NOTTINGHAM CRIME AND DRUGS PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Maria'

Date of death: August 2020

FINAL OVERVIEW REPORT

November 2022

Chair and Author: Carol Ellwood-Clarke QPM
Supported by: Ged McManus

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Family Tribute

Maria's daughter provided the Review Panel with the below poem, written by Maria to her Mother in 1999 –

I'm Sorry and I Love You

My brother's they have gave you grief,

But I have gave you pain,

Every time I try my best,

I make it worse again.

I always make you worry,

I make you feel upset and cry,

All I want's to make you happy,

though I get it wrong and don't know why.

I hope that you can understand,

that I have never meant to hurt you.

If you understand and hate me not,

I will find happiness that this time is true.

I could even get to like myself,

Just by knowing you understand.

If I know that your behind me,

then on my feet I'll land.

Thanks for being patient,

for always being there,

for always loving me,

for always showing me you care.

I feel honoured with your friendship,

unworthy of love so true.

In debt for all you've done for me,

SO GRATEFUL FOR HAVING YOU.

I Love you Mum, your loving daughter xxx

Dated – 25 October 1999

1. INTRODUCTION

1.1 Nottingham Crime and Drugs Partnership and the Domestic Homicide Review Panel offers its sincere condolences to Maria's family.

1.2 This report of a Domestic Homicide Review (DHR)[1] examines how agencies responded to, and supported Maria, a resident of Nottingham, prior to her death in Summer 2020. The review has been completed following Home Office Domestic Homicide Review statutory guidance (2016)[2].

1.3 Maria had been in a relationship with Alan for approximately 2 years prior to her death in the summer of 2020. Alan was arrested and charged with Maria's murder. Early 2021, Alan pleaded guilty to the manslaughter[3] of Maria and was sentenced to six years and nine months' imprisonment. HH Judge Burgess stated: "Occasions like this are extremely hard for all involved. A woman has lost her life, children have lost their mum. The sentence will never change that. The harm caused by you could not have been greater. Maria died of a subarachnoid haemorrhage caused by a blow to the head, which was caused by you".

1.4 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse, and 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.

1.5 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies

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[1] Section 4 of this report sets out in more detail the purpose of a DHR and the terms of reference the review panel adopted.

[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[3] https://www.cps.gov.uk/legal-guidance/homicide-murder-and-manslaughter

Manslaughter can be committed in one of three ways:

1. Killing with the intent for murder but where a partial defence applies, namely loss of control, diminished responsibility or killing pursuant to a suicide pact.
2. Conduct that was grossly negligent given the risk of death, and did kill ("gross negligence manslaughter"); and
3. Conduct taking the form of an unlawful act involving a danger of some harm that resulted in death ("unlawful and dangerous act manslaughter").

have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.6 It is not the purpose of this DHR to enquire into how Maria died. This is determined through other processes.

1.7 The Senior Coroner reviewed the case following the trial and a decision was made to close the case, as the death had been dealt with at Crown Court.

2. TIMESCALES

2.1 Following Maria's death, formal notification was sent to Nottingham Crime and Drugs Partnership by Nottinghamshire Police on 4 August 2020. A meeting was held on 2 September 2020 where it was agreed to conduct a Domestic Homicide Review. The Home Office were notified of the decision.

2.2 The first meeting of the Review Panel took place on 10 November 2020. All panel meetings were held virtually during the Covid-19 pandemic and contact was maintained with the panel via email and telephone calls. In total, the panel met six times.

2.3 The DHR covers the period from 1 September 2018 to 1 August 2020. The start date was chosen as it was identified that this was the start of the relationship between Maria and Alan. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.

2.4 The Domestic Homicide Review was presented to Nottingham Crime and Drugs Partnership Chair on 15 October 2021 for sign off (and formally presented to the CDP Board on 13 December 2021) and concluded on 22nd November 2021 when it was sent to the Home Office.

2.5 Amendments were requested by the Home Office on 21st June 2022 and the amended report was resubmitted to the Home Office on 21st September 2022.

3. CONFIDENTIALITY

3.1 Until the report is published, it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim, and perpetrator: these were agreed with Maria's family.

3.3 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Maria	Victim	48	White British female
Alan	Perpetrator	59	White British male

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 10 November 2020.

4.2 The DHR panel set the period of review from 1 September 2018 (start of relationship) to 1 August 2020.

4.3 **The purpose of a DHR is to**:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.
  [Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7]

4.4 **Specific Terms**

1. To identify all incidents and events relevant to the named persons and identify whether practitioners and agencies responded in accordance with agreed processes and procedures at the time of those incidents.
2. What evidence did your agency have that identified Maria at risk of domestic abuse, including coercive control? Did your agency's

response follow inter-agency and multi-agency procedures in response to the victim's needs?

3. Establish whether relevant single agency or inter-agency responses to concerns about the victim and the assessment of risk to her and others was considered and appropriate.

4. What evidence did your agency have that identified Alan as a perpetrator of domestic abuse, including coercive control? Did that response follow inter-agency and multi-agency procedures in response to the offender's needs?

5. Establish whether relevant single agency or inter-agency responses, to concerns about the offender and the assessment of risk to him and his risk to others, were considered and appropriate.

6. Consider the efficacy of IMR authors' agencies' involvement in the multi-agency risk assessment conferencing (MARAC)[4] process.

7. Consider the efficacy of IMR authors' agencies' involvement in a multi-agency /Multi-disciplinary Team meetings regarding domestic abuse.

8. How did agencies respond to the transient lifestyle, including mental health and substance misuse, of the victim and offender?

9. To what extent were the views of the victim and offender (and where relevant, significant others) appropriately taken into account to inform agency responses?

10. Identify any areas where the working practices of agency involvement had a significant positive or negative impact on practice or the outcome. Including, agencies' response to the victim and offender's engagement with their service.

11. Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to the victim and/or offender, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic and impact on national and/or local policy and guidance.

12. Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their

[4] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

responsibilities and duties and worked together to manage risk and safeguard the victim, and the wider public.

13. To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring / reappearing in this review: taking into account if and when these actions were implemented within the agency.

5. METHOD

5.1 On 8 October 2020, Carol Ellwood-Clarke was appointed as the Independent Chair and Author. The Chair was supported in the role by Ged McManus.

5.2 The first meeting of the DHR panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews (IMR)[5] and the others, short reports.

5.3 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified and auxiliary information sought.

5.4 The DHR Chair liaised with the panel members to identify family members or friends to help inform the DHR process. This is covered in Section 6.

5.5 The Chair wrote to Alan to invite him to contribute to the review. Alan agreed to be seen and a visit was arranged to see him in the company of his Offender Manager (OM). Alan did not accept any responsibility for domestic abuse in his relationship with Maria or his previous partners. He blamed all incidents on his partners and their use of alcohol or other substances. He showed no insight into his own behaviour. Alan's contribution is captured in the report, where relevant.

Practitioner Event

5.6 In March 2020, a practitioner event was held. The event was facilitated by Carol Ellwood-Clarke and Ged McManus. Due to the Covid-19 pandemic,

[5] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review

the event was held online. A total of 24 front-line practitioners attended from 11 agencies, all of whom had worked with Maria and Alan.

5.7 The Chair produced a summary of key events for attendees prior to the event. Practitioners were divided into two groups, with a mixture of agencies in each group. The facilitators discussed the details of the case and gathered practitioners' views and experiences in the following areas:

- What challenges did you face in engaging with Maria and Alan?
- What were the challenges in providing services to Maria and Alan?
- Were you able to liaise with and share information with other agencies?
- Did your agencies policies/processes promote or hinder your engagement with Maria and Alan?
- Were you able to access support from your supervisor/manager?
- What did we do well?
- How do you think we can do things differently that might reduce the risks to other people in future?

5.8 Practitioners provided valuable information which has been included within the report, where relevant.

5.9 The Chair of Nottingham Crime and Drugs Partnership agreed for an extension of the timeframe for the DHR to be completed, as a result of delays due to the criminal investigation and the Covid-19 pandemic. The Home Office were notified of the extension. Details of extensions are included at Appendix F.

5.10 Thereafter, a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The draft report was shared with Maria's family who were invited to make any additional contributions or corrections.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND THE WIDER COMMUNITY

6.1 The Chair wrote to Maria's daughter to inform them of the review and included the Home Office Domestic Homicide Review leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet (AAFDA)[6]. The letter was delivered by the Police Family Liaison Officer.

6.2 The Chair contacted the Victim Support National Homicide Service Worker for the family, to ensure that the family had support throughout the DHR process.

6.3 The Chair spoke to Maria's daughter who provided valuable information for the review: this has been included in the report, where relevant.

6.4 The Chair spoke to the landlord of the property where Alan had lived at since March 2019. The landlord stated that he was aware that Alan was in a relationship with a female but did not know her name. The landlord had no knowledge of any domestic abuse between Alan and the female and stated he had received no concerns from other residents regarding Alan and/or visitors to his property. The landlord stated his contact with Alan was limited to matters of rental and property maintenance.

6.5 The Chair visited Maria's daughter in person to discuss the review and identified learning. A draft copy of the report was provided to Maria's daughter, who was supported by her Victim Support National Homicide Service Worker during this meeting. Maria's daughter was given the opportunity to feedback on the report and relevant changes were made were appropriate.

6.6 Maria's daughter attended a panel meeting and spoke to agencies about her mother. Maria's daughter commented on agencies' involvement and areas of the review where she felt that there was learning, both locally and nationally. This has been included in the report.

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[6] https://aafda.org.uk/

6.7 The Review Panel did not identify any friends of Maria's who could be contacted to inform the review.

7. CONTRIBUTORS TO THE REVIEW

7.1 This table show the agencies who provided information to the review.

Agency	IMR	Chronology	Report
Adult Social Care – Nottingham City Council	✓	✓	
Changing Lives CF03 Project			✓
Crown Prosecution Service			✓
Department for Works and Pensions (DWP)			✓
Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company	✓	✓	
East Midlands Ambulance Service (EMAS)	✓	✓	
Edwin House		✓	✓
Framework Housing Association	✓	✓	
Housing Aid – Nottingham City Council	✓	✓	
Jericho Road		✓	✓
Juno's Women's Aid	✓	✓	
MARAC[7]			✓
NHS Nottingham and Nottinghamshire Clinical Commissioning Group	✓	✓	
National Probation Service	✓	✓	
Nottingham Healthcare NHS Foundation Trust		✓	
Nottingham Recovery Network	✓	✓	
Nottinghamshire Police	✓	✓	
Nottingham University Hospitals		✓	✓
Women's Centre		✓	✓

[7] MARAC – this is the collective response and collation of information sharing and minutes from MARAC process. The report from MARAC for the purpose of this review identified which agencies held information about individuals, what actions were created and if they were completed. See also 7.4.12

YMCA	✓	✓	

7.2 The IMRs contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

7.3 Nil returns were received from:

- Nottingham City Homes
- Equation Men's Service
- Neighbourhood Development Team
- Opportunity Nottingham
- Nott's SVSS
- Nottingham SARC – victim on system but did not have face-to-face assessment.
- St Ann's Advice Centre
- DHU Healthcare CIC – No 111 contact with victim since 2017
- Nottingham Trent University
- Nottingham University
- Nottingham Fire and Rescue Service
- CityCare
- Community Protection
- Opportunity Nottingham
- Children's Social Care

7.4 Below is a summary of contributors to the review.

7.4.1 **Adult Social Care – Nottingham City Council**

Nottingham City Adult Social Care department carried out its statutory duties under the Care Act 2014 in relation to assessment and provision of support to meet identified needs for adults living in Nottingham City who have been assessed as eligible for support to meet their social care needs. Where possible, we do this through a strength based approach, reablement and building community connections. We also have a statutory duty under the Care Act in relation to the safeguarding of citizens in Nottingham who have been identified as having care and support needs under the Care Act, and as a result of these needs, are unable to keep themselves safe from harm.

7.4.2 **Changing Lives CF03 Project**

Changing Lives was set up in the North East and has been helping the most vulnerable and socially excluded people for 50 years. The organisation has four pillars of work – accommodation, recovery, employment and women's services. Changing Lives CF03 East Midlands sits under the women's pillar in providing criminal justice services. CF03 is a social inclusion Education, Training and Employment (ETE) project funded by the MOJ, contracted to a prime (Ingeus) who in turn sub contract Changing Lives to deliver services to women within this project. The aim of the service is to engage with people who are subject to criminal justice requirements, be that custody or community orders / licences, and are furthest away from the labour market. There is a pipeline of support within the partnership to ensure that the individual has access to host of support needs opportunities, these include, recovery, emotional wellbeing, family support, and finance debt and benefits. The end aim is to support people into accessing training and employment opportunities to enhance their ability to refrain from further offending and contribute to the economy. Changing Lives has provided this service to women in the East Midlands, South Yorkshire and the North East since 2015.

7.4.3 Crown Prosecution Service

The Crown Prosecution Service (CPS) is the main prosecuting authority in England and Wales. In our daily operations, we work in partnership with all agencies in the criminal justice system. We work especially closely with the police, although we are independent of them. The CPS has 14 areas/regions across England and Wales – the CPS East Midlands Region serves the counties of Derbyshire, Leicestershire, Lincolnshire, Northamptonshire and Nottinghamshire, including the cities of Nottingham, Derby, Leicester, and the county of Rutland.

7.4.4 Department for Works and Pensions

The Department for Work and Pensions (DWP) is responsible for welfare, pensions and child maintenance policy. As the UK's biggest public service department, it administers the State Pension and a range of working age, disability and ill health benefits to around 20 million claimants and customers.

7.4.5 Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

The Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company is working with the Reducing Reoffending Partnership to provide supervision and a range of interventions to enable offenders to successfully rehabilitate. The Reducing Reoffending

Partnership (RRP) comprises of Ingeus (a major provider of people-centre services), CGL (the largest substance misuse provider in the UK) and St Giles Trust (a leading criminal justice charity).

7.4.6 **East Midlands Ambulance Service**

EMAS provide emergency 999 care and telephone clinical assessment services for a population of 4.8 million people. Every day, EMAS receive around 2,500 calls from members of the public who have rung 999. On average, EMAS receive a new emergency call every 34 seconds. EMAS employ more than 4,000 staff and have over 70 facilities including ambulance stations, two Emergency Operations Centres (Nottingham and Lincoln), training and support team offices, and fleet workshops. During 2020/2021, EMAS received 994,144 calls and we responded to 713,235 calls for service.

7.4.7 **Edwin House**

The key aim of Edwin House is to provide a 24-hour consultant led, nursing and structured recovery orientated treatment to those aged 18 years and over, in supporting them to become abstinent from substances of misuse, including alcohol. Edwin House offers medically assisted detoxification/stabilisation programmes of care tailored to address individual need.

7.4.8 **Framework Housing Association**

We are a charity delivering housing, health, employment, support and care services to people with a diverse range of needs across the East Midlands in Derbyshire, Lincolnshire, North Lincolnshire and Nottinghamshire, and also in Sheffield. Regardless of their past, or the challenges they face, we empower people to achieve financial stability, social inclusion and independence, because we believe that everyone has the right and potential to achieve a better future.

7.4.9 **Housing Aid – Nottingham City Council**

Housing Aid is a service within Nottingham City Council and is responsible for delivering the statutory homeless function in the city. The service supports households who find themselves homeless or threatened with homelessness. The service covers the Nottingham City area. The service will provide advice, assistance and support to households in the prevention of homelessness and where this is not possible, support to secure an alternative housing solution.

7.4.10 **Jericho Road**

Established in 2000, Jericho Road Project is a charity working with women affected by the sex industry in Nottingham and Nottinghamshire. We aim to equip and enable women to make informed, life-changing choices: adopting a person-centred approach to support around physical, emotional, practical and spiritual needs. We provide a range of services through which we assist and support women in their choices to live a life away from the sex industry. This includes Street outreach, prison and resettlement work and Befriending and Recovery support offered at our base, or off-base locations.

7.4.11 **Juno Women's Aid**

Juno Women's Aid is the largest domestic abuse organisation in Nottinghamshire and one of the largest in the UK. We work with women, children, and teens who have been affected by domestic abuse in Ashfield, Broxtowe, Gedling, Nottingham City, and Rushcliffe. We run a wide range of services including the 24-hour Nottingham and Nottinghamshire Freephone Domestic and Sexual Violence Helpline. This is where you can speak to one of our specialist trained female support workers – 24hrs a day, 365 days a year.

7.4.12 **MARAC**

Nottingham City Multi-Agency Risk Assessment Case Conference (MARAC) is a multi-agency meeting to discuss the highest risk domestic abuse cases. The MARAC does not own agency information but is a means of dialogue for all agencies to share information known, to enable an up-to-date risk management plan to be created to reduce risk and increase safety of the survivor, children and other vulnerable adults, while holding the perpetrator to account. Specialist highly trained Independent Domestic Violence Advocates (IDVAS) offer support to the survivors and represent them at the MARAC meeting.

7.4.13 **National Probation Service**

The National Probation Service is a statutory criminal justice service that supervises high-risk offenders released into the community. NPS works with the Her Majesty's Prison and Probation Service.

7.4.14 **NHS Nottingham and Nottinghamshire CCG**

Our role involves deciding what services are needed for our diverse local populations, ensuring that they are provided and checking that they are delivering what's needed. We are responsible for the healthcare of a population of just over one million people – whether it is visiting your GP, seeing the nurse, picking up a prescription, or having treatment in hospital.

The area covered by our CCG includes all of Nottingham City and Nottinghamshire county, except Bassetlaw. CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

7.4.15 **Nottingham Healthcare NHS Foundation Trust**
Nottinghamshire Healthcare is positive about providing integrated healthcare services, including mental health, intellectual disability and community health services. Almost 9000 dedicated staff provide these services in a variety of settings, ranging from the community through to acute wards, as well as secure settings. The Trust also manages two medium secure units, Arnold Lodge in Leicester and Wathwood Hospital in Rotherham, and the high secure Rampton Hospital near Retford.

7.4.16 **Nottingham Recovery Network**
Providing a single point of free support, advice and treatment to people who use alcohol and drugs in a problematic way across Nottingham City.

7.4.17 **Nottinghamshire Police**
Nottinghamshire Police is the territorial police force responsible for policing the shire county of Nottinghamshire and the unitary authority of Nottingham in the East Midlands of England. The area has a population of just over 1 million.

7.4.18 **Nottingham University Hospitals NHS Trust**
We're based in the heart of Nottingham and provide services to over 2.5 million residents of Nottingham and its surrounding communities. We also provide specialist services for a further 3-4 million people from across the region. We're one of the largest employers in the region, employing around 16,700 people at QMC, Nottingham City Hospital and Ropewalk House. QMC is where our Emergency Department (ED), Major Trauma Centre, Nottingham Treatment Centre and the Nottingham Children's Hospital are based. It is also home to the University of Nottingham's School of Nursing and Medical School. Nottingham City Hospital is our planned care site, where our cancer centre, heart centre and stroke services are based. Ropewalk House is where we provide a range of outpatient services, including hearing services.

7.4.19 **Nottingham Women's Centre**
We work to help all women in gaining the confidence and skills needed to become stronger and more independent. We provide a safe and supportive environment in which women can do this, either by: taking part

in training and activities; getting support and accessing services; or, campaigning and becoming active to bring about change.

