant and possibly the use or threat of weapons which he had access to too. The assaults including the incident were XY coerces RAA into the car and then assaults her, which are reported to Police result in charges being NFA'd. Assaults are also observed and reported by family members.
- Coercion, threats and intimidation: The Review Panel does not have a full picture of XY's behaviour in this context, although there are reports (including by RAA to police officers) that he had made threats to kill. Whatever means he used to coerce, threaten and intimidate, these were clearly effective: it was evident that RAA was isolated, in part because XY and his family had her constantly cooking and meeting XY's every need.

[12] Domestic Homicide Reviews 2020- 2021 Report

[13] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/statutory-definition-of-domestic-abuse-factsheet

- Emotional and Psychological abuse and isolation: The Review Panel does not have a full picture of XY's behaviour in this context, although as regular arguments were reported to the police and noted by family as well as being disclosed by child A, this is likely to have been a significant feature of the relationship. The impact of this abuse on RAA's mental health is significant with XY repeatedly using suicidal ideation as a means of control and changing the 'goal posts' of whether he will agree to a divorce, along with his alleged infidelity. XY would have been aware of her unresolved past trauma which made RAA vulnerable to psychological distress.
- Children and pregnancy: It is unclear if or how the children were used by XY to abuse RAA. The children are described on one occasion as being fearful of XY. The children have both witnessed or been present when abuse has occurred, agencies need to look beyond witnessing abuse and seek to understand coercive control in the relationship and impact on children. RAA and the children are aware of the omnipresence of the abuser in any interactions with services and clearly understand the consequences of the 'rules written and unwritten' he controls the space for any action. However, it is of note that RAA was fearful that contact with services could lead to the loss of her children. It is believed this is based on what XY had told her and her experiences with services focusing on her mental health rather than the impact the loss of child A's twin had on her mental health and previous trauma she had endured.
- Economic abuse: It is unclear as the extent of his financial coercion over RAA however, financial challenges appear to have been a challenge in their relationship with RAA appearing to be providing the main source of income. It is not mentioned in any agency reports as to the economic status of XY. His control of finances may relate to him limiting the capacity of RAA to leave by limiting her access to funds for transport or accommodation. XY is reported to have demanded money observed by family and RAA having to ask for financial support from her parents due to his lifestyle.

4.12 Clearly, the picture of domestic abuse and impact of psychological distress of abuse presented was not known to all agencies, nor known in full. However, different agencies knew about domestic abuse, mental health concerns, cultural pressures during their contact with RAA and XY, as well as the children. It is relevant to note that at various points in the past RAA had left the family home and was reported as wanting to end the relationship and said this herself. She had actively sought information about how to obtain an Islamic divorce. She was in the previous months to her death actively bidding for alternative accommodation. At the point of her death the couple were estranged and had been informed that should they reconcile statutory agencies would become involved. This may have added pressure on RAA and resulted in a sense of hopelessness that there was no alternative in resolving the situation.

5. Conclusions:

The impact of a client in considering suicide can be terrifying for practitioners. Suicide refocuses practitioners' attention, restructuring the way they were thinking and communicating at the time to justify their decision making. For many domestic abuse professionals this can be a good thing from a practice perspective. The consequences of suicidal ideation in domestic abuse cases can be devastating as we have seen in RAA's case. On the other hand, this is precisely why abusers weaponise suicide threats to control victims. Yet engagement with XY was

recognised as being at a basic level. There are areas around professional curiosity that can be developed to enhance best practice and offer early intervention strategies to address a perpetrator's use of abuse.

Research by the National Vulnerability Knowledge and practice programme identify suspected victim suicide is strongly characterised by intimate partner domestic abuse, it is heavily gendered to female victims, and victims are most commonly in their mid-20s to mid-40s the age group RAA was in. Services need to work to and be cognisant of local partnership safeguarding requirements and referral processes, to help safeguard domestic abuse victims with mental health concerns. One of the key findings was most commonly deaths occurred by hanging, poison or drugs again RAA falls into this cohort. Moving towards prevention, a case of best practice highlighted a Police Force that has implemented a process whereby an attempted suicide of a domestic abuse victim is reported to the local Independent Domestic Violence Advocate (IDVA) service, who contacts that individual to provide additional support.

It is known that family involvement and engagement can be key to recovery for individuals diagnosed with mental illness. Previous studies have found that people using mental health services are more likely to stick to their treatment plans and have better outcomes when they have supportive family members involved in their care. Most government policies and mental health guidelines suggest that staff members should involve carers in patients' treatment. It is evident that RAA had supportive family members who advocated for her, however her main carer her partner, in part as RAA highlighted, had a significant impact on her mental state and having access to an IMCA or IDVA may have assisted agencies understanding the role XY's behaviour played in disenabling RAA's trust in services by informing RAA he had connections in agencies and would know her plans. Professionals need to be clear as to the question being asked of the victim and recognise that individuals may be able to make decisions with capacity in response to certain questions and may not in others due to fear. Assessing capacity can be particularly challenging in domestic abuse situations, where the person is cared for by their intimate partner and is seen to be making decisions which put or keep themselves in danger. For example, a decision to continue to live with an abusive partner might be a free and informed decision based on a full understanding and appreciation of the risks and the alternative courses of action, including support available. A decision not to leave may also be based on a realistic fear of the behaviour the perpetrator has threatened if the victim were to disclose abuse or try to leave the relationship. Research shows that women are at most risk of serious harm from the perpetrator when they are leaving the abusive relationship. Case law has clarified that there is scope for local authorities (using the principle of inherent jurisdiction) to commence proceedings in the High Court to safeguard people who do not lack capacity, but whose ability to make decisions has been compromised because of constraints in their circumstances, coercion or undue influence. A principle of the Mental Capacity Act is that a person only has full capacity if they have access to all the relevant information about the decision they are making. If, after considering the options carefully, you believe they are not free to make decisions then it is time to make a defensible decision about the next steps. This information is taken from Adult Safeguarding and Domestic Abuse — A guide to support practitioners and manager (second edition, 2015).

6. Lessons Identified

This part of the report will summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action. Early learning identified during the review process and whether this has already been acted upon is captured in Single Agency Actions Appendix 3.

6.1 It is acknowledged that there was some impact of the pandemic on how agencies and services interacted with RAA in the early scoping period. The pressures on RAA to manage the home, keeping her children and family safe played a role in her help seeking process. RAA was working out which was the safest way to exit her marriage, whilst meeting the requirements of various assessments by agencies to appease XY. Someone experiencing domestic abuse needs to feel safe and have a safe place to go to. Meetings with Derbyshire Social Services as restrictions were lifted were held virtually with RAA with her agreement. Although it was considered not having face-to-face meetings had an impact it cannot be discounted either the lack of personal connection with services. The added complication in RAA's situation was the concept of her being responsible for "upholding family ties" too. In cases where cultural dynamics play a role it is considered dishonourable to leave a marriage. The suggestion is to apply a holistic approach using a professional curiosity lens of how the intersectionality of life links together for anyone in the future e.g. using a culture gram may assist in building rapport in the future.

