Nottingham Crime and Drugs Partnership

DOMESTIC HOMICIDE REVIEW

'Mark'

Died Summer 2019

EXECUTIVE SUMMARY

For Home Office Submission

June 2021

Chair and Author - Carol Ellwood-Clarke QPM

Independent support to Chair and Author – Paul Cheeseman

CONTENTS

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Nottingham Crime and Drugs Partnership [the statutory Crime and Disorder Partnership] in reviewing the homicide of Mark a resident in their area.

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

Name	Relationship	Age	Ethnicity
Mark	Victim and nephew of John	37	White British male
John	Perpetrator and uncle of Mark	44	White British male
Adult A	Previous partner to Mark		White British female
Adult B	Previous partner to Mark		White British female
Adult C	Family member		White British female

1.3 Mark died following injuries sustained in an assault at John's home address. Mark had been living at the address in the months prior to his murder. John was arrested at the scene. John was convicted of the manslaughter of Mark, on the grounds of diminished responsibility and sentenced to 7 years and 4 months imprisonment.

1.4 Nottingham Crime and Drugs Partnership Chair, following communication with the Home Office determined the murder of Mark met the criteria for a domestic homicide review [DHR]. All agencies that potentially had contact with Mark and John prior to the homicide were asked to secure their files. The panel met three times and due to the Covid-19 pandemic all meetings were held online. Mark's family were involved in the review process, having access to the report and contact with the Chair. The overview report was presented to Nottingham Crime and Drugs Partnership on 21 June 2021.

2. CONTRIBUTORS TO THE REVIEW

2.1 The table below shows the agencies that contributed to the review and the material they were able to supply.

Agency	IMR	Chronology	Summary Report	DHR Scoping Information
CityCare[1]				✓
East Midlands Ambulance Service (EMAS)				✓
Framework[2]	✓	✓		✓
Greater Nottingham Clinical Commissioning Group	✓	✓		✓
MARAC[3]		✓	✓	
Nottingham City Council, Adult Social Care		✓	✓	✓
Nottingham City Council, Children's Services			✓	✓
Nottingham City Council, Housing Aid		✓	✓	
Nottingham City Homes				✓

[1] CityCare deliver a range of nursing and healthcare services shaped and developed by the needs and wishes of the communities we serve. From health visiting and education for young families, to community nursing and home-based rehabilitation services for older people, and from NHS urgent care centres to specialist diabetes, nutrition and dietetics sessions.

[2] A charity delivering housing, health, employment, support and care services to people with a diverse range of needs across the midlands and the north of England – in Nottinghamshire, Lincolnshire, Derbyshire and Sheffield.

[3] Multi Agency Risk Assessment Conference

Nottingham Healthcare NHS Foundation Trust	✓	✓		✓
Nottinghamshire Police	✓	✓		✓
Nottingham University Hospitals				✓
Police Scotland		✓	✓	

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

1. DHU Healthcare CIC
2. Nottingham University
3. Equation
4. National Probation Service Nottinghamshire
5. Nottingham Trent University
6. Nott's Sexual Violence Support Services
7. Nottingham Recovery Network and Clean Slate
8. Opportunity Nottingham
9. Sexual Assault Referral Centre - Topaz Centre
10. St Ann's Advice Centre
11. Community Protection
12. Nottingham City Council –Neighbourhood Development.

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

3. THE REVIEW PANEL MEMBERS

3.1 The panel members were:

Review Panel Members		
Name	**Job Title**	**Organisation**
Paula Bishop	Domestic Violence & Abuse Policy Officer	Nottingham Crime & Drugs Partnership
Paul Cheeseman	Support to Independent Chair and Author	
Rhonda Christian	Designated Nurse Safeguarding Adults	Greater Nottinghamshire Clinical Commissioning Group Partnership
Clare Dean	Chief Inspector	Nottinghamshire Police
Lisa Del Buono	Service Director	Framework Housing Association
Carol Ellwood	Independent Chair and Author	
Louise Graham	Community Safety Officer (Sexual Violence Lead)	Nottingham Crime & Drugs Partnership
Hannah Hogg	Corporate Safeguarding Lead	Nottinghamshire HealthCare Foundation Trust
Jane Lewis	Community Safety Strategy Manager (Domestic & Sexual Violence Strategic Lead)	Nottingham Crime & Drugs Partnership
Ishbel Macleod,	Performance and Clinical Change Manager	Nottingham City Council Adult Services
Debbie Richards	Service Manager	Nottingham City Council Housing Aid
Specialist Members		
Oliver Bolam	Head of Mental Health & Whole Life Disability	Nottingham City Council

Apollos Clifton-Brown	Operations Manager	Nottingham Recovery Network[4]
Cath Wakeman	Chief Executive Officer and Trauma Therapist	IMARA[5]

3.2 The panel met three times and the review chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny.

[4] https://www.nottinghamrecoverynetwork.com/Providing a single point of free support, advice and treatment to people who use alcohol and drugs in a problematic way across Nottingham City.

