Nottingham Crime & Drugs Partnership

Working together to reduce crime, disorder & the misuse of drugs and alcohol

EXECUTIVE SUMMARY

Domestic Homicide Review

'Tina'

Died: Spring 2019

Nottingham Crime and Drugs Partnership

Independent Author and Chair: Hayley Frame

Report Dated: 11th May 2021

Amended July 2022

THE REVIEW PROCESS

This summary outlines the process undertaken by Nottingham Crime and Drugs Partnership domestic homicide review panel in reviewing the homicide of Tina[1] who was a resident in their area.

The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

The victim, Tina, was 64 years of age at the time of her death. She was White British.

The perpetrator, ADULT A, was 51 years of age at the time of the fatal incident. He is White British.

DT is the adult daughter of Tina.

Criminal proceedings were completed in November of 2019 and ADULT A was found guilty of murder and was sentenced to life imprisonment with a minimum of 18 years to be served.

The review commenced in 2019 once criminal proceedings had concluded. Prior to this, all agencies that potentially had contact with the victim and/or perpetrator prior to the point of death were contacted and asked to confirm whether they had any involvement with them.

Six agencies contacted confirmed contact with the victim and/or perpetrator and were asked to secure their files.

CONTRIBUTORS TO THE REVIEW

- Nottinghamshire Police
- DLNR CRC
- NPS Nottinghamshire
- NHS Nottingham and NHS Nottinghamshire CCG (formerly Greater Nottingham CCP)
- Juno Women's Aid (formerly known as WAIS)
- Nottingham City Council Domestic Abuse Referral Team (DART) - Multi agency – Children and Adults services, Juno, Police and CityCare – notifications to GPs.

Individual Management Review authors were all independent from any direct management of the case.

The following agencies were written to as part of the scoping process for the review, but held no information:

[1] This is a pseudonym chosen by the victim's family

- CityCare
- Community Protection
- DHU Healthcare CIC
- EMAS – *only contact for call out incident at death in Lincolnshire*
- Framework Housing Association
- Neighbourhood development
- Nott's Sexual Violence Support Services
- Nottingham City Council - Children's Services – *only hold information regarding Grandchildren.*
- Nottingham City Council –Neighbourhood Development.
- Nottingham Recovery Network and Clean Slate
- Nottingham Trent University
- Nottingham Trent University
- Nottingham University
- Nottinghamshire Fire and Rescue Service
- Opportunity Nottingham
- Sexual Assault Referral Centre - Topaz Centre
- St Ann's Advice Centre

THE REVIEW PANEL MEMBERS

Agency	Name	Role
N/A	Hayley Frame	Independent Chair of panel/author
CDP	Jane Lewis Paula Bishop	Community Safety Strategy Manager (Domestic & Sexual Violence Strategic Lead) DVA Policy Officer Lead
Juno Women's Aid	Jennifer Allison Yasmin Rehman	Head of Services County & Accommodation CEO
Adult Social Care, Nottingham City Council	Ishbel Macleod	Performance and Clinical Change Manager
NHS Nottingham and NHS Nottinghamshire Clinical Commissioning Group	Nick Judge	Designated Nurse for Safeguarding Adults
Nottinghamshire Police	Clare Dean	Chief Inspector PPU DHR Lead
Lincolnshire Police	Andy McWatt	SIO
EMSOU East Midlands Specialist Operations Unit	Martin Holvey	Regional Review Officer
NPS Nottinghamshire	Lisa Adkins-Young	Deputy Head
DLNR CRC	Sue Parker	Deputy Head of Service
NCC children's services - DART	Samantha Danyluk	Service Manager -CFD-MASH and Duty Service (including EDT)

The panel met on four occasions. All panel members were all independent from any direct management of the case.

AUTHOR OF THE OVERVIEW REPORT

The Independent Author/Chair is a qualified and Social Work England registered Social Worker having qualified in 1995. Since 2010, she has authored Serious Case Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews. This is the 9th Domestic Homicide Review authored by Hayley. Hayley has had no connection with the Crime and Drugs Partnership other than in an independent role and is independent from all professionals and agencies that have contributed to this review.