6.3 In episode 2 August 21 Derbyshire Social Services made a request to Nottingham Team for information on previous assessments, this information wasn't received until Dec 21. Also, a request was made to Derbyshire Police on September 21 and was received prior to the strategy meeting in December 21. It is of note that if information on the history of vulnerabilities within the family had been shared earlier this may have informed professionals to understand the distress to the interventions by the family due to the dynamics of domestic abuse and cultural pressures evident between the parents alongside RAA's mental vulnerability. A point noted was the connectivity between professional curiosity and the child's voice, with professionals asking the right questions at the right time. Having that curiosity to explore families and individual's cultures and what that means on impact on risk and children. It is acknowledged as a learning point that an earlier escalation to Nottingham Children's Services for the information would have benefited the Strategy meeting.

6.4 A significant relationship in RAA's life was with her GP who had a clear understanding of the lived experience of domestic abuse and the impact on her mental health and wellbeing. The 'new normal' was virtual meetings and this gave an opportunity for the GP to attend whereas previously this would have not been possible. Having the GP input at the strategy meeting with her knowledge of the links between mental health, suicide ideation and domestic abuse was invaluable. It enabled the strategy meetings to fully appreciate the risks posed and enabled professionals to enact appropriate safety plans based on known risks. It was evident suicidal ideation was a known risk in RAA's case and the GP advocated strongly on RAA's behalf to ensure professionals were aware of the risk.

6.5 DASH- RIC Risk assessment was used to identify the level of harm by Police and specialist domestic services. It is dependent on the information provided primarily by the identified victim with limited opportunity to verify details. This is a strength in that a first-hand account of an incident is captured from source, however the flaw is that it can also be a deficit because traumatised victims may minimise, confuse incidents leading to an inaccurate impression of the level of risk. RAA was subsequently assessed as medium risk. It is in November 21 after further incidents and the separation from XY that her risk is identified as high and a MARAC-to-MARAC transfer is arranged from Derbyshire to Nottingham. The DASH-RIC has an option for "professional judgement" to be included as part of the assessment. It appears in the reports supplied that there was a reliance to reach the threshold for MARAC on the numerical threshold of 14 and above, rather than using professional judgment or escalation of risk that would have included RAA's vulnerabilities and meet the MARAC threshold perhaps earlier in time.

6.6 It is acknowledged that the two DASH RIC assessments completed by specialist agencies at the time do not reflect the actual extent of RAA's mental health history. Case notes however acknowledge RAA's psychological distress. A resource to support mental health professionals identify and respond to Domestic Violence and Abuse is available. [14] The DASH RIC has no practice guidance on exploring the suicidal risk with the client which is gap when working with a traumatised victim. The risk assessments did not link the domestic abuse to her suicidal ideation. Subsequently the agencies have attended suicide awareness training from Harmless and have a suicide policy for staff to refer to. Additionally, it is proposed from the MARAC review to have additional questions at that point to illicit a fuller background history of their suicidal ideation using professional curiosity rather than a closed question approach. It is also noted the area's best practice of being part of the Real Time Surveillance for suicide prevention sharing learnings from DHR's with the City and County suicide prevention agenda. This includes additional training on suicide prevention for front line services as part of previous learning currently being implemented.

6.7 The MARAC provides an effective way for agencies to share information, identify patterns of abuse and put plans in place to mitigate risk to protect victims and hold the perpetrator to account. The MARAC assesses risk to the identified victim and in RAA's case where she feared for her father especially, he could also be included alongside any other family members or associates who may be at risk.
The MARAC in December 21 enabled RAA to access the specialist support from domestic abuse services. As a forum for exchanging information to produce a comprehensive assessment of risk it was effective.

6.8 There was a reluctance for RAA to disclose information due to fear of repercussions. Some agencies were aware of the potential risk to RAA and other members of the family from information she disclosed. It is apparent there were a number of staff changes during the scoping periods and new staff

[14] https://www.kcl.ac.uk/mental-health-and-psychological-sciences/research/lara-vp-download

taking over mid-way through assessments who may not have been aware of the MARAC without consent form thus facilitating an earlier referral to MARAC based on escalation or professional judgment. It is possible to still make a referral without the consent of the victim for high-risk referrals to MARAC. It must be clear what legal justifications are being used in the information sharing without consent form, which provides these grounds and a lesson learned is to recirculate the guidance to MARAC partners because of the review.

6.9 RAA had identified needs especially around her mental ill health and although an adult at risk PPN was submitted it appears no adult safeguarding assessment was carried out. Under the Care Act RAA should have met the threshold for assessment and a learning point is to track referrals and follow up to request the rational for non-acceptance by the referring agency. There potentially was a missed opportunity for her to have access to an independent advocate that again may have assisted in her engaging with services. In Derbyshire a development is that the DART team will review all incidents and PPN assessments to establish patterns of behaviour and potential risk factors allocating cases to the relevant departments and ensuring information is shared with partners in a timely manner.

6.10 RAA felt she couldn't trust the Police as there had been an incident where she was allegedly threatened, and her father attended the scene before the Police. There was also information shared by her father that details about RAA had been shared inappropriately and this reinforced her reluctance to give statements. It is acknowledged that RAA's decisions not to support prosecutions could have been influenced by her own self-preservation for fear of repercussions and her own way of managing her risk. It is stated evidence led prosecutions were considered. An option from the learning would have been to consider a DVPO/N[15] allowing RAA some time to consider space for action or a DVD[16] disclosure as although she had lived with her partner for a number of years, she may not have been aware of his extensive history with the Police. The Police in Nottingham have commenced a Pilot scheme to assist victims of domestic abuse. The pilot is a multi-agency approach enabling access to alarms for an immediate Police response. They have also included access to a suicide prevention application called 'Staying Alive', the app provides resources and strategies. It is clear both Police forces are committed to promoting awareness of domestic abuse and providing tools to officers such as body worn cameras to enhance evidence gathering.

6.11 Throughout the scoping period there are references to coercive controlling behaviours which impacted on RAA's everyday life. From the initial disclosure in 2015 when XY denies all allegations of the assault, the message to RAA he is

[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/506148/2016-03-08_DVPO_report_for_publication.pdf#:~:text=A%20DVPN%20is%20an%20emergency%20non-molestation%20and%20eviction,immediate%20support%20they%20require%20in%20such%20a%20situation.

[16] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet

in control. The use of Non-Fatal Strangulation (NFS) which wasn't a standalone offence at the time, is used by perpetrators as a tactic to exert their control over their victim giving a message that the abuser has control of whether the victim lives or dies. Evan Stark and Professor Jane Monckton Smith both speak about NFS as part and parcel of coercive control behaviour. It instils fear of the consequences of non-compliance and the victim's own fragility of being unable to protect themselves, bearing in mind this act was whilst RAA was pregnant[17] with child B, when we often see an escalation of domestic abuse. A former United States Police Officer Joe Bianco states "more than two decades of research have revealed that strangulation is the calling card of manipulative controlling dangerous men, this is because strangulation indicates the dynamic of Coercive Control". Coercive control legislation has been on the statute since 2015 and although there is a substantial amount of reports the conviction rate is still relatively low. A challenge is evidence gathering in such cases and the prosecutions rely on statements from those affected as well as other corroborative material. The Police have invested in additional training for Front Line staff including College of Policing training DA Matters to assist officers to gather other material to aid future victimless prosecutions.