[5] https://www.imara.org.uk/

Imara is an independent specialist service that supports children, young people and their family following a disclosure or discovery of child sexual abuse.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 Carol Ellwood was appointed as the Chair and Author of the report. Carol retired from thirty years public service [British policing – not Nottinghamshire] 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.

4.2 The Chair was supported throughout the DHR process by Paul Cheeseman who has a similar background and retired from full time work in 2014. Paul Cheeseman has experience of chairing and authoring Domestic Homicide Reviews.

4.3 Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews, domestic homicide reviews and have completed the Home Office online training for undertaking Domestic Homicide Reviews.

4.4 Neither have undertaken a DHR within Nottingham prior to this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The review covers the period 1 January 2018, [which was the time that Mark returned to live in Nottingham] until the date of Mark's murder in August 2019.

The purpose of a Domestic Homicide Review [DHR][6]

a] 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.

b] 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.

c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d] 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.

e] Contribute to a better understanding of the nature of domestic violence and abuse; and

f] Highlight good practice.

Specific Terms of Reference for IMR[7] Authors -

1. To identify all incidents and events relevant to the named persons (Mark and John) and identify whether practitioners and agencies responded in

[6] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

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

accordance with agreed processes and procedures at the time of those incidents.

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

3. Establish whether relevant single agency or inter-agency opportunities to respond to concerns about the victim, (Mark) and the assessment of risk to him and risk to others was considered and appropriate.

4. To establish whether practitioners and agencies involved considered the levels of risk as identified in the DASH RIC[8] appropriately taking into account:

    i. The number of incidents in the relationship between Mark and John, not just incidents against that individual.

    ii. The referral onto agencies (via the DART[9]) for notification of the abuse (with a specific requirement for DART to provide information regarding the actions arising from each DASH RIC received).

    iii. Counter allegations.

    iv. The history of abuse in their relationships and previous relationships.

5. To establish whether practitioners and agencies involved used routine enquiry and scoped patterns of abuse when domestic abuse was

[8] The Domestic Abuse, Stalking and Harassment and 'Honour'-based violence Risk Indicator Checklist (DASH RIC) form should be used by all non-police workers in Nottingham and Nottinghamshire who receive a disclosure of domestic abuse. The form allows you to better assess risk and make an appropriate referral for support, including to the Multi-Agency Risk Assessment Conference (MARAC).

[9] Domestic Abuse Referral Team - The DART is a multi-agency team of people who continue to be employed by their individual agencies (local authority, police and health services) but who are co-located. Co-location is considered the most effective way of building relationships, trust and understanding between agencies so that staff are confident about sharing information. This multi-agency team will deal exclusively with domestic abuse concerns within the City where there are children or a pregnant woman in the household or where a vulnerable adult who meets the threshold for Social Care Services is being subjected to domestic abuse.

discussed/disclosed and how this information was shared with partner agencies.

6. 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.

7. 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.

8. To what extent did gender disparity take place when the level of risk was being recorded for domestic abuse incidents for Mark and John. Are male victims rated a higher risk from a lower level of harm?

9. Determine if agencies relied too much on self-reporting events/information from Mark and John and did agencies scrutinise and challenge self-reported events?

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

11. Establish whether relevant single agency or inter-agency opportunities to respond to concerns about the offender, (John) and the assessment of risk to him and his risk to others was considered and appropriate.

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

13. Identify any areas where the working practices of agency involvement had a significant positive or negative impact on practice or the outcome.

14. 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.

15. 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 Mark and the wider public.

16. 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.

6. SUMMARY CHRONOLOGY

6.1 Mark

6.1.1 Mark had a troubled childhood. His parents had separated when he was young, and Mark was brought up witnessing domestic abuse, as well as being subjected to violence himself. Mark was known to have difficulty controlling his anger which often resulted in physical acts of violence. Mark had been involved in criminality and had spent time in prison. Mark reported to professionals that he had poor mental health, and self-diagnosed anxiety and depression.

