Nottingham Community Safety Partnership

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Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Julie
in August 2020

Report Author: Christine Graham
July 2022

Preface

The Nottingham Community Safety Partnership (formerly Nottingham Crime and Drugs Partnership) and the Review Panel wish at the outset, to express their deepest sympathy to Julie's family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken in an open and constructive manner, with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by the Nottingham Community Safety Partnership on receiving notification of the death of Julie in circumstances that appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This overview report has been compiled as follows:

Section 1 begins with an **introduction to the circumstances** that led to the commission of this review, and the process and timescales of the review.

Section 2 **sets out the facts** in this case, **including a chronology** to assist the reader in understanding how events unfolded that led to Julie's death.

Section 3 provides **detailed analysis of agency involvement.**

Section 4 analyses the **domestic abuse** within the relationship.

Section 5 explores **Julie's vulnerability.**

Section 6 considers **suicide and domestic abuse.**

Section 7 brings together the **lessons identified, and Section 8** sets out the **recommendations** of this review.

Section 8 draws together **the conclusions** of the Review Panel.

Appendix One provides the **terms of reference** against which the panel operated.

Appendix Two sets out the **ongoing professional development** of the Chair and Report Author.

Where the review has identified that an opportunity to intervene has not been taken, this has been noted in a text box. Examples of good practice are highlighted in italics.

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Section One – Introduction

1.1 Summary of the Circumstances Leading to the Review

1.1.1 This report of a Domestic Homicide Review examines agency responses and support given to 'Julie', a resident of Nottingham Community Safety Partnership area, prior to her death in August 2020.

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

1.1.3 Julie was only 42 years old when she died at her home in August 2020. She was a woman who had experienced a difficult and traumatic life. Julie had been with her partner for 25 years, and they had five children together: two of whom had been adopted, and two who were living with other carers (under a Special Guardianship Order). Julie and her partner's youngest child was living with the couple. Julie and her partner had both been Class A drug users (heroin and crack cocaine), and both were reported to be on a methadone programme to assist them with reducing their addiction.

1.1.4 In the early part of the year of her death, Julie had been sentenced to six months in prison for an offence of witness intimidation. The relationship between the couple was subject to multiple instances of domestic abuse, and after Julie's release from prison, and thus in the months prior to her death, both had been arrested for assaults upon each other. At the time of Julie's death, the couple were living apart because her partner was subject to a Domestic Violence Protection Order (DVPO), which had been imposed two weeks previously.

1.1.5 It was on an evening in August 2020 that the police received a call from a friend of Julie's partner, as they were concerned for her welfare. It was reported that she had been drinking heavily earlier in the day and had been threatening suicide. They were concerned because they did not now know where she was. The police began initial enquiries to try and trace her. Throughout the evening, the police and health authorities attempted to contact her; however, none of their efforts were successful.

1.1.6 By 11 pm, Julie could still not be contacted, and so, after further contact, the ambulance service returned to the address. An empty box of tablets was visible on the windowsill. As a result, both the fire service and police were recalled. Access was gained to the house, and Julie was found deceased in the downstairs lounge.

1.1.7 At a subsequent inquest, HM Coroner came to a finding that Julie's death was as a result of 'drugs and alcohol'. She had a mixture of drugs in her system: of which, the quantities of two could have been fatal in themselves. This, coupled with high levels of alcohol, was the cause of death.

1.1.8 It is within this context that this review is set.

1.1.9 The review will consider in detail, agency contact and involvement with Julie and her partner for the period of one calendar year prior to her death. It will also draw upon and reference other relevant incidents or life events prior to that year period. The period of one year was

chosen because it contained significant events leading up to Julie's death, which reflected ongoing issues in her life.

1.1.10 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides or other deaths where the person dies. Furthermore, whether domestic abuse may have been a contributory factor or a key factor in the person's life. For these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening again in the future.

1.2 Reasons for Conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, Julie died as a result of drugs and alcohol and had been a victim of domestic abuse; therefore, the criteria have been met.

1.2.4 The purpose of the 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 policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice.

1.3 Methodology and Timescales for the Review

1.3.1 On 9th October 2020, Nottingham Community Safety Partnership were notified by East Midlands Ambulance Service (EMAS), regarding a death that it was believed met the criteria for a Domestic Homicide Review.

1.3.2 The Chair of the Nottingham Community Safety Partnership considered the notification. After consulting with board members, they agreed that the criteria had been met.

1.3.3 The Home Office was notified of the decision to carry out a DHR on 10th November 2020.

1.3.4 The Independent Chair and Report Author were appointed at the end of November 2020.

1.3.5 The first panel meeting was held on 11th January 2021. The following agencies were represented at the meeting:

- Nottingham CityCare Partnership
- Derbyshire, Lincolnshire, Nottinghamshire and Rutland Community Rehabilitation Company
- Department of Work and Pensions
- East Midlands Ambulance Service
- East Midlands Special Operations Unit (EMSOU) Regional Review
- Juno Women's Aid
- National Probation Service
- Nottingham and Nottinghamshire Clinical Commissioning Group (Now Integrated Care Board)
- Nottingham Community Safety Partnership
- Nottingham City Council – Children's Services
- Nottingham City Homes
- Nottingham Healthcare NHS Foundation Trust
- Nottingham University
- Nottinghamshire
- St Ann's Advice Centre

1.3.6 Following the reunification of probation services, the panel had one member from the new National Probation Service.

1.3.7 At the first meeting, the panel considered its composition, and it was agreed that St Ann's Advice Centre could be released from the panel, as they were not involved with the subject of the review. Nottingham Women's Centre was invited to join the panel because they had worked with Julie prior to her death.

1.3.8 As a chronology had been compiled prior to the first panel meeting, Individual Management Reviews (IMRs) and summary reports were commissioned from:

- Nottingham CityCare Partnership – Summary report
- Derbyshire, Lincolnshire, Nottinghamshire and Rutland Community Rehabilitation Company – IMR
- Department of Work and Pensions – Summary report
- East Midlands Ambulance Service – Summary report

- Nottingham and Nottinghamshire Clinical Commissioning Group – Summary report
- Nottingham Healthcare NHS Foundation Trust – IMR
- Nottingham University Hospital – Summary report
- Nottinghamshire Police – IMR
- Trent PTS – Summary report

1.3.9 All report authors were independent and had no direct involvement with Julie.

1.3.10 The panel met on three further occasions, and the review was completed in August 2023. The review was not completed within six months because of the extraordinary pressures on agencies due to COVID-19. Julie's mother did not feel able to engage with the review initially; however, after the conclusion of the inquest, she accepted support from AAFDA[1], and time was then spent allowing her to contribute to the review.

1.4 Confidentiality

1.4.1 The content and findings of this review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the anonymity of the deceased, and her family and friends, the subject of the review will be known as Julie.

1.4.3 This pseudonym was chosen by the Report Author.

1.5 Terms of Reference

1.5.1 The Domestic Homicide Review set out to explore the following areas:

- 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 and/or offender's needs.
- Consider the efficacy of report authors' agencies' involvement in the multi-agency risk assessment conferencing (MARAC) process.
- Consider the efficacy of report authors' agencies' involvement in a multi-agency / multidisciplinary team meetings regarding domestic abuse.
- Consider the efficacy of report authors' agencies' involvement in a multi-agency / multidisciplinary team meetings regarding the victim's mental health.
- Establish whether relevant single agency or inter-agency responses to concerns about the victim and the assessment of risk to her and others, were considered and appropriate.

[1] Advocacy After Fatal Domestic Abuse

- 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.
- To what extent were the views of the victim and offender (and where relevant, significant others), appropriately considered to inform agency responses.
- Identify any areas where the working practices of agency involvement had a significant positive or negative impact on practice or the outcome.
- 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, in Nottingham City, where domestic violence is a feature.
- 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, her family, 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.

1.5.2 The full Terms of Reference can be found at Appendix One.

1.6 Engagement with Julie's Family

1.6.1 **Julie's partner**

1.6.2 It is normal practice for Nottingham Community Safety Partnership to write to the family – to explain that a review is to be undertaken – when the Home Office is advised. In this case, due to human oversight, this did not happen. As this was a human error, no recommendation is made in relation to this.

1.6.3 In January 2021, shortly after being appointed, the Chair and Overview Report Author wrote to Julie's partner advising him of the review and inviting him to engage with the review. He was provided with the Home Office leaflet and information about support available through AAFDA (Advocacy After Fatal Domestic Abuse).

1.6.4 In July 2021, the Chair and Overview Report Author once again wrote to Julie's partner, as no contact had been made with the review.

1.6.5 Officers from Children's Social Care tried, without success, to contact Julie's partner to discuss the review with him.

1.6.6 The review respects his decision not to contribute to the review.

1.6.7 **Julie's mother**

1.6.8 The same oversight set out above at 1.6.2, relates equally to Julie's mother.

1.6.9 The Chair and Overview Report Author wrote to Julie's mother in January 2021, informing her about the review. She was provided with the Home Office leaflet and information about support available through AAFDA (Advocacy After Fatal Domestic Abuse).

1.6.10 Within a couple of days, she had telephoned the Overview Report Author, who was able to explain to her about the review. During the conversation, she agreed to being referred to AAFDA. This was done immediately, and AAFDA contacted her and waited on her signing the consent to work with them. AAFDA did not hear from her, and it was agreed that, later in the review, the Overview Report Author would contact her again and encourage her to engage with AAFDA.

1.6.11 Over the following weeks, there was intermittent contact between Julie's mother and AAFDA, but she did not sign the consent. It became clear that, not surprisingly, she had been very confused about the different processes and the different roles that people held. The Overview Report Author continued to write periodically to Julie's mother to keep her updated with the progress of the review – always encouraging her to engage with AAFDA.

1.6.12 In November 2021, Julie's mother telephoned the Overview Report Author and intimated that she wished to engage with the review. Consequently, AAFDA were asked to contact her again. In January 2022, Julie's mother signed the consent form to work with AAFDA, and her advocate and the Overview Report Author met on Teams to discuss the stage that the review had reached. A copy of the Terms of Reference draft was shared with her.

1.6.13 In May 2021, Julie's mother's advocate indicated that she did not feel the need to meet with the panel, as she was not intending to contest anything in the report. She did not feel able to meet with the Chair and Report Author but may write a tribute to Julie prior to publication.