TERMS OF REFERENCE FOR THE REVIEW

The following case specific areas were addressed in the Individual Management Reviews and shaped the analysis of the Overview Report:

- 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.

- To establish whether practitioners and agencies involved followed appropriate inter-agency and multi-agency procedures in response to the victim's /or offender's needs.

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

- Consider the efficacy of IMR Authors' agencies involvement in the Multi Agency Risk Assessment Case Conference (MARAC) process.

- To establish whether practitioners and agencies involved considered the levels of risk as identified in the DASH RIC appropriately taking into account:
    - The number of incidents in the relationship between Tina and ADULT A, not just incidents against that individual.
    - The referral onto agencies (via the DART) for notification of the abuse (with a specific requirement for DART to provide information regarding the actions arising from each DASH RIC received)
    - Counter allegations
    - The history of abuse in their relationships and previous relationships

- To establish whether practitioners and agencies involved used routine enquiry and scoped patterns of abuse when domestic abuse was discussed / disclosed and how this information was shared with partner agencies.

- To establish whether practitioners and agencies involved recorded information appropriately to identify named persons in their records when domestic abuse was identified and explored relationships, e.g. did not just state partner / son.

- To establish whether the role of IRIS within the GP setting was available and if it was, was it utilised and if not why not.

- Determine if agencies relied too much on self reporting events / information from Tina and ADULT A and did agencies scrutinise and challenge self-reported events.

- To establish if the risk posed by ADULT A was managed appropriately and if how this was impacted by the complexities of the criminal and civil arenas working in silo.

- To what extent were the views of the victim and offender and significant others, appropriately taken into account to inform agency actions at the time.

- Identify any gaps in, and recommend any changes to, the policy, procedures and practices of the agency and inter-agency working with the aim of better safeguarding families and children where domestic violence is a feature in Nottingham City.

- 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 to work together to manage risk and safeguard the victim Tina, and the wider public.

- 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.

SUMMARY CHRONOLOGY

Tina and ADULT A had been involved in an on/off relationship since approximately November 2013. ADULT A has previous convictions for domestic abuse in Scotland.

During Tina and ADULT A's relationship, there were 8 occasions where a domestic abuse incident was reported to the police and a DASH RIC was completed. 6 were completed where Tina was the victim and 2 where ADULT A was the victim. Of the 8 completed, 6 were medium risk and 2 were standard risk. The case never met the threshold for MARAC. Tina was referred to Women's Aid but withdrew from the support offered.

ADULT A was known to the Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company as a result of a conviction for breach of non-molestation orders made in respect of his close family members.

In 2019, Tina and ADULT A went on holiday to the East coast to stay on a caravan park.

During this holiday, the East Midlands Ambulance Service and Lincolnshire Police attended to a third party report of a woman being assaulted inside a caravan by a male. Tina had

received significant and extensive head and facial injuries. She was treated at the scene but sadly died a short time later.

Tina's adult daughter has contributed to the review and her perspectives are detailed fully in the overview report. Tina's daughter received specialist advocacy support to engage in the review process. ADULT A also contributed to the review and his responses to questions posed to him are provided in the overview report.

KEY ISSUES ARISING FROM THE REVIEW

There was no recorded mention of the Domestic Violence Disclosure Scheme which could have highlighted ADULT A's domestic convictions in Scotland prior to having met Tina. This request could have been made by officers through the 'right to know' process despite Tina not having made a request through the scheme.

On 3 occasions Tina signed the DASH RIC and gave her consent for information to be shared with agencies. The process would be that the DASH RIC would then be sent to the Domestic Abuse Referral Team for them to signpost the survivor to appropriate support services. There are no records of this having taken place for Tina. It would seem that the reason for this was due to Tina not having care or support needs that would meet the criteria for a service from Adult Social Care.

There were 3 occasions where the GP could have taken a far more proactive approach – Tina presented with injuries on two occasions and ADULT A also presented to the GP, accompanied by Tina, stating that he was verbally aggressive towards her.

The reason for Tina's decision to withdrawn from Women's Aid services could also have been probed further. Tina's employer could have demonstrated greater professional curiosity regarding the nature of her relationship with ADULT A. They were aware that it was volatile.