6.1.2 Mark had four children. Two of these were from a long-term relationship. In 2015 Mark met a female online, he moved up to Scotland to live with her. The couple had two children (twins) together. There was violence in this relationship, and the family were known to the authorities in Scotland. This relationship ended in 2018 after Mark had been convicted of a domestic abuse crime against his partner.

6.2 Background to John

6.2.1 John had been brought up living with his Mother and Father. Following the death of his Mother, John obtained tenancy of the family home. John had several people residing in his home since the death of this Mother. Some of these have been referred to as John's 'carer'. The review had access to a statement provided to the Police, from a person, who described themselves as being John's carer since July 2014, and who would help John with his bills, benefits, general living and support John during medical appointments. This role was an arrangement between John and the individuals concerned. There are no records that any of these roles have been or required to have been reviewed as part of a carer's assessment[10].

6.2.2 John had trained as a chef but had previously told a Social Worker that he would like to have been a boxer. John has been described as a 'big softy', and despite being of large build he was a kind person who would help

[10] https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/#:~:text=Under%20the%20Care%20Act%202014,outcomes%20they%20want%20to%20achieve

The Care Act 2014 sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support.

anyone by buying them food or allowing them to stay at his home. This often led to the Police being called to the property, due to complaints about John and his friends' behaviour, which was linked to alcohol abuse.

6.3 Mark and Johns' Relationship

6.3.1 John is the Uncle of Mark. In the months prior to his murder Mark had moved in to live with John after he had become homeless and sleeping rough. John stated that he felt pressure to have Mark stay with him as he was a family member. Mark had told a previous partner that he did not enjoy living with John and that they argued every day as John's behaviour was erratic, which Mark tried to control. Mark had described how John was victimised by people who used him for his money and his house as a meeting place. Mark reported that he had taken on a caring role for John, which also resulted in Mark sharing household bills and looking out for John. Mark did not seek help from agencies with John as he understood this to be his role.

6.3.2 Information provided to the Police during the criminal investigation, described how the relationship between Mark and John had been volatile, in that there were daily arguments which included threats and physical pushing. These were described as daily events, over matters such as the washing machine, and Mark not contributing any money for food and bills. In the weeks prior to Mark's murder, John's friends stated that there had been a couple of issues which had impacted on John's anxiety, which included the suspension of his Employment and Support Allowance[11] and the anniversary of his Mother's death.

6.4 Key Events

6.4.1 John had been known to the Police since 2004. A high portion of these incidents related to alcohol abuse by John and people who frequented his home. John had no previous convictions. In 2014, John received a Police

[11] https://www.gov.uk/employment-support-allowance

ESA gives you: money to help with living costs if you're unable to work, support to get back into work if you're able to. You can apply for ESA if you're employed, self-employed or unemployed.

caution[12] for a common assault on an adult, when he hit a friend whilst under the influence of alcohol.

6.4.2 Mark had been known to the Police since 2000. These offences were for dishonesty and drug related matters. In November 2018, Mark was convicted of a domestic abuse crime in Scotland. At the time of his murder, Mark had eleven impending prosecutions for criminal offences.

6.4.3 During July and August 2018 the Police attend three incidents at John's home address. These related to arguments between John and his friends during the consumption of alcohol. Concerns were raised around financial exploitation of John, the vulnerability of John was identified, and a referral was made to the Neighbourhood Team.

6.4.4 After returning to Nottingham from Scotland Mark was involved in several domestic abuse incidents with his previous partner. These matters were reported to the Police and referrals were made to Children's Social Care. Mark was seen by a GP in relation to anxiety and depression and episodes of self-harm. Mark was advised to self-refer to Improving Access to Psychological Therapies (IAPT)[13], which is also known as Let's Talk Wellbeing. In December 2018, Mark self-referred to IAPT and was offered an appointment in January. Mark did not attend the appointment.

6.4.5 Towards the end of December 2018 the Police received a telephone call from a male who stated that John had threatened to stab him. The male stated that he did not believe the threat. John was seen by the Police, and it was noted that he struggled to comprehend what was being said.

[12] https://www.cps.gov.uk/legal-guidance/cautioning-and-diversion

A police caution is a formal alternative to prosecution in minor cases, administered by the police in England and Wales. It is commonly used to resolve cases where full prosecution is not seen as the most appropriate solution.