1.6.14 It was agreed with her advocate that, on Julie's mother's behalf, she would review the overview report and feedback comments.

1.6.15 The Report Author, who was in correspondence with the advocate, made it clear that, at any point in the process, if Julie's mother felt that she wished to meet, the process would be paused to allow this to take place.

1.6.16 The Review Panel recognises the trauma that Julie's mother has experienced and respects her wishes.

1.7 Contributors to the Review

1.7.1 Those contributing to the review, do so under Section 2(4) of the statutory guidance for the conduct of DHRs, and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All panel meetings included specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review, and were referenced to the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation, either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- Nottingham CityCare Partnership – Panel member and summary report
- Derbyshire, Lincolnshire, Nottinghamshire and Rutland Community Rehabilitation Company – Panel member and IMR
- Department of Work and Pensions – Panel member and summary report
- East Midlands Ambulance Service – Panel member and summary report
- Juno Women's Aid – Panel member providing independent domestic abuse specialist advice
- National Probation Service – Panel member
- Nottingham and Nottinghamshire Clinical Commissioning Group – Panel member and summary report
- Nottingham Community Safety Partnership – Panel member
- Nottingham City Council (Children's Services) – Panel member
- Nottingham City Homes – Panel member
- Nottingham Healthcare NHS Foundation Trust – Panel member and IMR
- Nottingham University Hospital – Panel member and summary report
- Nottinghamshire Police – Panel member and summary report.

1.7.5 The review is grateful to Sarah Kessling, from Harmless CIC[2], for her input into this review: in helping the panel to explore Julie's thought processes.

1.8 Review Panel

1.8.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Independent Report Author	
Karen Turton	Domestic and Sexual Violence and Abuse Specialist	Nottingham CityCare Partnership
Kerry Jackson	Advance Customer Support Senior Leader	Department of Work and Pensions
Lucy Gascoigne	Head of Safeguarding	East Midlands Ambulance Service
Adrian Morgan	Review Officer	East Midlands Special Operations Unit (EMSOU) Regional Review Unit
Sarah Kessling	Strategic and Resilience Lead	Harmless
Yasmin Rehman	Chief Executive Officer	Juno Women's Aid
Nick Judge	Associate Designated Nurse Adult Safeguarding	Nottingham and Nottinghamshire Integrated Care Board
John Matravers	Strategic Lead for Safeguarding Partnerships	Nottingham City Council – Children's Services
Heather Fry	Safer Neighbourhood Housing Manager	Nottingham City Homes
Paula Bishop	Domestic Violence and Abuse Policy Lead	Nottingham Community Safety Partnership

[2] https://harmless.org.uk/

Rebecca Graham	Operations Manager	Nottingham Recovery Network
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospitals
Helen Voce	Chief Executive Officer	Nottingham Women's Centre
Julie McGarry (replaced by Julie Gardner)	Associate Director for Safeguarding	Nottinghamshire Healthcare Foundation Trust
Clare Dean (replaced by Mark Dickson)	Chief Inspector	Nottinghamshire Police
Lisa Adkins-Young	Deputy Head	Probation Service

1.8.2 All the panel members were independent of any direct involvement with Julie.

1.9 Domestic Homicide Review Chair and Overview Report Author

1.9.1 Gary Goose took the role of Independent Chair for this review. He is a former police officer who served with Cambridgeshire Constabulary, rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary led the police response to the families of the Soham murder victims. From 2011, Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility, as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner, developing a performance framework.

1.9.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years, managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing Level 2 and 3 meetings, as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.9.3 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country, in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries, such as those undertaken by the IOPC, NHS England, and Adult Care Reviews.

1.9.4 Neither Gary Goose nor Christine Graham is associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[3]

1.9.5 Full details of the ongoing professional development of the Chair and Report Author are included in Appendix Two.

1.10 Parallel Reviews

1.10.1 HM Coroner heard a virtual inquest on 28th April 2021 that was attended by the Chair of the Review.

1.10.2 The Coroner came to a finding that Julie's death was as a result of 'drugs and alcohol'. She had a mixture of drugs in her system: of which, the quantities of two could have been fatal in themselves. This, coupled with high levels of alcohol, was the cause of her death.

1.10.3 The Coroner did not find that there was sufficient evidence to conclude that Julie had intended to take her own life.

1.10.4 There were no other reviews undertaken.

1.11 Equality and Diversity

1.11.1 Throughout this review process, the panel has considered the issues of equality. In particular, the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.11.2 Julie and her partner were both White British. There has been nothing throughout the review to suggest that either party was treated by any agency without due regard for any protected characteristics.

1.11.3 Women's Aid state: '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[4]

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016
[4] (Women's Aid Domestic abuse is a gendered crime, n.d.)

1.11.4 **Multiple and complex needs**

1.11.5 Harris and Hodges carried out a study in Nottingham that examined the 'Response to Complexity'[5]. In their work, they explain that intersectionality is a term used to express the interdependent nature of women's multiple and intersecting experiences. They point out that the intersecting experiences of women's lives can create very different contexts in which they experience seeking help and support. They quote Thiara, who points out that a failure to understand the intersecting nature of women's experiences can limit women's access to helping services[6].

1.11.6 It has been acknowledged for several years that the experience of domestic or sexual violence can lead to mental health problems and substance misuse. In turn, people struggling with mental health problems and substance misuse are more vulnerable to further violence[7].

1.12 Dissemination

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

- Julie's mother
- Nottinghamshire Police and Crime Commissioner
- Domestic Abuse Commissioner
- The Chief Officer of all organisations engaged in the review

[5] Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964

[6] Thiara, R, Hague, G, Mullender, A, 2012, Losing out on both counts: Disabled women and domestic violence, Disability and Society 26, 6, 757–771. cited in Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964

[7] Complicated Matters: A toolkit addressing domestic and sexual violence, substance misuse and mental ill-health, AVA, 2013

Section Two – The Facts

2.1 Introduction

2.1.1 For clarity, this section contains 'facts' as they were known and recorded at the time and is gathered from a variety of sources. It does not contain analysis or other subjective comment: it is purely a chronology of what was known at the time.

2.1.2 As stated within the introduction to this case, Julie was 42 years old when she died. The review has sought to understand Julie and life from her perspective. This has been difficult because there has been no engagement from family and friends. We do not place any criticism around that lack of engagement, and we fully respect their decision to cope with Julie's death in the way best suited to them. As a result, our knowledge of Julie 'as a person', has been drawn from professionals' records.

2.1.3 This review is aware of some of the issues that Julie faced in her life, and it is clear that she suffered considerable adverse childhood experiences. Whilst the details of those experiences are known to this review, they are not repeated within this report: this is in order to protect her memory and those of her family. This review will consider whether organisations viewed Julie's life through the lens of a person affected by trauma.

2.1.4 As an adult, Julie had been with her partner for 25 years, and they had five children together: two of whom had been adopted, and two who were living with other carers under a Special Guardianship Order. The reason for the Order was recorded as parental substance misuse, chaotic lifestyle, and criminal activity. Julie and her partner had both been Class A drug users (heroin and crack cocaine) and both were reported to be on a methadone programme. Julie and her partner's youngest child was living with the couple.

2.1.5 Domestic abuse appears to have been a regular feature of their lives together. Historically, reports were made by both against each other: there were 10 incidents of domestic abuse, concerning the couple, reported to Nottinghamshire Police between 2012 and 2017. These concerned allegations of assaults and verbal arguments between the pair, with both recorded as victims and perpetrators. Both parties declined to pursue prosecutions and although arrests were made at various times, none of the incidents resulted in court appearances.

2.1.6 Julie disclosed to services that she had been using illicit substances (specifically heroin and crack cocaine) intravenously for approximately 17 years, which she said that she had funded by prostitution. She said that she had stopped using illicit substances in 2009 when she was initially prescribed methadone followed by Subutex. Before her death, she said that she had been drug-free for 10 years, and that she had been free of all substitute medication for two years.

2.1.7 She had been diagnosed, at the age of 17, with a personality disorder, elements of bipolar, schizophrenia, and depression and anxiety. She had been diagnosed in 2009 with post-traumatic stress disorder. She was, at the time of her death, being prescribed two forms of anti-psychotic medication to manage this, which she said helped with her anger management issues. Julie also suffered with carpal tunnel syndrome, making it difficult for her to grip with either hand. She had surgery that had been unsuccessful.

2.1.8 During a conversation with a professional, Julie identified herself as a highly strung individual, easily agitated, and was conscious that she had to keep this in to avoid conflict. She did not present as someone with deficits in her thinking but rather someone who, at times, struggled to manage their behaviour.

2.1.9 In a pre-sentence review for a criminal offence that she committed (January 2020 sentence), Julie referred to her own child as being her purpose for life and recognised that the child would be affected if she received a custodial sentence. We know from what Julie said to agencies towards the end of her life, that her children were important to her, and she feared that her youngest child would be taken into care in the way that her older four had been.

2.2 Chronology – outside the scope of the review

2.2.1 **2018**

2.2.2 During 2018, Julie and her partner became involved in a criminal investigation in relation to threats made to another woman known to Julie. As a result of the interactions, Julie was arrested for witness intimidation, and her partner was convicted of carrying a knife in public. Julie's case continued through 2019, and in December, she was convicted. She was subsequently sentenced to six months' imprisonment (see later for details).

2.2.3 Later in the year, Julie was referred to the MOSAIC[8] service, as she was experiencing pain in both her hands and had a previous history of carpal tunnel syndrome. At her appointment, Julie said that she was feeling stressed and had some unintentional weight loss. She said that she was seeing her GP later in the week to explore these issues. It was agreed that a referral would be made to the Nerve Conduct Clinic (NCC).

2.2.4 **2019**

2.2.5 Julie was involved with specialist drugs services (Nottingham Recovery Network – NRN) and by April 2019, had completed a medically assisted detoxification from opiates: this was after a prolonged period of stability on opioid substitute therapy (OST). She was kept open to her keyworker in the recovery case management team for a period of support, post detoxification.

2.2.6 After the appointment with the nerve clinic (2.2.3), she was told that the nerve problems she had reported previously did not match with carpel tunnel syndrome.

2.2.7 In May, NRN offered her access to the group programme provided by the psycho-social team, and a written copy of the group programme was given to her. By the end of May, she said that she did not want to access group work and was 'feeling better and more confident than she had in a long time'.