7.4.20 **YMCA**

We provide housing services to support homeless young people and vulnerable adults across Nottingham, Mansfield and Goole (East Riding of Yorkshire), plus deliver a residential Settled Care provision offering emergency accommodation for children at risk.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Lisa Adkins-Young	Interim Deputy Head	National Probation Service, Nottinghamshire
Jennifer Allison	Head of County Services	Juno Women's Aid
Andrew Baxter	Deputy Chief Crown Prosecutor	Crown Prosecution Service, East Midlands
Paula Bishop	Domestic Violence & Abuse Policy Officer	Nottingham Crime & Drugs Partnership
Lisa Del Buono	Service Director	Framework Housing Association
Clare Dean	Detective Chief Inspector	Nottinghamshire Police
Carol Ellwood-Clarke	Independent Chair and Author	
Lucy Gascoigne	Head of Safeguarding	East Midlands Ambulance Service (EMAS)
Jay Grech	Area Manager Midlands and North West	Changing Lives CF03 Project
Kerry Jackson	Advanced Customer Support Senior Leader	Department for Works and Pensions (DWP)
Grace Kinsey	Specialist Safeguarding Practitioner	NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Ishbel Macleod,	Performance and Clinical Change Manager	Nottingham City Council Adult Services
Julie McGarry	Lead for Domestic Abuse and Sexual Safety	Nottingham Healthcare NHS Foundation Trust

Ged McManus	Independent Reviewer	
Sue Parker	Interim Deputy Head of Service	DLNCRC
Yasmin Rehman	Chief Executive Officer	Juno Women's Aid
Debbie Richards	Service Manager	Nottingham City Council Housing Aid
Julie Stevens	Safeguarding and Assessment Quality Assurance Practice Lead	Adult Social Care
Emily Stringer	Adult Safeguarding Specialist Practitioner	Nottingham University Hospitals
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospitals NHS Trust

8.2 The Chair of Nottingham Crime and Drugs Partnership was satisfied that the Panel Chair and Author were independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met six times and the circumstances of Maria's death were considered in detail with matters freely and robustly considered, to ensure all possible learning could be obtained. Due to the Covid-19 pandemic, panel meetings met virtually. Outside of the meetings, the Chair's queries were answered promptly via email or telephone call, and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

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

9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing) in 2017 after thirty years, during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[8].

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

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

9.5 Carol Ellwood-Clarke has recently completed another DHR for Nottingham Crime and Drugs Partnership, which is currently with the Home Office for quality assurance.

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

10. PARALLEL REVIEWS

10.1 HM Coroner for Nottingham opened and adjourned an inquest. The Chair notified Her Majesty's Coroner that a DHR was being undertaken. An inquest was not held as the Senior Coroner determined that the death had been dealt with at Crown Court.

10.2 Nottinghamshire Police completed a criminal investigation following Maria's death. Alan was charged with the murder of Maria. In January 2021, Alan pleaded guilty to manslaughter. Alan was sentenced to six years and nine months' imprisonment.

10.3 The review was not aware of any other investigations that have taken place since Maria's death.

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include “over fifties” or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs

for the purposes of this provision but adherence to a particular football team would not be].

- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[9]

11.3 In 2014, Maria sustained a subdural haematoma[10] and craniotomy[11] following an assault. This required brain surgery and engagement with neurological services. The police informed the review that this left her with memory loss and difficulty in recalling exact times and dates. Family members stated that Maria never completed treatment for this injury.

11.4 Maria's daughter stated that the injury caused her mother to have seizures, and when these occurred; she would appear 'child like' and be unable to communicate or recall events for a period of time. The review identified that from the information known to agencies, Maria did not have care and support needs as defined by the Care Act 2014.

11.5 Alan had no known protected characteristics that would have fallen within Section 4 of the Equality Act 2010. Professionals applied the principle of Section 1 Care Act 2005:

[9] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[10] https://www.nhs.uk/conditions/subdural-haematoma/symptoms/
A subdural haematoma is a serious condition where blood collects between the skull and the surface of the brain. It is usually caused by a head injury.

[11] https://www.uhs.nhs.uk/OurServices/Brainspineandneuromuscular/Neurosurgery/Diagnosisandtreatment/Braintumours/Craniotomy.aspx
A craniotomy is an operation where a disc of bone is removed from the skull using special tools to allow access to the underlying brain.

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

11.6 Maria had been diagnosed with chronic obstructive pulmonary disease (COPD)[12]. Maria had alcohol dependency. In 2019, Maria had been an inpatient to help reduce her alcohol intake. Maria stayed one day. Maria had also been referred into drug and alcohol services. Maria had sporadic contact with her GP service which centred mainly around routine health appointments (such as being called for annual health review) and issues with alcohol dependency.

11.7 Maria informed professionals that she had a history of anxiety and depression since the age of 19, as well as reported previous overdose attempts. In August 2014, Maria's GP referred her into Crisis Resolution and Intensive Home Treatment Team. After a case discussion, the referral was deemed not appropriate for the service as Maria was not suicidal but was experiencing social stressors including homelessness. Later that year, in November 2014, Maria was referred to a mental health team, but did not attend two appointments that had been offered. Maria's GP was notified. The Review Panel acknowledged that whilst mental health issues are not a cause or excuse for domestic abuse, they can be an aggravating factor.

11.8 Alan had limited contact with his GP. Alan had previously been referred to services for alcohol treatment requirement as part of his licence conditions.

11.9 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act. It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.

11.10 All subjects of the review are white British. There is nothing in agency records that indicated that any subjects of the review lacked capacity[13], in accordance with the Mental Capacity Act 2005.

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[12] https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/

[13] The Mental Capacity Act 2005 established the following principles;
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".

Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".

12. DISSEMMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The Family
- Nottingham Crime and Drugs Partnership
- All agencies that contributed to the review
- Nottinghamshire Police and Crime Commissioner
- Domestic Abuse Commissioner

Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".

Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
[Mental Capacity Act Guidance, Social Care Institute for Excellence]

13. BACKGROUND, CHRONOLOGY AND OVERVIEW

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically, and details key events. A list of key events in the case is produced at Appendix C. This section builds on the lives of Maria and Alan and is punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, information provided by family, practitioners and material gathered by the police during their investigations. These events are factual. Analysis appears in Section 14.

13.1 Maria

13.1.1 Maria was described by her daughter 'as someone who craved to be loved; however, this craving drove her towards predatory men'. Maria had five children, two of whom were adopted at birth and are living with adoptive families. Maria had a number of relationships which were abusive until she met a male in 2000. Maria started using heroin whilst in this relationship. In 2019 the male committed suicide which then led Maria back to abusive relationships. Maria's daughter stated that her Mother had undiagnosed mental health problems, and at the age of 38 she had been diagnosed with bipolar. Maria consumed alcohol, often to excess. Maria's use of illicit drugs and alcohol led to involvement of Children's Social Care. The last contact with the service being in 1999.

13.1.2 Maria was very literate and enjoyed writing poetry. Maria had written a piece for a national magazine on her life experiences. Despite her own troubles, Maria gave great life advice to her children. Her family described her as being the 'prison mum' who other inmates went to for advice.

13.1.3 After leaving prison, Maria went to live with her mother, but was not able to stay in the accommodation long-term as she lived in a complex for older people. Maria felt her mother was judgemental of her past behaviour, which impacted on Maria's ability to live with her mother.

13.1.4 Whilst in prison, Maria had reconnected with her Christian faith and upon release had started to attend a church in Nottingham. After she met Alan, Maria stopped going to church: the family described how it was too difficult for Maria to have time away from him. The review has not been able to identify which church Maria attended.

13.2 Alan

13.2.1 Alan had a criminal record. He was first convicted in 1974. Alan was known as a perpetrator of domestic abuse with previous partners dating back to 2009. Alan had three convictions for domestic abuse from 2013, 2016 and 2018. On 26 March 2018, Alan was sentenced to 23 weeks' imprisonment for an assault on his then partner. Alan was also issued with a restraining order. Alan had been heard at MARAC as a perpetrator of domestic abuse in 2011 and 2018.

13.3 Maria and Alan's relationship

13.3.1 Maria's family described Alan as controlling and violent. The family provided examples of his behaviour during contact with the Chair. The family stated that Maria had recently moved from her mother's address when her relationship with Alan began. Alan had stable accommodation and an income from his work [undeclared] and this provided Maria with stability. Maria's family felt that she was judged for her past behaviours and would not get the chance of stable accommodation, hence, her acceptance of her situation with Alan. They stated that Maria was prepared to put up with violence in order to stay away from drugs in hostels and other accommodation.

13.3.2 It was quickly apparent to the family that the relationship between Maria and Alan was violent. Maria began drinking excessively again. Maria told her daughter: "If I get drunk, I don't feel the beatings". On one occasion, Maria's daughter drove to Nottingham concerned for her mother's safety and described how Alan had been obstructive and had hidden Maria's bank card. Maria's family stated that she always ensured she had the exact change in her purse, to cover her bus fare, should she ever need to flee the violence and return to her mother's house. The family stated that this was part of her safety planning and recalled how regardless of what situation she would be in, she would never spend the money. The family stated that upon her death, she had that money in her possession.

13.3.3 Maria's daughter described how her mother was not allowed to bathe on her own, and that Alan insisted that they bathed together every night, and that only he could wash her hair and body. Maria's daughter recalled an occasion where her mother had bathed at her house. When Alan came to the house and discovered this, he started shouting at Maria and challenged

her as to who had washed her body, stating that it was his, and only he could touch it.

13.3.4 Alan stated that he had met Maria in a pub in Nottingham city centre. She had moved into his flat as the place that she was living was not very nice: they had lived together for a time. Alan said that he was working every day as a jobbing builder and gardener whilst Maria didn't work. Alan said that his relationship with Maria wasn't consistent and that she would come and go from his flat as she wished. During the times when she wasn't living at the flat, they would still get together. For example, Alan might find Maria waiting for him at the bus stop when he went to work in the morning, or they would meet after he had finished work and go for a drink.

13.4 Events prior to September 2018 (pre-Terms of Reference)

13.4.1 In 1999, Maria was sentenced to a 12-month community service order for an offence of child neglect. Maria was managed by the Probation Service. Records are no longer available from this time.

13.4.2 In 2014, Maria was assaulted and suffered a significant brain injury. The injury required surgery for a bleed on the brain, and also medical treatment. The assault was committed by a youth who Maria had been drinking: this was not domestic abuse related.

13.4.3 In February 2017, Maria was sentenced to 32 months' imprisonment for an offence of robbery. The victim was an elderly female. Maria was released from prison in October 2017 on a home detention curfew and managed at MAPPA, Category 2, Violent Offender by the National Probation Service. Maria attended appointments regularly with her probation officer in line with the requirements of her licence. Maria was referred to Nottingham Recovery Network for her alcohol and substance misuse: her engagement was inconsistent. It was known that Maria did on occasions use illicit drugs and consume excessive alcohol.

13.4.4 In December 2017, Maria moved into accommodation provided by YMCA after reporting to be homeless.

13.4.5 On 1 February 2018, Alan was discussed at MARAC following an assault on his then partner in January 2018. An action was raised at the meeting for a DVDS[14] to be considered if Alan became involved in another relationship.

[14] Domestic Violence Disclosure Scheme.

13.4.6 During the first six months of 2018, Maria was in a relationship that was violent. Maria was seen by professionals with injuries sustained from assaults by her partner. DASH risk assessments were completed. Professionals discussed with Maria in regard to supporting her in applying for information via a DVDS: Maria declined. In April 2018, a multi-agency meeting was held to discuss the risk to Maria and how professionals could support her in understanding the risk, and also the safeguarding options. Maria refused consent for a referral to Adult Safeguarding Team. Maria was deemed to have capacity. The offender for these assaults was recalled to prison in June 2018.

13.5 September – December 2018

13.5.1 On 11 September 2018, Alan was released from prison on licence until 8 March 2019 and supervision until 11 September 2019. Alan was supervised by DLNRCRC. Alan was seen by his Supervising Officer regularly.

13.5.2 On 13 September, Maria reported that she had been assaulted by her partner. This was a new relationship: the perpetrator was not Alan. Maria contacted Juno Women's Aid helpline. Maria did not support a complaint to the police. Maria was offered a DVDS, which she declined. The male was a known perpetrator of domestic abuse. Maria was referred to MARAC and the case was heard on 24 October 2018.

13.5.3 On 18 September, Maria was seen with facial injuries by staff from YMCA. Maria disclosed that she was 'in another abusive relationship'. Maria would not disclose the name of the perpetrator but said that she had been in a relationship with him for 6 weeks. Maria stated that he abused her weekly and had used weapons, including threats from a knife, and using a metal pole. Maria stated she was aware of his previous history but that she did not feel at risk from him. Maria declined to report the assault to the police. YMCA staff completed an adult safeguarding referral and DASH risk assessment and submitted a referral to MARAC. This perpetrator was not Alan.

13.5.4 Maria's probation officer discussed the injuries and assault with her. Maria did not provide details of the offender. Contact was made with the YMCA

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

as Maria had not been staying at her accommodation and was at risk of receiving a warning. Maria's probation officer changed the reporting requirements to weekly to ensure that Maria was seen during this time.

13.5.5 The Adult Safeguarding referral was allocated to a social worker who, following contact with Maria, determined that she did not have care needs. A referral was made to MARAC by Adult Social Care. There were subsequent referrals made after this time to Adult Social Care, which were passed to the Domestic Abuse Referral Team (DART) for assessing and allocation.

13.5.6 By the end of September 2018, Maria was at risk of eviction from the YMCA. However, following contact by her probation officer, it was agreed to keep the room available due to her vulnerabilities in relation to domestic abuse. At this time, Maria had moved into another property. Maria's probation officer later undertook a home visit and discussed the suitability of the address with Supervision, due to the offender of the recent assaults residing at the address. (This is addressed in Section 14).

13.5.7 On 26 September, Maria was seen by her probation officer with facial injuries, which she stated were accidental. A social worker also attended this appointment. Maria was advised to report the matter to the police and encouraged to consider seeking information through a DVDS, but she declined. Maria agreed that an IDVA could attend her next appointment. Following this appointment, Adult Social Care closed their case.

13.5.8 On 18 October 2018, Maria met with an IDVA during her appointment with Probation. Maria declined to provide details of her partner but agreed for feedback from the MARAC to be given by her probation officer, due to the risk of further abuse. Maria stored the IDVA's phone number under a different name on her phone. On 24 October, the MARAC meeting was held.

13.5.9 At the end of October, Maria was seen by professionals with facial bruising and a possible cracked rib. Maria stated she had fallen down the stairs the previous week. Maria declined that she had been assaulted.

13.5.10 On 15 November 2018, Maria attended for her flu jab. Maria asked staff if she could leave via an emergency exit as her partner was waiting for her and she was scared. A DART referral was submitted, and the case was allocated to a social worker. Following information sharing between professionals, the partner was recalled to prison. Maria had been in a

relationship with this male for several months. Maria was seen and denied that she had been assaulted. Maria declined support from an IDVA.

13.5.11 On 9 December 2018, Maria was assaulted by Alan. The matter had been reported by a member of the public. Alan was arrested. Maria declined to provide the police with a statement. Alan was interviewed and released from custody. Advice was sought from the Crown Prosecution Service (CPS) and Alan was later charged with an offence of assault. This was the first account that agencies knew of the relationship between Maria and Alan.

13.5.12 On 13 December, a multi-agency meeting was held to discuss the risks to Maria from her previous relationship (offender now in prison) and her new relationship with Alan. The meeting was attended by Probation, Nottinghamshire Police, Adult Safeguarding and a representative from MARAC. The following actions were agreed:

- Probation to be invited to MARAC.
- New incident with Alan to be raised at MARAC.
- Probation to review option for Maria to move to Approved Premises. Alternative to approach current landlord for move to another property.
- Police to place a marker on Maria's address
- Assess Maria's mother for support package if Maria moves to Approved Premises.
- To commence mandatory drug testing and discuss rehab.
- Inform Maria about refuges and offer joint meeting with MARAC for safety and planning.

13.5.13 On 14 December, Maria's probation officer informed DLNRCRC that Alan had assaulted Maria and been arrested. The following day, Maria made a 999 call to the police. The police found Maria at Alan's address – Alan asked Maria to leave the property. No offences were reported or identified. The incident was not recorded as domestic abuse.

13.5.14 On 17 December, Maria was seen with facial injuries. When asked, Maria denied that she was in a relationship with Alan and stated he was an old friend and that she just 'wanted to be loved'. The following day, the MARAC was held. Research around Alan was included in Maria's case. At the end of December, Maria's probation officer discussed the relationship with Alan, which Maria maintained was just friendship. Maria was offered and declined support from an IDVA.

13.6 Events in 2019

13.6.1 On 10 January 2019, the IDVA closed Maria's case. The decision was reached as Maria had declined support, though contact numbers had been provided. Six days later, Maria's probation officer contacted Juno Women's Aid to request support for Maria. As the case had been closed, Maria's name was placed on a waiting list for RISE[15]. Contact information was provided for the helpline for emotional support and the Women's Centre.

13.6.2 On 18 January 2019, police responded to a 999 call made by Maria, during which a male could be heard shouting. Both Maria and Alan were intoxicated. Maria was taken to her own accommodation. This incident was not recorded as domestic abuse.

13.6.3 On 30 January, Maria attended a welcome meeting at the Women's Centre. Maria asked to join the Crafty Club, which is open access and was added to the waiting list for counselling. Three days later, at the beginning of February, the police received a call that Maria had been assaulted by Alan. Maria was seen several days later and denied that she had been assaulted. Maria had no visible injuries.

13.6.4 On 6 March, Maria attended an appointment with her probation officer. Maria was intoxicated and stated she had been in a pub with a male prior to her appointment. The probation officer expressed concerns that Maria had not progressed, since December, in addressing alcohol use. Later that day, Maria was assaulted by Alan. The police attended the incident and Alan was arrested. Alan was charged with an assault on Maria and another person at the property. Alan was released on conditional bail. It was understood that Maria had now moved into Alan's property. A DART referral was completed, which was risk assessed as medium. Contact was attempted with Maria, which was unsuccessful. The case was closed after contact with NRN to establish what support was in place and to provide contact details for the Women's Centre.

13.6.5 On 14 March 2019, Maria's case was allocated from the waiting list at RISE. However, as there were no contact details for Maria, the initial contact could not progress. A request was made for contact information from Probation. This was not responded to and a further request for information was made on 12 April.

[15] https://equation.org.uk/rise-service/
Rise is Nottingham City medium risk support for domestic abuse.

13.6.6 On 10 April 2019, Maria informed her probation officer that she wanted to access detox to address her alcohol consumption. A referral was completed for Edwin House.

13.6.7 On 16 April, Alan breached his bail conditions by returning to his home address: Alan was arrested. The bail conditions were later changed to remove the condition regarding attendance at the property.

13.6.8 On 24 April, the same day, the Witness Care Unit sent a text message to Maria's mobile phone to remind her of the trial date. On the same day, Maria attended an appointment with her probation officer. Maria was intoxicated and disclosed, during the meeting, significant alcohol consumption and that she was involved in sex work. Maria was referred to Jericho Road. It was agreed for her to meet with a worker on 30 April, but Maria cancelled the appointment as she reported she had fallen out of a taxi and bruised her face. A further appointment was arranged for 3 May.

13.6.9 On 28 April, Maria's daughter contacted the police and reported that her mother had phoned her to say she was injured. Police found Maria with Alan. Maria denied that she had been assaulted. Alan was arrested for breach of bail and remanded in custody for the case to be heard on 3 May, when he was released from custody. The assault by beating offences had been dismissed.

13.6.10 Maria met with a worker from Jericho Road on 3 May. It was noted that Maria was very open during the contact and that she recognised she needed help. Maria stated she drank alcohol all day, as much as she had money for and spoke about the trauma of her life, the loss of family members, injuries, rape, domestic abuse, and going to prison for robbery. Maria met with the worker the following week and continued to engage.