[13] https://www.nottinghamshirehealthcare.nhs.uk/letstalkwellbeing

IAPT is a largely self-referral service. The service provides psychological assessment and treatment (talking therapies) for common mental health problems, which 1 in 4 of us will suffer with at some stage in our lives. This includes depression, anxiety, panic, phobias, obsessive compulsive disorder (OCD), trauma and stress.

6.4.6 At the beginning of 2019 Mark became homeless and was reported to be sleeping rough. At the end of January Mark was arrested following an incident with his previous partner. The incident was classed as high-risk domestic abuse and referred to MARAC and Children's Social Care. Children's Social Care commenced Section 47[14] enquiries in accordance with the Children Act 1989. Whilst in Police custody Mark was seen by Liaison and Diversion Service. Mark discussed that he suffered with depression and severe anxiety for which he was in receipt of medication, and that he had never accessed mental health services. Mark was provided with information about Nottingham Wellbeing Hub[15] and a crisis contact information leaflet. Mark was released from police custody on pre-charge bail with conditions around non-contact, there was no condition for where he should live and sleep. The conditions were in place up until the point of charge in July 2019.

6.4.7 On 14 February 2019 the incident involving Mark was discussed at MARAC. Although Mark was identified as the perpetrator his needs regarding his mental health were recognised and shared. The MARAC identified the high-risk Mark posed to his immediate family members not just the victim in the incident. The MARAC considered if Mark posed a risk to John whose address he was living at as an immediate solution at the time of the incident. There was no information shared in the meeting which identified any risks from Mark to the residents of the property.

6.4.8 On the same day as the MARAC, Mark telephoned the street outreach team[16] to self-refer. Mark stated he had been sleeping rough for two weeks following his arrest by the Police. The team also received an email from a

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14 https://www.scie.org.uk/publications/introductionto/childrenssocialcare/childprotection.asp

15 https://www.nottinghamwellbeinghub.org/
The Wellbeing Hub provides free, confidential support and advice to people seeking support for mental health, drugs or alcohol use, housing and employment.

16 https://www.frameworkha.org/service/street-outreach-nottingham

Framework's Street Outreach Team serves two main purposes: to engage with and help rough sleepers and to quantify the extent of street homelessness in partnership with other agencies such as local authorities. Team members are at the forefront of our work to stop rough sleeping and street homelessness. They work in the early hours of the morning in order for them to identify those in the greatest need of support.

friend of Mark's who reported Mark as being homeless and in need of help. Mark attended at Housing Aid and made an application for accommodation. The case was later closed in March 2019 as Mark did not progress the application. Mark moved in to live with John around February 2019.

6.4.9 On 22 February, Mark attended Highbury Hospital[17] and requested help with his mental health. Mark was seen by the Crisis Resolution Home Treatment Team (CRHT)[18] and it was determined that his needs would be best met by Liaison and Diversion Service as Mark was seeking support around court attendance. Over the following two weeks, the Liaison and Diversion service telephoned Mark to arrange contact but each phone call was rejected. Mark was discharged from the service. A letter was sent to Mark's GP.

6.4.10 On 26 March, Police received a call from the carer of John who stated that Mark's presence at the house was causing increased levels of anxiety for John. The caller intimated that Mark was becoming volatile. The Police attended and were informed that Mark had raised his voice whilst speaking to a person on the telephone, this had caused John to become anxious. No offences had been identified and advice was given.

6.4.11 At the beginning of May 2019 Mark was arrested by Police on behalf of Police Scotland, for the criminal matters reported by Adult B. Mark was later released from custody after being interviewed. These matters were still under investigation at the time of Mark's murder.

6.4.12 On 9 July, Mark was charged with criminal offences in relation to the incident in January 2019. Mark was bailed to court with conditions. One of these conditions was – 'to live and sleep each night at John's address'. At point of charge Mark was offered further support which he declined. Mark was provided with a custody release booklet[19] and a Support Services leaflet[20].

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[17] https://www.nottinghamshirehealthcare.nhs.uk/highbury

[18] This team provides a 24 hour, seven day crisis resolution service that offers assessments to people with significant mental illness who would otherwise be admitted to hospital.

[19] A booklet handed out after release from Police custody which contains contact details for support agencies.

[20] A directory of key local and national support services.