2.2.8 On 19th May, Julie attended the Urgent Treatment Centre (UTC) where she reported that she had been bitten by a dog.

2.2.9 In June, she was seen at NRN by her keyworker and consultant addiction psychiatrist. It was noted that she continued with low level cannabis smoking, along with what was described

[8] This is a service focussing on the assessment and management of musculoskeletal/non-musculoskeletal problems. The MOSAIC service brings together the expertise of professionals from different health backgrounds.

as non-dependant alcohol consumption: she was given 'harm minimisation' advice about both. The consultant notes stated that Julie was 'happy for discharge from service to occur in light of sustained abstinence from opioids'. Mental health advice would be given to her GP, and the risks regarding her mental health were noted as being low on that day. Julie was made aware of how to access support in the future, should she require this. Her planned discharge took place.

2.2.10 Julie did not attend her appointment with the NCC, and she was discharged in August.

2.3 Chronology – the last year of Julie's life (August 2019 onwards)

2.3.1 The information within this section includes details known to agencies during the last year of Julie's life. Where there are documented discussions that contain evidence of Julie's state of mind or the issues that she faced, they are included within the text in order to assist the reader's knowledge of her as a person.

2.3.2 Throughout this period, she was receiving regular prescriptions from her GP for two types of drugs that are used to help treat a range of mental health depressive illnesses. Each instance of repeat prescription has not been recorded within this section.

2.3.3 In August and September 2019, Julie was in contact with her GP about what she described as 'low mood', and she continued her prescriptions.

2.3.4 In October, Julie attended the hospital emergency department. She said that she had been having a psychosis and had assaulted someone in the street. She said that she repeatedly punched them but that they had retaliated and had assaulted her, resulting in bruising and pain to her right wrist. Julie was asked if her injuries were the result of domestic abuse; however, she denied this and denied any risk of domestic abuse. She was asked about domestic abuse twice and denied this on both occasions. ***This is an example of good practice.*** Julie said that she was being supported by the GP for her mental health issues and was waiting for an appointment. She said that her psychotic episodes were happening more frequently and that she was scared that she may do something that she regretted. Julie said that she lived with her partner and their child. Due to concerns about Julie's mental health, a social care referral was made.

2.3.5 Julie was referred by the ED to The Department of Psychological Medicine (DPM). A core assessment was completed, during which, Julie disclosed that she had anger outbursts and was afraid that she might hurt someone, although much of her anger was directed towards herself. She said that she had been with her partner for 25 years and that this was a stable and supportive relationship. The couple lived in a council flat, and Julie said that they did not get on with a lot of their neighbours. She disclosed the involvement of CSC with her children. It was reported that the child that remained in her care, was a protective factor. Julie said that she had feelings associated with stress when thinking about her child being taken into care, and she thought that these feelings stemmed from the distress that she felt around her other children. Whilst Julie said that she had issues with anger, she stated very strongly that they were not aimed at her child. Julie indicated a volatile relationship with her mother and disclosed issues relating to her early life. Whilst Julie had an extensive history of drug misuse, she had been abstinent for 10 years. Julie reported using cannabis daily and binge drinking five nights a week if it was a bad week. She said that she used

alcohol as a coping strategy and did not see it as a current problem. She felt that the medication she had been prescribed was not helping. Julie said that she had attempted counselling but had trouble in talking about past traumatic events.

2.3.6 A mental state examination (MSE) was carried out as part of the assessment process, and she was noted to be a 'well-kept woman' with obvious bruises to her wrists that she said were self-inflicted. She expressed some anxiety about thoughts that others might be looking at her in the street. There was no evidence of psychosis. She presented with some insight into struggles in the past relating to past trauma but had limited knowledge about the impact of this on her current anger.

2.3.7 As part of the risk assessment undertaken, there were no risks identified to herself and no domestic abuse identified. Following the assessment, a care plan was completed. The clinical formulation was that Julie was currently experiencing high levels of distress, manifesting itself in anger and outbursts that could sometimes lead to her punching the walls. It was acknowledged that she had experienced trauma in her life and was finding these past experiences hard to manage. Julie often became angry when talking about these experiences but was reluctant to engage in talking therapies to aid this. Julie, at the time of the assessment, was using alcohol to cope but did not see this as a problem. The clinician concluded that she would benefit from input from services to help manage this and that she would benefit from talking therapies when she felt ready to access them.

2.3.8 The care plan included discharge from DPM and for Julie to self-refer to the Wellbeing Hub for assessment and ongoing support with her alcohol use. A discharge letter was sent to her GP, in which it was mentioned that she had said that she was in a stable and supportive relationship.

2.3.9 In November, Julie self-referred to Trent PTS (Psychological Therapies Service[9]). An appointment for an assessment was booked for her.

2.3.10 Julie saw her GP on 22nd November, when she spoke about getting stressed about the impending court case and said that she had thoughts of self-harm. She told the GP that she was going to IAPT soon.

2.3.11 On 5th December, at Nottingham Crown Court, Julie was found guilty of witness intimidation (for the 2018 offence, see 2.2.2 previous). Sentencing was adjourned until 11th January 2020.

2.3.12 Julie attended her assessment at Trent PTS in December and was taken into treatment. In this assessment, it was noted that Julie spoke of 'low mood, crazy thoughts', 'lifelong problems and finding things very difficult currently'. Her goals were to overcome her past and be a better person. It was noted that it was intended to focus on 'attachment, self-esteem and real-self work'. During the assessment, Julie disclosed issues in her childhood. The assessment noted that she had difficulty in relationships after being abandoned and running away at times. Julie disclosed that, whilst running away, she was kidnapped, held hostage, and sexually abused by multiple men, being subdued with heroin.. The assessment noted her subsequent involvement in drug use and prostitution, which led to her children being removed by social services.

[9] Part of the IAPT service – Improving Access to Psychological Trent PTS is a talking therapy service within primary care mental health and specialises in depression and anxieties.

2.3.13 **2020**

2.3.14 On 3rd January, Julie was given a prescription and advised her GP that she was to be sentenced later in January.

2.3.15 Julie's ESA claim was terminated on 9th January.

2.3.16 On 10th January, Julie appeared in court for her sentencing. She was sentenced to 6 months' imprisonment and was subject to a Restraining Order (not to contact the witnesses).

2.3.17 Three days after sentence, Trent PTS were contacted by HMP Foston Hall, enquiring about Julie. After the necessary consent to share her information was approved (on 15th January), the notes were provided. The GP report was sent, and the case was closed. Julie's GP was advised that her care at Trent PTS had been transferred to the prison service.

2.3.18 Julie had been flagged on the CRC system as a perpetrator of domestic abuse for a while. In March, this was deregistered by the OM.

2.3.19 On 9th April, Julie was released from custody and was subject to standard licence conditions and went to live with her partner. She was subject to Post-Sentence Supervision until 9th April 2021. The Offender Manager (OM) visited her at home shortly following her release. The OM could not enter the house due to COVID-19 restrictions, and she was then supervised by telephone.

2.3.20 Julie informed her OM that there had been an argument between her and her partner on 15th April, and she had left the address to go to a friend's house. The OM made a referral to CSC and referred Julie to Nottingham Women's Centre for the Healthy Relationships programme. **This is an example of good practice.** Julie was also referred to the community support worker for additional support, and the OM ensured that she had the details for Clean Slate in case she wished to discuss any alcohol issues. Julie told the OM that she had not yet claimed her benefits, as she did not have an email account. The OM advised her about getting an account. The OM checked with the police and confirmed that there had been no calls to Julie's home address or her friend's address. The OM rang her the next day to see how she was, and Julie informed them that she had not returned to her partner. The OM again asked if she needed support with alcohol; Julie said that she did not.

2.3.21 On 24th April, Julie called the police to report that she had been assaulted by her partner at their home address. Julie said that her partner had punched her in the right eye, hit her with a broom handle, and tried to strangle her on the floor. She was observed to have a slight bruise to her eyelid and reddening in the area. Her partner was present and was arrested. Julie provided a witness statement and details for a DASH form and Domestic Abuse Public Protection Notification (DAPPN), and she said that she was willing to support a prosecution. She said, in her statement, that whilst she was in prison, her partner had said that he did not wish her to return home on her release, and he had been abusive to her since her release. She said that she was frightened of being a victim of further violence, was being isolated from her friends, and had suicidal thoughts.

2.3.22 Her partner was interviewed and denied the offence: he said that he had been a victim of an assault by Julie. He showed officers a bruise on his arm that he said had been caused by Julie.

2.3.23 There was no independent evidence to support Julie's complaint, and it was referred to the Crown Prosecution Service, who decided that no further action would be taken. Julie was updated on the phone, and a follow-up letter was sent offering further assistance if requested. Although Julie provided details for the DASH and DAPPN, she declined the information to be shared with partner agencies. She said that this was because she had lost access to four of her children, and she thought it would impact on her child if CSC became aware. A safeguarding referral was made to CSC regarding her child (in line with policy), albeit that she had not been present at the time of the incident. This was recorded as medium risk domestic abuse.

2.3.24 On 27th April, the OM was advised by the MASH that Julie's partner had assaulted her. The OM contacted Julie the next day to bring forward a planned contact. Julie told the OM that her partner was not living at the house and that she did not want him back. She said that she had made a statement, but she did not want to press charges. The OM sought the advice of the DLNR's housing and welfare worker and was told that it was not possible for them to assist Julie with her rent arrears. The OM promised Julie that she would chase up the peer support for her, and Julie confirmed that she was OK for food and money.

2.3.25 Julie made a claim for Universal Credit for her and her child, from 29th April. In May, Nottingham City Homes set up an Alternative Payment Arrangement in respect of Julie's UC, to ensure that her rent was paid, and she maintained her tenancy. Direct payments were also arranged from her UC to cover her rent arrears.

2.3.26 On 4th May, the OM completed the OASys (offender assessment). This highlighted that Julie was a risk of harm to the public, specifically those in conflict with her or her partner and child, due to previous substance misuse and witnessing domestic abuse. At their meeting with Julie on this day, the OM was told by Julie that CSC had made contact but that they had no concerns. Julie confirmed that her partner was still living elsewhere and that she did not want contact with him.

2.3.27 On 8th May, Julie contacted DWP to advise that she had split from her partner, that the relationship had ended because of violence, that he was not allowed into her house, and that she had a crime number. The work coach responded the next day, thanking her for informing them and advising that she could get in touch at any time if she needed further support.