13.6.11 In June 2019, Maria was seen in the Neurology Clinic in relation to chronic headaches and concerns in relation to her brain injury from 2014. Maria disclosed that she had recently fallen, which caused facial injuries. Maria was advised to reduce her alcohol intake. Maria was not asked about domestic abuse.

13.6.12 On 13 June, Maria was collected by a worker from Jericho Road and taken to Edwin House, where she was admitted commencing a programme of detox. The following day, Maria self-discharged against medical advice.

13.6.13 On 26 June, Maria's licence ended. The same day, Alan appeared at court and pleaded not guilty to assault on Maria. This was related to the incident from 9 December 2018. The Court IDVAs had tried to contact Maria, but the contact number they had was no longer in use. The case was closed to the Court IDVA. A trial was arranged for 18 September 2019. Alan was released on unconditional bail. This case was later dismissed, and no further action was taken.

13.6.14 On 7 July, Maria approached a police officer and reported that she was being controlled by Alan, who limited what money she had and how many cans of alcohol and strength she could have. Maria said Alan constantly rang her to see where she was, and he had to listen whenever she made a call. Maria provided a witness statement. Alan was interviewed and denied the offence. Maria later stated she wanted to retract her statement and would not support a prosecution.

13.6.15 On 20 August, Maria's mother contacted the police, via 999, and stated she had received a text message from Maria asking for help. Maria's mother believed she was being assaulted by Alan. Police found Maria at Alan's address. Maria denied that she had been assaulted.

13.6.16 On 11 September, the post-supervision period for Alan ended.

13.6.17 On 19 November, Maria made a 999 call to the police to report she had been punched in the head and stomach by Alan. The police were unable to locate or contact Maria for several days. When contact was made, Maria declined to make a statement. Two weeks later, on 5 December, Maria approached a police officer and reported that she had been assaulted by Alan. Maria was seen to have blood around her mouth. Alan was arrested. Maria declined to provide a statement. The police gathered evidence to present an evidence-based case to the CPS. This included details of the incident on 19 November. The CPS reviewed the case. No charges were made against Alan. The case was assessed as medium risk and referred to DART. The case was closed in accordance with DART policies.

13.6.18 On 18 December, Alan was found rough sleeping by the Street Outreach Team. Alan was provided with accommodation. This was the only occasion Alan was seen to be rough sleeping.

13.7 Events in 2020

13.7.1 On 31 January 2020, Maria telephoned the police, via 999, to report that Alan had taken her phone. The call was made from a phone box. Maria and Alan were found at his house. The phone was in Maria's bag. The police took Maria to her mother's address.

13.7.2 On 18 February, a member of the public contacted the police and reported that they had found Maria in the street. Maria was semi-clothed and had been sexually assaulted. The offender was arrested, and a police investigation was undertaken. Maria was referred to Adult Social Care.

13.7.3 On 16 April 2020, Maria contacted the police, via 999, and reported that Alan had taken her bank card and 'thrown' her out of the house. Maria informed the police that she had given her bank card to Alan the previous week and had called at his house to collect it. Alan was not at the property. Maria was taken to another address.

13.7.4 On 25 May, Maria was seen by the Street Outreach Team rough sleeping. Maria was provided with a contact card and made aware of the referral/assessment process. A week later, Maria was seen again by the Street Outreach Team. Maria stated that she was being abused, but would not go into detail.

13.7.5 On 13 June, Maria telephoned the Street Outreach Team asking to be assessed. Maria was seen the following day, outside a volunteer centre. Maria disclosed that she was fleeing domestic abuse, perpetrated by her partner. Maria stated she was worried he was looking for her. This is covered further in Section 14.

13.7.6 On 16 June, Maria was assessed by the Street Outreach Team. The assessment took place via telephone. Maria was referred to Housing Aid and signposted to somewhere she could get a shower (at her request). Maria's case was allocated to a Housing Aid advisor who called the number on the referral. The phone was answered by a male who described himself as Maria's friend. A message was left with the male asking Maria to call Housing Aid.

13.7.7 Maria telephoned the Street Outreach Team the next day asking for an update in relation to her Housing Aid referral. Maria was provided with the number to contact Housing Aid direct. Maria telephoned Housing Aid on three occasions, the first being on 17 June, when the Housing Aid advisor

was not available, and a message was left that Maria had telephoned. The Housing Aid advisor later called the number left by Maria but was advised by the male who answered the phone that Maria was no longer in his company. The Housing Aid advisor arranged to call the following day. The next day, the Housing Aid advisor made several calls to speak with Maria, these were all unsuccessful.

13.7.8 On 21 June, Maria contacted the police and reported that Alan had been threatening towards her and would not let her go. The following day, Maria telephoned Housing Aid to speak with the Housing Aid advisor: a message was left for the advisor to call Maria back. The same day, the police contacted the Street Outreach Team requesting if Maria had been seen, due to the incident on 21 June. Maria was not seen by the Street Outreach Team until 22 June.

13.7.9 On 23 June, Maria was seen by the police and stated she was no longer in a relationship with Alan. Two days later, Alan was arrested for an offence of drunk and disorderly, following an incident with a group of street drinkers. Alan was later charged in relation to this incident.

13.7.10 On 26 June 2020, Maria attended at hospital following an assault by a female. The police attended the incident. During the incident, Maria was knocked unconscious.

13.7.11 On 8 July, the Housing Aid advisor telephoned the Street Outreach Team and explained that they had been unable to contact Maria. A further call was made to the phone number on the referral: the male who answered the call stated he had not seen Maria for several days.

13.7.12 On 28 July 2020, Maria was seen by the Street Outreach Team, rough sleeping. The following month Maria was found deceased.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

To identify all incidents and events relevant to the named persons and identify whether practitioners and agencies responded in accordance with agreed processes and procedures at the time of those incidents.

14.1.1 All incidents and relevant events are detailed within Section 13 and Appendix C and, therefore, will not be repeated under this Term of Reference. The analysis will focus on agencies responses to those incidents.

Adult Social Care

14.1.2 Maria was not known to Adult Social Care (ASC) until a referral was received on 18 September 2018. The referral and consequent interagency information identified Maria as a woman with a history of relationships with male perpetrators of domestic abuse. Between September 2018 and August 2020, six referrals were made to ASC: all referrals were due to domestic abuse. Alan was the named perpetrator in three of the referrals.

	Date	Perpetrator
1	19.09.18	Unknown
2	19.11.18	Unknown
3	20.12.18	Alan
4	20.03.19	Alan
5	05.12.19	Alan
6	27.02.20	Unknown

14.1.3 The first two referrals were considered as Adult Safeguarding enquiries under Section 42 of the Care Act 2014. The third referral occurred during the second safeguarding enquiry. The enquires identified that Maria had capacity to make decisions and choices in relation to the safeguarding concerns and that she did not have social care needs.

14.1.4 The fourth and fifth referrals were medium risk referrals made via the Domestic Abuse Referral Team (DART). The DART worker read the previous safeguarding interventions and identified that Maria did not have any eligible social care needs. The case was discussed with a Senior Social Worker and it was agreed for the referrals to be closed in accordance with DART processes. Details of the DART process is contained at Appendix D.

14.1.5 The final referral was made to Nottingham Health and Care Point. This was screened by an experienced Senior Practitioner which identified that

there was no evidence that Maria had social care needs. The information was recorded, and no further action was deemed necessary. The outcome was in accordance with expected practice standards and appropriate, given the information known to ASC at that time.

Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

14.1.6 On 14 December 2018, Alan's probation officer was informed by the National Probation Service that he had assaulted Maria. Following this information being received, Alan did not see his probation officer for a month; however, the allocated probation officer had a period of annual leave during this time. Alan should have been seen sooner and several actions undertaken including a risk review, a home visit, and a request to the police to clarify if there had been any other incidents of domestic abuse. These steps are standard expected practice, as outlined in the Community Rehabilitation Company (CRC) domestic abuse and general practice guidance[16]. When Alan was seen, his account of the assault was taken at face value and not challenged.

14.1.7 In March 2019, Alan committed a further assault against Maria and assaulted another female. Following this incident, Alan's probation officer discussed with their line manager whether to recall Alan to prison, as he was in breach of his licence. As Alan had not been charged at that point and the fact that his licence period was due to end within a day, it was decided not to progress with a prison recall. Despite this decision, a new risk assessment and request for information from the police should have been undertaken. These actions did not take place. The probation officer recorded in a contact record review that they would undertake 1-1 work with Alan regarding domestic abuse and managing conflict. The DHR panel have seen no record that this work was undertaken; however, the probation officer verbally told the review that this did take place.

14.1.8 There was also an option for Alan to have been given a formal written warning, but this did not occur. However, it should be noted that any enforcement action taken during the period of a licence cannot be used for enforcement during the post-sentence supervision period. Therefore, had Alan been issued with a warning in December 2018 and/or March 2019, this could not then have been used as evidence of poor behaviour during his post-sentence supervision. The warning could also have been used to enforce any poor behaviour committed during the post-sentence supervision more quickly. Alan's probation officer did discuss the

[16] DLNR & SWM CRC Domestic Abuse Policy and Staff guidance 2018
Every Case Essentials – Case Management 2018

subsequent charges and details of the incident with Alan – during these discussions Alan denied assaulting either victim.

14.1.9 The DHR panel considered the response by the CRC. The panel were informed that since 2018, the CRC have invested time and resources into improving practice with domestic abuse perpetrators. There have been mandatory briefing events for staff on the topics of domestic abuse, child safeguarding and adult safeguarding, following the introduction of the emergency delivery model in response to the pandemic. During the completion of this DHR, staff within the CRC were undertaking mandatory workshops with their line managers, entitled "working effectively with domestic abuse perpetrators". The panel were informed that requesting information from the police and undertaking safeguarding checks are more routinely carried out. Further work is planned as the CRC moves towards reunification with the National Probation Service, with workshops focussed on risk assessment and risk management. The CRC has identified learning in their response to this DHR and made relevant recommendations. The DHR panel agreed that the CRC (now The Probation Service) should provide assurances to the Nottingham Crime and Drugs Partnership that the learning has been embedded into practice and has made a relevant recommendation. [Recommendation 1]

East Midlands Ambulance Service

14.1.10 East Midlands Ambulance Service (EMAS) responded to several 999 calls to see Maria. On all incidents, Maria was seen in a public place, and not at her home address. Maria was treated in line with her presenting needs. On the occasions that Maria was not conveyed to hospital, there is evidence that the crew assessed capacity around her decisions not to travel.

14.1.11 On 18 May 2018, EMAS recorded information during contact with Maria that she had been spat on by a known person. Whilst Maria did not give names of the perpetrator, questions were not asked about domestic abuse or onward referrals made. This has been identified as learning by EMAS and a relevant recommendation made. Whilst this incident is outside the timescale for the review, it has been analysed due to the identified learning.

14.1.12 On 18 February 2020, EMAS raised a safeguarding referral to Adult Social Care, GP, and domestic abuse services in response to a 999 call. The crew made specific references in the referral that without support from services, they were concerned that Maria would be at further risk of harm. Maria was taken to a place of safety.

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

14.1.13 On 15 November 2018, Maria attended an appointment for her flu jab. Maria disclosed to a health professional that she wanted an alternative exit from the building to escape her abusive partner (this was not Alan). Whilst at the surgery, Maria called Women's Aid to seek help leaving the building, but they were unable to come to the surgery. Contact was made with the police and Maria was advised to contact Housing Aid to source alternative accommodation. A referral was made to the MASH. This was an opportunity for a DASH risk assessment to have been completed. This did not occur. There is no record if an alternative exit was provided.

14.1.14 Maria had limited involvement with her GP during the timescales of the review. Contact centred around routine health appointments and issues with her alcohol dependency and headaches. There was a lack of professional curiosity around domestic abuse. Records did not identify if Maria was alone or accompanied during consultations, which may have accounted for Maria not being asked about domestic abuse. There were entries in her GP records regarding non-attendance at appointments, and attempts to contact Maria which were unsuccessful. The CCG have identified learning regarding their involvement in the case and made a relevant recommendation.

Housing Aid

14.1.15 Maria was referred to Housing Aid by the Street Outreach Team, in June 2020, having been seen sleeping rough in the city centre. The referral was made via the ALERT system, which was an online referral mechanism used by agencies. The referral identified Maria as a victim of domestic abuse. The perpetrator was not identified within the referral. Maria had advised the Outreach Team that she was not engaging with any other support services.

14.1.16 The referral was allocated to a member of the Advice Team and, as Maria was identified as someone who was potentially homeless that night, attempts to contact her were made the same day. This is standard practice and procedurally what is expected. The number on the referral form was called and the phone was answered by a male. The identity of this person is not recorded in the casefile, but it is noted that he described himself as being Maria's friend. Despite his identity being unknown, a message was left with him asking Maria to make contact with the officer. Maria did return the call, but as the officer was not immediately available, a message was taken for her to call Maria back. This call was returned, but Maria was not with the friend. The officer made several attempts to reach Maria the following day and was unable to do so. Messages were left with

the friend to make contact and to ask to speak to a colleague if her allocated officer was unavailable.

14.1.17 The DHR panel were informed that at the time of the referral being made, the Customer Hub within which Housing Aid sits was closed due to the Covid-19 pandemic. Housing Aid had an office which enabled those unable to access the service via other means to do so. Housing Aid would normally offer both an appointment and drop-in service for those who required immediate assistance. The option to come into the office to seek assistance was available; however, it was (and still is) the case that where an individual had other means to speak to the service, i.e. telephone or online, they were encouraged to do so. It was not clear in records that Maria had been informed that she would have been able to present to the service in person.

14.1.18 Maria's case was closed to the service on 8 July 2020, as the officer had been unsuccessful in her attempts to reach Maria. Prior to closing the case, the officer contacted the Street Outreach Team in a further attempt to try to contact her. The officer was advised that Maria had not been seen by the Outreach Team since mid-June 2020 and that the Outreach Team did not have an active 'case' with Maria as she had not been found rough sleeping. The officer left a message on the casefile, held by the Street Outreach Team, for Maria to be referred back to Housing Aid if found rough sleeping. A further call was also made to the friend's telephone number and he too advised that he had not seen Maria for a few days. A message was left with him to let Maria know that she could contact the service at any time if she needed assistance.

14.1.19 At the end of March 2020, and in response to the Covid-19 pandemic, the Government gave a directive to Local Authorities to provide emergency accommodation for those known to be rough sleeping in their areas. This initiative was termed 'Everyone in'. Within Nottingham, 70 rooms within 2 hotels were secured for rough sleepers. This included alternative provision for 30 individuals who were living in rough sleepers' accommodation (shared sleeping spaces were no longer deemed suitable because of the virus), and an off the street offer for 40 rough sleepers. The 'Everyone in' initiative was for an initial period of 12 weeks. Within Nottingham, this meant hotels up until 13 June 2020 for the 'off the street' provision, and 18 June 2020 for the accommodation providing the alternative to the shared sleeping provision. Strategic meetings were held during this time with MHCLG (Ministry of Communities and Local Government) regarding continuation of the funding. Further funding was not available and a period of 'step down' commenced on 25 May 2020: after this date, there were no new placements made into either hotel. Anyone found rough

sleeping after this date was referred into Housing Aid through the 'usual' channels. This included any referrals made via the ALERT system. Maria was referred to Housing Aid three days after the 'off the street' provision had closed.

14.1.20 The DHR panel reflected on the involvement of Housing Aid and acknowledged that the initial referral detailed that Maria was a victim of domestic abuse. The phone number provided on the referral was always answered by a male, the identity of whom was not known, nor was it asked. On the one occasion that Maria returned the call to Housing Aid, the allocated worker was not able to take her call, and Maria was advised that she would be called back. Further contact with Maria was not made. The DHR panel concluded that Housing Aid had been reassured by the Street Outreach Team who reported that Maria had not been seen rough sleeping, and that this informed their decision-making to close the referral. Housing Aid have identified learning around their involvement, including the recognition of domestic abuse and professional curiosity when contact with potential clients is unsuccessful or prevented. Whilst the review has not identified who the male was that answered the phone calls, the panel agreed that on reflection, given Maria's vulnerabilities and history of domestic abuse, alternative methods should have been undertaken to contact Maria.

Juno Women's Aid

14.1.21 At the time that Maria accessed support, Juno Women's Aid was known as WAIS (Women's Aid Integrated Services). Maria was supported for 12 months with the following services:

- WAIS 24 Helpline
- WAIS City IDVAs
- WAIS RISE medium Risk Support Service
- WAIS Court IDVA service.

In April 2020, WAIS re-branded and changed its name: becoming Juno Women's Aid. On 1 April 2020, Juno Women's Aid implemented a new service model, and revised its organisational structure. The new service model is a needs-led, strengths-based, and risk-assessed model of service provision, rooted in the principles of Women's Aid, Change that Lasts model[17]. The model was developed following widespread consultation with survivors and staff. The model strives to ensure that women are referred

[17] https://www.womensaid.org.uk/our-approach-change-that-lasts/

into Juno Women's Aid services through one route and once in service are supported by one key SASS (Survivor Advocacy and Support Worker), irrespective of changes to the level of risk assessed at a particular time. The model is to support survivors to build and maintain a relationship of trust with a single SASS worker who will have a fuller picture of the experience and context of the survivor and her case, rather than moving workers each time risk levels change. The only exception to this is if the service user has a court worker but, in such instances, there will be a lead SASS worker working alongside the survivor and Court IDVA. It is impossible to state if this service model would have made a difference to Maria's experience of services from Juno Women's Aid. However, with hindsight, had the service model been in place when Maria was referred into Juno Women's Aid, then it would have been expected that Maria's SASS worker would have had a fuller understanding of the situation, contact details, and have built a trusting relationship with her over the time she was engaged with services.

14.1.22 The panel member for Juno Women's Aid informed the review that the support Maria received did not always meet the standards they should have. Contact details for Maria were incorrect, despite the case having been heard at MARAC and the involvement of several agencies, including a number of Juno Women's Aid services. This would have resulted in delays in Maria being able to access the support she would have needed at that time.

14.1.23 The IDVA team followed processes and procedures, and at times worked creatively to engage Maria in support and to safety plan with her. When Maria declined support, IDVAs worked with Probation, Adult Social Care and police to share intelligence and expertise regarding safety planning to keep Maria as safe as possible. The court attempted contact to keep Maria updated. This contact was unsuccessful.

14.1.24 Maria sought help from WAIS and was referred into the RISE Team by her probation officer on 16 January. On these occasions, Maria was placed on a waiting list. The RISE Team (medium risk support team) attempted to contact Maria to offer support, however, this did not take place for eight weeks after Maria was placed on the waiting list. When contact was attempted on 14 March, it became apparent that the contact number for Maria was incorrect. RISE staff asked Probation for up-to-date contact details in March and again on 12 April. There is no record that RISE workers attempted to check with City IDVA colleagues (who would have supported Maria's case at MARAC) or Helpline colleagues (who had also been in contact with Maria) to establish contact details. In addition to the issues raised regarding Maria's contact details, the delay of eight weeks in

contacting Maria is of significant concern, as is the fact that RISE team staff, including managers, were not reviewing the case files in this period as part of allocation and case review processes. This has been identified as an area of learning by Juno Women's Aid and as such they are implementing a number of changes to processes to support staff, avoid delays in contacting survivors, and ensure survivor information is accurate.