6.12 A key point raised was about using professional curiosity much earlier as part of an early intervention strategy, in looking at the motivation behind certain actions when there was clearly a history of ongoing domestic abuse. In the Deserve to be Heard campaign[18] the report found that black and minoritised women survivors have to confront heightened barriers including discriminatory responses and a lack of understanding of cultural issues when seeking help from mainstream services resulting in their exclusion from support services and potential further traumatisation (Thiara and Harrison 2021). The family was subject to statutory child protection and child in need plans, there is evidence suggesting that when parental conflict is frequent, intense, and poorly resolved it can put children's mental health and long-term outcomes at risk. In the information given to Social Services both children developed physical symptoms of distress. In reports their voice appears limited with the focus on actions by parents rather than supportive interventions for the children. Early intervention programs[19] that were completed in 2015 as part of the child protection plan may have raised awareness at the time however, in later assessments the option of revisiting specialised work does not appear to have been considered. On one hand there is a presentation that everything is 'fine' as in the instance of the joint claim in November 2020, this occurs during covid restrictions with a phone consultation with RAA. This allows both parties access to see each other's information including messaging between customers and DWP staff. For a victim of domestic abuse, it would be difficult therefore to make any disclosure without fear of reprisals. In this case it is circumstantial as to whether the coercive control was being escalated to include financial control and thereby making it more difficult for RAA to leave as she was now intrinsically linked financially with limited access to money without her partner knowing. BC describes RAA asking for money for the children on occasions which would indicate that XY monitored the finances and RAA was restricted

[17] https://www.nhs.uk/pregnancy/support/domestic-abuse-in-pregnancy/

[18] https://www.womensaid.org.uk/wp-content/uploads/2023/08/DTBH-Impact-Report.pdf

[19] https://www.eif.org.uk/resources

in accessing monies, a further suggestion that he was coercively controlling her access to finances. It is of note this claim occurs only eleven months after the significant suicide attempt and following the serious incident in June when Police attended when XY had self-harmed, then a subsequent incident of alleged assault and a family dispute recorded in the September suggesting domestic abuse was continuing in the relationship. RAA was still experiencing episodes of psychological distress so had added vulnerability and possibly open to manipulation from her abuser. It is difficult to determine if there was any coercion in applying for a joint claim. A practice point is to consider a more holistic assessment with safe routine enquiry regarding domestic situations and separate individual access to maintain confidentiality and offer an opportunity for disclosure.

7. Multi Agency Recommendations:

The review would ask that NCSP monitor action plans and that outcomes are impact assessed within the organisations. The following multi-agency recommendations are made to NCSP:

Recommendation 1: To improve assessments to offer early intervention[20] to inform a fuller picture of the context and mapping of abuse by taking account of historical dynamics of abuse incidents, not just the current incident, using professional curiosity to inform their actions as required.

Agencies screening and/or making assessments[21] of domestic abuse cases look at the clusters of incidents taking account of historical dynamics of abuse not just the current incident as recommended by Prof Jane Monkton Smith in the Homicide Timeline model. Consent is acknowledged and professionals consider making an informed decision using appropriate legislation on a case-by-case basis, to make a justifiable rationale to gather further information, when necessary, from partner agencies if consent is withheld using the recognised without consent form. A briefing guidance has already been compiled by NCSP to ensure current workforce staff are aware.

Recommendation 2: To improve holding perpetrators to be accountable for their actions and understanding the impacts on those affected

To develop meaningful engagement of those who harm by including a diverse approach to address the lived experiences of all parties and other intersectionality's in those experiencing abusive behaviours that are controlling and harmful. A whole family approach would contribute to reducing risk of misinterpreting motivation and behaviours in the context of coercive controlling abuse by abusers[22]. As mentioned, using a training package such as the ENGAGE[23] model for those less familiar with interviewing those who harm

[20] file://early-intervention-in-domestic-violence-and-abuse-full-report.pdf

[21] https://new.basw.co.uk/sites/default/files/resources/181181_basw_england_domestic_abuse_guidance.pdf

[22] https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator interventions/standards-for-domestic-abuse-perpetrator-interventions-accessible

[23] ENGAGE | WWP European Network (work-with-perpetrators.eu)

would be of benefit. Early intervention in addressing harmful behaviours would follow recent Government recommendations.

Recommendation 3: Improve communications, information sharing and risk management when multiagency working across authorities and geographical boundaries. Agreeing a purposeful communication strategy for all concerned assisting in building on the strengths of all parties involved in proceedings.

At the initial cross boundary meeting It is agreed that the partnership have a multi-agency consultation around the impact and influence they will have in the family's life, mapping out the contact points of the family with agencies, what is the best way to communicate timely updates and information, (including to confirm if there is no update) robustly enabling all agencies to remain fully informed. This ensures a holistic picture of circumstances and context of risk is maintained. Identification of the single point of contact for the family enabling a strength-based approach and recognising that relationships with families due to the process may increase communication barriers. Agreeing a purposeful communication strategy for all concerned would assist in building on the strengths of all parties involved in proceedings.

Recommendation 4: Consider each case individually where domestic abuse is a factor and that due to domestic abuse a person's ability to make an autonomous decision is impacted due to coercion, fear or threat of harm and those factors need to be considered when assessing capacity.

In considering how adults at risk maybe supported a lesson taken from the review is that although one adult safeguarding referral was made by Derbyshire Police it was not submitted to the Adult Social Care, due to their understanding the victim had capacity and at the time was refusing any referrals to support services. A child concern was instead submitted to Derbyshire Children's Services as children were present. There were also other opportunities for other agencies to refer into safeguarding, however, these opportunities again do not appear to have been taken at significant points. As Adult safeguarding did not receive a referral, they could not offer support under the Care Act that may have been available to RAA. As best practice it is suggested that Police, Nottingham City Council / Derbyshire County Council Adult Duty Workers who are responding to DART / Domestic Abuse referrals ensure they review the history of the case and do not respond to referrals in isolation, irrespective of risk rating to ensure adults at risk in domestic abuse cases are assessed under the Care Act 2014 where they meet the threshold for assessment under Sec. 42 reason to suspect abuse. Where Coercive Control is identified links to the Serious Crimes Act 2015 part 5 Section 76 are made in conjunction with Police to determine capacity around coercion as in Case Law DL v A Local Authority 2012[24] … is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are … (a) under constraint; or (b) subject to coercion or undue influence; or (c) for some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent". (para 54). If

[24] https://www.39essex.com/information-hub/case/dl-v-local-authority-others

an adult decides to refuse an assessment, it must nevertheless still be carried out if (for example) the adult is experiencing, or is at risk of, abuse or neglect, including self-neglect (section 11 of the Care Act). Whether the adult's decision to refuse is unwise or not is not a relevant consideration. Their decision to refuse must be reviewed in the context that due to the domestic abuse situation the DA Act 2021 that a person cannot consent to the infliction of serious harm and therefore the decision to remain is not an autonomous decision due to fear or threat of harm , in the sense that the assessment must be carried out and the adult's eligible needs must be met, again provided that the ordinary residence rules and costs and charging criteria are met. A human rights-based approach to safeguarding and risk assessment needs to support people to understand their legal rights, identify coercive or exploitative behaviours, make informed decisions about risk based on potentially differing viewpoints and manage risk from a person centered, strength-based perspective. Public bodies have a duty to consider vulnerability in a practical and contextual way (s149 Equality Act 2010 and Hotak v LB Southwark [2015]). Assessment and safeguarding duties are triggered on deliberately low thresholds[25]- namely, the appearance of need and continues, despite capacitated refusal by an adult, if the local authority has concerns there is a risk of abuse or neglect (s11(2) Care Act 2014 and South-end on Sea Council v Meyers [2019]).
Also, carers are assessed where domestic abuse is suspected in line with best practice. Best practice requires inquisitive enquiry, so all safeguarding issues are understood in context, as in the duty of safeguarding s42 of the Care Act. Where identified those at risk have access to an IMCA/IDVA especially where coercive controlling behaviour is identified in the context of domestic abuse to ensure their capacity to make informed choices is not compromised.[26]

Recommendation 5: Embed mapping incidents, understanding abusive patterns and use of the 8 stage of homicide / suicide timeline.