2.3.28 On 28th May, Julie informed DWP that her partner had moved back into the home.

2.3.29 During June and July, Julie was having input from Nottingham Women's Centre on the Healthy Relationships programme and was having monthly contact with her OM. Her life, at this time, seemed stable.

2.3.30 As part of her UC benefit, Julie was required to have regular scheduled phone calls with her work coach to discuss her steps into work and the barriers that she may need to be supported to overcome. These monthly telephone calls began on 17th June. As part of this discussion, it was agreed that due to Julie's mental health, she was not ready to move back into work yet.

2.3.31 On 30th June, Julie finished her Healthy Relationships sessions with Nottingham Women's Centre. At this last session, Julie said that she was feeling better about many aspects of her life, particularly her accommodation situation.

2.3.32 On 29th July, Julie's partner contacted the police to complain that he had been assaulted by her at their home address. He said that Julie had thrown an ornament at him, causing a cut to his chin. He also had scratch marks on his face. Both had been drinking. Julie was arrested; however, her partner declined to make a statement, allow officers to photograph his injuries, or share information with partner agencies.

2.3.33 Whilst Julie was in police custody, a referral was made to the Liaison and Diversion Team because there were concerns that Julie was struggling with her mental health. A clinician from the team attended the police station and saw Julie.

2.3.34 There was no independent evidence to corroborate the assault by Julie, and she was released without charge. A DAPPN was completed and a PPN safeguarding referral was made in relation to the child who was present at the time of the incident. This was recorded as medium risk domestic abuse.

2.3.35 On 8th August, Julie contacted the police and reported that her partner had been verbally abusive and violent towards her for the past two weeks, and she now wanted him removed from the home address, as he was not on the tenancy agreement. She said that she had been assaulted by him on either 30th or 31st July, and that he had been abusive towards her since that date. He had kicked her legs, and she showed the officers bruising that was still visible on her upper leg. Their child was not present at the time of the visit by officers but was at a friend's address. Julie's partner was arrested on suspicion of assault and taken to the custody suite.

2.3.36 Julie provided a witness statement and provided photographs of her injuries. She provided details for the DASH risk assessment, with consent to share information with partner agencies, which would include Juno Women's Aid and local authority, as appropriate. She said that she would support a prosecution. Julie explained to officers that they had been on holiday to Ingoldmells with their child and had returned home earlier that day. The abuse had continued throughout the holiday. She said that she was looking to end the relationship and wanted her partner to leave the home address, as he was not included on the tenancy agreement. She said that she felt depressed and had suicidal thoughts. She disclosed that her partner had a drink problem, had stopped her seeing her friends, and was using their child to cause her emotional distress.

2.3.37 Julie's partner was interviewed on 9th August, when he produced a prepared statement via his legal representative. He denied assaulting Julie and said that the injuries had been caused when he was restraining her, following the assault on himself (on 28th July). There was no independent evidence to support the allegation of assault by Julie, and a decision was taken by the police not to pursue a prosecution. The incident resulted in a medium risk assessment. A child safeguarding referral was made in respect of the child, and a PPN was submitted to the Domestic Abuse Support Unit for referrals to partner agencies, in line with force policy.

2.3.38 Following the decision not to pursue a prosecution, a Domestic Violence Prevention Notice (DVPN) was authorised by a Superintendent and served on Julie's partner on 9th August. The conditions imposed were that he must leave the home address, not go within 100 metres of the address, and not contact or harass Julie. The DVPN was authorised for 48 hours, pending an application to the Magistrates Court for a Domestic Violence Prevention Order (DVPO).

2.3.39 On 11th August, Nottingham Magistrates Court imposed a DVPO with similar restrictions. This was to remain in force until 7th September 2020.

2.3.40 On 11th August, Julie's OM spoke with her, and Julie told her that there had been domestic abuse incidents against her on 24th and 25th July and 8th August. Julie told her that her partner had been given a DVPO and was no longer living at the home address, and that she did not want him back. The OM discussed with Julie, the list of things that she needed to do, such as contact her GP, contact DWP about her Universal Credit, book a COVID-19 test (as she had not been feeling well), and contact Trent PTS. The OM also contacted CSC for an update on the assessment. On 12th August, the OM contacted the police about the incident on 9th August.

2.3.41 Julie saw her OM on 18th August and said that CSC had been in touch. During the appointment, Julie said that she was feeling down, and the OM suggested a referral to Nottingham Women's Centre for support. The following day, the OM confirmed this with CSC and was advised that Julie was being assessed for Child In Need support.

2.3.42 A pre-Notice letter was sent to Julie by Nottingham City Homes on 21st August, advising her that the level of her rent arrears was, at that time, £1478.28.

2.3.43 On 27th August, Julie self-referred to Trent PTS and disclosed issues of 'mental health, loss and trying to deal with my past'. She indicated yes to couple's therapy.

2.3.44 The following day, the police received a call from a third party who was acting on behalf of Julie's partner. They expressed concern for the welfare of Julie, who had been drinking heavily earlier in the day. Julie's partner had been staying at the address, despite the conditions of the DVPO, and had been unable to locate Julie. Their child was staying at the home of a friend. The control room attempted to call Julie's phone, but there was no reply. There was no voicemail facility. A further attempt was not answered, and therefore a text message was sent to Julie's mobile: the number having been provided by the third-party caller.

2.3.45 The ambulance service received the incident from the police and were advised that a known alcoholic had threatened to end their life at around 4 pm that day. At 9 pm, a note was added to the CAD that it was unknown where the patient was, and that the caller had been to the property but the patient did not answer. The caller believed that the patient was inside, but she had not been heard. The caller said that if the dog was not barking, then Julie was not there. This information resulted in the call being recorded as CAT 5: this resulted in the ambulance that was en route, being stood down to attend a higher priority call.

2.3.46 Further attempts were made by the police and the ambulance service's mental health worker to try and contact Julie during the evening: all of which were unsuccessful. As a result, the ambulance service, fire service, and the police reattended at just after 11 pm. After gaining entry, they found Julie (already deceased) in the downstairs lounge. On scene, the ambulance crew documented that there was evidence of other drugs, possibly morphine, ingested along with alcohol. A safeguarding referral was raised by EMAS, as children's toys were seen in the property

Section Three – Overview and Analysis of Agency Involvement

3.1 This section looks specifically at the interactions between Julie and each agency who had contact with her during the scope of the review. It is accepted that there may be some duplication from the previous section; however, this allows the reader to examine each agency without referring back to the previous section.

3.2 **NOTTINGHAM CITYCARE PARTNERSHIP**

3.2.1 Nottingham CityCare Partnership is a community social enterprise that is commissioned to deliver a range of community health services that are shaped by the needs of the communities it serves.

3.2.2 Julie and her child accessed the following services:

- Children's Public Health 0-19 Nursing Service (CPHN) – This service is responsible for delivering the Healthy Child Programme. This is a universal programme of screening, health/development reviews and advice around health and wellbeing. Health programmes and interventions are delivered to improve health outcomes for children and young people and their parents/carers
- MOSAIC Service – This is a service focussing on the assessment and management of musculoskeletal/non-musculoskeletal problems. The MOSAIC service brings together the expertise of professionals from different health backgrounds.
- Urgent Treatment Centre (UTC) – This service provides access to assessment and treatment for anyone who needs support with a health problem that is urgent, but not life-threatening. This is a walk-in service, open 365 days a year: no appointment is needed. The centre offers assessment and treatment for health conditions such as animal bites.
- Domestic Abuse Referral Team (DART) – There are two members of Nottingham CityCare Partnership staff based in the DART. Their role is to share relevant health information to support screening and assessments undertaken by family support workers or social workers. When the assessment has been completed, Nottingham CityCare Partnership staff share the outcome and the Domestic Abuse Stalking Harassment and Honour Based Violence Risk Indicator Checklist (DASH RIC), or Domestic Abuse Public Protection Notice (DAPPN), with the Children's Public Health 0-19 Nursing Service. Staff also send an email to the GP practice of the victim, with the DASH RIC or DAPPN attached.

3.2.3 **Community Public Health Nursing 0-19 Service (CPNH 0-19)**

3.2.4 Julie's daughter was referred to the CPHN 0-19 service on 7th September 2012, after concerns about historic and current safeguarding concerns. She remained open to the service throughout the scope of this review.

3.2.5 On 20th June 2019, the CPHN 0-19 service ended their care of Julie. It is customary practice by this service to open a record for the child's mother antenatally. Mothers are then usually discharged from the service when the child's two-year developmental review is completed. In some circumstances, for example, when there are safeguarding concerns, the mother's record could remain open for a longer period of time.

3.2.6 **MOSAIC Service**

3.2.7 On 30th August 2018, Julie was referred into the Mosaic service, as she reported she was experiencing pain in both hands and had a previous history of carpal tunnel syndrome. Her health history was reviewed, and this included recognition that Julie was a previous drug user and was not taking her prescribed Subutex. It was also noted that she had a history of anxiety and depression.

3.2.8 After investigations, Julie was advised that her tests were normal and that the symptoms did not fully fit with carpal tunnel syndrome. She was offered another appointment. This was then cancelled by the service, and she was asked to make another appointment. When Julie did not make another appointment, she was discharged from the service on 8th August 2020.

3.2.9 **Urgent Care Centre**

3.2.10 On 19th May, Julie attended the Urgent Treatment Centre (UTC) where she reported that she had been bitten on the back of her head by a dog two hours previously, and she said that she had seen some hairs in the dog's mouth after the incident. There was no evidence of a wound on her head, but a scratch approximately three inches long was seen on her shoulder. This was described by the clinician as very minor. The wound was cleaned, and Julie was given medical advice about what she should do if her condition deteriorated. She was then discharged.

When Julie attended the UTC, the staff were not able to view the information in Safeguarding Information Node (SIN) that would have revealed any history of domestic abuse that the staff could then have responded to.

The SIN provides a chronological summary of all safeguarding concerns, albeit that it relies on individual practitioners entering the relevant information. SIN is part of SystmOne and therefore is visible to users of SystmOne (with appropriate safeguarding access rights).

Had the practitioner been able to see the domestic abuse history, then they could have asked more questions in relation to the dog bite.