14.1.25 The panel were informed that over the coming years, all Juno Women's Aid staff and team managers will be expected to undertake and achieve the Women's Aid DAPA (Domestic Abuse Prevention Advocate) qualification[18] (equivalent to IDVA) to ensure that all those supporting survivors can do so confidently, irrespective of risk level, and deliver the appropriate service. This will further support the service model of being allocated a dedicated support worker wherever possible, and to ensure consistency of contact.

14.1.26 A Juno Women's Aid service manual setting out clear processes has been written in line with domestic abuse sector standards set by Women's Aid England and SafeLives. The service manual includes clear processes and information regarding timeframes for making contact with survivors (within 48 hours), case allocation and case management. The panel heard that this was being published at the time of the review and will be made available to all Juno Women's Aid operational staff. Ongoing training in use of 'On Track', Juno Women's Aid's internal case management system, has been refreshed and will be rolled out quarterly for all operational staff. Juno Women's Aid's service model was implemented just as the Government enforced a nationwide lockdown: the rollout was difficult. However, Juno Women's Aid is striving to ensure the learning from this case, and others, is incorporated into ongoing service improvement plans. In addition, Juno Women's Aid's Board of Trustees and CEO have established a Quality Assurance Sub-Group of the Board to review learning from DHRs and Safeguarding Adult and/or Local Child Safeguarding Practice Reviews are addressed and to ensure improvements in quality and service standards are implemented and monitored.

14.1.27 On 13 September 2018, Maria rang the 24-hour helpline twice asking for support. The calls were outside of office hours and the only support the helpline could offer was over the phone; however, Maria wanted to access the building for face-to-face support. This was not possible as Juno Women's Aid does not offer out-of-hours face-to-face services. The DHR panel reflected on this response and were informed that if Maria had been

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[18] https://www.womensaid.org.uk/events/tackling-preventing-domestic-abuse-certificate-manchester/

in immediate danger, then the police would have been notified. When calls are made to the 24hr helpline, an assessment of need is undertaken to establish what action the caller wants to happen in accordance with their safety at that time. The Helpline asked Maria to ring back before 10am the following day, therefore ensuring that she would have been allocated an early face-to-face crisis drop-in appointment. Maria did not call back. The IMR panel member informed the review that on reviewing the case notes and discussions with Head of Service for Helpline, Maria should have been offered an early face-to-face appointment the following day with a support worker. Maria may still not have attended but a support worker would have been available to support her had she been able to access this service.

14.1.28 The panel were informed that Juno Women's Aid have invested in a new and improved phone system that has increased the number of lines available to survivors seeking help, from 5 to 15. The organisation is currently looking into the possibility of providing additional support and training for Helpline staff and relief workers delivering this service. As part of Juno Women's Aid's learning from this case, the organisation has been reviewing the response from Helpline staff to out of hours. Juno Women's Aid does not record calls made to the Helpline service as part of our regular monitoring and review of the service. The organisation is currently looking into the possibility of calls being recorded and used as part of DHR and other review and monitoring mechanisms and training for staff. Ongoing discussion with the telephone system provider have begun and will also require consultation with staff. A process of managers listening in to day time calls as part of internal quality assurance mechanisms are also being developed. The panel acknowledged the significant changes that had taken place within Juno Women's Aid and the further changes that were being considered. The panel have made a recommendation for Juno Women's Aid to provide evidence and assurances to Nottingham Crime and Drugs Partnership on the progression and implementation on the changes. [Recommendation 8]

MARAC

14.1.29 Whilst MARAC is not an agency, but a process to allow agencies to share information and work together to reduce and manage risk, it has been included within this section to provide an overview of the MARAC involvement on this case. The DHR panel have been informed that, since this case, there have been changes to the MARAC process. The mechanism for sharing information has changed and is now done by a secure, encrypted cloud base system (ECINS) to enable faster sharing of information amongst agencies and monitoring and outcome of actions.

14.1.30 Maria was referred to MARAC twice in 2018. The perpetrator was not Alan. However, by the time of the second MARAC in December 2018, it was known that Maria was in a relationship with Alan and he was known to be a perpetrator of domestic abuse. Alan's details were included within the details of the December 2018 referral, with information researched, shared and actions created. The DHR panel recognised this as good practice.

National Probation Service (Nottinghamshire)

14.1.31 Maria was released from custody in October 2017 subject to Home Detention Curfew, which expired on 28 February 2018. Maria's licences and supervision expired on 28 February 2019. Maria was a MAPPA Category 2 (Violent) nominal, managed at Level 1 (single agency) with National Probation Service (NPS) as the lead agency. Maria was assessed as posing a medium risk of serious harm to the public. Maria was released with licence conditions, which included seven standard conditions related to residence, being of general good behaviour, and not committing further offences. There were specific conditions to address Maria's risks: interventions related to offending behaviours (alcohol/drugs/violence); drug-testing; and, no contact with the co-defendant and the victim without permission.

14.1.32 Maria's Offender Manager (OM) managed her case in line with expectations encapsulated in the guidance: 'Practice Framework National Standards 2015'. This guidance also highlights the responsibilities of the OM in Safeguarding Adults in line with the statutory framework set out by The Care Act 2014 in protecting adults with needs for care and support who are experiencing, or at risk of, abuse and neglect. It places a shared duty on local authorities and key agencies, including Probation, to liaise with each other in respect of their relevant care and support functions. In Maria's case, the risks related to the OM becoming aware of her being a victim of domestic abuse/violence. Further guidance relevant to the management of Maria's case was the 'NPS Midlands Strategy for Women Offenders 2017-2019' and how this was translated into the expectations of local practices of NPS Nottinghamshire staff at the time. This policy was introduced in August 2017 and, therefore, would have started to be introduced and embedded into local practice during Maria's supervision period.

14.1.33 Since Maria's supervision expired, the NPS have trained over 500 staff in Trauma Informed Training across the Midlands division. It was recognised that such training was necessary to effectively engage with women under their supervision: given the vulnerabilities and mental health issues and prevalence of significant trauma in the background of women who find themselves in the Criminal Justice System. The DHR panel recognised that

this would have been valuable training and knowledge to Maria's OM had it been in place at that time.

Nottinghamshire Police

14.1.34 Nottinghamshire Police responded to incidents of domestic abuse between Maria and Alan. Alan was the perpetrator on all these incidents. In addition, the police attended incidents of domestic abuse where Maria was a victim with other perpetrators. On one occasion, Alan was arrested for an offence of drunk and disorderly. This incident occurred when Alan was found drinking with other street drinkers and became abusive to police when asked to leave the area. Maria and Alan were often under the influence of alcohol during contact with the police and whilst Maria provided the police with information, it was often the case that Maria would not support a prosecution.

14.1.35 Overall, the police took positive action, and on two occasions gathered evidence to support an evidence-based prosecution (November and December 2019). The police can use bad character evidence[19] as part of their file submissions for certain offences, including domestic abuse. The admissibility of bad character evidence in criminal proceedings is governed by Part 11 Criminal Justice Act 2003 (Sections 98-113) – section 99 of which, abolished the existing common law rules. The IMR author for Nottinghamshire Police reported that this was used during the prosecution of an assault on John's former partner in January 2018. Nottinghamshire Police's policy on the investigation of domestic abuse does reference to the use of bad character when undertaking prosecutions of domestic abuse. The DHR panel recognised that the use of bad character evidence can maximise the chances of securing a prosecution of domestic abuse. This was not routinely undertaken in this case and this has been identified as an area of learning and a relevant recommendation made by the police.

14.1.36 The Deputy Chief Crown Prosecutor for East Midlands attended the panel and provided a written review of the cases. The review stated that the reviewing lawyer considered all available evidence presented by the police. One of the key aspects was the account given to the officer at the scene and whether this could be admitted as evidence under the "res gestae" provisions. Res gestae evidence is admissible under s118(4) Criminal Justice Act 2003: It is res gestae if the court is satisfied that "the statement was made by a person so emotionally overpowered by an event that the possibility of concoction or distortion can be disregarded". The account given to the officer at the scene did have the potential to be res

[19] https://www.cps.gov.uk/legal-guidance/bad-character-evidence

gestae evidence. However, this and the photos of injury and a broken vase at the scene were the only evidence. Maria accepted that she was heavily intoxicated: this was also recorded by the attending officer, which affected the reliability of the account that she gave and as such it was decided that there was insufficient evidence to provide a realistic prospect of conviction.

14.1.37 Maria provided a statement to the police in March 2019 after she had been assaulted by Alan. Alan was charged with the assault and appeared at court on 8 March 2019, where he was released on bail with conditions not to contact Maria and to stay away from the address she was living at. On 3 May, the charge of assault was withdrawn by the CPS who offered no evidence at court. Maria had not attended at court. This decision was not known by the police, who continued to submit documentation to the CPS after this date.

14.1.38 The panel were informed that the decision to charge the matter was made by CPS Direct and this was the correct decision. Both witnesses at this stage confirmed that they were willing to support a prosecution and their statements, coupled with the injuries, provided a realistic prospect of conviction. The case was further reviewed on 23 April, by which stage it was clear that both witnesses were showing signs of reluctance. Neither had been in contact with the Witness Care Unit. The Witness Care Unit attempted to contact Maria on at least 5 separate occasions by phone call and several times by text message. A task was raised for an officer to visit on 24 April, and chased a further two times. Prior to the trial, there was no record of Maria ever confirming her attendance at the trial.

14.1.39 At this stage, the reviewing lawyer should have escalated the fact that there had not been any response from the officer to the request to attend the victim’s home address. Following this, it may have been appropriate to have requested a background report and consider a summons to endeavour to secure attendance; however, it is impossible to conclude whether there would have been a response to a summons or indeed a later warrant, or whether a court would have granted such applications, but that was a further step that was possible in this case. Instead, the reviewing lawyer indicated in review that if the witnesses did not attend, the advocate at trial should seek an adjournment. CPS stated it would have been prudent to have requested a background report, with a view to considering summonses, given that it was clear at the point of the review that the victim was reluctant. When the victims did not attend on the day of the trial, an application was made by the trial advocate to adjourn, as per the reviewing lawyers’ instructions. However, the court refused the adjournment due to lack of information regarding the witness’s non-

attendance and, as such, the prosecution was left with no alternative but to offer no evidence.

14.1.40. Given Maria's vulnerabilities and transient lifestyle, the DHR panel have seen no evidence that Maria was aware of this court date and the requirement for her to attend and give evidence. The police held no record of the trial date. The police had been unable to contact the victim to gather a victim personal statement and therefore a letter had been sent to her last known address. The police have a witness management service (WMS) who, post charge, make contact with victims and witnesses to establish the need for any special measures when attending court, and are responsible for notifying victims/witnesses of trial dates. The WMS did make efforts to contact Maria via phone, text and letter, but received no response. Emails were sent to the police officer who had interviewed Alan and a generic email to the prisoner processing team, to request contact with Maria. The WMS did not receive a response from either: this was not progressed further. The police have identified learning in relation to their response and made relevant recommendations.

14.1.41 The panel considered if the case identified wider learning in relation to the criminal justice system around engagement and contact with victims of domestic abuse. Including, cases of domestic abuse which are often investigated as 'stand-alone' investigations, and cases files submitted to the CPS for single events which do not provide a holistic overview of the case.

14.1.42 In considering the wider learning, the Deputy Chief Crown Prosecutor stated that, on each case, the police had provided a domestic abuse risk assessment which was considered by the reviewing lawyer. The decision to refuse charge was correct for the reasons detailed in 14.1.32. In relation to the incident from March 2019, this should have been escalated as per the comments in 14.1.35 as the purpose of the background report is to inform the CPS of the risks around any decision to witness summons/warrant: which is always a serious step that CPS would only consider if there was clear information from the police that to do so would not be detrimental to the witness. The CPS Domestic Abuse policy requires a background report to be provided by the police before a decision is made to obtain a witness summons to secure attendance of the witness.

14.1.43 Where a victim has not attended on the day of trial and there has been no previous suggestion that they would not attend, the trial advocate should make an application for time, so as to make enquires as to why the witness has not attended. If this adjournment is not granted, a decision must be made on the available evidence. Invariably, unless there is positive information that the witness is ill, or has been prevented from attending, or

has not been warned to attend, the court will not grant an adjournment of a trial. Should a case be dismissed due to the lack of attendance, contact should be made with the victim as soon as possible (within 24 hours), confirming the outcome of the case and the removal of any bail conditions.

14.1.44 The panel were further informed that it is not always possible to ensure that the same reviewing lawyer considers all cases involving the same perpetrator if the period of alleged offending behaviour is over a protracted period of time due to staff movement, court listings, or other considerations. However, the perpetrator's offending history should be brought to the prosecutor's attention by the police and there is an expectation that, in all domestic abuse cases, a full history of previous incidents, including incidents that have not led to a prosecution, are provided to the reviewing lawyer. This is to ensure that the reviewing lawyer is appraised of all previous incidents between the parties. Where a perpetrator has several cases within the system at the same time, the CPS will endeavour to ensure that all cases are dealt with by one prosecutor, with overarching responsibility for all the proceedings. This may be difficult where cases appear in different venues and fall across differing teams within CPS.

14.1.45 The panel acknowledged the information provided by the CPS and agreed that there was learning from the case in relation to contacting and engagement with victims through the Witness Care Unit. The panel have made a recommendation in relation to this learning. [Recommendation 2]

Nottingham University Hospital

14.1.46 In June 2019, Maria was seen in Neurology Clinic for chronic headaches, a background of her brain injury. The clinic letter stated that Maria had disclosed a few weeks previously "she accidently tripped over a kerb and fell, hitting her chin, which left her with quite a bit of bruising which has now resolved". Maria was not asked about domestic abuse. This should have taken place.

14.1.47 In February 2020, Maria was seen in the Emergency Department following a sexual assault. The perpetrator was reported to be a friend. Maria disclosed physical assaults including strangulation and physical abuse. Maria had visible injuries including red marks around her neck. Maria's mother and Alan were present with Maria. Records do not indicate if Maria was seen alone. A DASH risk assessment was not completed. Given the history of the intimate relationship between Maria and her friend, this would have been expected – in line with NUH 'Managing Domestic Abuse in a Healthcare Setting' policy – particularly, given that Maria had a safeguarding alert on her record. The DHR panel have been informed that

completion of DASH risk assessments has been raised at a senior level with ongoing training for all staff in the Emergency Department in relation to domestic abuse and violence, how to support survivors, and the correct process to follow to assess risk and share information/make referrals into partner agencies. The DHR panel received an update during the completion of the review that all Emergency Department staff are to attend training in recognising and responding to domestic abuse. This training includes policy, process and information sharing. Any cases identified where policy has not been followed, are investigated via the Trust reporting process and reviewed by senior teams within governance. The team managers in the Emergency Department are to work closely with the safeguarding lead to ensure actions are taken to provide learning/training where there are identified gaps. The Trust also now employs a specialist Domestic Abuse worker to provide advice and support to survivors and staff.

Street Outreach Team – Framework

14.1.48 Maria's first encounter with the Street Outreach Team was in May 2020, when she was found rough sleeping. Maria was reluctant to speak, but stated she was fleeing domestic abuse: she was in the presence of several other people who were rough sleeping. Maria was provided with a contact card and informed about the referral and assessment process. This contact was in accordance with the Street Outreach Team procedures.

14.1.49 On 13 June 2020, Maria called the Street Outreach Team to be assessed. The following day, Maria informed staff that she was fleeing domestic abuse from her partner and that she was worried that he was looking for her. Maria did not provide details of who the partner was. During the assessment on 16 June, Maria repeated that she had left a violent relationship and had been rough sleeping for a week. No enquiries were made to obtain further information in relation to the domestic abuse. A DASH risk assessment was not completed. The concerns raised by Maria should have been raised with colleagues and management as there were additional resources in the form of a clinical psychologist and a qualified social worker, which could have been utilised on this case. This has been identified as an area of learning, and relevant recommendations made, including a requirement for urgent training.

14.1.50 The DHR panel were informed that since the learning has been identified, all staff have received domestic abuse training. All incidents where domestic abuse is identified are now monitored, and feedback is given to practitioners where further personal learning is identified.

YMCA

14.1.51 Maria's engagement with the YMCA was predominantly prior to the terms of reference for this review. Maria had been placed at the YMCA following her release from prison. The YMCA completed DASH risk assessments with Maria, due to domestic abuse in previous relationships. Between 31 July 2018 and 19 October 2018, Maria's presence at the YMCA became irregular and she was reported to be away from the hostel for multiple nights. Whilst Maria was seen during this period, her contact became less frequent. The YMCA worked with the Probation Service regarding Maria's accommodation. Maria was in an abusive relationship at this time and the room was made available to her should she decide to return. The case was closed to the YMCA when Maria found alternative accommodation. This is covered in 14.3.3.

14.2 Term 2

What evidence did your agency have that identified Maria at risk of domestic abuse, including coercive control? Did your agency's response follow inter-agency and multi-agency procedures in response to the victim's needs?

Adult Social Care

14.2.1 All the referrals to ASC detailed Maria's disclosure of physical abuse. Maria did not disclose coercion and control during her conversations with social workers, however, information from other agencies provided to ASC contained evidence of coercion and control. This included multiple phone calls whilst Maria was at an appointment, and her involvement in sex work.

Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

14.2.2 The CRC were aware that Maria was at risk of domestic abuse at the time of her relationship with Alan. Alan was a known perpetrator with convictions for domestic abuse. At the time Alan's relationship started with Maria, he was being managed by the CRC following conviction and release from prison for a domestic abuse offence. It was noted in records that Alan did not readily acknowledge or accept that Maria was his partner. The response to this is detailed in Term 1.

14.2.3 Juno Women's Aid

Juno Women's Aid were aware that Maria was at risk of domestic abuse. Services and support were provided to Maria over a 12-month period. The contact and level of engagement was in accordance with policies and procedures. The response is detailed in Term 1.

National Probation Service (Nottinghamshire)

14.2.4 On Maria's release from custody, a timely OASys[20] assessment was completed. Maria disclosed an open account of her experiences of relationships, both familial and intimate, as being extremely traumatic from her early childhood years and into adulthood. This included significant violence and sexual abuse, which led to Maria developing maladaptive coping strategies, including substance misuse, and resulting in a transient and chaotic lifestyle. It was noted that a degree of sensitivity and patience was needed when talking to her about these events.

14.2.5 Shortly after Maria's release from custody, a pattern emerged, with Maria entering relationships with men who had convictions for serious violent offences, including domestic abuse. Throughout the period of Maria's supervision, she was known to the NPS to be in four relationships: all of these men were subject to Probation supervision at the time of their relationship with Maria. When the identity of the males became known, information was shared with agencies, which resulted in positive action being taken, including one perpetrator being recalled to prison. When Maria's relationship with Alan became known, this was immediately shared with his probation officer at the CRC, however, there was no further follow up by the OM with CRC. This was a missed opportunity. Maria still had six months left on her licence at this time and further incidents were known to NPS.

14.2.6 A Professionals' Meeting was held by police after the first incident of domestic abuse with Alan. Following the meeting, OM6 made a referral for a female-only Approved Premises bed for Maria, with the hope that having her reside in a probation-run hostel that was staffed 24/7 and out of Nottinghamshire, would force Maria to have to reside as directed. Maria did not qualify for this bed space as spaces were limited and reserved for individuals who needed closer monitoring due to the High Risk of Serious Harm they posed to the public. It recognised that this was a proactive approach to offer some protective accommodation.

14.2.7 Maria did not want to share any information with NPS related to the abusive relationships, and often would express this to OMs when probing questions were asked, particularly in relation to Alan. Maria never told her OMs about incidents where she was a victim and the police attended. The DHR panel have seen evidence that OMs persisted in their efforts to

[20] OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the Probation service nationally from 2002 to measure the risks and needs of criminal offenders under their supervision.

engage Maria with support, including providing Maria information on DVDS with regards to the history of her partners.