It is clear that the involvement of the DLNR CRC with ADULT A could have been more robust and provided greater scrutiny of his personal relationships and the risk of domestic abuse. The initial sentence plan and risk assessment concluded that ADULT A was medium risk of serious harm through intimidation and violence to known adults including family members and partners/ex partners. His relationship status and health of his relationship was not discussed despite their being opportunity to do so. At the time of sentencing he was believed not to be in a relationship but this changed by the time of his initial sentence plan. Tina was not named in the risk assessment.

CONCLUSIONS AND LESSONS TO BE LEARNED

It is clear from the history of this case that ADULT A had a history of targeting vulnerable women and this dated back to his time spent in Scotland. However, his profile and offending history were such that he did not trigger offender management systems. He was not perceived to be a high risk offender. The police in Scotland were unaware of ADULT A's return to Nottingham and had no requirement or statutory basis upon which to monitor his movements.

Once in Nottingham, there was opportunity to offer Tina the DVDS and measures have now been taken to increase police capacity to do so.

It is clear that greater professional curiosity could have been shown by those agencies in contact with ADULT A and Tina. A more proactive approach to DVDS could have provided information to Tina about ADULT A's history although it is likely that the level of coercive control exhibited by ADULT A towards Tina made it very difficult for agencies to engage and support her.

Had all information been pooled together by the DLNR CRC they would have had a different assessment of risk of ADULT A. However, even if the DLNR CRC had obtained all relevant background information and assertively managed ADULT A's case; the likelihood is that he still would not have been deemed to be an offender who was a risk of committing homicide.

The decision that Tina and ADULT A made to go away for her birthday could not have been changed by professional intervention. ADULT A's actions, and his actions alone, on 29/5/19 caused Tina's death.

RECOMMENDATIONS FROM THE REVIEW

The overview findings and recommendations are as follows:

a) As with many DHRs, the issue of recording of relationships on systems requires further action. How agencies record information – names, dates (who, when, what, why) and the linking and recording of relationships by all agencies requires review. The CDP Board and Safeguarding Partnerships should provide the steer for this.

b) A significant factor within this DHR has been that of professional curiosity. This should be embedded within the local failure to engage framework and a briefing note disseminated across agencies within the City.

c) Those women without dependent children who do not meet the criteria for adult social care are slipping through the net in terms of domestic abuse support. Older survivors are even less likely to engage with support services. A review of this cohort and a needs analysis should be completed on a local and national level.

INDIVIDUAL AGENCY LEARNING

Learning identified by individual agencies as noted in their Individual Management Reviews are listed below:

<u>Nottinghamshire Police</u>

- All staff engaged in the domestic abuse process should be reminded the DVDS has an element of right to know as well as right to ask.

- Nottinghamshire Police include DVDS questions within the risk assessment process. This will ensure staff consider both elements of the DVDS in each case of Domestic Abuse.

Probation (including DLNR CRC)

- Ensure that all information available on NDelius/from Court/from Police is acted upon appropriately and ensure all relevant checks are undertaken where there is evidence of any domestic abuse.
- Ensure that all decisions linked to a case are fully documented – demonstrate how and why a case decision has been made – this should include changes to planned interventions.
- Use Professional Curiosity to challenge and investigate information provided by the service user particularly in relation to safeguarding issues and share such information with relevant agencies.
- Ensure OASys assessments detail all known concerns and reflect any other assessment made for interventions.
- Review OASys assessment when new information is provided
- Ensure that recent attendance on the Domestic Abuse and Safeguarding Refresher training is transferred into practice and any learning is discussed in Supervision.
- Use of Supervision and Management Oversight recording in NDelius to demonstrate discussions with line manager about domestic abuse and safeguarding concerns.
- An analysis into the knowledge and understanding of staff of interfamilial abuse and links to partner abuse and an action plan if any learning needs are identified.

NHS Nottingham and Nottinghamshire CCG

- The CCG to undertake further analysis into barriers for GPs in completing details of family groups and relationships to identify ways of improving practice.