Recommendation One

It is recommended that Nottingham CityCare Partnership explores with the Integrated Care Board (ICB) and GP practice, the most appropriate way to ensure that safeguarding information is easily visible to other services.

3.3 **DEPARTMENT OF WORK OF PENSIONS (DWP)**

3.3.1 **Impact of COVID-19**

3.3.2 Due to the COVID-19 restrictions to protect customers and staff alike, face-to-face appointments were not being booked into Jobcentres. DWP implemented temporary measures to ensure customers' claims were accepted and put into payment remotely, without seeing or speaking to the customer. This was the process applied to Julie's claim.

3.3.3 However, Universal Credit provides a journal functionality that customers and supporting staff can use to interact digitally – sending each other messages, etc. Julie used this facility during her new claim process on 8th May. She advised DWP that she had split from her partner, that the relationship had ended because of violence, that he was not allowed into her house, and that she had a crime number. The work coach responded the next day, thanking her for informing them and advising that she could get in touch at any time if she needed further support.

The review notes that DWP guidance supports this response: staff can signpost customers to various organisations nationally and locally for relevant advice and support, if needed. Julie did not ask for any support, and her claim status, as a single person, supported her statement that she had now separated from her partner.

3.3.4 On 28th May, Julie informed DWP that her partner had returned to her home. Under Universal Credit policy, if a customer lives with their partner and both are eligible for Universal Credit, they are part of a 'benefit unit' and share a joint award of benefit. This means one payment is made into a nominated bank account for the couple. Therefore, from that point on, Julie and her partner became part of the same benefit unit for Universal Credit purposes. This also meant that both partners could see any journal messages posted by each other or by DWP.. It is noted that Julie's partner would not have been able to see any messages posted prior to the joining of the claim.

3.3.5 As part of the requirement of receiving Universal Credit, Julie had regular scheduled phone calls with her work coach – to discuss the steps that she needed to take to get into work and to support her in addressing any barriers. This began on 17th June and was set as monthly appointments. As part of this first phone call, Julie's mental health was discussed, and it was agreed that Julie was not ready to move back into work.

3.3.6 The work coach recalled that Julie did not ask for any support, nor share information about her relationship with her partner, during the monthly phone calls, which continued throughout July and August.

3.3.7 The DHR panel asked DWP to consider if Julie should have been referred to specialist support from the domestic abuse lead. The panel was advised that all work coaches receive training in domestic abuse so that they can identify concerns and offer support, including signposting to relevant agencies. They can seek advice from the domestic abuse lead at any time but would only handover the customer to the specialist lead if it were a complex case and needed intensive hands-on involvement to support someone in the process of fleeing.

3.3.8 Julie did not ask DWP for a support relating to her relationship. The conversations with her did not flag up any safeguarding concerns about her safety. When she had indicated a problem with the relationship at the beginning of her claim, she was responded to within a day, and she did not seek any further support.

There are no specific recommendations for this organisation.

3.4 NOTTINGHAM AND NOTTINGHAMSHIRE CLINICAL COMMISSIONING GROUP (on behalf of Julie's GP)

3.4.1 The GP provided primary care services to Julie, and she attended in relation to mental health issues and insomnia. The GP record indicates that Julie was flagged as harmful substance

misuse, alcohol misuse, victim of domestic abuse, and personality disorder. She was a long-standing patient and had regular contact with the GP surgery for management of her prescription medication and her mental illness.

3.4.2 There is a coded/flagged episode in relation to domestic abuse, but no disclosures of domestic abuse were made to the GP surgery within the scoping period.

There is no evidence that the GP proactively asked Julie about how things were at home or more specifically about domestic abuse.

3.4.3 The GP practice has two monthly adult safeguarding meetings where concerns about identified patients are discussed; however, as Julie was not identified at this time as a victim of domestic abuse, she was not discussed at these meetings.

3.4.4 The practice manager confirmed that the practice has a robust system for reviewing and filing MARAC minutes.

There are no specific recommendations for this organisation. The Report Author did consider making a recommendation in relation to routine enquiry; however, as there is work ongoing as a result of other DHRs in Nottinghamshire, this was not felt necessary.

3.5 **NOTTINGHAM CITY HOMES**

3.5.1 Julie rented her home from Nottingham City Homes. Following her release from prison in April 2020, the rents team worked with Julie's Female Specialist Community Support Worker at Probation, to put in place a plan for Julie to pay her rent and clear her accumulated rent arrears.

3.5.2 In May 2020, Nottingham City Homes set up an Alternative Payment Arrangement in respect of Julie's UC – to ensure that her rent was paid, and she maintained her tenancy. Direct payments were also arranged from her UC to cover her rent arrears.

3.5.3 **Impact of COVID-19**

3.5.4 Between April 2020 and August 2020, all enforcement action was suspended by NCH because of the COVID-19 pandemic. The suspension of evictions continued until the end of May 2021, although other enforcement action, such as serving legal notices, was permitted from August 2020.

3.5.5 In August 2020, NCH started to send letters to tenants advising them of the level of their rent arrears. A pre-Notice letter was sent to Julie on 21st August, advising her that the level of her rent arrears was, at that time, £1478.28.

3.5.6 Due to the COVID-19 pandemic, home visits were not being made in relation to rent arrears. Without these restrictions, several home visits would have been made to Julie following her release from prison – in partnership with the Female Specialist Community Support Worker.

There are no specific recommendations for this organisation.

3.6 **NOTTINGHAMSHIRE HEALTHCARE FOUNDATION TRUST (NHCFT)**

3.6.1 Nottinghamshire Healthcare Foundation Trust (NHCFT) provides integrated healthcare services, including mental health, intellectual disability, and physical health services.

3.6.2 NHCFT had extensive involvement with Julie, dating back to 2012. She was seen both in clinic and at home. There is evidence on the records that NHCFT was aware of Julie's early life experiences, which included being kidnapped and raped at the age of 17. She was also known to have a history of heroin addiction. NHCFT was also aware of the domestic abuse that Julie had experienced, with prolonged abuse and many physical assaults that went unreported. The records indicate that Julie's partner had also claimed that she had assaulted him, including with a knife.

3.6.3 **14th October 2019**

3.6.4 Julie attended the emergency department with badly bruised wrists that she said had occurred as a result of her punching the wall, which she disclosed was as a result of her mental state. Julie was referred to the Department of Psychological Medicine (DPM). This is a 24-hour liaison psychiatry service covering the Nottingham University Hospitals. It provides assessment, consultation, and management advice in respect to patients aged 18 – 65 who present with mental health needs and associated risks. This includes patients who present with suicidal thoughts or following self-harm or suicidal acts. DPM also has the capacity to offer short-term outpatient follow-up – to work holistically with patients to provide ongoing assessment, treatment (if indicated), psychological support, and signposting to other services, if required.

3.6.5 A referral is made via an electronic means. Once a referral is passed from ED to DPM, there is a 1-hour response time in place to provide assessment.

3.6.6 Julie was seen by two clinicians, as is standard practice when a patient presents with aggression/anger outbursts. During the assessment, Julie engaged and had the opportunity to express her thoughts, feelings, and behaviours. She shared details of her past trauma and experiences. The assessment did not pick up any indicators of *abuse from others*. However, the assessment did pick up indicators around risk of *abuse to others*.

> The risk assessment did pick up indicators of abuse towards others – mainly that Julie was aggressive towards others, and she used the term that she may 'do something stupid' in the future. These feelings of aggression were not aimed at any individual.
>
> Evidence of further enquiry around this statement and the context in which it was made, may have been beneficial to elicit more understanding of risk and the associated implications.

3.6.7 During the assessment, Julie disclosed that some of her children had been taken into care but said that she would not harm the child that remained in her care. Julie also disclosed that she would 'binge drink' five times a week.

Her word appears to have been taken at face value, with no checks made on behalf of the child. There was no evidence that safeguarding concerns, regarding Julie's drinking pattern and its impact on her child, were considered.

Clinical staff in the DPM team have an awareness that when a patient attends ED and safeguarding concerns arise, the staff in the ED will routinely complete a referral to Children's Social Care, so it is possible that they assumed that this had been done.

However, they did not know that this had been done.

The review is advised that members of the Trust's Safeguarding Team have met with the clinical leads from the Department of Psychological Medicine, and the Liaison and Diversion Team have been assured that the Think Family Strategy has been disseminated throughout the service.

Julie disclosed a history of trauma and relationships in her home; however, if clinicians had been more professionally curious about this, a deeper understanding may have been gained into the impacts of these events on Julie and how this may have contributed to risk factors.

3.6.8 Upon discharge, a copy of the core assessment, the risk assessment, summary, and care plan are provided to the patient's GP within seven days. This was completed.

It is standard practice that the patient is involved in the discharge plan and are given a copy that they sign. There is no evidence on the records that a copy of a care plan was given to Julie.

3.6.9 **29th July 2020**

3.6.10 Having been arrested for common assault, Julie was referred to the Liaison and Diversion Team whilst in police custody.

3.6.11 This is a multi-disciplinary service that works with people from the age of 10 years upwards, who come into contact with criminal justice agencies. The service offers assessment, liaison, diversion, and when required, short-term follow-up. Operational hours are from 8 am – 8 pm.

3.6.12 The referral was received by the Liaison and Diversion Team at 10.42 pm: as this was outside the operating hours, this was actioned the following morning. Each morning, referrals are prioritised – with those in custody about to be released being seen first. This appears to have been the response in this case. However, the incorrect date of birth for Julie was provided on the referral; consequently, when the clinician undertook a search, they could not see that Julie had been engaged with the service previously.

The review is advised that members of the Trust's Safeguarding Team met in July 2021. The clinical lead circulated an email to staff in the Liaison and Diversion Team, reminding them to check correct patient identifiable information when meeting clients in custody, to ensure that they match with the health records.

Recommendation Two

It is recommended that NHCFT Safeguarding Team seeks assurance from senior colleagues in the Liaison and Diversion Service, that the referral mechanism is robust and allows for the appropriate assessment and care planning of patients in a timely manner.

3.6.13 Julie had a brief conversation with the clinician, as she was about to be released from custody. She said that she was struggling with her mental health and indicated that she would be interested in talking to someone but not at that time. She was given an opt-in letter to allow her to make contact at a later time, and the numbers for the mental health crisis team and NHS 111 were provided.