14.2.8 As an agency, NPS had a duty of care to Maria. When Maria presented with injuries or was considered at risk, concerns could have been shared with police due to the significant risks identified and Maria's vulnerabilities. The OM did not complete a DASH checklist with Maria to ascertain if she met the criteria for MARAC. However, her historic reluctance to share information or engage with agencies may have led to the MARAC criteria not being met. If this had been the case, there would have been an option for a professional override to refer to MARAC. The OM could have discussed the case with a Senior Probation Officer for oversight and guidance.

14.2.9 The DHR panel were informed that all OMs within the NPS are expected to complete mandatory training on domestic abuse, safeguarding children and safeguarding vulnerable adults. Additionally, in Nottinghamshire, in 2018 it was mandatory for all OMs grade staff to complete a training session on coercion, control and stalking behaviours: 'Murder in Slow Motion' delivered by Laura Richards, an expert in the field. This was implemented as a result of a domestic homicide in 2018 and, in addition, all staff were expected to complete training with the Serious Further Offence's Team on lessons learned from recent serious further offences.

Nottingham Recovery Network

14.2.10 Maria disclosed one incident of domestic abuse to her Substance Misuse Practitioner. This matter had been reported to the police and was subject of the MARAC in December 2018. The practitioner worked with Maria to put controls in place to support her and mitigate the risks from a domestic abuse and substance misuse point of view. However, Maria denied being in a relationship with Alan. The practitioner agreed that Maria could be seen with her at the Wellbeing Hub: in the form of 3-way appointment to help Maria's engagement. Maria declined their support around safety planning.

Nottinghamshire Police

14.2.11 Maria contacted the police to report that she was a victim of domestic abuse and that Alan was the perpetrator. The police response to these incidents has been captured in Section 13 and Term 1.

14.2.12 In July 2019, Maria provided a statement to the police where she described coercive and controlling behaviour. Maria stated that after the first two months of meeting Alan, she started to notice a change in his behaviour, whereby he controlled what she did. This included him taking her bank

card and hiding it, limiting the money she had access to, and manipulating her to give him money. Alan would limit the amount of alcohol she consumed, including what strength. Also, he constantly phoned her when she was not with him, wanting to know where she was. Maria stated that she was isolated from her friends, she could not use her phone when she was in his presence, and that he was suspicious of her with other men. Maria only left his address on her own when she knew that Alan was working. Alan was interviewed on a voluntary basis and denied any coercive or controlling behaviour. Maria then contacted the police and requested to withdraw her statement. No further action was taken. This decision not to proceed with the case was made by the police, as the evidence provided by Maria did not reach the evidential threshold required.

14.2.13 The DHR panel acknowledged that the evidence that Maria had provided reached the criteria for coercive and controlling behaviour as defined by Section 29 of the Serious Crime Act 2015. Maria's family provided information to the Chair that identified that Maria was being controlled by Alan, including him preventing her from having her bank card and isolation from her family. [See 13.3]

Street Outreach Team – Framework

14.2.14 Maria made two disclosures that she was fleeing domestic abuse to the Street Outreach Team. This did not result in a DASH risk assessment for either disclosure. [See 14.1.44 & 14.1.45]

14.3 Term 3

Establish whether relevant single agency or inter-agency responses to concerns about the victim and the assessment of risk to her and others was considered and appropriate.

Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

14.3.1 At no stage during Alan's involvement with the CRC was a request made to the police for information on domestic abuse incidents involving Alan. There was no reassessment of his risk following the two reported incidents of domestic abuse in December 2018 and March 2019. Case reviews were undertaken but these did not involve a reassessment of the risk or sentence plan objectives to actively address the risk to Maria.

The Jericho Road Project

14.3.2 Maria was referred to the Jericho Road Project by her probation officer. The referral stated that Maria was fragile and required support for her sex work, alcoholism, and mental health. During the first contact with a worker, Maria was seen with a bruise on her face. Maria stated that she had fallen. The referral did not mention that Maria was a victim of domestic abuse and, therefore, Maria's account for her injury was not challenged or probed further. The DHR panel felt that this was a missed opportunity and prevented a DASH being completed and a referral to DART.

14.3.3 The Review Panel took account of the UK Charity Against Violence & Abuse (AVA)[21] and their work on the Stella Project which has pioneered work around multiple disadvantage, working to address the overlapping issues of gender based violence and abuse, drug and alcohol use and mental health. The panel have identified this as leaning and made a relevant recommendation. [Recommendation 3]

National Probation Service (Nottinghamshire)

14.3.4 On 26 September 2018, Maria provided details of a new address which was a shared property with two men, one of whom was a known perpetrator of domestic abuse. The OM raised concerns, with senior management within NPS, about Maria residing at the address. It was determined that the NPS could not legally prevent Maria from residing at the property, as she did not pose a risk to the other residents. Maria was reminded that she still had a room at the YMCA at this time.

14.3.5 Maria's OM completed a review of the OASys assessment in response to this incident. The IMR author from Probation identified that the assessment reflected the concerns, but could have been strengthened by the Risk Management Plan detailing how the risks would be managed.

14.3.6 Throughout the period of Maria's supervision, there were two OASys assessments completed: one on her release from custody, and the other appropriately when Maria moved into the address with a known perpetrator of domestic abuse. The assessment should be reviewed at significant points or changes. An OASys review would have been expected after the OM became aware that Maria had been assaulted by Alan, as this was a new relationship. A termination OASys would have been expected. However, at the time and due to significant work pressures, this assessment was not prioritised. The DHR panel were informed that Termination OASys (as with any National Probation Service OASys) are only

[21] https://avaproject.org.uk/

countersigned for qualified offender managers if the service user is assessed as high or very high risk of harm, or where a case is managed by a probation service officer and risk assessed as medium. Where a supervising officer is a trainee, all assessments are countersigned. Termination OASys are not part of the National Probation Service targets, as the supervision and contact with the individual has ended and the termination assessment is to reflect the progress of that individual as a record for future, in the event they are under supervision at a future point.

Street Outreach Team – Framework

14.3.7 When Maria was seen by the Street Outreach Team, she was in the presence of at least one other rough sleeper, usually several, therefore engagement was rather fleeting and restricted by other persons being present. The Street Outreach Team were aware that Maria was a victim of domestic abuse and whilst it was difficult to have had conversations with Maria, the IMR author has acknowledged that a DASH risk assessment should have taken place.

14.3.8 The assessment with Maria took place over the telephone. Maria was in the presence of other people at the time and the assessment was completed across two phone calls to allow Maria to find somewhere private to talk. Maria did not discuss domestic abuse during the assessment and there is no record that this was raised with her, but it was documented in the referral form sent through to Housing Aid.

14.4 Term 4

What evidence did your agency have that identified Alan as a perpetrator of domestic abuse, including coercive control? Did that response follow inter-agency and multi-agency procedures in response to the offender's needs?

Adult Social Care

14.4.1 Alan was identified as the perpetrator on three referrals to ASC. The referral named him as being responsible for physical abuse towards Maria. The ASC response to that information was in accordance with policies and procedures at that time.

Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

14.4.2 Alan's history, previous assessments and convictions identified him as a serial perpetrator of domestic abuse. Alan completed no work whilst in

prison to address his domestic abuse offending. When Alan was released on licence, there was insufficient time for him to be referred to an accredited programme, e.g. Building Better Relationships. The DHR panel were informed that consideration should have taken place for a referral to a Pathway Intervention called Safer Choices (designed to address domestic abuse) and that this was highlighted during the initial risk management and sentence plan objectives, but despite two further incidents of concern, there was no record that the referral was made. The DHR panel agreed that this was a missed opportunity.

14.4.3 The panel were informed that Alan was sentenced without a report being requested from Probation, which sometimes happens where it is likely that offenders will be given a custodial sentence. In these circumstances, the court staff then complete the basic requirements of a new sentence and complete a risk assessment on OASys ready for the case being allocated. There was a delay in this risk assessment being countersigned: the Senior Probation Officer was absent from work. The case was allocated to the CRC, and there is a process in place where if, on receipt of a case, the CRC do not agree with the risk assessment that has been made, they can escalate this back to the NPS via their risk escalation process. There was no record that the CRC requested a review of the risk assessment.

14.4.4 On 8 March 2019, Alan's probation officer provided a summary, at the request of the court, regarding Alan's engagement whilst on licence. The summary was sent in an email and stated: "His compliance and engagement has been good whilst on licence. Due to the nature of the offences against 2 women, one of whom is his 'girlfriend' I would ask the court to consider a community order with BBR requirement. He will be NFA when he leaves court today as he has assaulted another tenant in the property and so I will be supporting him in finding alternative accommodation". The DHR panel reflected that the summary did not address Alan's denial around his relationship and the risk that he presented as a perpetrator of domestic abuse.

14.4.5 When Alan contributed to the review, he denied any responsibility for domestic abuse in the relationship with Maria and stated that it was all Maria's responsibility because of the drink and drugs that she was using and that none of it was his fault. When asked about his convictions for domestic abuse in previous relationships, Alan stated that the women had issues with drink or drugs and any issues in the relationships were their responsibility, not his. Alan showed no self-awareness or insight into his own behaviour, stating: "You know what it's like, as soon as they say anything they are believed". Alan highlighted a number of failed prosecutions to support his belief that he had not done anything wrong in

his relationship with Maria. The DHR panel recognised that the views of Alan were typical of a perpetrator of domestic abuse. The DHR panel agreed that Alan's views and understanding of domestic abuse need to be considered at the point of his release from custody.

East Midlands Ambulance Service

14.4.6 EMAS had no record that Alan was a perpetrator of domestic abuse. On the incidents where Maria was seen, there was no record that Alan was present. Recording of others present 'on scene' is expected practice.

Juno Women's Aid

14.4.7 Alan was known as a perpetrator of domestic abuse with previous females prior to his relationship with Maria. During contact with Maria, she did not immediately name Alan to the IDVA as the perpetrator of her abuse. However, once it was recorded by Juno Women's Aid that the perpetrator in this case was named in several other cases of domestic abuse, this should have been noted in the case notes and as part of any ongoing risk assessments. During the only face-to-face contact with an IDVA, Maria was unable to save the contact details of the service on her phone, unless it was recorded in a different name, for fear that it would be seen by her perpetrator. This is recognised behaviour of coercion and control.

MARAC

14.4.8 Alan was recognised by agencies and discussed at MARAC. Within Nottingham, the use of the Integrated Offender Management (IOM) scheme for domestic abuse perpetrators is used. The panel have had access to the criteria, which includes that the perpetrator needs to be under National Probation Service or CRC supervision as well as other criteria, including a scoring matrix. Alan did not reach the criteria to be considered for IOM.

14.4.9 Nottingham is in the early stages of delivering a pilot perpetrator programme, funded by Home Office/Ministry of Justice. The pilot will run until September 2021, with 2 cohorts running – one via Group Work and one via 1-1 sessions. The DHR panel were informed that the first group of perpetrators were identified by the police, and the second group being identified by Children's Social Care. Following the pilot, a full evaluation will take place which will be commissioned from an external provider.

Nottinghamshire Police

14.4.10 Alan had a criminal history which dated back to 1997. This included convictions for domestic abuse. On 6 January 2018, Alan assaulted his then partner whilst under the influence of alcohol and cocaine. Alan was

named as a perpetrator at MARAC in 2013, 2016 and 2018. Alan was arrested for offences against Maria. Case files were presented to the CPS. Alan was charged with an offence of assault in March 2019. The case was later withdrawn. [See Term 1]

14.4.11 The family provided the review with detailed information and evidence that Alan was a perpetrator of domestic abuse: this included evidence of coercive and controlling behaviour. The family stated that they were not aware elements of Alan's behaviour were classed as domestic abuse, until after the death of Maria and they started to do research online around domestic abuse. These indicators are detailed at paragraph 13.3 and include –

- Access to finances (financial abuse)
- Control personal hygiene routine
- Isolation
- Economic abuse

14.4.12 The Review Panel took cognisance of the definition of economic abuse as an element of coercive control. Economic abuse is a legally recognised form of domestic abuse and is defined in the Domestic Abuse Act 2021. The UK charity Surviving Economic Abuse[22] details that 1 in 6 women in the United Kingdom has experienced economic abuse by a current or former partner. The charity describes economic abuse has including – 'exerting control over income, spending, bank accounts, bills and borrowing. It can also include controlling access to and use of things like transport and technology, which allow us to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs'.

14.4.13 The panel reflected on the information that was known to family and friends that had been gathered as part of the homicide investigation. The panel considered the information in terms of the definition of coercive and controlling behaviour as defined by Section 76 Serious Crime Act 2015. The panel agreed that Alan's behaviour, along with the other elements of the case, now known, clearly identified coercion and control. The full extent of Alan's control over Maria was not known to professionals. This has been identified as an area of learning. [Recommendation 7]

14.5 Term 5

[22] https://survivingeconomicabuse.org/about-us/

Establish whether relevant single agency or inter-agency responses, to concerns about the offender and the assessment of risk to him and his risk to others, were considered and appropriate.

14.5.1 This has been addressed within Term 1, 2, 3 and 4.

14.6 Term 6

Consider the efficacy of IMR authors' agencies' involvement in the multi-agency risk assessment conferencing (MARAC) process.

14.6.1 Juno Women's Aid are active partners in the MARAC process. Maria received support from the City IDVA team, as she had been referred to MARAC. This would have been known to the RISE team who would have been able to liaise with colleagues in this team as well as access information from case notes. As stated above, all Juno Women's Aid staff are trained by Women's Aid England or SafeLives, or are in the process of being trained to manage all cases, irrespective of risk assessment levels, including high risk.

14.6.2 There were no records on Maria's NPS case notes of the MARAC meetings taking place. Both of which occurred during Maria's supervision by NPS. The MARAC Administrator provided information related to NPS input and actions for both meetings. The process was that an NPS representative would ask the OM to provide input to the MARAC by completing a specific form and the representative would attend meetings and present the OM updates and then, following the meeting, would relay via email (and telephone contact if an urgent matter) any actions for the OMs. For both MARAC meetings, the OM provided an update for Maria via the NPS representative.

14.6.3 NPS were tasked with two actions from the first MARAC: consideration of recall, for both Maria and the named perpetrator (not Alan); and, to complete a home visit. A recall was not appropriate as Maria had not committed a further offence. A home visit was not completed. At the second MARAC, there was an action for all agencies to refer Maria back to MARAC if it was evident that Maria and Alan were in a relationship. There is no evidence that this was done, despite agencies being aware that Maria was in a relationship with Alan, and seeing her with unexplained injuries.

14.6.4 An action was raised from the MARAC in February 2018 for all agencies to consider a DVDS should Alan be involved in another relationship. No agency instigated a 'right to know' application when it was known that

Maria was in a relationship with Alan. There was evidence from Maria's probation officer that a DVDS was discussed with her, but Maria declined to support the process. A DVDS does not require the consent of a victim for the process to be initiated. The DHR panel agreed that a DVDS should have been progressed for Maria, given Alan's history of domestic abuse.

14.6.5 The panel were informed that, since this case, additional resources are now in place within the Domestic Abuse Support Unit. These staff review domestic abuse cases to consider the DVDS process across all standard/medium risk (high risk being considered at MARAC) and offers a 'right to know' where required. This systematic consideration of DVDS for every domestic abuse incident has led to an increase in disclosures (2019 – 498 processed, 215 disclosures; 2020 – 605 processed, 250 disclosures). The staff members work alongside IDVA support, thereby improving service delivery to survivors. The panel acknowledged this change in process and have therefore not made a recommendation for the identified learning around DVDS.

14.6.6 Maria's daughter had very strong views about the disclosure of information. She told the panel that she felt information should have been shared with her to help her to understand the risk towards her mother. During the panel meeting, she stated: "It was ok for professionals to ask me to identify my Mother's body, and bury my Mother, but not understand the risk that was present in her life until after her death, and this is very upsetting". Maria's daughter stated that had she been aware of Alan's previous convictions and non-conviction information, she would have 'checked in' with her mother more and spoken to her about ending and moving away from the relationship. The current legislation within the DVDS scheme does not permit the sharing of information, other than to the person at risk, unless those individuals lack capacity. Maria's daughter stated that, in her view, there should be a process for professionals to be able to share information with family or named individuals. The panel have identified this as an area of learning and made a national recommendation. [Recommendation 4]

14.7 Term 7

Consider the efficacy of IMR authors' agencies' involvement in multi-agency / Multi-disciplinary Team meetings regarding domestic abuse.

Adult Social Care

14.7.1 The Review Panel saw evidence of effective multi-agency working and information sharing towards the end of 2018, when Maria's case had been allocated to a student social worker. Flexible approaches were undertaken to engage with Maria and contact and joint working took place with agencies such as Probation, Nottinghamshire Police and Women's Aid.

14.7.2 The DHR panel were informed that the student social worker was from the 'Grow Your Own' initiative, which is a Government funded scheme to support staff employed by Local Authorities to study for a social work qualification alongside working. This is a two-year course, affiliated to Manchester Metropolitan University. The Local Authority pay a proportion of the fees and provide placements and practice educators. Nottingham City fund several places each year in Children and Adults teams as part of their recruitment strategy. The DHR panel acknowledged that the work of the student social worker was thorough, detailed and, at times, innovative.

14.8 Term 8

How did agencies respond to the transient lifestyle, including mental health and substance misuse, of the victim and offender?

14.8.1 Prior to meeting Alan, Maria was staying at the YMCA in Nottingham. This was difficult as she was surrounded by the temptation of drug users and dealers with heroin and crack cocaine freely available. The family told the Chair that her room was broken into, and she was attacked by another resident [they believed this person was then excluded]. Maria could not go back to stay with her mother, and staying with her family was not an option because all of her connections in Worksop would have led her back into drugs. Her family told the Chair that what Maria needed most was stable accommodation without the temptation of drink and drugs, but 'the system just doesn't work like that'.

14.8.2 Maria's family felt that agencies did very little to connect people with the services they could offer. They stated that a notice board full of posters at the YMCA would not translate into anything unless someone talked to potential service users about what was on offer. Maria's daughter told the panel that when she visited her mother at the YMCA, there was no information or posters in the foyer or other accessible areas, on what constitutes domestic abuse, nor what services were available locally and nationally to support victims. The family felt that this was a missed opportunity. The YMCA panel member agreed to look at the availability of information within YMCA premises. Maria's daughter stated that a

strengths-based approach, which valued Maria's strengths rather than judged her past, might have been helpful for her mother.

Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

14.8.3 The probation officer undertook a significant amount of work in dealing with Alan's accommodation issues. On reflection, the focus of the work by the probation officer was predominantly on his accommodation needs as opposed to his risk and re-offending. Alan had no identified mental health needs and denied any substance misuse.

National Probation Service (Nottinghamshire)

14.8.4 During the first two weeks of her release, Maria disclosed being dependent on alcohol. Maria was referred to Clean Slate for support around long-standing substance misuse issues (also part of her licence conditions). She was signposted to AA meetings and encouraged to keep drink diaries. Maria was also referred to the Changing Lives programme, who provide mentor support to individuals experiencing homelessness, domestic violence, addiction, and long-term unemployment in order to make positive change. This also included help with completing forms, etc. with respect of claiming benefits and attending related assessments with Maria. Throughout Maria's supervision, OMs recorded regular contact with these agencies and when there were concerns, these were shared promptly. It was noted that these agencies would also offer support in relation to drug use if this became a feature of Maria's lifestyle.