NCSP to highlight to all partner agencies Prof Jane Monckton Smith's eight-stage domestic homicide and Suicide Timeline pattern models and ensure that they are aware of the benefits of incorporating them practically in assessments. This is currently being addressed with a local seminar organised later this year 2023.

Recommendation 6: Improve identification and understanding of the links between domestic abuse and suicide. Understand the local and national referral pathways for support at crisis point using a trauma informed approach.

Nottingham CityCare Partnership, Notts Health Care Trust, and Primary Care, to share with health practitioners the recent new NICE quality standards regarding clinical indicators of domestic abuse and NICE[27] guidelines on Self-harm: assessment, management and preventing recurrence 2022. Also consider guidelines and training around developing mental health risk assessment to consider formulations which link domestic abuse and suicide risk where appropriate. Using individual mental health and safety plans which consider the risk posed by domestic abuse and the risk of suicide. This is also to

[25] https://www.scie.org.uk/safeguarding/adults/practice/sharing-information
[26] DL v A local authority (2012) – category of vulnerable adults who are open to exploitation due to coercion
[27] https://www.nice.org.uk/guidance/NG225

be considered across the border for Derbyshire services building on the work currently being undertaken by the Elm Foundation in conjunction with the ICB in Derbyshire.

Recommendation 7: To Improve understanding of the impacts of trauma on those affected by domestic abuse and linked to their risk around suicidal ideation.

The need for trauma informed approaches to practice, for clients and for the workforce were identified in both areas. Services, that respond with compassionate understanding to their 'cry of pain'[28] are essential to prevent suicide or further acts of self-harm. Trauma focused professionals who ask victims 'what happened to you?' rather than 'what is wrong with you?' recognise the relevance of the abuse within a victim's relationship and the broader social context in which they find themselves, are key. Additional complexity in terms of cultural abuses, such as so-called 'honour' based violence are addressed, once again with understanding and compassion. This can be achieved by offering victims/survivors trauma cards[29] to produce to services so services are aware their response may be affected by their lived experience and should be considered when requesting statements or engagement with professionals.

Recommendation 8: NCSP with all partners promote awareness around suicide prevention in line with the National Suicide Prevention Alliance best practice guidance.

NCSP with all partners promote awareness around suicide prevention[30] in line with the National Suicide Prevention Alliance best practice guidance. Consider domestic abuse in local and national suicide prevention strategies. It is noted that NCSP are part of the real time surveillance for suicide which is best practice and link reviews to their strategic suicide prevention oversight group.

National Recommendations: [31]

Recommendation 9:

The Police and partner agencies involved in Domestic Abuse cases should be made aware of an elevated risk of both intimate partner homicide and of victim suicide where coercive or controlling behaviour (CCB) is present. Frontline and supervisory personnel within safeguarding victim units should consider referrals to suicide prevention interventions in setting safeguarding actions when CCB is identified.

Recommendation 10:

There should be a continued push within policing to identify, record and take positive action where coercive or controlling behaviour (CCB) is identified. The number of convictions around CCB is disproportionate to the number of reports, with only a small number of cases where the specific offence of

[28] Williams, J.M.G. (2014) Cry of Pain: Understanding Suicide and the Suicidal Mind; Piatkus

[29] https://healthwatchessex.org.uk/2022/11/healthwatch-essex-launch-trauma-card-to-empower-trauma-survivors/

[30] https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance

[31] www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf

controlling or coercive behaviour is recorded or charged. The nature and extent of prior coercive control is severe in situations which culminate in a victim dying by suicide, which reinforces the importance of identifying, recording and charging for controlling or coercive behaviour in a timely and accurate manner.

Recommendation 11:

It is recommended that the College of Policing, in consultation with the Home Office and NPCC develop training to directly address the evidential issues experienced in domestic abuse cases where suicide and/or coercive or controlling behaviour is identified to enable abusers to made accountable. The College of Policing has developed a DA Matters Investigators' Immersive Learning Hydra programme to give officers a better understanding of how to evidence coercive and controlling behaviour, how to progress 'course of conduct' investigations and develop effective case files. This training is for those officers who investigate and progress domestic abuse cases and is a two-day Hydra programme to be delivered in-force by trained trainers.

8. Glossary

Abbreviation Stands for:

AAFDA Advocacy After Fatal Domestic Abuse
ACE's Adverse Childhood Experiences
ASG Adult Safeguarding
CAADA Co-ordinated Action Against Domestic Abuse
CAMHS Children and Adolescent Mental Health Services
CATS Juno Women's Aid Children's And Teen Service
CBT Cognitive Behaviour Therapy
CCG Clinical Commissioning Group
CHISVA Children's ISVA
CRHT City Crisis Resolution and Home Treatment Team
CIN Child in Need
CMHT Community Mental Health Team
CPS Crown Prosecution Service
CSC Children's Social Care
CYP Children & Young People
CYPFS Children, Young People's and Families' Service
DA Domestic Abuse (DV Domestic Violence)
DASH Domestic Abuse, Stalking and Honour-based violence risk assessment
DHR Domestic Homicide Review
DSL Designated Safeguarding Lead
DVSA Domestic and Sexual Violence and Abuse
EDI Equality, Diversity & Inclusion
EMAS East Midlands Ambulance Service
GP General Practitioner
HBA Honour Based Abuse
HOT Housing Options Team

IMR Individual Management Review
IOM Integrated Offender Management scheme
ISVA Independent Sexual Violence Adviser
MARAC Multi Agency Risk Assessment Conference
MARF Multi Agency Request for services form
NCSP Nottingham Community Safety Partnership
NFA – No Further Action
NHCFT Nottingham Health Care Trust
NHS National Health Service
NMWN Nottingham Muslim Women's Aid
OFSTED Office for Standards in Education
PPN Public Protection Notice
PTSD Post-Traumatic Stress Disorder (CPTSD Complex Post- Traumatic Stress Disorder)
SARC Sexual Assault Referral Centre
SDVC Specialist Domestic Violence Court
SILP Serious Incident Learning Process
SIO Senior Investigating Officer
SV Sexual Violence
SW Social Worker (e.g. SW1)

Home Office

Interpersonal Abuse Unit
2 Marsham Street
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SW1P 4DF

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29th May 2024

Dear Sharon,

Thank you for resubmitting the Domestic Homicide Review (DHR) report (RAA) for Nottingham Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 24th April 2024. I apologise for the delay in responding to you.