3.6.14 Julie's case was kept open for two weeks, but she did not opt in to the service.

3.6.15 When a triage assessment is undertaken and there are risks identified, as part of the discharge process, the patient's GP is notified. As Julie did not have a triage assessment, the GP was not notified that she had spoken to the Liaison and Diversion Service and that a service had been offered.

This resulted in the clinician not having an overview of Julie's past history, and the need to potentially safeguard Julie and others was not identified. A knowledge of this history may have led to an alternative response from the clinician.

Recommendation Three

It is recommended that NHCFT Safeguarding Team liaises with colleagues in the Information Assurance Team to gain further understanding around the duplication of electronic files and the risk that this poses. A method of mitigating the associated risks should be explored.

3.7 **NOTTINGHAMSHIRE POLICE**

3.7.1 **24th April 2020**

3.7.2 Julie called the police to report that she had been assaulted by her partner at their home address. Officers attended within 15 minutes, and Julie said that her partner had punched her in the right eye, hit her with a broom handle, and tried to strangle her on the floor. She was observed to have a slight bruise to her eyelid and reddening in the area. Her partner was present and was arrested. Julie provided a witness statement and details for a DASH form and Domestic Abuse Public Protection Notification (DAPPN) and said that she was willing to support a prosecution. She said, in her statement, that whilst she was in prison, her partner had said that he did not wish her to return home on her release and he had been abusive to her since her release. She said that she was frightened of being a victim of further violence, was being isolated from her friends, and had suicidal thoughts.

The review notes that although Julie had previously contacted the police to report assaults by her partner, this was the first time she had gone on to provide a witness statement and support a

prosecution. The review notes that there appeared to be a change in her attitude following her release from prison, and she was no longer accepting of domestic abuse. This will be discussed later in the report.

3.7.3 Her partner was interviewed and denied the offence: he said that he had been a victim of an assault by Julie. He showed officers a bruise on his arm that he said had been caused by Julie.

> There is no record that on this occasion, or any of the other occasions included in this review, that any effort was made to speak to Julie's child. Although she was relatively young, best practice would have been to speak to the child alone and consider any immediate welfare or safeguarding needs, under the 'voice of the child' guidelines.

The review has been advised that, since this incident, positive steps have been taken to remind officers of the 'voice of the child' principles when attending domestic abuse incidents. An online briefing tool and video have been produced, and the DAPPN now includes a prompt for officers to consider the 'voice of the child'.

3.7.4 There was no independent evidence to support Julie's complaint; therefore, it was referred to the Crown Prosecution Service, who decided that no further action would be taken. Julie was updated on the phone, and a follow-up letter was sent, offering further assistance if requested. Although Julie provided details for the DASH and DAPPN, she declined the information being shared with partner agencies. She said that this was because she had lost access to four of her children, and she thought it would impact on her child if CSC became aware. A safeguarding referral was made to CSC regarding her child (in line with policy), albeit that she had not been present at the time of the incident. This was recorded as medium risk domestic abuse.

On behalf of the review, the IMR author has revisited the letter that was sent to Julie. It was sent by the PCSO and explains their role in revisiting those who are subject to domestic incidents. Their direct mobile contact number was given. Whilst the letter infers that there is further support available, it does not specifically provide numbers for partner agencies.

The review considered making a recommendation about this aspect; however, it is heartened by the work being done within Nottinghamshire Police to address this issue: as set out below.

Since the review, Nottinghamshire Police have had small Z-cards produced for all officers and PCSOs to carry, giving details of support available to victims of domestic abuse. The cards contain a single freephone number that puts the victim directly in touch with Juno Women's Aid. From this single call, the victim is then signposted to additional support agencies to meet their specific needs. This service does not appear on a victim's phone bill, is free from all UK mobile phones and landlines, and has a free translation service to increase accessibility.

Further work is currently ongoing to produce a mobile phone application for all officers' phones that will provide a directory of support (in the hands of all officers) to support victims of DA. It is expected that this application will be available in 2023.

The review has seen a copy of the DASH risk assessment. In this assessment, Julie states that her partner had tried to strangle her in the past. The additional risk that previous strangulation poses

is well researched. 68% of women who are at high risk of domestic abuse, will experience near-fatal strangulation[10]. In some studies, non-fatal strangulation has been shown to increase the risk of homicide sevenfold[11].

Following the introduction of non-fatal strangulation legislation, this review notes the additional information from the police regarding training and awareness.

Information was disseminated widely across Nottinghamshire Police, by way of additional guidance, and was provided to all officers and staff when the new legalisation was implemented. This included guidance that officers should consider as victims of domestic abuse those who have suffered non-fatal strangulation as high risk for DA unless other factors reduce this risk. Other factors could include, how long ago the incident occurred, how the strangulation occurred, and other immediate safeguarding considerations (such as offender is well away from victim, victim has moved to location the offender is not aware of). Since the new legislation was launched, there has been an increase in victims being identified as suffering this form of attack and graded as high risk. There has also been considerable work carried out to increase arrests of high-risk DA offenders. Nottinghamshire Police have a robust system in place to manage any DA where strangulation is a factor, including consideration of high-risk DASH-PPN, early arrest of suspect, referral to CPS for charge whilst in custody, and where charge/bail conditions are not likely, the use of DPVN/DPVOs.

Recommendation Four
It is recommended that consideration is given to ensuring that DASH risk assessments in which strangulation is a factor, are rated as high: regardless of the other answers given.

3.7.5 **8th August 2020**

3.7.6 Julie reported to the police that her partner had been verbally abusive and violent towards her, and she wanted him removed from the home address, as he was not on the tenancy agreement. Her partner was arrested on suspicious of assault and taken to the custody suite.

3.7.7 Julie provided a witness statement and provided photographs of her injuries. She provided details for the DASH risk assessment, with consent to share information with partner agencies, including Women's Aid and local authority, as appropriate. She said that she would support a prosecution. Julie explained to officers that they had been on holiday to Ingoldmells with their child and had returned home earlier that day. The abuse had continued throughout the holiday. She said that she was looking to end the relationship and wanted her partner to leave the home address, as he was not included on the tenancy agreement. She said that she felt depressed and had suicidal thoughts. She disclosed that her partner had a drink problem, had stopped her seeing her friends, and was using their child to cause her emotional distress.

3.7.8 Julie's partner denied assaulting Julie and said that the injuries had been caused when he was restraining her, following the assault on himself (on 28th July). There was no independent evidence to support the allegation of assault by Julie, and a decision was taken by the police not to pursue a prosecution. The incident resulted in a medium-risk assessment. A child safeguarding referral was made in respect of the child, and a PPN was

[10] Taliaferro, E., Hawley, D., McClane, G.E. & Strack, G, 2009, Strangulation in Intimate Partner Violence. *Intimate Partner Violence: A Health-Based Perspective.* Oxford University Press, Inc., 217-235. Cited in Strangulation in Intimate Partner Violence, V6.24.19, Training Institute of Strangulation Prevention

[11] Campbell et al., 2007, cited by Monckton Smith et al, Domestic Abuse, Homicide and Gender, Palgrave Macmillan, 2014

submitted to the Domestic Abuse Support Unit for referrals to partner agencies, in line with force policy.

3.7.9 Following the decision not to pursue a prosecution, a Domestic Violence Prevention Notice (DVPN) was authorised by a Superintendent and served on Julie's partner on 9th August. The conditions imposed were that he must leave the home address, not go within 100 metres of the address, and not contact or harass Julie. The DVPN was authorised for 48 hours, pending an application to the Magistrates Court for a Domestic Violence Prevention Order (DVPO).

3.7.10 On 11th August, Nottingham Magistrates Court imposed a DVPO, with similar restrictions. This was to remain in force until 7th September 2020.

This was evidence of positive action being taken in response to the report made by Julie.

3.7.11 The Officer in the Case (OIC) tried to update Julie (via her mobile phone) when the DVPN had been served. There was no answer, so the officer sent an update to her email address. There is no record of the officer receiving a reply from Julie.

> Best practice would have been for an officer or a member of support staff to visit Julie to ensure that she was updated and to consider any safeguarding issues.
>
> There is no record that other agencies were notified about the DVPN.

3.7.12 Following her death, Julie's partner made a statement to the police. In this statement, he said that he had returned to the address on 9th August to collect his belongings. He said that he stayed with Julie – with her permission – until the date of her death, as he was concerned about her alcohol abuse and the welfare of their child. He also said that in the weeks leading up to her death, Julie had been drinking heavily and was taking pregabalin. She had been prescribed this whilst in prison, but he did not know where she was getting it from on release.

> Julie's partner was, by staying with her, in breach of the DVPN/DVPO. This was not reported to the police as a breach. Presumably, as there is no evidence to suggest that Julie knew about them, she did not know it was a breach to be reported.

On 18th August 2020, Nottinghamshire Police introduced a Domestic Violence and Stalking Proactive Intervention Policy to monitor the conditions imposed by DVPOs: this was applied to all DVPOs issued after that date. This new policy is managed by a Civil Order Safeguarding Officer and extends to monitoring compliance with such orders. Had the DVPO against Julie's partner been made a few days later, it would have been monitored by this new policy.

3.7.13 **Monitoring civil orders**

3.7.14 As stated earlier, compliance with civil orders is the responsibility of the Civil Order Safeguarding Officer. Once a successful application has been made for a DVPO, a NICHE entry is produced that creates automatic tasks:

- The Force's PNC Bureau updates the perpetrator's nominal record with details of the DVPO so that officers attending reports of any breaches are aware of the relevant dates and conditions
- A task is created for the Safer Neighbourhood Team covering the address of the victim, to make personal visits as deemed necessary, to provide safeguarding advice, and to ensure that the perpetrator has not returned, or otherwise breached the conditions of the DVPO
- Relevant partner agencies (such as Juno Women's Aid or Equation) are advised about the DVPO.

3.8 NOTTINGHAM RECOVERY NETWORK (NRN)

3.8.1 NRN provides substance misuse services in Nottingham. Julie had been a client of the service since June 2009. Her compliance with, and responsiveness to, treatment varied over time; however, by 2016, there was a high level of concordance with opioid substitute therapy (OST) and engagement with one-to-one keyworker sessions.

3.8.2 Julie had been historically prescribed methadone. This reduced well, and she was transferred onto buprenorphine to facilitate the end stage of a medically assisted detoxification. Low level cannabis use was noted throughout. Julie did not identify this as an area that she required any specific intervention with, although she was working towards eventual abstinence. There were some periods of potentially problematic alcohol consumption; however, these were appropriately addressed and were interspersed with significant periods of alcohol abstinence.