14.8.5 Maria was also referred to the Women's Centre, which was in line with the Women's Strategy guidance, to complete the 'Changes Programme' as part of her supervision. This referral allowed Maria to access other support services, such as counselling. However, Maria's lifestyle became too chaotic for her to be able to comply and engage with the programme. Her OM adopted a supportive approach and accompanied Maria to her induction and subsequent appointment. The DHR panel acknowledged the value of a supportive approach in encouraging Maria to engage. The OM worked with Maria's keyworkers at Clean Slate and Changing Lives to arrange, where possible, appointments on the same day to encourage compliance and engagement, and work in a flexible way with regards to compliance.

14.8.6 Maria had had a licence condition related to drug testing, which was in place given her history of substance misuse linked to her index offence. The related NPS policy (PI 30/2014) provides guidance on how this testing should be carried out, but allows flexibility of the OM in how frequent the

testing is and what action, if any, needs to be taken considering any positive tests. The aim is to use the testing to support individuals to stay drug-free. Whilst drug testing was available through her licence conditions, it was acknowledged that Maria was already engaged with substance misuse services which offered support for both alcohol and drug issues. Tests were taken intermittently on suspicion of her using cocaine, one of which was positive and the other negative. The IMR author acknowledged that drug testing could have been used more frequently during the course of Maria's supervision and has identified this as a learning and made a relevant recommendation.

14.8.7 An immense amount of work was undertaken by her OM and Clean Slate in applying for and obtaining a placement at a residential Detox facility for Maria towards the end of her supervision. This represented an opportunity to engage Maria in accessing support to address her increased substance use prior to the end of her supervision period. The placement was not successful as Maria checked in and discharged herself the following day. The DHR panel acknowledged that service users who have long-term substance misuse issues may have several attempts to complete detoxification before this is successful, and so her engagement on this occasion would not be unusual for someone in her situation.

Nottingham Recovery Network

14.8.8 Maria was offered 152 intervention appointments throughout her substance misuse treatment journey. There were regular 1-1 appointments made; however, these were not always kept, and an inpatient alcohol detox was organised at Edwin House on 14 June 2019. Maria's case was discharged on 12 July 2019, due to her licence conditions ending. Throughout this time, Maria's Substance Misuse Practitioner worked closely with other agencies to manage and reduce Maria's substance misuse, and information was shared where relevant. Maria engaged relatively well with her treatment plan and Substance Misuse Practitioner, to address her substance misuse issues (hazardous and harmful drinking). Maria engaged in structured treatment programmes that were alcohol specific, with varying success, before she was discharged.

Nottinghamshire Police

14.8.9 Since this case, the police, in partnership with the NHS, have introduced a Triage Car staffed by a police officer and mental health nurse who can be deployed to incidents where mental health is believed to be an issue. Nottinghamshire Police Control Room also has access to the NHS database. Whilst neither Maria nor Alan presented with mental health needs, this has been included in this term of reference to highlight the ongoing work to

respond to mental health issues which can be associated with domestic abuse. In addition, upon arrest, offenders have access to a nursing practitioner at the point of arrival into custody.

Street Outreach Team – Framework

14.8.10 The focus of the Street Outreach Team with rough sleepers is on engagement. Often, individuals are resistant to this for a number of reasons, but the team seek to persist until individuals are engaged and assessed by the team. At this point, the focus shifts to signposting and referral, with the goal of helping the individual to gain accommodation. In Maria's case, engagement was difficult initially, particularly her level of disclosure, purely because she was never encountered alone. However, she did pursue an assessment and a referral was made to Housing Aid appropriately.

14.8.11 The panel considered agencies' involvement in this case – with clients who live a transient lifestyle. The review has identified learning for all agencies in terms of engaging with those individuals, particularly where there are known vulnerabilities such as domestic abuse, mental health and drug and alcohol abuse. The panel acknowledged that it is these cases where agencies often report being unable to engage or contact individuals, and this often results in referrals and cases being closed.

14.8.12 The panel were informed of work that had been undertaken in relation to disseminating learning from previous Domestic Homicide Reviews around 'safe contact' with victims of domestic abuse. The panel had access to the 'Safe Contact' briefing document and list of agencies which had received the document during the early part of 2021. The panel recognised this as good practice.

14.8.13 The panel were informed of ongoing work within Nottingham to respond to people who live a transient lifestyle. Examples were given of a social worker and nurse now forming part of the Street Outreach Team. In addition, Housing Aid have a mobile assessment officer who goes out into the community with the Street Outreach Team. Work has also progressed for an IDVA to be based within Housing Aid, to respond to clients where domestic abuse is evident.

14.8.14 The panel also learnt that, since 2014, Nottingham City has benefitted from the National Lottery's Fulfilling Lives programme. This has meant that there have been significant resources available through Opportunity Nottingham (ON), specifically focussed on improving outcomes for people living with Severe and Multiple Disadvantage (SMD). SMD is defined as facing two or more of the following issues: mental health problems;

homelessness; offending; substance misuse; or, being a victim of violence, abuse, or coercive control perpetrated by a current or ex-partner. The programme had a remit to both directly address the needs of this population and to develop an evidence base to influence systemic change in the way services engage with them. Agencies have been able to refer individuals living with SMD, presenting anywhere across the system, to ON. An assessment would then establish whether their needs were sufficient to meet the project's threshold. The project was targeted at the most challenging and vulnerable segment of this population and aimed to work with 500 individuals over the 8-year funding period.

14.8.15 As a result of ON's activity and the raised profile of SMD, Nottingham City's Integrated Care Partnership (ICP) has committed to "supporting people who face SMD to live longer and healthier lives" as a priority area. The ICP has supported the development of the Wrap around MDT (WAMDT) – a key element of the SMD work stream that will inform future commissioning decisions. ON has one year of further funding and will cease operations in July 2022. Planning for ON's decommissioning has been going on for some time and the adoption of SMD, as a priority theme by the ICP, is one of the foundations of that planning. The expectation is that responses to SMD will increasingly form part of mainstream service specification and design.

14.8.16 The panel agreed that Maria should have been referred to ON, as she reached the case criteria. The panel has not been able to establish why Maria was not referred. The work of the ON was recognised as good practice, and the panel agreed that the learning from this case should be used to inform future structure and delivery, in addition to the awareness of ON amongst professionals. [Recommendations 5 & 6]

14.8.17 Maria's daughter told the panel that she felt agencies needed to be proactive and flexible when working with victims of domestic abuse, particularly those who have complex needs and additional vulnerabilities. Maria's daughter provided examples of how she felt agencies could consider different approaches to working with victims. These included consideration of helping them engage in voluntary work such as working in cafés, which provide food for the homeless, and activity classes and courses, such as arts and crafts. In addition, Maria's daughter stated that in her mother's case, the option to move into a refuge would not have been appropriate: she was a middle-aged single woman who required stability in her life and would have benefited from alternative accommodation such as a self-contained flat or room, where she would have felt that she had a purpose in her life. The panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 9]

14.8.18 Maria's daughter also raised with the panel the issue of publicity and awareness of domestic abuse. She told the panel that people who are homeless may not have access to publicity campaigns such as leaflet drops or social media campaigns. In addition, she stated that she felt that there was a lack of publicity through television and radio. She also noted that the recent Covid-19 pandemic had been an ideal opportunity for television campaigning to have taken place, as there were periods of this time that her mother had been living in a flat with Alan, and not leaving the property. Maria's daughter stated that a more proactive targeted approach should be undertaken, particularly with rough sleepers and people with complex needs and vulnerabilities, and cited examples such as professionals openly discussing domestic abuse and providing information leaflets, even if a person has not disclosed that they are a victim. She said that domestic abuse should be part of all conversations and professionals should not feel awkward to have these discussions.

14.8.19 The panel acknowledged the views of the family and were informed that there had been detailed publicity campaigns undertaken across Nottingham, but agreed that the family had made valid points in raising the awareness further. The panel have identified this as learning and made a relevant recommendation. [Recommendation 7]

14.8.20 The review panel were informed of the following publicity campaigns and ongoing programmes that had taken place across Nottingham:

- Help a friend campaign – targeted campaign on social media, which was also rolled out across the city with posters in telephone boxes and other prominent areas in different languages. The local helpline is Freephone so the telephone boxes can encourage homeless people to call. A radio ad was delivered through podcast services, which are more usually listened to on headphones – a more discreet channel than TV and radio. The podcast service has reached 100k, with 238,000k hits via social media.
- White ribbon campaign – linked to 16 days of action which occurs in November, focussed on men, to challenge male perpetrators. This reached 2,500 men during a city centre 'give away' and provided white ribbon resources through professional networks and social campaigns.
- Reel Equality – a campaign about gender equality. Films were shown in local communities and is also being delivered as a programme for young people going forward called Reel Respect. The campaign included outreach through free mother-daughter screenings in low-income areas.
- Social media ambassadors – these are volunteer led and linked to Equation and Juno Women's Aid.

- Community Champions
- Safe spaces – training to pharmacies which is built on the Ask Me Ambassadors training which has been delivered across local communities for the last five years.
- Support not Silence – men's campaign on social media and targeted resource distribution.
- Change That Lasts – this includes the Ask Me Ambassadors, Trusted Professionals training, particularly with social workers and other professionals to develop their understanding on how to engage with survivors.
- Work is due to commence on 'bystander' training and a campaign titled: "Cut it out", which is aimed at hairdressers, is due to commence in Spring 2022.
- During the Covid-19 pandemic, there was a targeted poster campaign in pharmacies and supermarkets.

14.9 Term 9

To what extent were the views of the victim and offender (and where relevant, significant others) appropriately taken into account to inform agency responses?

14.9.1 Maria's engagement with Adult Safeguarding social workers was inconsistent; however, when they were able to either see her in person, or speak to her by telephone, they were able to discuss safety planning with her, and also the services that were available to support her such as Women's Aid. Maria was able to clearly explain to social workers that she did not want the social work involvement.

14.9.2 Alan completed a self-assessment questionnaire at the start of his involvement with CRC. Alan highlighted "repeating the same mistakes" and "reading writing and number work" as areas of concern for himself. The probation officer stated that during work with Alan in relation to his offending (around emotional management and conflict resolution), Alan would engage if asked but was not openly forthcoming. As stated earlier, details on this work was not recorded.

14.9.3 During contact with Juno Women's Aid, Maria's views were taken into account. This included offering to meet in venues which were safe and convenient and not completing a DASH with her. Several attempts to have a face-to-face or phone contact with Maria were offered, but due to her fear of repercussion from Alan, only one face-to-face meeting took place.

14.9.4 Maria was seen by the police on each occasion a domestic abuse incident was reported. Her views and wishes were taken into account. On two occasions, the police progressed complaints of domestic abuse on an evidenced-based approach without the support of Maria. This was undertaken in recognition of the risk that Alan portrayed and the offences that he had committed.

14.10 Term 10

Identify any areas where the working practices of agency involvement had a significant positive or negative impact on practice or the outcome. Including, agencies' response to the victims and offender's engagement with their service.

14.10.1 Whilst not reflective of a positive or negative impact on practice or the outcome, the panel recognised the challenges that were presented by agencies from March 2020 following the Covid-19 pandemic, and the changes that had to be made to service provision: in particular, face-to-face contact. This has been detailed in earlier sections of this report.

14.11 Term 11

Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to the victim and/or offender, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic, and impact on national and/or local policy and guidance.

14.11.1 Alan did not complete an accredited domestic abuse perpetrator programme following his conviction in 2018. Whilst this is not because of agencies' capacity to deliver the service, alternative options were not considered that would have allowed work to have been undertaken within his licence timescales. [See Term 1]

14.11.2 The 24-hour domestic abuse helpline does not offer crisis drop-in sessions outside usual working hours and, therefore, the first time Maria made contact, she was asked to make contact again the following day. This was a potential 'first chance' opportunity that was missed.

14.11.3 During the Covid-19 pandemic, the review identified areas where agencies' response had been affected due to restrictions in place following national

enforcement. This included engagement and contact with Housing Aid, as detailed earlier within Section 14. Therefore, this will not be repeated here.

14.11.4 As per the Women's Strategy, all OMs involved in supervising Maria throughout the course of her licence supervision were female. In total, the case was actively managed by 5 OMs. Regular change in OMs is not ideal for any service user, as building a trusting relationship is important. However, given the high staff absences due to sickness and vacancies in NPS Nottinghamshire at the time, these changes were unavoidable. The grade of staff supervising Maria was appropriate given Maria was assessed as posing a Medium Risk of Serious Harm. Aside from the transfer of supervision to OM2, handovers took place as required. The DHR panel were informed that, since this case, there has been significant recruitment of new OMs and workloads have reduced.

14.11.5 The Street Outreach Team had limited engagement with Maria in the months prior to her death. At that time, the Street Outreach Team were regularly finding 20 people rough sleeping daily and had around 80 people in temporary hotels under the Governments "Everyone In" scheme, due to Covid-19 pandemic. The situation created an unprecedented workload. The Street Outreach Team had to adapt to new ways of working. It was not possible for the team to cover every single location possible during its outreach sessions, and the team focussed largely on known rough sleepers in disclosed locations. Maria's stated location was always checked once the Street Outreach Team were aware of it, in line with standard operating procedures. The Street Outreach Team have increased staffing since the timescales of the review.

14.11.6 Framework also experienced serious IT matters and loss of access to databases, and therefore it has not been possible to clarify if emails were sent and/or received. In addition, the shared Team's emails have since been deleted due to GDPR.

14.12 Term 12

Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their responsibilities and duties and worked together to manage risk and safeguard the victim, and the wider public.

14.12.1 The DHR panel learning is captured at Section 16.

14.12.2 Individual agency learning, as contained within their IMRs, is detailed below.

14.12.3 Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

- Response to accredited programmes for domestic abuse.
- Professional curiosity and challenge.
- Assessment of risk and sentence plans following new information.
- Completion of home visits.
- Risk Management and Supervision

14.12.4 East Midlands Ambulance Service

- Importance of obtaining and documenting the perpetrator's details.
- Adult Safeguarding referrals – discussing concerns with the adult, gaining wishes and feelings and, where possible, gaining consent. Obtaining safe and up-to-date contact details.
- Recognising the safeguarding risks and impact on health for adults experiencing homelessness, those in temporary accommodation with transient lifestyles, substance misuse, and domestic abuse.
- EMAS has no referral pathways into drug and alcohol services with consent. This may be an appropriate pathway for support, especially when threshold for adult social care is not met.

EMAS has informed the review that work has begun on the development of a new pathway. As EMAS are a regional service, this has been commenced in Lincolnshire. Once this has been established and proved effective, it will be mirrored across the other areas.

EMAS has provided the review with information in relation to their commitment to safeguarding training, which includes:

- Recent review of Domestic Abuse Policy
- Information on 24-hour Domestic Abuse Helpline.
- Delivery of education using 'Think Family' approach. At the end of 2019-2020, EMAS were 93% compliant Trust-wide for safeguarding education.
- Continuing commitment to Safeguarding Education via a variety of training platforms.
- On 24 November, an EMAS article was shared across the organisation to raise awareness with staff about the safeguarding risk associated with homelessness. The short film 'Lone' by Emmanuel House in Nottingham, was also shared.

14.12.5 NHS Nottingham and Nottinghamshire Clinical Commissioning Group

- The use of alerts on system1 to note historical domestic violence which may lead the professionals to enquire further with professional curiosity.
- Use of DASH–RIC with similar patients.
- To establish a process to contact patients who do not attend appointments but have a risk history that may suggest domestic violence.
- Recording of safeguarding outcomes.
- Recording of who is present during consultations.

14.12.6 Housing Aid

- Recording of contact with individuals known to service user.
- Ensuring service user is aware of available options to access service.
- Awareness of other agencies to facilitate contact.

14.12.7 Jericho Road Project

- Knowledge of vulnerabilities on receipt of referrals.

14.12.8 Juno Women's Aid

- Recording of contact details. [This has been addressed within the organisation with more frequent case management and case reviews taking place to rectify this issue]

14.12.9 National Probation Service (Nottinghamshire)

- Information sharing.
- MARAC processes.
- Joint working with CRC Offender Managers.
- Adherence to drug testing policy.
- Management oversight.

14.12.10 Nottinghamshire Police

- Awareness of bad character evidence and processes to record information.
- Holistic overview.
- MARAC actions and outcomes.

14.12.11 Street Outreach Team – Framework

- Training on domestic abuse.
- Recording of information.
- Multi-agency working.
- Responding to additional interventions.

14.12.12 YMCA

- Broader stakeholder input into plans to support a robust approach to risk management and support.

14.13. Term 13

To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring / reappearing in this review: taking into account if and when these actions were implemented within the agency.

14.13.1 The panel identified the following themes within this DHR which have been identified within previous DHRs commissioned by Nottingham Crime and Drugs Partnership:

14.13.2 Record-keeping including not linking family records and/or relationships

(DHRs – Hansard, Hornpipe, Hickwall, Hoplite, AIS, Chapeau)

Guidance has been developed with regards to record-keeping to share with agencies across the city. This covers the key aspects of record-keeping and, importantly, a quick reference sheet on how and what to record on case notes for good record-keeping. This has been developed from a DHR Loam recommendation and will be circulated to all agencies in September 2021.

Once the action plan for DHR Loam[23] is complete, all agencies involved in the review will be asked to provide audit evidence that this has been effective in improving record-keeping.

Guidance on Professional Curiosity is also being developed jointly with Nottingham City Adult Safeguarding and Nottingham City Children's Safeguarding Boards. Once this has been finalised, it will be shared with the CDP Board and Adult and Children's Safeguarding Boards.

14.13.3 Multiple Disadvantage and Complex Needs

(DHRs Hornpipe, Hickwall, Hoplite, AIS, Chapeau)

This theme will be reviewed by the DHR ALIG in November 2021. Work is also underway locally to develop the Severe Multiple Disadvantage Integrated Care Pathway.

14.13.4 Mental Health and Domestic Abuse

[23] DHR Loam is currently with the Home Office Quality Assurance Panel – October 2021

(DHRs Hansard, Hornpipe, Hickwall, Hoplite, AIS, Chapeau)

Mental Health and Domestic Abuse is a theme identified in all DHRs, although there have been no recommendations from any DHR Overview Reports. Although there is a vast amount of research into mental health and domestic abuse, the DHR ALIG have reviewed all DHRs to determine the types of mental health and if there were any identifiable barriers to support locally. 9 out of 10 survivors experienced mental ill health and only 1 perpetrator did not have any mental health issues identified. Mental ill health ranged from low level, e.g. stress and anxiety, to diagnosed conditions such as personality disorders. Levels of support varied from accessing medication via GPs and utilising Talking Therapies, to accessing secondary care services. Some survivors and perpetrators also self-medicated with drugs and, all apart from 1 survivor, with alcohol.

Nottingham Crime and Drugs Partnership are currently looking to jointly commission a more in-depth review.

15. CONCLUSIONS

15.1 Maria was a vulnerable woman who had been a victim of domestic abuse in previous relationships and during her relationship with Alan. These relationships were violent in nature. Maria would often not disclose the abuse or name her perpetrator to professionals for fear of physical reprisals. Maria's vulnerabilities meant that she was at risk of abuse from known perpetrators of domestic abuse. Maria would minimise this risk to professionals. Maria's family told the Chair that Maria had 'wanted to be loved'.

15.2 Maria led a transient lifestyle, with no fixed residence. Maria was known to alcohol and substance misuse services. In the months prior to her death, Maria was reported to be "sofa surfing" and sleeping rough in a car park in Nottingham city centre. Maria's vulnerabilities meant that she was at risk and a target for perpetrators of domestic abuse.