6.4.13 On 10 July 2019 Mark visited his GP practice and requested an appointment with a GP to discuss his medications. It was noted that the medications had not been issued since January 2019. Mark was informed that an appointment could be made with GP+[21] for that day, but Mark declined. Mark telephone the GP practice on 29 July 2019 and requested an appointment with a GP. An appointment was arranged for 2 August.

6.4.14 On 1 August 2019 the Police received a call from a relative of John who reported that Mark had been causing problems and was no longer welcome at John's house. Officers attended at the house and spoke with John, who stated that he had allowed Mark to stay with him as he had nowhere else to live. John was given advice about asking Mark to leave and that further contact could be made with the Police if Mark refused to leave. [It was established during the criminal investigation that John had asked Mark to leave after the Police had left, but later that evening they had been out together to a local pub].

6.4.15 The following day, Mark attended the appointment with his GP. During the consultation Mark stated that his anxiety and depression were getting worse, and he had not been taking any medications for several months. Mark described how he was suffering with panic attacks and racing heart. Mark admitted to taking cannabis daily to help with his anxiety along with consumption of alcohol. Mark was issued with a prescription to re-start his medication and advised to self-refer to IAPT. Mark was provided with safety net advice[22] around deterioration of mental health and contacting the Samaritans[23]. Mark was later found deceased. John was arrested and later charged in relation to the murder of Mark.

[21] GP+ is an extended hours GP service for Nottingham City patients. This is not a walk-in service and appointments have to be pre-booked through the reception team at a patient usual GP practice.

[22] The term "safety net" in this context was to illustrate that Mark had been sign posted to organisations if he felt his mental health was deteriorating and there were services available he could turn to if he was not able to see a GP.

[23] https://www.samaritans.org/branches/nottingham/

7. KEY ISSUES ARISING FROM THE REVIEW

7.1 Mark and John were known to have vulnerabilities. Mark had anxiety and depression and had sought help from a GP. Mark had been prescribed medication, although his use of the medication was not consistent. Mark self-referred to IAPT and was offered an initial appointment. When Mark did not attend this appointment and future contacts had been unsuccessful his case was closed. Mark had also been provided with information on how to access support services to help with his mental health. There was no record that Mark had contacted these agencies. Mark admitted to a GP that he used illicit drugs to help him cope with this mental health.

7.2 In 1984, when John was 9 years old, he was recorded as having a moderate learning difficulty as opposed to a learning disability. Had John been diagnosed with a learning disability he would have been placed on the Learning Disability Register[24] and had access to yearly reviews. John attended mainstream schools and did not have a statement of educational needs. In 2016, Adult Social Care undertook an assessment of John following a referral from John's GP. The outcome was that John was not eligible for receipt of services. There is no evidence that John lacked capacity in accordance with the Mental Capacity Act 2005.

7.3 Whilst the Police attended two incidents involving Mark and John, these did not identify evidence of any criminal offences that required Police to take further action or the involvement of other agencies.

7.4 The panel recognised that Mark and John's relationship did not fit the criteria of domestic abuse in terms of the Cross-Government Definition of domestic abuse[25] –

'Any incident or pattern of incidents of controlling, coercive or 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'.

[24] https://www.nhs.uk/conditions/learning-disabilities/annual-health-checks/

[25] https://www.gov.uk/government/news/new-definition-of-domestic-violence

The definition of 'family members' as per the Home Office document – 'Information for Local Areas on the change to the Definition of Domestic Violence and Abuse'[26], describes 'family members' as being that of - mother, father, son, daughter, brother, sister & grandparents; directly-related, in-laws or step-family. The relationship of uncle and nephew is not determined as 'family members'.

7.5 The panel identified that there was wider learning for agencies in recognising and understanding the context of familial abuse, and where there were known vulnerabilities such as mental health, risk and trigger factors within that that relationship.

26 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf

8. CONCLUSION

8.1 Mark had been living with John for six months prior to his murder. John had agreed with this living arrangement to prevent Mark becoming homeless and having to live on the streets of Nottingham.

8.2 The Police attended two incidents involving Mark and John. Both incidents related to their living arrangements and how this impacted on John. Neither incident identified that any criminal offences had taken place and appropriate advice was given. No other agency had any involvement with Mark and John's living arrangements. There was no knowledge of any violence within the relationship.

8.3 On the day of Mark's murder, he had spent time in the presence of John at a local public house. Following an argument, John stabbed Mark, which caused a fatal injury. John pleaded guilty to the manslaughter of Mark and is currently serving a prison sentence.