The QA Panel felt that it was a positive report that included a good representation of panel members to reflect cross-boundary working, identified good practice, clearly stated the independence of the Chair and included condolences to the family. The reference to the impact of the COVID-19 pandemic and lockdown on victims and survivors of domestic abuse and the inclusion of research from Women's Aid and Refuge was commended.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, and at the request of the CSP that only the Executive Summary is to be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This

should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

DHR RAA - victim took mix of medication prescribed to her. The victim had taken the overdose at her own property and then travelled to her ex-partners property where her children were staying for the weekend and later died there. The victim experienced Mental ill health, PTSD, anxiety and childhood trauma. Control & Coercion, financial abuse and HBVA were identified as well as other risks from ex-partner.

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence: • **Key milestones achieved in enacting recommendation** • **Outcome** Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?	RAG
1	To improve assessments to inform a fuller picture of the context and mapping of abuse by taking account of historical dynamics of abuse incidents not just the current incident using professional curiosity to inform their actions as required.	Agencies screening and/or making assessments of domestic abuse cases look at the clusters of incidents taking account of historical dynamics of abuse not just the current incident as recommended by Prof Jane Monkton Smith in the Homicide Timeline model. Consent is acknowledged and professionals consider making an informed decision using appropriate legislation on a case-by-case basis, to make a justifiable rationale to gather further information, when necessary, from partner agencies if consent is withheld using the recognised information sharing without consent form. A briefing guidance has already been compiled by NCSP to ensure current	Local	Agencies involved in assessments to ensure they include: - The full background history wherever possible and pattern of incidents in order to provide a holistic assessment. - To utilise multi-agency working and safeguarding arrangements to consider legal grounds for information sharing without consent - To take account of cultural considerations and links to mental health where suicidal ideation is identified.	CSP – **Nottingham Agencies** •Nottingham City Council Adult Social Care, •Nottingham City Council Childrens and integrated Families, •NHS Nottingham and Nottinghamshire ICB, •NHCFT, •Nottinghamshire Police, •Probation Service, **Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety**			PDF Honour-based-abuse-practice-summary-2(Best Practice Guidance when HBA is highlighted The importance of information sharing guidance was circulated 29/9/21 PDF Guidance on Multiagency data shar https://nspa.org.uk/wp-content/uploads/2023/04/Sarah-Dangar-Learning-Legacies-bringing-visibility-to-domestic-abuse1.pdf Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021 PDF Domestic_homicides_and_suspected_victim	

DHR RAA - victim took mix of medication prescribed to her. The victim had taken the overdose at her own property and then travelled to her ex-partners property where her children were staying for the weekend and later died there. The victim experienced Mental ill health, PTSD, anxiety and childhood trauma. Control & Coercion, financial abuse and HBVA were identified as well as other risks from ex-partner.

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		workforce staff are aware.			• Derbyshire Police • Derbyshire Children's Services • Derbyshire Community Health Services NHS Foundation Trust				
2	To improve holding perpetrators to be accountable for their actions and understanding the impacts on those affected.	Early intervention in addressing harmful behaviours would follow recent Government recommendations in addressing perpetrators behaviours. To develop meaningful engagement of those who harm by including a diverse approach to address the lived experiences of all parties and other intersectionality's in those experiencing abusive behaviours that are controlling and harmful. A whole family approach would contribute to reducing risk of misinterpreting motivation and	Local	When working with perpetrators of domestic abuse to consider different approaches to understand the different experiences and intersectionality of individual perpetrators and survivors of abuse, using a whole family approach. To utilise professional curiosity to explore the dynamics of relationships in context of domestic abuse. To access training and tools to assist working with	CSP – **Nottingham Agencies** • Nottingham City Council Adult Social Care, • Nottingham City Council Childrens and integrated Families, • NHS Nottingham and Nottinghamshire ICB, • Nottinghamshire Police, • Probation Service, • Nottingham Muslims			https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator-interventions Domestic Abuse Practice Guidance for both Children and Family/ Adult Social Workers PDF 181181_basw_england_domestic_abuse_g	

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		behaviours in the context of coercive controlling abuse by abusers. As mentioned, using a training package such as the ENGAGE model for those less familiar with interviewing those who harm would be of benefit.		perpetrators and early intervention methods such as the Engage Toolkit, local training and resources (Equation), referrals to Your Choice perpetrator programme (where relevant).	Women's Network • Juno Women's Aid **Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety** • Derbyshire Police • Derbyshire Children's Services • Derbyshire Community Health Services NHS Foundation Trust				
3	Improve communications, information sharing and risk management when multiagency working across authorities and geographical boundaries.	At the initial cross boundary meeting It is agreed that the partnership have a multi-agency consultation around the impact and influence they will have in the family's life,	Local	To develop a purposeful communication strategy for all parties involved in proceedings detailing in	• Nottingham City Council Childrens and integrated Families,				

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	Agreeing a purposeful communication strategy for all concerned assisting in building on the strengths of all parties involved in proceedings.	mapping out the contact points of the family with agencies, what is the best way to communicate timely updates and information, (including to confirm if there is no update) robustly enabling all agencies to remain fully informed. This ensures a holistic picture of circumstances and context of risk is maintained. Identification of the single point of contact for the family enabling a strength-based approach and recognising that relationships with families due to the process may increase communication barriers.		Multi-agency action / safety plans - who is lead - what the impact and outcomes will be for family members - timelines - scheduled updates - communication strategies.	**Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety** • Derbyshire Children's Services				
4	Consider each case individually where domestic abuse is a factor and that due to domestic abuse a person's ability to make an autonomous decision is impacted due to	In considering how adults at risk maybe supported a lesson taken from the review is that although one adult safeguarding referral was made by Derbyshire Police it	Local	Improve understanding of the impacts of control and coercion upon a person's capacity by skilling the workforce in linking	Nottingham City Council Adult Social Care **Derbyshire Agencies**			https://www.local.gov.uk/topics/community-safety/domestic-violence-and-abuse	

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	coercion, fear or threat of harm and those factors need to be considered when assessing capacity.	was not submitted to the Adult Social Care, due to the victim having capacity and refusing any referrals to support services. It was instead submitted to Derbyshire Children's Services as children were present. There were also other opportunities for other agencies to refer in too, however, these opportunities again do not appear to have been taken at significant points. Nottingham City Council / Derbyshire County Council Adult Duty Workers who are responding to DART / Domestic Abuse referrals should ensure they review the history of the case and do not respond to referrals in isolation, irrespective of risk rating to ensure adults at risk in domestic abuse cases are assessed under the Care Act 2014 where they meet the threshold for		the legislation of coercive control Serious Crimes Act sec 76 part 5; DA Bill 2020 and domestic abuse procedure within the Care Act 2014 sec 11 sec 14.24 and sec 68 By the inclusion of training for frontline staff and provision of an operating procedure/manual	**Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety** Derbyshire County Council Adult Social Care				

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		assessment under Sec. 42 reason to suspect abuse. Where Coercive Control is identified links to the Serious Crimes Act 2015 part 5 Section 76 are made in conjunction with Police to determine capacity around coercion as in Case Law DL v A Local Authority 2012 … is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are … (a) under constraint; or (b) subject to coercion or undue influence; or (c) for some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent". (para 54). If an adult							

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		decides to refuse an assessment, it must nevertheless still be carried out if (for example) the adult is experiencing, or is at risk of, abuse or neglect, including self-neglect (section 11 of the Care Act). Whether the adult's decision to refuse is unwise or not is not a relevant consideration. Their decision to refuse must be reviewed in the context that due to the domestic abuse situation the DA Act 2021 that a person cannot consent to the infliction of serious harm and therefore the decision to remain is not an autonomous decision due to fear or threat of harm , in the sense that the assessment must be carried out and the adult's eligible needs must be met, again provided that the ordinary residence rules and costs and charging criteria are							