15.3 Alan was a serial perpetrator of domestic abuse. Alan had convictions for domestic abuse and had previously been sentenced to prison for some of these offences. At the time Alan commenced a relationship with Maria, he was on licence following his release from prison after conviction for assaulting a previous partner. Alan had never completed any work to address his offending behaviour. Information provided to the review by agencies and from Alan, detailed that he did not accept that he was a perpetrator of domestic abuse.

15.4 There were opportunities for Maria to have been provided with information to help her make informed decisions about the risks that she faced. Maria's family told the panel they felt that this information should have been disclosed to them, as well as Maria, as this would have allowed them an opportunity to have provided additional support and intervention with Maria.

15.5 During the latter few months of this case, agencies and professionals were having to work within the confines of local and national restrictions imposed due to the Covid-19 pandemic. This resulted in limited contact and engagement with Maria, with agencies having to adapt to new ways of working.

15.6 There have been significant changes within agencies' organisational structures and service delivery during the completion of this review. Whilst this has been recognised by the panel, the panel have identified learning from the review in relation to engagement with victims, information sharing, knowledge and awareness of domestic abuse, and support services. This learning has been embedded into recommendations.

In addition to panel recommendations, individual agencies have identified learning for their respective agencies and made recommendations to address this. Throughout the completion of this review, panel meetings have reviewed individual agencies' progression of implementing their learning.

15.7 Maria's family provided a valuable contribution to the review, by providing information, attending, and speaking to panel members via online meetings. In addition, the Chair met with Maria's family to share and discuss draft reports. The panel wish to extend their thanks to the family for this contribution.

16. LEARNING IDENTIFIED

16.1 The Domestic Homicide Review Panel's Learning (Arising from panel discussions)

16.1.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at Term 11. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action, a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
During the completion of this review, learning was identified for staff working with perpetrators of domestic abuse, which included understanding and reviewing risk, and gathering all relevant information to inform that risk.
Lesson
Understanding risk assessments and risk management are essential for practitioners who work with offenders of domestic abuse. Whilst work in this area has commenced, the learning needs to be embedded into practice.

Learning 2 [Panel recommendation 2]
Narrative
Victims who live a transient lifestyle may not respond to routine methods of contact such as letters or telephone contact. Services need to be able to adapt in these situations and consider other methods of engagement, including the identification of a lead professional or point of contact, to ensure that victims are informed of key events and dates within criminal court cases.
Lesson
Those involved in engaging with witnesses during the criminal justice processes, need to ensure that they have a flexible approach, and consider all options when seeking contact.

Learning 3 [Panel recommendation 3]
Narrative
Where information is missing from agency referrals, particularly for cases where there is evidence of complex needs and identified vulnerabilities, it creates a situation that the person or agency receiving that referral is not in possession of all the known facts and this can reflect on the level of service that they provide.

Lesson
Referrals for clients who have complex needs and identified vulnerabilities, should contain all relevant information, including vulnerabilities and areas of risk.

Learning 4 [Panel recommendation 4]
Narrative
There were opportunities in this case for information to be shared with the victim to help inform them of the risk that was present in their relationship. This did not occur. Whilst processes have been implemented to address this area of learning, the case has identified further learning around the consideration of sharing information to family members and/or named individuals, to allow those named persons to then provide advice and support to the person at risk.
Lesson
Information sharing with family members and/or named individuals can provide an opportunity for support and advice to be given to victims, in managing and understanding the risk.

Learning 5 [Panel recommendation 5 & 6]
Narrative
A multi-agency response that works with individuals who have identified vulnerabilities can provide a targeted approach that meets the needs of the individual's health and social needs. Professionals need to be aware of the Integrated Care Pathway and how they can refer eligible clients.
Lesson
The learning from this case should be disseminated to the Integrated Care Pathway to inform future commissioning of services. Professionals need to be aware of the Integrated Care Pathway and how they can refer eligible clients.

Learning 6 [Panel recommendation 7]
Narrative
The review identified that coercion and control was not known as a form of domestic abuse by the family. Whilst the review was aware of detailed publicity awareness campaigns that had taken place, it was identified that this had not been accessible to all areas of the community.
Lesson
Publicity campaigns need to ensure that they are accessible to all members of the community and that those campaigns provide information on the

types of domestic abuse, how concerns can be reported, and how access to support agencies gained.

Learning 7 [Panel recommendation 8]
Narrative
The review heard how Juno Women's Aid were responding to the learning identified during the completion of this review, and the processes being undertaken to implement organisational change in response to the learning.
Lesson
Nottingham Crime and Drugs Partnership need to be provided with evidence that the changes being implemented, are embedded into practice to address the learning identified.

Learning 8 [Panel recommendation 9]
Narrative
The review identified that agencies needed to understand the complexity and vulnerability of victims, and how this affected engagement and provision of services. Services needed to adapt their methods of engagement and services offered, to ensure that they were inclusive, relevant, and accessible for all victims of domestic abuse.
Lesson
Flexible approaches need to be in place when working with victims, and providing services, including accommodation to victims of domestic abuse.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	The Probation Service to provide evidence to Nottingham Crime and Drugs Partnership that the learning within this review has been embedded into practice.
2	That Nottingham Crime and Drugs Partnership seeks assurances from those agencies involved in the criminal justice system, and in particular the Witness Care Unit, that the learning from this case has been disseminated and embedded into practice. Also, that all options of engagement and contact with witnesses, including the identification of a main point of contact, are considered as part of the witness management process.
3	That all agencies involved in this review provide evidence to Nottingham Crime and Drugs Partnership that agency referrals, where there is evidence of complex needs and vulnerabilities, are populated with all relevant information including vulnerabilities and risk factors.
4	That the Home Office and Government consider the learning from this case in relation to third-party disclosure of information when reviewing current legislation and guidance in relation to domestic abuse.
5	That Nottingham Crime and Drugs Partnership ensures that the learning from this review is used to inform the ongoing work around the remit of the Integrated Care Partnership.
6	That all agencies involved in this review provide evidence to Nottingham Crime and Drugs Partnership that their agency is aware of the Integrated Care Pathway and referral pathway.
7	That Nottingham Crime and Drugs Partnership's Domestic Abuse Strategy details how it will respond to raising awareness on domestic abuse for all areas of the community, in particular, those with complex needs and additional vulnerabilities.
8	That Juno Women's Aid provide evidence and assurances to Nottingham Crime and Drugs Partnership that the operational changes and learning from this review have been embedded into practice. This recommendation should be completed within six months.
9	That all agencies involved in this review provide evidence to Nottingham Crime and Drugs Partnership on how their agency

Number	Recommendation
	has embedded the learning from this review, in terms of engagement and services, including accommodation to victims of domestic abuse.

17.2 Single-agency recommendations

17.2.1 Single-agency recommendations are contained within the action plan at Appendix D.

Appendix A

Definition of Domestic Abuse

Domestic violence and abuse: new definition

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

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[24]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;

[24] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C

EVENTS TABLE

The following table contains a summary of important events that will help with the context of the Domestic Homicide Review. It is drawn up from material provided by the agencies that contributed to the review.

Events Table	
Date	**Events – Pre-TOR**
12.05.99	Maria sentenced to a community service order for 12 months for child neglect.
22.09.11	Alan referred to MARAC as a perpetrator of domestic abuse.
2014	Maria suffered significant traumatic brain injury.
12.10.14	Maria was the victim of assault by 16yr old male.
03.02.17	Maria sentenced to 32 months' imprisonment for a robbery.
13.10.17	Maria released from prison.
01.02.18	Alan discussed at MARAC.
26.03.18	Alan sentenced to 23 weeks' imprisonment for domestic abuse offence. Alan issued with restraining order.
12.04.18	Maria assaulted by her partner.
08.06.18	Maria assaulted by her partner.
Date	**Events during TOR**
11.09.18	Alan released from prison on licence until 11 September 2019.
13.09.18	Maria reported that she had been assaulted by her partner. Contact made with Juno Women's Aid.
18.09.18	Maria reported she had been assaulted by her partner.
19.09.18	Adult Social Care received referral from YMCA for Maria. One of several referrals received from this date.
19.09.18	Maria seen with injuries. Reported to be from a fight with a female.
24.09.18	MARAC referral from Adult Social Care.
24.09.18	Maria seen with facial injuries.
25.09.18	Maria at risk of eviction from YMCA.
26.09.18	Maria attended meeting with Probation and social worker. Presented with a black eye. Reported to have been caused accidentally.
29.09.18	Alan moved to new accommodation.
Oct 2018	Maria abandoned accommodation at YMCA.
01.10.18	Adult Social Care case closed.
10.10.18	Probation officer completed a home visit to Maria's new address.
18.10.18	Maria met with IDVA.
24.10.18	MARAC meeting
25.10.18	Maria seen by probation officer with male. Maria smelt of alcohol and suspected being under influence of drugs. Maria would not name male.
31.10.18	Maria reported falling down the stairs last week and bruising her face/possibly cracking a rib.
06.11.18	MARAC actions were fed back to Maria.

15.11.18	Maria attended medical appointment. Requested emergency exit from premises.
20.11.18	Maria's case allocated to student social worker Adult Safeguarding Team.
29.11.18	IDVA contacted Maria, support declined.
09.12.18	Alan arrested for assault on Maria.
13.12.18	Multi-agency meeting held to discuss Maria.
14.12.18	Alan's probation officer informed of incident with Maria.
15.12.18	Police attended incident between Maria and Alan.
17.12.18	Maria seen with facial injury.
18.12.18	MARAC meeting held.
20.12.18	Social worker completed a Section 42 enquiry. Case closed.
28.12.18	Maria seen by probation officer and relationship with Alan discussed.
31.12.18	Maria offered and declined support from IDVA.
10.01.19	IDVA closed case.
16.01.19	Probation contact Juno Women's Aid to request support from IDVA for Maria.
17.01.19	Alan told probation officer he is not in contact with Maria.
18.01.19	Police attended an argument between Maria and Alan. Both were intoxicated. Maria taken to her own flat.
30.01.19	IDVA closed case.
30.01.19	Maria attended welcome meeting at Women's Centre.
02.02.19	Police received call that Maria had been assaulted by Alan. Maria denied an assault.
01.03.19	Maria told probation officer she had been in relationship with Alan for two months.
06.03.19	Maria assaulted by Alan. Alan was arrested and charged with assault on Maria and another female.
08.03.19	Alan released on conditional bail.
13.03.19	Alan seen by probation officer and denied assaults.
14.03.19	Maria allocated by RISE Team.
20.03.19	Maria reported no further contact with Alan to probation officer.
10.04.19	Maria expressed wanting to access detox.
11.04.19	Referral completed for Edwin House inpatient detox
12.04.19	Maria allocated by RISE Team.
16.04.19	Alan arrested for breach of bail.
23.04.19	Alan's bail conditions varied.
28.04.19	Maria's daughter contacted police reporting Maria had been assaulted. Police saw Maria who denied any assault. Alan arrested for breach of bail.
01.05.19	Alan appeared at court for breach of bail x 2 (pleaded guilty). Remanded in custody for assault, matters to be heard on 3 May.
01.05.19	Maria seen by probation officer with bruising to face. Denied being assaulted and stated she fell out of a taxi.
03.05.19	Maria referred to Jericho Road.
03.05.19	Alan released from custody. Assault by beating offences dismissed.
15.05.19	Referral submitted for Edwin House for residential detox for Maria.

15.05.19	Maria disclosed sex work to fund alcohol.
June 2019	Maria was seen in Neurology Clinic.
12.06.19	Maria discharged from Clean Slate
12.06.19	Maria engaged in detox assessment.
14.06.19	Maria admitted to Edwin House inpatient detox.
15.06.19	Maria self-discharged against medical advice from inpatient detox.
18.06.19	Women's Centre - Case closed after no contact
26.06.19	Maria's licence ended.
26.06.19	Alan appeared at court. Pleaded not guilty. Remanded on unconditional bail
04.07.19	Alan told probation officer that he was single.
07.07.19	Maria approached police officers and reported that she was being controlled by Alan.
20.08.19	Maria's mother rang 999 to report she had received text message from Maria asking for help. Maria seen in company of Alan. Both intoxicated. No complaints.
28.08.19 & 02.09.19	RISE Team attempted to call Maria. No answer.
11.09.19	End of post-sentence supervision period for Alan.
01.10.19	Maria removed as MAPPA Level 2.
19.11.19	Maria rang 999 and reported being assaulted by Alan.
05.12.19	Maria approached a police officer and reported being assaulted by Alan. Alan was arrested for this and incident on 19 November.
08.12.19	Maria seen by paramedics with chest pains after smoking crack cocaine. Refused to go to hospital.
18.12.19	Alan found rough sleeping in the Wellbeing Hub Car Park.
31.01.20	Maria contacted police and reported that Alan had taken her phone. Police attended. Maria and Alan were intoxicated. Phone found in Maria's bag.
18.02.20	Member of the public made a 999 call to police after Maria found naked in the street. Maria alleged sexual assault. Male was arrested. Police investigation undertaken.
27.02.20	Adult Social Care closed referral from 18.02.20.
11.03.20	Maria was referred by her GP into CityCare's MOSAIC service.
16.04.20	Maria made a 999 call to police reporting that Alan had taken her bank card and had thrown her out of the house.
25.05.20	Maria seen rough sleeping.
01.06.20	Maria found rough sleeping.
13.06.20	Maria telephoned Framework. Service explained to her.
14.06.20	Maria seen by Street Outreach Team.
16.06.20	Maria referred to Housing Aid.
17.06.20	Maria called into Housing Aid and requested to speak to advisor.
18.06.20	Housing Aid made several attempts to call Maria. Male answered. Advisor arranged further call to Maria after weekend.
21.06.20	Maria contacted police and stated Alan had been threatening towards her and wouldn't let her go anywhere.
22.06.20	Maria called into Housing Aid to speak to advisor for assessment.

	Police contacted Street Outreach Team.
23.06.20	Alan arrested for drunk and disorderly. Charged and bailed to court.
23.06.20	Framework – Maria seen in Huntington St Car park.
26.06.20	Housing Aid – further call to friend. Maria not with him.
26.06.20	Maria assaulted – head injury. Transferred to Queens Medical Centre hospital.
27.06.20	Framework - location checked – not found
30.06.20	Framework - location checked – not found
08.07.20	Housing Aid contacted Street Outreach Team.
28.07.20	Maria seen rough sleeping.
August 2020	Maria found deceased. Alan arrested for murder and subsequently charged.

Appendix D

DART Processes

The DART referral is screened by a social worker. Where there is consent for a medium risk referral or the referral is classed as high risk with or without consent, the social worker will review any previous involvement with the citizen referred through DART.

Where there are no previous case notes/social care records, the DART worker will try to establish if the citizen has any social care needs, either via the information on the DASH RIC/PPN or by contact with the referrer/citizen themselves.

Where a citizen has identified social care needs, then a referral will be made to the Adult Safeguarding Team under the duties embedded in the Care Act. Where a citizen does have a social care record, the DART worker will look at the previous involvements of Adult Social Care to establish if the citizen has social care needs and requires referral to the Adult Safeguarding Team.

Where a citizen has no identifiable social care needs, the DART worker will attempt to contact them to signpost them to alternative services/support.

Appendix E

Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	The Probation Service provide evidence to Nottingham Crime and Drugs Partnership that the learning within this review has been embedded into practice.	Local	Understanding how essential risk assessments and risk management is, to be embedded into practice	Probation		May 2022	
2	That Nottingham Crime and Drugs Partnership seeks assurances from those agencies involved in the criminal justice system, and in particular the Witness Care Unit, that the learning from this case has been disseminated and embedded into practice. Also, that all options of engagement and contact with witnesses, including the identification of a main	Local	Processes to enable a flexible approach, and consider all options when seeking contact with witnesses / victims.	CDP	To be raised at Nottinghamshire and Nottingham City DSVA Criminal Justice Group meeting March 2022.	May 2022	

	point of contact are considered as part of the witness management process.						
3	That all agencies involved in this review provide evidence to Nottingham Crime and Drugs Partnership that agency referrals, where there is evidence of complex needs and vulnerabilities, are populated with all relevant information including vulnerabilities and risk factors.	Local	Review of referral forms to ensure prompts for information are there.	• Adult Social Care – Nottingham City Council, • Changing Lives CF03 Project, • Crown Prosecution Service, • Department for Works and Pensions (DWP), • East Midlands Ambulance Service (EMAS), • Framework Housing Association, • Housing Aid – Nottingham City Council, • Jericho Road, • Juno's Women's Aid, • NHS Nottingham and Nottinghamshire Clinical	3/11/21 – **CCG** – work has been done and will be reviewed at meeting on 5th Nov with information advising completion within 2 weeks.	May 2022	

				Commissioning Group, • Nottingham Healthcare NHS Foundation Trust, • Nottingham Recovery Network (including Edwin House), • Nottinghamshire Police, • Nottingham University Hospitals, • Nottingham Women's Centre, • Probation Service, YMCA			
4	That the Home Office and Government consider the learning from this case in relation to third-party disclosure of information when reviewing current legislation and guidance in relation to domestic abuse.	National	DVDs consultation and DA Act 2021 to make guidance statutory.	Home Office		**?**	
5	That Nottingham Crime and Drugs Partnership ensures	Local	Assist with development and	CDP	Severe Multiple Disadvantage (SMD) Integrated Care Pathway	July 2022	

	that the learning from this review is used to inform the ongoing work around the remit of the Integrated Care Partnership.		commissioning of ICP		review is aware of DHRs and complex needs identified in all of them locally. To look at in more detail by the SMD group alongside trauma informed support.		
6	That all agencies involved in this review provide evidence to Nottingham Crime and Drugs Partnership that their agency is aware of the Integrated Care Pathway and referral pathway.	Local	Provide evidence in Impact and Audit Statements	• Adult Social Care – Nottingham City Council, • Changing Lives CF03 Project, • Crown Prosecution Service, • Department for Works and Pensions (DWP), • East Midlands Ambulance Service (EMAS), • Framework Housing Association, • Housing Aid – Nottingham City Council, • Jericho Road, • Juno's Women's Aid,	3/11/21 – **CCG** – work has been done and will be reviewed at meeting on 5th Nov with information advising completion within 2 weeks.	Oct 2022	

				• NHS Nottingham and Nottinghamshire Clinical Commissioning Group, • Nottingham Healthcare NHS Foundation Trust, • Nottingham Recovery Network (including Edwin House), • Nottinghamshire Police, • Nottingham University Hospitals, • Nottingham Women's Centre, • Probation Service, YMCA			
7	That Nottingham Crime and Drugs Partnership's Domestic Abuse Strategy details how it will respond to raising awareness on domestic abuse for all areas	Local	To explore formats and locations for publicity	CDP	14/10/21 – Equation to link with Emmanuel House to look at messages and where to target information. To check Street Outreach	May 2022	

	of the community, in particular those with complex needs and additional vulnerabilities.				Team, have access to DVA information cards.		
8	That Juno Women's Aid provide evidence and assurances to Nottingham Crime and Drugs Partnership that the operational changes and learning from this review have been embedded into practice. This recommendation should be completed within six months.	Local	Evidence learning has been embedded	Juno Women's Aid		May 2022	
9	That all agencies involved in this review provide evidence to Nottingham Crime and Drugs Partnership on how their agency has embedded the learning from this review, in terms of engagement and services, including accommodation to victims of domestic abuse.	Local	Ensuring staff are aware of learning and any changes in practice	• Adult Social Care – Nottingham City Council, • Changing Lives CF03 Project, • Crown Prosecution Service, • Department for Works and Pensions (DWP),	3/11/21 – **CCG** – work has been done and will be reviewed at meeting on 5th Nov with information advising completion within 2 weeks.	May 2022	