3.8.3 A relatively stable social situation, with several positive developments/changes, was noted in the latter years of treatment, including a long-term and secure tenancy, her ability to effectively budget, and to manage her home environment and her child care responsibilities to a good standard.

3.8.4 There was some reference to 'arguments' with her partner, although Julie identified the relationship as supportive overall. Julie had some difficulties with her mental health, notably low mood, anxiety, and difficulty with emotional regulation at times of distress. To this end, she was seen periodically by one of the NRN consultant addiction psychiatrists who liaised with Julie's GP about prescribing for her mental health. She was offered access to the group programme, provided by the psycho-social team within NRN, and given a written copy of the group programme during a keywork session on 3rd May 2019.

3.8.5 During her next appointment, on 30th May 2019, Julie said that she did not wish to access group work and was 'feeling better and more confident than she has done for a long time'. A further appointment, jointly with the keyworker and Julie's consultant addiction psychiatrist, was agreed prior to planned discharge.

3.8.6 On 10th June 2019, Julie was seen jointly by her keyworker and consultant addiction psychiatrist. It was noted that she continued low level cannabis smoking, along with non-dependant alcohol consumption: she was given harm minimisation advise about both. The consultant notes state: 'Happy for discharge from service to occur in light of sustained abstinence from opioids. Mental health advice will be given to GP by myself via OPL (further details of consultation to follow in this) - risks re MH low today. Julie aware how to access support in the future should she require this'.

3.8.7 Planned discharge took place following this review, with no further contact with Julie for the 14 months prior to her death.

3.8.8 **Summary of practice**

3.8.9 Julie's face-to-face appointments with her keyworker were typically delivered through home visits. She had 36 appointments between 2016 – 2019.

3.8.10 Ongoing risk assessments noted an awareness of historic domestic abuse and identified the need for continued monitoring, and these were reflected in each keyworker review.

3.8.11 There is evidence of close multi-disciplinary working during the period when Julie's child was open to social care.

3.8.12 Regular medical reviews took place with one of NRN's addiction consultant psychiatrists, with whom Julie had formed a good therapeutic relationship. There was regular liaison between NRN and Julie's GP in managing her treatment and prescribing.

3.8.13 There were minimal changes in personnel, with Julie having the same keyworker for several years. This allowed for an authentic, honest, and trusting professional relationship and a consistent approach when working with her. Most keywork sessions were in the form of home visits, which allowed for a clearer understanding of her day-to-day life to be formulated and appropriate interventions to be delivered.

There are no specific recommendations for this organisation.

3.9 **NOTTINGHAM UNIVERSITY HOSPITAL NHS TRUST (NUH)**

3.9.1 **Involvement outside the scope of the review**

3.9.2 Julie had been known to NUH from 2006, and this early involvement was mostly in relation to her pregnancies. Staff that supported Julie during her pregnancies were aware of her issues with alcohol and substance misuse. The midwifery teams were also aware that there had been domestic abuse between Julie and her partner. During routine enquiry about domestic abuse in her most recent pregnancy, Julie gave a positive response that there had been previous domestic abuse, but there was no disclosure during the pregnancy.

3.9.3 **October 2019**

3.9.4 When Julie attended ED on 14th October 2019, she said that she had been having a psychosis and had assaulted somebody in the street. She said that she had repeatedly punched them, but that they had retaliated and had assaulted her: this resulted in bruising and pain to her right wrist. Julie was asked if her injuries were because of domestic abuse, and she denied this and denied any risk of domestic abuse. Julie was asked twice about domestic abuse; she denied this being a risk on both occasions. ***This is an example of good practice.***

3.9.5 Julie told staff that she was being supported by the GP for her mental health issues and was waiting for an appointment at the Trent PTS. She said that her psychotic episodes were happening more frequently, and she was scared that she would do something that she regretted. Julie was seen by the Department of Psychological Medicine (DPM), and they deemed her medically fit for discharge.

As DPM is provided by Nottinghamshire Healthcare Foundation Trust, records of this interaction were held on their records and not available to ED staff. It is possible that there was information held in their assessment that would have assisted ED staff on this occasion, or at future attendances, to assess risk factors more accurately.

The issue of documentation and effective information sharing between the two systems was raised at the Mental Health Steering group on 21st February 2022. It was agreed that there would be a standardised area for mental health information to be written that is used by both the mental health teams and NUH staff. The system used is called Nervecentre and is currently used for all patients in ED or admitted to the Trust. The IT teams are looking at adapting this to also add an area for MH documentation, to improve information sharing and allow effective handover from mental health teams. This is in development but is not yet live.

3.9.6 Julie was asked about who lived with her and if she had any children; she advised that she lived with her child and partner. She stated that her daughter had previously been open to children's social care but that the case was now closed. Due to concerns about her mental health, a Children's Social Care referral was made. ***This is an example of good practice.***

3.9.7 There is evidence of good practice in response to the information that Julie disclosed in safeguarding the child and clinical questioning relating to domestic abuse.

There is evidence of good practice in ED in relation to clinical questioning when Julie attended with injuries. When Julie attended, ED staff consistently considered that Julie may not be telling the truth about how her injuries occurred and asked appropriate questions[12]. Trust guidance in relation to domestic abuse, supports professional challenge when there is a concern regarding mechanism of injury.

3.10 **NOTTINGHAM WOMEN'S CENTRE (NWC)**

3.10.1 In May 2020, Julie was referred to the Healthy Relationships Group by her Offender Manager at the CRC.

3.10.2 The referral provided little information other than that it was said that she was 'medium risk of harm', with no indication of harm to herself or others.

The review notes that NWC has identified the need to seek fuller information from referrers and have already begun to implement this. The referral form with Probation is being reviewed, and NWC will insist on a fully completed referral before beginning work with women.

The review is advised that this work is now under a new Ministry of Justice contract, and referral is now made through an electronic system. Despite this change, there are still significant issues with poor referrals, and NWC and Probation are meeting on a monthly basis to improve this situation.

[12] There were a number of occasions when this has been seen, albeit most are outside the scope of the review and therefore have not been described in detail in this report.

3.10.3 **Healthy Relationships Group**

3.10.4 This is a short course – delivered weekly over five sessions – looking at healthy relationships, what is and isn't healthy, and how to build supportive relationships in the future. Information is provided about specialist agencies who can provide support around domestic abuse.

3.10.5 In normal times, Julie would have been in a group of between three and 10 women who would go to the centre for a two-hour session – once a week for five weeks. The learning materials would have been delivered by the caseworker, who would facilitate discussion between the women.

3.10.6 Julie's initial assessment was over the phone, and the caseworker was able to build a picture of Julie's current situation. They identified ways in which NWC could assist Julie – with rent arrears and counselling. Julie did speak to the Welfare Benefits worker at NWC but advised them that Probation had resolved the issue with her rent arrears.

3.10.7 There were six phone calls, once a week, when the caseworker listened to Julie and offered guidance where appropriate. On one occasion, Julie mentioned an argument with her partner. The caseworker explored if Julie felt safe with him at home, and she said that she did.

3.10.8 On her last session, Julie was told about groups and activities available at NWC, should she wish to access them in the future. In this final session, Julie said that she was feeling better about many aspects of her life, particularly her accommodation situation.

3.10.9 **The impact of COVID-19 lockdown**

3.10.10 The centre was closed due to lockdown, so the sessions were delivered individually over the telephone. This meant that Julie did not have the benefit of peer learning and support.

3.10.11 The caseworker only spoke to Julie on the phone and never met Julie face to face. Consequently, the opportunity to spot any changes in her behaviour, from week to week, was lost. It was difficult to build up a rapport with the women over the phone and so the sessions were quite light touch.

3.10.12 However, the benefit of offering the sessions individually was that the caseworker was able to spend more time with each woman and focus the session on their needs. Julie would have been asked how she was feeling, and would have had the time to talk each week: she would not have had this time in a group setting.

3.10.13 Working over the phone with clients who are in abusive relationships is particularly challenging, especially for clients who have not had any face-to-face contact prior to lockdown. It is difficult for the caseworker to be sure if the abusive partner is present and if the client can speak freely.

The review notes the good practice adopted to arrange with the client, the time that it is most appropriate to call and to agree safety words and signals, and the review acknowledges that this is difficult if the initial assessment is carried out over the phone.

That said, because of engagement with this review, NWC has learned that Julie was experiencing domestic abuse at the time of their engagement and cannot be certain that her partner was not present during the calls and may have prevented her from speaking more freely.

3.11 **PROBATION SERVICE (previously COMMUNITY REHABILITATION COMPANY)**

3.11.1 On 9th April 2020, Julie was released from custody and was subject to standard licence conditions and went to live with her partner. The Offender Manager (OM) visited her at home shortly following her release. The OM could not enter the house due to COVID-19 restrictions, and she was then supervised by telephone.

3.11.2 On 4th May, the OM completed the OASys (offender assessment). It highlighted that Julie was a risk of harm to the public, specifically those in conflict with her or her partner and child, due to previous substance misuse and witnessing domestic abuse.

The OASYS that was completed was Level 1, which although contained a full risk assessment section, did not include details relating to wider issues such as health, relationships, employment, etc. Given Julie's history of domestic abuse, child protection, and mental health, a more comprehensive Layer 3 assessment should have been completed.

The review has been advised that it is now policy that all new OASys assessments must now be completed at Layer 3; therefore, no recommendation is made.

3.11.3 At this meeting the OM was told by Julie that CSC had made contact but that they had no concerns.

There is no record that the OM confirmed this with CSC or contacted them to ensure that some form of assessment of the situation was being undertaken.

3.11.4 The risk management plan intended to address the risk issues, included the following objectives:

- Monitoring and enforcement of licence conditions
- Signposting to agencies / interventions, if required
- Information exchange between all agencies involved
- Frequent contact with the police for domestic abuse call outs / incidents form completed.

3.11.5 The sentence plan objectives for Julie were:

- To improve her problem-solving skills
- To improve her self-esteem
- Emotional support
- To assess and reduce Julie's risk of reoffending and harm.

3.11.6 The OM spoke to their line manager on 28th April, as they were concerned that when they had contacted CSC to speak to the nominated worker, they were told that CSC did not have the referral made on 15th April.