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		met. A human rights-based approach to safeguarding and risk assessment needs to support people to understand their legal rights, identify coercive or exploitative behaviours, make informed decisions about risk based on potentially differing viewpoints and manage risk from a person centered, strength-based perspective. Public bodies have a duty to consider vulnerability in a practical and contextual way (s149 Equality Act 2010 and Hotak v LB Southwark [2015]). Assessment and safeguarding duties are triggered on deliberately low thresholds- namely, the appearance of need and continues, despite capacitated refusal by an adult, if the local authority has concerns there is a risk of abuse or neglect (s11(2) Care Act 2014							

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		and South-end on Sea Council v Meyers [2019]). Also, carers are assessed where domestic abuse is suspected in line with best practice. Best practice requires inquisitive enquiry, so all safeguarding issues are understood in context, as in the duty of safeguarding s42 of the Care Act. Where identified those at risk under sec 68 have access to an IMCA/IDVA especially where coercive controlling behaviour is identified in the context of domestic abuse to ensure their capacity to make informed choices is not compromised.							
5	Embed mapping incidents, understanding abusive patterns and use of the 8 stage of homicide / suicide timeline.	NCSP to highlight to all partner agencies Prof Jane Monckton Smith's eight-stage domestic homicide and Suicide Timeline pattern models and ensure that they are	Local	CSP to share Jane Monkton-Smith 8 stages of homicide	CSP			Seminar on 18th April 2023 8 Stages of homicide is on Equations Website and incorporated into Training.	

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		aware of the benefits of incorporating them practically in assessments. This is currently being addressed with a local seminar organised later this year 2023.							
6	Improve identification and understanding of the links between domestic abuse and suicide. Understand the local and national referral pathways for support at crisis point using a trauma informed approach.	Nottingham CityCare Partnership, Notts Health Care Trust, and Primary Care, to share with health practitioners the recent new NICE quality standards regarding clinical indicators of domestic abuse and NICE guidelines on Self-harm: assessment, management and preventing recurrence 2022. Also consider guidelines and training around developing mental health risk assessment to consider formulations which link domestic abuse and suicide risk where appropriate. Using individual mental health safety plans which consider risk posed by domestic	Local	Elevation of referral pathways in regard to reducing suicide risk as part of National Strategy which includes Domestic Abuse share the following: - Best Practice NICE quality standards regarding clinical indicators of domestic abuse - NICE guidelines on Self-harm: assessment, management and preventing recurrence 2022. - Guidelines and training around developing	CSP – **Nottingham Agencies** • NHS Nottingham and Nottinghamshire ICB, • NHCFT, • NUH **Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety** **Derbyshire Agencies** • Derbyshire Community Health			https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028 Self-harm: assessment, management and preventing recurrence https://www.nice.org.uk/guidance/ng225	

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		abuse and risk of suicide. This also to be considered across border for Derbyshire services building on the work currently being undertaken by the Elm Foundation in conjunction with the ICB in Derbyshire. .		mental health risk assessment to consider formulations which link domestic abuse and suicide risk where appropriate - Use individual mental health safety plans which consider risk posed by domestic abuse and risk of suicide.	Services NHS Foundation Trust				
7	To Improve understanding of the impacts of trauma on those affected by domestic abuse and linked to their risk around suicidal ideation.	The need for trauma informed approaches to practice, for clients and for the workforce were identified in both areas. Services, that respond with compassionate understanding to their 'cry of pain' are essential to prevent suicide or further acts of self-harm. Trauma focused professionals who ask victims 'what happened to you?' rather than 'what is wrong with you?'	Local	- Use trauma informed approaches to support survivors and staff - Offer victims/survivors trauma cards to produce to services so services are aware their response may be affected by their lived experience and should be	**Nottingham Agencies** •Nottingham City Council Adult Social Care, •Nottingham City Council Childrens and integrated Families, •Nottinghamshire Police, •Probation Service,			https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice Suicide risk in people with post-traumatic stress disorder: https://www.ucl.ac.uk/news/2020/nov/ptsd-contributes-suicide-risk-particularly-women	

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		recognise the relevance of the abuse within a victim's relationship and the broader social context in which they find themselves, are key. Additional complexity in terms of cultural abuses, such as so-called 'honour' based violence are addressed, once again with understanding and compassion. This can be achieved by offering victims/survivors trauma cards to produce to services so services are aware their response may be affected by their lived experience and should be considered when requesting statements or engagement with professionals.		considered when requesting statements or engagement with professionals. - Embed Trauma Informed practice in policy and procedures of agencies dealing with Domestic Abuse victims and perpetrators - Provision of trauma informed training for front line staff who will interact with survivors where training isn't provided as part of their agency training and development programme.	**Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety Derbyshire Agencies** • Derbyshire Police • Erewash BC – Housing Options • Derbyshire Children's Services • Derbyshire Community Health Services NHS Foundation Trust				
8	NCSP with all partners promote awareness around suicide	This will improve practice by considering domestic abuse in the	Local	To embed the Suicide Timeline risk training by	CSP – **Nottingham Agencies**			DHR where there has been a suicide and the learning is shared with the local Suicide RTS group	

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	prevention in line with the National Suicide Prevention Alliance best practice guidance.	context of local and national suicide prevention strategies. It is noted that NCSP are part of the real time surveillance for suicide which is best practice and link reviews to their strategic suicide prevention oversight group		Prof Jane Monkton Smith in agencies as part of the continued commitment to share DHRs and learning where there has been a suicide with the local suicide prevention group. Work with suicide prevention group to support promoting awareness of risk factors between suicide and domestic abuse.	•Nottingham City Council Adult Social Care, •Nottingham City Council Childrens and integrated Families, •Nottingham CityCare Partnership, •Nottingham City Council Housing Solutions , •Juno Women's Aid, •NHS Nottingham and Nottinghamshire ICB, •Nottingham City Council Housing service, •NHCFT, •NUH, •Nottingham Muslim Women's Network, •Nottinghamshire Police,			https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028	

Appendix A - Overview Report Action Plan – August 2024

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					• Probation Service, • Framework - Nottingham Recovery Network (NRN) & Clean Slate **Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety Derbyshire Agencies** • Derbyshire Police • The Elm Foundation • Erewash BC – Housing Options • Derbyshire Children's Services • Derbyshire Community Health Services NHS				

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					Foundation Trust				
9	The police and partner agencies involved in Domestic Abuse cases should be made aware of an elevated risk of both intimate partner homicide and of victim suicide where coercive or controlling behaviour (CCB) is present. Frontline and supervisory personnel within safeguarding victim units should consider referrals to suicide prevention interventions in setting safeguarding actions when CCB is identified.	Improve practice and potential outcomes by elevating access to appropriate interventions to safeguard those at risk	National	Work with suicide prevention group to support promoting awareness of risk factors between suicide and domestic abuse.	Police		This is a national recommendation which we are unable to monitor the progress of	College of Policing www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf	
10	There should be a continued push within policing to identify, record and take positive action where coercive or controlling behaviour (CCB) is identified. The number of convictions around CCB is disproportionate to the number of reports, with only a small number of cases where the specific offence of controlling or	Improve evidence gathering to enable positive CCB outcomes and increase numbers of convictions	National	Work with suicide prevention group to support promoting awareness of risk factors between suicide and domestic abuse.	Police		This is a national recommendation which we are unable to monitor the progress of	College of Policing www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf	