				• East Midlands Ambulance Service (EMAS), • Framework Housing Association, • Housing Aid – Nottingham City Council, • Jericho Road, • Juno's Women's Aid, • NHS Nottingham and Nottinghamshire Clinical Commissioning Group, • Nottingham Healthcare NHS Foundation Trust, • Nottingham Recovery Network (including Edwin House), • Nottinghamshire Police, • Nottingham University Hospitals,			

				• Nottingham Women's Centre, • Probation Service, YMCA			

DHR Hashtag Agency IMR Recommendations

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
DLNR CRC							
1.1	Following new information relating to risk, service users should be instructed in for an additional appointment to discuss new concerns in a timely manner. There should be an appropriate response to this new information by the supervising officer e.g. reassessment of risk.	New information relating to risk should be acted upon as soon as possible for good risk management decisions to be made.	Staff learning		11 June 2021	An all DLNR staff bulletin highlighting the key themes from local DHRs, Serious further offence investigations and Safeguarding Reviews was issued on 11/06/2021. Responding to new information relating to risk is one of these elements. Ongoing consolidation of learning from DHRs, SFOs and Safeguarding reviews	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						will also continue once DLNR CRC merge with the NPS on 26/6/21.	
1.2	All domestic abuse perpetrators to have the following condition added to their licence. "To notify your supervising officer of developing intimate relationships".	Risk management of domestic abuse perpetrators will be strengthened.	Practice development with CRC staff	Sept 2021	9 September 2021	Update – 10.9.21 – Unification has now taken place. Discussion in Managers meeting to issue a reminder to staff that this condition should be included for all perpetrators who are on a current sentence for domestic violence offence. Discussion regarding this will take place with the NPS once DLNR CRC have merged with that organisation. It is understood that this licence condition is standard practice within the NPS.	Green
1.3	Probation staff to be reminded to follow the	New information relating to risk	Staff learning		11 June 2021	An all DLNR staff bulletin highlighting	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
	existing policy for full risk assessment and sentence plans (OASYS Layer 3) to be completed on all domestic abuse perpetrators and for risk to be reviewed when there is new significant information.	should be acted upon as soon as possible.				the key themes from local DHRs, Serious further offence investigations and Safeguarding Reviews was issued on 11/06/2021. Responding to new information relating to risk and OASYS level completion is one of these elements. Ongoing consolidation of learning from DHRs, SFOs and Safeguarding reviews will be continued once DLNR CRC merge with the NPS on 26/6/21.	
1.4	Probation staff to be reminded to use all available sources of information, e.g. previous records when making risk assessment and sentence plan recommendations.	Good risk assessment and sentence planning requires extensive knowledge of the previous history of offenders.	Staff learning		11 June 2021	An all DLNR staff bulletin highlighting the key themes from local DHRs, Serious further offence investigations and Safeguarding Reviews was issued on 11/06/2021. Using all available sources of	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						information relating to risk in completion of assessments is one of these elements. Ongoing consolidation of learning from DHRs, SFOs and Safeguarding reviews will be continued once DLNR CRC merge with the NPS on 26/6/21.	
1.5	Probation staff to be reminded to follow the existing policy for police/safeguarding checks to be carried out on all domestic abuse perpetrators at the start of supervision and at points when new information relating to risk emerges.	Safeguarding policies provide good guidance designed to manage risk.	Staff learning		11 June 2021	An all DLNR staff bulletin highlighting the key themes from local DHRs, Serious further offence investigations and Safeguarding Reviews was issued on 11/06/2021. Following safeguarding policy and making the appropriate checks is one of these elements. Ongoing consolidation of learning from DHRs, SFOs and Safeguarding reviews will be continued once	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						DLNR CRC merge with the NPS on 26/6/21.	
1.6	Probation staff to be reminded to follow the existing policy for home visits to be carried out on all domestic abuse perpetrators upon release and at points when new information relating to risk emerges.	Home visits are an integral element for risk assessment and risk management.	Staff learning		11 June 2021	An all DLNR staff bulletin highlighting the key themes from local DHRs, Serious further offence investigations and Safeguarding Reviews was issued on 11/06/2021. The requirement to undertake home visits is one of these elements. Ongoing consolidation of learning from DHRs, SFOs and Safeguarding reviews will be continued once DLNR CRC merge with the NPS on 26/6/21.	Green
1.7	Probation staff to be reminded of the existing policy that new information received pertaining to risk is discussed with	Liaison with partner agencies is integral to good risk management and risk assessments.	Staff learning		11 June 2021	An all DLNR staff bulletin highlighting the key themes from local DHRs, Serious further offence investigations and	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
	all appropriate agencies including the agency that provided the information.					Safeguarding Reviews was issued on 11/06/2021. Responding to new information relating to risk and discussing this with partner agencies is one of these elements. Ongoing consolidation of learning from DHRs, SFOs and Safeguarding reviews will be continued once DLNR CRC merge with the NPS on 26/6/21.	
1.8	Probation staff to be reminded to consider issuing formal warning letters to service users in cases where action e.g. recall for breach of licence conditions, is considered but not taken.	Timely enforcement action is a key indicator of good risk management.	Staff learning		11 June 2021	An all DLNR staff bulletin highlighting the key themes from local DHRs, Serious further offence investigations and Safeguarding Reviews was issued on 11/06/2021. Appropriate and swift enforcement is one of these elements. Ongoing consolidation	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						of learning from DHRs, SFOs and Safeguarding reviews will be continued once DLNR CRC merge with the NPS on 26/6/21.	
1.9	Probation staff to be reminded to refer to Pathway Interventions e.g. Safe Choices/Spectrum for domestic abuse perpetrators, when accredited programmes are not applicable.	Structured interventions are integral to the risk management of domestic abuse offenders.		Sept 2021	Ongoing	10.9.21 – Unification has now taken place. Programmes teams are currently promoting interventions in relation to domestic abuse. There are still some restrictions on group work delivery owing to the ongoing pandemic and the required restrictions on occupants within buildings. However, staff are using alternative 1-1 sessions where work is required and programmes are delivering telephone work with offenders identified as priority	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						need. Groups are commencing now, limited to 6 participants, but the backlog of participants is being prioritised according risk and sentence expiry date. Owing to the pandemic, there have been limited options for the delivery of accredited programmes. Given this, staff have been instructed to refer offenders to other pathway interventions which are suitable e.g. Safer Choices, because these are being delivered 1-1. Ongoing consolidation of learning from DHRs, SFOs and Safeguarding reviews will be continued once DLNR CRC merge with	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						the NPS on 26/6/21 and the importance of structured interventions for domestic abuse perpetrators will continue to be a focus.	
1.10	Probation staff to be reminded to record details of one-to-one work carried out as per existing policy.	Accurate recording is essential for risk assessment and management of offenders.	Staff Learning		11 June 2021	An all DLNR staff bulletin highlighting the key themes from local DHRs, Serious further offence investigations and Safeguarding Reviews was issued on 11/06/2021. Accurate recording is one of these elements. Ongoing consolidation of learning from DHRs, SFOs and Safeguarding reviews will be also continued once DLNR CRC merge with the NPS on 26/6/21.	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
1.11	Probation staff to ensure that the principles of professional curiosity are applied to the risk assessment and risk management of service user.	Professional curiosity is an integral element for good risk management and assessment.	Staff learning bulletin		11 June 2021	An all DLNR staff bulletin highlighting the key themes from local DHRs, Serious further offence investigations and Safeguarding Reviews was issued on 11/06/2021. Professional curiosity is one of these elements. Ongoing consolidation of learning from DHRs, SFOs and Safeguarding reviews will be continued once DLNR CRC merge with the NPS on 26/6/21.	Green
1.12	Ongoing quality audits are completed by line managers to ensure that the expectations and requirements of key policy documents are implemented	Quality audits are required to ensure that staff are adhering to the required expectations of practice as well as professional development purposes.		Ongoing	Ongoing	Line managers have been undertaking monthly case audits on an ongoing basis. These audits will continue once the organisation has merged with the NPS.	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
EMAS							
2.1	To continue to raise awareness to all EMAS staff via education, alerts, articles and audit, the need to make safeguarding personal and the importance of discussing referrals with patients as well as consent.		Learning events	Sept 2021	24 September 2021	We have completed a learning from events session (01/07/2021) which included making safeguarding personal and mental capacity, this was a multi-agency session co delivered with Adult Social Care. Audit has commenced September 2021. ENEWs article Summer 2021 including, best practice for safeguarding referrals and domestic abuse. Ongoing training for new and existing staff, face to face and eLearning all include making safeguarding personal and consent for referrals.	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
2.2	EMAS to explore creating Pathways to drug and alcohol services for referrals with consent.	Improve information sharing.	Create pathways		December 2021	A pilot for information sharing with drug and alcohol services in Lincoln is now live. A meeting was held with Nottinghamshire drug and alcohol services to replicate, was held 07/09/2021, we are now processing information sharing agreement to get this Live in Nottingham. Pathway for County and City to be live by 31/12/2021.	Green
NHS Nottingham and Nottinghamshire CCG							
3.1	The CCG need to explore the barriers to completing DASH-RIC in primary care services.	A work stream is being developed in the CCG focusing on Domestic Abuse within the ICS for unwarranted variation.	To discuss with the safeguarding adult board about an audit being completed within the ICS**.**	October 2021	**TBC** This action will encompass various DHRs and update the CSP and ALIG on this action.	Safeguarding board minutes. Work stream development.	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
3.2	GP Services to apply a did not attend process for high risk/vulnerable patients with support of the CCG linking with primary care.	To keep patients engaged with primary care and ensure vulnerable adults have oversight from medical professionals.	That a "did not attend" policy is included in the Self-Assessment Framework for GP practices to assess as part of a yearly audit.	May 2021	May 2021	3.6 3.8 and 3.9 on the document already in place from the CCG. GP Saf.docx	Green
3.3	Use of alerts on system1 to guide professionals to make every contact count.	To promote professional curiosity when the clinicians access that patient's records, and prompt to ask questions when they present to services.	To put an alert on TeamNet which is accessed by GPs to demonstrate how this can be completed on System1 and included on the SAF for auditing.	July 2021	September 2021	3.6 3.8 and 3.9 on the document already in place from the CCG. Applying Safeguarding Codes t	Green
Housing Aid							
4.1	Consider 'safe contacts' and how to reach the victim where domestic abuse is identified within referral. Be		Re-circulate the 'Safe contacts' guidance with all colleagues.	31 July 2021	21 July 2021	21 July 2021 - Team Meeting Minutes Red.	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
	aware when speaking to 'friends' of the individual and record name and relationship to the individual within casefile.		Add 'Safe contacts' Guidance to induction training. Remind all colleagues of the importance of recording who they speak with and their relationship to the applicant.	31 July 2021 31 July 2021		Minutes circulated to all staff including those absent on the day on 29 July 2021.	
4.2	Where contact cannot be established directly with the individual, the officer will make contact with the referring agency for support in making contact.		All staff to be reminded to make contact with referring agency when contact cannot be made.	31 July 2021	21 July 2021	21 July 2021 - Team Meeting Minutes Red. Minutes circulated to all staff including those absent on the day on 29 July 2021.	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
4.3	In person appointments / drop-in offered where victims of abuse are identified and where they do not have their own means of contacting the service.		Reminder to colleagues working with rough sleepers that there is an office presence.	31 July 2021	21 July 2021	21 July 2021 - Team Meeting Minutes Red. Minutes circulated to all staff including those absent on the day on 29 July 2021. Updated Procedure Procedure for closing cases due to lack of c	Green
4.4	Where the service is unable to reach the individual, consideration will be given to whether it is appropriate to refer to the police for support.		To be included in procedure that details steps to be taken before closing cases due to a lack of contact.	31 July 2021	21 July 2021	21 July 2021 - Team Meeting Minutes Red. Minutes circulated to all staff including those absent on the day on 29 July 2021.	Green
NPS Nottinghamshire							
5.1	Ensure contact is maintained with the appropriate CRC	The purpose of this is to ensure information	This action relates to information	10 June 2021	10 June 2021	Copy of email provided that was circulated via an email to all	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
	colleague when concerns are known about a CRC case.	sharing is taking place as well as appropriate responses made to any information coming to light which is indicative of risk. With the impending unification of Probation Services in June 2021, however, moving to a Unified Model will bring responsibility for the management of all individuals subject to probation services into the new NPS. It is anticipated that this change will improve communication sharing between OMs.	sharing between DLNR and NPS. As noted, both organisations unify on 26th June 2021. The data systems will merge in October. As an interim position, an email notification to all staff was sent on 10.6.2021 to re-iterate the importance of continued liaison and discussions around linked cases during the period between June and October, whilst systems			Nottinghamshire staff which gets to every member of staff currently in NPS: "Hi All, A recent DHR identified two actions for NPS staff; 1. Improvement was required in the communication/information sharing between NPS and CRC on linked cases. At unification we anticipate that this will be less problematic going forward, however, we will experience a lag between unification and our case recording systems aligning (October). Therefore, this email is a reminder to all officers to ensure that we **continue to liaison between officers where we have knowledge that cases are/or may be, linked**. This information needs to	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
			remain separate.			be recorded on Delius under "sensitive" contact. 2. To ensure staff are aware of the NPS drug testing policy and implement it in relevant cases where this is a licence condition. Where professional judgement is applied, this should be clearly recorded in contacts. As we had been operating under our EDM through Covid we ceased testing. As we return to normal service please and resume testing please use this as an opportunity to refresh your understanding of the requirements when a testing condition is included on a licence (attached is the Covid drug testing guidance reminding us to use PPE). To assist please find attached the Drug Testing and Drug Appointment Licence and Post Release	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						Supervision guidance – 2015. Section 4 explains how we determine the suitability of the requirement, decide on the frequency of testing and agree the substances to be tested for. I would ask you to also review Annex A which contains a **suitability Matrix** and Annex B which determines **how frequently testing should take place. Any deviation from the prescribed testing schedule needs to be clearly recorded under a professional judgement comment on Delius.** Drugs testing not only assists us in assessing risk, it can also be a supportive measure for people on probation who want to demonstrate abstinence and a reduction in their risk. Many thanks	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						Lisa Adkins-Young Deputy Head National Probation Service Nottinghamshire "	
5.2	For OMs to ensure that the NPS drug testing policy is implemented in relevant cases where there is a licence condition. Where professional judgement is applied, this should be clearly recorded in contacts.	To ensure consistent application of testing guidance in all cases.	As above, included within this email was a reminder to staff of the relevant guidance and precautions guidance (during Covid) for resuming testing.	10 June 2021	10 June 2021	Copy of email provided that was circulated via an email to all Nottinghamshire staff which gets to every member of staff currently in NPS: "Hi All, A recent DHR identified two actions for NPS staff; 3. Improvement was required in the communication/information sharing between NPS and CRC on linked cases. At unification we anticipate that this will be less problematic going forward, however, we will experience a lag between unification and our case recording systems aligning (October).	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						Therefore, this email is a reminder to all officers to ensure that we **continue to liaison between officers where we have knowledge that cases are/or may be, linked**. This information needs to be recorded on Delius under "sensitive" contact. 4. To ensure staff are aware of the NPS drug testing policy and implement it in relevant cases where this is a licence condition. Where professional judgement is applied, this should be clearly recorded in contacts. As we had been operating under our EDM through Covid we ceased testing. As we return to normal service please and resume testing please use this as an opportunity to refresh your understanding of the requirements when a testing condition is	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						included on a licence (attached is the Covid drug testing guidance reminding us to use PPE). To assist please find attached the Drug Testing and Drug Appointment Licence and Post Release Supervision guidance – 2015. Section 4 explains how we determine the suitability of the requirement, decide on the frequency of testing and agree the substances to be tested for. I would ask you to also review Annex A which contains a **suitability Matrix** and Annex B which determines **how frequently testing should take place. Any deviation from the prescribed testing schedule needs to be clearly recorded under a professional judgement comment on Delius.** Drugs testing not only assists us in assessing risk, it can also be a	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						supportive measure for people on probation who want to demonstrate abstinence and a reduction in their risk. Many thanks Lisa Adkins-Young Deputy Head National Probation Service Nottinghamshire " Drugs testing guidance (NPS action) 2021-05-04 EDM - Oral Fluid Drug Testin	
Nottinghamshire Police							
6.1	Nottinghamshire Police to promote and raise awareness amongst staff of the use of Bad Character evidence in domestic abuse investigations. A "living" document, for repeat perpetrators, could be		Change in procedures		Complete	There is now a Domestic Abuse search on Niche which provides all previous DA reports which can be cut and pasted on to the MG16 (Bad Character Evidence). This saves the officer from having	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
	created and flagged within NICHE for repeat perpetrators to reduce duplication of effort in repeat cases.					to look through all occurrences on Niche. A living document (MG16) is not proportionate as the bad character application needs to be tailored to a specific case rather than a rolling log. It must be relevant. A living document could mean that potential incidents to support the particular case were overlooked and incidents that weren't relevant, could be included.	
6.2	Nottinghamshire Police to promote and raise awareness amongst staff, involved in the investigation of domestic abuse cases, the need to include the DV history of the victim and perpetrator		Change in procedures		Complete	The requirement for Bad Character is on the Domestic Abuse checklist. Without this being completed, CPS will not consider the file for charging advice. Every file requires prosecutors	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
	in prosecution/ decision files.					print so there is a record for CPS.	
6.3	Nottinghamshire Police to ensure there is a process in place to manage actions, which may be protracted, raised at MARAC meetings.				11 Oct 2021	30/9/21 – DVDs referrals for high risk cases as an action for the MARAC, the following was agreed to ensure the survivor is aware: • If Domestic Violence Disclosure Scheme (DVDS) referral, the following should be considered: o DVDS referrals ('Right to ask' and 'Right to know') can be made by agencies before the MARAC and information of this request shared as part of MARAC information. o **'Right To Ask' DVDS referral** ▪ The most appropriate agency	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						would gain consent from the survivor and make a referral to the police by calling 101. ○ **'Right To Know' DVDS referral** ▪ If a survivor is not engaging, e.g. with IDVA service and there are concerns, the agency with concerns can contact the police by 101 and make a 'Right to know' referral for the survivor to be informed (if after police assessment it is deemed appropriate). 27/9/21 – revised process information being sought.	
Framework Housing Association (Street Outreach Team)							

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
7.1	All staff will be fully trained with a refresher course on Domestic Abuse.	Ensure risks around Domestic Abuse are identified and appropriate referrals made.	Arrange and complete training for all SOT staff.	March 2021	17 March 2021	Operations Manager confirms further refresher training delivered to whole Outreach Team in March.	Green
7.2	To consider a web-based programme for the recording of information to mitigate any further risk of technology issues (access through the Citrix platform).	To mitigate any further risk of technology issues and loss of access to data through local system problems.	Identify and mobilise a suitable solution to provide better resilience.	May 2021	May to June 2021	From Framework Head of Information & Technology: "We moved our servers into the cloud onto Microsoft's Azure platform for increased resilience and improved backup & recovery. This has removed the single point of failure that was the networking equipment & infrastructure located locally. So long as the street Outreach Team have internet access, even if it is via their FHA mobiles or 4G Dongles, then they can reliably connect	Green

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence	RAG
						through to their data and applications”.	

Appendix F

Requests to CDP Board

DHR Hashtag June 2021