8.4 The review identified that circumstances surrounding familial violence, particularly in relation to wider family relationships did not meet the definition for domestic abuse in accordance with current legislation on this case. However, the panel acknowledged that Mark's murder did meet the criteria for a domestic homicide review.

8.5 It was clear to the review panel that Mark and John had vulnerabilities which impacted on their relationship and that these vulnerabilities and previous incidents were not considered to inform a holistic view of the case when agencies were in contact with Mark and John. The panel have identified learning for this case for all agencies working across Nottinghamshire.

8.6 Mark's family provided valuable information to the review which has been included within the report and the DHR panel thank the family, including previous partners of Mark for their contribution.

9. LEARNING

9.1 DHR Panel learning

9.1.2 Whist there was no evidence of domestic abuse or coercive control, prior to Mark's murder, the DHR panel considered, the learning that had arisen from this case for agencies working across Nottinghamshire and how this learning could be disseminated. The panel agreed that the learning should be disseminated via a learning document, highlighting the key themes, including individual agencies learning and recommendations.

9.1.3 Below is a summary of the DHR panel identified learning. The DHR panel agreed that the learning would be reflected under headings to address the five key areas of learning, with a single recommendation to address and respond to the learning:

Vulnerability – understanding the vulnerabilities of individuals, including that people with learning disabilities are at a high risk of abuse and exploitation. The role and expectation of Professionals in identification, including sharing of information and signposting individuals to support and access to information.

Risk factors – understanding of risk factors and how these are managed and shared amongst agencies, particularly in relation to familial violence. Ensuring that risk factors are considered and addressed when identified by Professionals.

Recording – where people are living, and who is in the household, including decision-making on these arrangements. To include where relevant, information is shared amongst agencies, where family dynamics and home circumstances change.

Holistic view – having an understanding and taking cognizance of previous incidents and information when reviewing cases and decision-making. To ensure that these incidents and any identified risk factors are addressed by Professionals when managing risk and responding to incidents.

Trigger factors – in relation to mental health needs and accessibility and engagement of support. To ensure that Professionals understand the

impact of mental health, and availability and signposting to relevant services.

9.1.4 The DHR panel were assured by the ongoing work that is taking place across Nottingham in relation to implementation of recommendations from previous DHRs. The learning from previous DHR's were not relevant for this review.

9.2 Agencies Learning

9.2.1 Housing Aid

- Processes for assessments, including client contact and information sharing.

9.2.2 MARAC

- Outcomes of agency actions.

9.2.3 Nottingham City Council Children's Services

- Review of history to inform decision making. (Training has been undertaken and this is now complete).

9.2.4 Nottingham Healthcare NHS Foundation Trust

- Accuracy of information sharing to inform multi-agency risk assessments and care planning.

9.2.5 NHS Nottingham & Nottingham CCG

- Groups and relationships should be recorded for all patients.
- GP practices should ensure that the names and relationships of people accompanying patients to appointments are recorded.

9.2.6 Nottinghamshire Police

- Gaps in service delivered to victim/perpetrator/other identified and areas of learning.

10. RECOMMENDATIONS

10.1 Panel and Agency Recommendations

10.1.1 The recommendations are:

DHR Panel Recommendations	
No	**Recommendation**
1	Nottingham Crime and Drugs Partnership produce a learning summary for dissemination to front line professionals and managers in all agencies concerning the death of Mark and contact with John. This should summarise the agency lessons that have been identified in this case and suggest practical ways in which professionals and managers might take a different approach to contact with clients who display similar vulnerabilities to those displayed by Mark and John and hence reduce their risk of harm.

MARAC	
No	**Recommendation**
1	For all agencies to provide updates on outcomes of actions they have completed.

Nottingham Healthcare NHS Foundation Trust	
No	**Recommendation**
1	Consideration to be given to providing the Safeguarding Service with access to LTW electronic records in order that accurate contemporaneous information can be obtained to inform multi-agency risk assessments and care planning.

NHS Nottingham and Nottingham Clinical Commissioning Group	
No	**Recommendation**
1	Groups and relationships should be recorded for all patients.
2	GP practices should ensure that the names and relationships of people accompanying patients to appointments are recorded.

Nottinghamshire Police	
No	**Recommendation**
1	Nottinghamshire Police to consider condensing, into one policy document, PS158 Vulnerability Policy and PD580 Incident Grading & Resolution Policy.

End DHR Hanover