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	coercive behaviour is recorded or charged. The nature and extent of prior coercive control is severe in situations which culminate in a victim dying by suicide, which reinforces the importance of identifying, recording and charging for controlling or coercive behaviour in a timely and accurate manner.								
11	It is recommended that the College of Policing, in consultation with the Home Office and NPCC develop training to directly address the evidential issues experienced in domestic abuse cases where suicide and/or coercive or controlling behaviour is identified to enable abusers to made accountable.	Improve training on gathering evidence from reliable sources to improve outcomes in convictions	National	Work with suicide prevention group to support promoting awareness of risk factors between suicide and domestic abuse.	Police		This is a national recommendation which we are unable to monitor the progress of	College of Policing www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf	

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DHR RAA IMR Agency Actions

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Nottingham CityCare Partnership							
1.1	Records are reviewed alongside strategy meeting minutes to ensure an accurate understanding of any potential public health need	To ensure Historical information is considered as part of any risk assessment and action plan	Include within the record keeping training and to be discussed as a safeguarding update at supervision and team meetings.	31st January 2023	February 2023	This will be audited by Record Keeping Audit via management supervision. 23/1/23 Discussion with the Clinical Educator and record keeping lead, they have agreed to update the record keeping training to embed the learning. The training will be updated and rolled out by mid Feb. PDF Safeguarding Update Children's Services st The information has been disseminated in the safeguarding updates for Q4, which are shared across the workforce. The safeguarding updates are also discussed at: • safeguarding supervision • quarterly 0-19 team meetings, attended by the Safeguarding Team	
1.2	There should be clarity on the dates of any significant safeguarding event to reduce risk of duplication and improve communication and record keeping in relation to safeguarding events.	To provide Clarity and accurate recording of meetings and avoidance of duplication	When reviewing minutes from safeguarding meetings, the reviewer to document the date of the meeting.		March 2023	This is also reviewed in management supervision by Clinical Service Managers. The learning has been disseminated in the safeguarding updates for Q4 2022/23, which are shared across the children's workforce. The safeguarding updates are also discussed at: • safeguarding supervision • quarterly 0-19 team meetings which are attended by the Safeguarding Team	

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1.3	At RCPC where there is consideration of closure to child protection plans, ensure consideration is given to the original reasons for ICPC and whether the original recommendations have been met and consideration given to factors that can influence people to retract disclosures of abuse		Further training to be given to staff around the difficulties in disclosing abuse and the reasons for retractions and the need to remain professionally curious and sensitively challenge.	28th Februar y 2023	January 2023	This learning will be monitored by the Childrens Public Health 0-19 Record Keeping Audit Nottingham CityCare Partnership mandatory Domestic Abuse training has been updated, (Jan 2023). Additional slides have been added which highlight the reasons why survivors may retract disclosures. The training identifies what steps practitioners should take when working with survivors who have made retractions. This information has also been added to the Domestic Abuse Resource Booklet which is disseminated to staff at induction and is available on our intranet pages and so accessible to all Nottingham CityCare Partnership staff. The reasons why DA survivors retract disclosures was also discussed at the Champions Safeguarding meeting held on the 19th Jan 23. Safeguarding Champions January 2	
Derbyshire County Council Children's Services							
2.1	To establish a stronger understanding across the workforce around the parental right to refuse a Section 17 Single Assessment and the	To ensure a consistent application of practice to seeking consent and explaining the nature of the consent to enable informed decision making by parents.	A 'practice matters' briefing to be circulated across the Derbyshire safeguarding service outlining the statutory expectations along with good practice guidance.	31st January 2023	29th March 2023	Audit will be completed through the regular reflective case review process supported by quality assurance managers.	

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	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • **Key milestones achieved in enacting recommendation** • **Outcome**	RAG
	actions to take in such circumstances.	To enable Growth in social work confidence				20/1/23 - This is on track to update / produce practice matters / practice standards as appropriate to include this learning. **29/3/23 –** completed.	
2.2	Cultural considerations to be further supported and encouraged in assessment and intervention across the workforce.	To ensure Practitioners to feel confident in seeking out the necessary skills, knowledge and support in order to enhance the delivery of service to people with varying cultural experiences.	Training in relation to cultural competence will be delivered to key individuals who can share this learning back into their service area and as such support practice across the whole workforce within early help and safeguarding services.	28th February 2023		This will be evidenced through Reflective team supervision to explore and support continued learning around cultural considerations in assessment and intervention and to gain an overview of the impact of this workforce development. 20/1/23 - Initial training session has taken place (by Research in practice) – including 3 members of our L&D training team – Plan / timeframe for wider roll out still needs to be agreed 29/3/23 - liaising with Learning & development partner as some work on this also being undertaken corporately to roll out across the council (some roll out has already taken place) – so we can combine / avoid duplication. On track for completion. On 17th January 2023 Research in Practice delivered a day's virtual facilitated seminars on **An Introduction to Cultural Competency** following participants watching 4 short pre-recorded films and completing exercised as prompted within those films. This package of learning was delivered to 28 participants from across our teams and explored what we mean by the term 'cultural competence'. It considers inclusive workspaces, direct work with children and adults, and intersectionality – all supporting the various ways in which we can use cultural identity positively and	

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						effectively. 2 L&D Trainers were part of this to support the wider roll out of this learning. That roll out was paused because Corporate Services had developed a plan to roll out a programme of training around Equality, Diversity & Inclusion to all DCC workforce - the first part of this (Induction) has been developed and is being rolled out as mandatory (to date 70% of the DCC workforce has completed this). In June 2023 a Development day for Early Help and Safeguarding managers / supervisors took place focussed on Leading in Colour - facilitated by The Staff College (over 100 attended) . Some of these issues are also embedded in the Aspiring Leaders programme being rolled out to all DCC leaders The week beginning July 17th 2023 was Derbyshire's first Practice week – the theme of which was 'equality and diversity'. Every day appreciative enquiries were facilitated on cases drawing out good practice in this area that had a positive impact on children and their families. Each service area also completed practice observations to add to the learning from practice in this area. 21/02/3034 - This actions are now closed	
2.3	Information sharing protocols to be strengthened	Information sharing to be timely in order that assessments and interventions with families can be fully informed	Information sharing protocols to be strengthened to include period by which responses should be provided.	31st March 2023	29th March 2023	Audit process - Information sharing is routinely sampled during reflective case review activity within children's services 20/1/23 - Information sharing protocols between children's services department and the police are currently in the process of review, it is anticipated that the work will be completed by the end of January	Green

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						2023 and this recommendation has been included therein. The east midlands regional protocol has been strengthened to ensure that escalation pathways across the region are clear to support timely sharing of information regionally. The Local Authority has strengthened the children's services transfer protocol which now includes timeframes for which responses to information should be provided. 29/3/23 – this action is closed, all relevant information sharing protocols have been reviewed and updated.	
2.4	The use of domestic abuse assessment tools to be utilised, as appropriate, within assessment and interventions with families.	To ensure Practitioner confidence in the use of such tools will increase. Assessments will be stronger in quality by the use of appropriate tools and assessments will be utilised as an opportunity for intervention.	A 'practice matters' briefing to be circulated across the Derbyshire safeguarding and early help service outlining the available tools along with good practice guidance. The multi-agency partnership will be introducing new domestic abuse risk assessment for children in 2023, this will be supported by new practice tools and guidance and will be launched in a workforce development programm	31st May 2023		Audit will be completed thought the regular reflective case review process supported by quality assurance managers. **20/1/23 -** A task and finish group has been established by the local safeguarding children's partnership to commission a new domestic abuse risk assessment framework for children, this work includes amendments to policy and procedure and supporting workforce development from a partnership perspective. **29/3/23** - the briefing has been completed and the first look at the tool is being shared with the partnership (DDSCB) on 25/04/23 – a further meeting is planned on 26/04/23 for DCC to consider any training needs / actions we may need to	

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						action to be able to embed / utilise this tool. On track for completion. On 2nd March 2023 Research in Practice delivered a day's virtual training on responding to families in which a parent / carer is using domestic abusive behaviours. 2 L&D Trainers attended and participated in that session to enable wider roll out. The DDCSB were leading on jointly agreeing / procuring a domestic abuse assessment tool(s) to be used across the partnership (including LAs). The DDSCB are still in the process of agreeing a toolkit. Once that toolkit is agreed – a L&D programme will be developed (including the development of guidance & Practice Matters) to launch the tool kit and embed it into the organisation 21/02/2024 - This action is now closed.	
2.5	Further strengthening of information sharing, the use of historical data and embed the use of the formal escalation policy	To ensure The policy will be utilised appropriately and confidently.	The partnership are undertaking a review to raise awareness and confidence in the use of the policy	31st March 2023	23rd March 2023	Audit will be completed through the regular reflective case review process supported by quality assurance managers 20/1/23 - The local children's partnership are currently reviewing and strengthening the pre-dispute and escalation pathway to support timely information exchange and dispute resolution through the local partnership. An annual programme of reflective case reviews is established and this will capture the appropriate use of the pre-	

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						dispute and escalation procedure. The learning arising from this work will inform future workforce development activities to drive impact. 23/3/23 – This action is complete and closed. The DDSCP have reviewed escalation pathways and the policy and procedure group sighted on the outcome. This activity provided assurance in relation to confidence in the sue of the policy.	
Primary School							
3.1	Agreed policy on how to respond if parent in future was to express suicidal ideation.	All DSLs have clarity on steps to taken when parent/ carer presents with suicidal ideation.	Script to follow for all DSLs if parent/ carer presents with suicidal ideation	31st March 2023		21/09/2024, the DSL team met and put in place a policy to support parents presenting with suicidal ideation. Further to this, DSL completed extra training on DA by attending a Domestic Violence Conference on 23.03.2023	
Juno Women's Aid							
4.1	Review Risk assessments to link domestic abuse and suicidal ideation	Risk assessments did not link the domestic abuse with suicidal ideation.	Update risk assessment s accordingly			**27/02/2024 -** Juno Case Management Policy. Procedure's manual inc suicide risk checklist. 5. Suicide checklist.docx Juno Safeguarding Policy.	
Nottingham City Council Children's Integrated Services							
5.1	Review current training delivered within Children's Integrated Services in respect of domestic abuse and working with perpetrators	All staff who work within the service have an awareness of the impact and links around mental health and suicidal ideation linked to domestic	Review training delivered to colleagues to ensure that it adequately covers links with mental health and suicidal ideation, barriers to access supporting linked to	28th February 2023		**12/02/2024 - CON emailed IMR. Awaiting feedback.**	

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		abuse to aid intervention and assessment. In addition to this that all staff have an understanding of the barriers that survivors may face when accessing support linked to cultural practices and feelings of shame and stigma. To ensure that all staff within the MASH have access to training around engaging with perpetrators of domestic abuse to aid their confidence when undertaking enquiries	cultural practices, stigma and shame. Review current training available to support practitioners in the MASH around engaging with perpetrators of domestic abuse.				
5.2	Briefing to be shared at service level learning meetings around the importance of engaging with non-resident parents.	All staff within the service understand the need to contact non-resident parents to ensure holistic decision making, assessments and intervention.	Full briefing to be developed alongside the principal social worker and the quality assurance team to be shared service wide as part of the ongoing practice developments.	27th January 2023		**12/02/2024 - CON emailed IMR. Awaiting feedback.**	
Nottingham City Homes							
6.1	Remind tenants to ensure household details are updated regularly	Have detailed knowledge of who is resident in our properties	Reminder provided at point of sign up to new tenancy. Reminder provided on website with link to provide information	30th April 2023	1st March 2023	Tenants are reminded of the need to keep household details updated at point of sign up to new tenancy. Reminder provided on website with link to provide information (page 9 Appendix 3) https://www.nottinghamcityhomes.org.uk/repairs/	
Notts HealthCare Foundation Trust							
7.1	The use of Routine Enquiry to continue to be promoted across all Nottinghamshire Healthcare trust Services.	Identify domestic abuse	See evidence section		1st February 2023	Actions completed 1.Domestic Abuse E learning is to be a mandatory requirement of all Notts HC staff. This in addition to other mandatory Safeguarding training. 2.Safeguarding Roadshows have been undertaken during 16 days of activism promoting routine enquiry at locations across the Trust. 3. Specific training can be accessed by teams relating to routine enquiry and completion of DASH.	

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						4. Routine Enquiry continues to be promoted through the SPOC. 5. Agreed for routine enquiry to be an ongoing Trustwide workstream within DSVA Subgroup.	
7.2	Trust Safeguarding team to ensure that Marac minutes are shared with all teams that are currently working with relevant parties.	To ensure that minutes are shared appropriately with all involved services for risk assessment purposes.	To be raised in team meeting	31st January 2023	1st February 2023	This has been raised within Safeguarding Team Meeting 01.02.2023. Minutes are available if needed. Marac Actions Process resent to the Team 01.02.23 to ensure all received this.	
Probation Service							
8.1	Prior to completing a risk assessment, probation practitioners should check if there are any historical records in the OASys INTBD	Risk assessments will improve in ensuring historic information is considered within the context of a new assessment. As noted within this report the practice is now ended.	All staff will be informed that they have to routinely check the INTBD section of OASys (prior to completing a review assessment) and incorporate any relevant information in their risk assessment	31st January 2023		**Audit -** Offender management Senior Probation Officers with the lead area for MARAC in Nottingham City and Nottingham County will 5 cases that have been heard at MARAC to check if the key information in the minutes have been incorporated into the risk assessment. MARAC Audits were conducted in August of 2023 by the City and County manager point of contact for MARAC (at that time). The audits for both probation delivery units identified a number of issues around the recording of information, which related to our case recording system (Delius). In the DHR the concern had been that the MARAC information was on the assessment system in non-disclosed information (OASYS NTBD), since that time there had already been a practice chance to ensure this information is recorded sensitively on the main record (Delius) and not on the assessment system (Oasys) which is less frequently viewed. Nonetheless, when the audit happened last August, there was differing practice in relation to the correct Delius contact being used and also a lack of consistency about the information from the minutes (relating to our case) being shared with the probation practitioner via the Delius contact). Following on from this audit there was a joint City and County review of the process and the process map for staff and case admin was updated to capture these errors. Alongside the audit we have also shared the issues around recording with our senior probation officers who have	

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						discussed this with individual teams. Therefore, that action is completed.	