3.11.7 In August, after the incidents of domestic abuse against Julie, the OM undertook all the expected activity – contacting the police for an update, contacting CSC, and offering / arranging additional support for Julie. The OM also ensured that the contact with Julie was the frequency that was needed to meet her needs. ***These were all expectations of good practice and in line with policy.***

3.11.8 **Time in custody**

3.11.9 Whilst she was in custody, Julie received input from her prison offender supervisors, who carried out appropriate needs assessments. Whilst she was in prison, Julie's experience of domestic abuse, sex working, and mental health were explored. The initial screening highlighted that Julie had been a victim of domestic and sexual abuse and that she had not had support for this previously. Julie was keen to engage with services available to her on release.

3.11.10 **Supervision on the community**

3.11.11 For a time, Julie had been flagged on the CRC system as a perpetrator of domestic abuse, but the OM deregistered this in March 2020. Following the alleged assault of her partner by Julie (July 2020), it does not appear that the OM considered if this alert should be reinstated.

> If the judgement by the OM was that the alert should not be reinstated, this decision-making should have been recorded, and consideration should have been given to updating the OASys risk assessment and sentence plan.

The review agrees with the IMR author that the complex and sensitive issue of victims of domestic abuse also potentially being perpetrators of violence, and how to manage this within probation supervision, is challenging. This difficult dynamic is aided by the 'Counter Allegation' policy (discussed later in this report) and procedure developed in response to another DHR. This will be explored later in the report.

3.11.12 **Impact of COVID-19**

3.11.13 The COVID-19 restrictions resulted in Julie being managed by telephone rather than face to face. However, as has been demonstrated, the supervision and support provided to Julie was of the required and expected quality; therefore, there is no evidence to suggest that this change of working practices impacted on her management.

Section Four – Domestic Abuse Within the Relationship

4.1 **EVIDENCE OF DOMESTIC ABUSE**

4.1.1 The Domestic Homicide Review is required to explore the trail of domestic abuse that Julie experienced. Set out below is the history of abuse that was known to agencies and how they responded. The information available to the review gives a view of physical abuse and verbal abuse. It is highly likely that other forms of abuse occurred but were not specifically mentioned to agencies.

4.1.2 It is believed that Julie and her partner had been in a relationship for approximately 25 years. Julie and her partner had five children, the youngest of whom was living with them. The police hold a long history of domestic abuse in the relationship. The review notes that on some occasions, Julie was recorded as the victim, and on others, she was recorded as the perpetrator. This will be explored further within the report.

4.1.3 **Historical information outside the scope of the review**

4.1.4 The first record of abuse available to the review, is when Julie attended hospital in 1997 and 1999, following assaults. On one occasion, she said that this had been caused by her partner, but no name was given.

4.1.5 During Julie's pregnancy in 2012, a routine enquiry about domestic abuse led to Julie disclosing historic domestic abuse; however, there was no disclosure or evidence of current abuse. ***Routine questioning is an example of good practice.***

4.1.6 Between 2012 and 2017, there were 10 incidents of domestic abuse reported to the police. These were allegations of assaults and verbal arguments between the couple, with both recorded as victim and perpetrator. On each occasion, both parties declined to pursue prosecutions and although arrests were made at various times, none of the incidents resulted in court appearances.

4.1.7 In April 2014, Julie attended the Ear, Nose and Throat Emergency Clinic at Nottingham University Hospital, having been referred by her GP. She disclosed that she had been punched in the face the week before, and she required reduction of a nasal fracture under local anaesthetic: she was discharged home on the same day. There is no evidence that she was asked about the punch and if it was domestic abuse.

> The Trust policy (in place at the time) stated that questions relating to the mechanism of injury should be made, and if domestic abuse is disclosed, a domestic abuse stalking and harassment risk assessment checklist (DASH-RIC) should be completed. There is no evidence that any questions were asked about her injury, or any risk assessment completed.

Since 2014, additional learning has been put in place within the ENT department, following an action from a previous DHR. All medical staff were included in, and underwent, additional training around professional curiosity, domestic violence and abuse, and completion of the DASH-RIC. Domestic abuse is included in Trust induction training for all patient-facing staff, and in the last 2 years, there

has been additional training around domestic abuse and violence in the yearly safeguarding mandatory training.

4.1.8 Between January 2014 and June 2014, the health visitor was alerted by the Domestic Abuse Referral Team (DART) to three domestic abuse incidents: Julie was listed as the survivor, and her partner as the perpetrator, in each of the incidents. The health visitor made several attempts to see Julie to discuss the domestic abuse incidents during this time. Julie and the child were seen on 30th April 2014. At this contact, Julie reported that her 17-year relationship with her partner had ended and that she was feeling low about this, although she reported that she knew it was the right thing to do. Julie stated that she was being supported by friends, her drug worker, and her Framework worker.

4.1.9 On 15th October 2015, an Initial Child Protection Conference was convened. This followed a further domestic abuse incident that occurred on 24th September. On this occasion, Julie was alleged to have assaulted her partner. Julie and her partner were reported to have separated; however, they were still living together in the same house. Their child was once again made subject to a Child Protection Plan; on this occasion, under the category of emotional harm.

4.1.10 The Child Protection Plan closed on 10th June 2016, and the child became a Child in Need (CIN). The CIN plan ended on 14th September 2016. During the period when the Child Protection Plan and Child in Need plans were open, there were no further reported domestic abuse incidents. The health visitor was part of the core group and continued to have contact with the family. No concerns were identified in relation to the child's health or development, and their basic needs were being adequately met.

4.1.11 On 17th October 2017, Julie contacted the police to report that she had been assaulted by her partner. She said that he had pushed an iron (unplugged, not hot) against her neck, albeit no injuries were caused. When the police arrived, he had left the scene, and Julie advised officers that she did not wish to make a statement or pursue a complaint. The following month, Julie's partner was spoken to by the police on the phone, by which time he had returned to the address. He said that Julie had been the aggressor, and he had left the address to let her cool down. Julie maintained that she did not wish to pursue a complaint. A decision was made not to pursue the complaint. It was recorded as standard risk domestic abuse.

4.1.12 **Within the scope of the review**

4.1.13 On 24th April, the police were called to the home address. Julie said that her partner had punched her in the right eye, hit her with a broom handle, and tried to strangle her on the floor. The officers observed a slight bruise to her eyelid and reddening to the area. Her partner was arrested. On this occasion, Julie was prepared to provide a statement and details for a DASH risk assessment. For the first time, Julie said that she was willing to support a prosecution.

4.1.14 She said that whilst in prison, her partner had said that he did not want her to return to the family home on her release. Since her release, he had been abusive to her. She said that she was frightened of being a victim of further violence, was being isolated from her friends, and had suicidal thoughts.

4.1.15 When spoken to by the police, Julie's partner denied the offence. He said that Julie had assaulted him and had shown the police a bruise on his arm. When the case was referred to the Crown Prosecution Service, they decided that, as there was no independent evidence to support Julie's complaint, no further action would be taken. This was recorded as medium risk domestic abuse.

4.1.16 At the end of July 2020, the police were called because Julie's partner reported that she had assaulted him. He said that she had thrown an ornament at him, causing a cut to his chin. Julie was arrested, but her partner declined to make a statement, allow officers to photograph his injuries, or share information with partner agencies. Julie was released without charge, and this was recorded as a medium risk domestic incident.

4.1.17 On 8th August, Julie contacted the police and reported that her partner had been verbally abusive and violent towards her over the past two weeks, and she wanted him removed from the address. Julie showed the officers, bruises on her upper leg where, she said, he had kicked her legs on 30th or 31st July. He had been abusive to her since that date. Her partner was arrested. Julie provided a witness statement and photographs of her injuries. She provided details for DASH and consented to the information being shared with other agencies. She said that she would support a prosecution.

4.1.18 Julie said that the family had been away on holiday but that her partner had abused her throughout the holiday. She said that she now wanted to end the relationship and wanted him to leave the address, as he was not on the tenancy agreement. She disclosed that her partner had been preventing her from seeing her friends and was using their child to cause emotional distress.

4.1.19 Julie's partner made counter allegations, saying that he had been restraining her following the assault on himself (on 28th July). It was decided that, as there was no independent evidence, the case would not be pursued. The incident was assessed as medium risk.

4.1.20 The police issued Julie's partner with a Domestic Violence Prevention Notice (DVPN): the conditions imposed were that he must not go to Julie's address and not contact or harass her. On 11th August, Nottingham Magistrates Court imposed a Domestic Violence Prevention Order (DVPO) that remained in force until 7th September.

The review notes the effective use of the legislation to prevent Julie's partner from contacting her.

4.2 A CHANGE IN JULIE'S VIEWS OF THE DOMESTIC ABUSE

4.2.1 Even though there was a long history of domestic incidents between Julie and her partner of 25 years, Julie had always declined to support prosecutions of her partner.

4.2.2 Julie spent three months serving a prison sentence between 11th January and 9th April 2020. Julie was released from prison on 9th April 2020 and went to live with her partner at her family home.

4.2.3 Following her release, Julie's approach to the police changed, and she agreed, when they were called, to make a statement, assist with the DASH, and said that she was willing to support a prosecution. This was a major change from incidents prior to her prison sentence, when she always declined to make a statement or support a prosecution.

4.2.4 It appears that, following her release, there was a change in attitude by Julie. She appeared to be no longer accepting of the relationship that involved abuse. On 15th April, Julie informed her OM that, following an argument with her partner, she had left the home address to stay with a friend. It is not known exactly how long she stayed with her friend; however, on 4th May, Julie confirmed to her OM that her partner was living elsewhere and that she did not wish to have further contact with him.

4.2.5 The review knows that in January 2020, the disclosures that Julie made in her assessment with Trent PTS, were shared with HMP Foston Hall (with her consent), so that they had an understanding of her history.

4.2.6 Unfortunately, it is not possible to know what led to this change of heart. The review was very keen to explore this, with a view to identifying the learning for others, but despite extensive attempts at three prisons, it has not been possible to establish what interventions Julie was involved with in prison. We do know that due to COVID-19, there were no formal programmes being held.

Recommendation Five

It is recommended that Her Majesty's Prison and Probation Service (HMPPS) explores the feasibility of one single record for a prisoner that follows them from prison to prison and records all the course and interventions with which they have engaged.

4.3 SITUATIONAL DOMESTIC ABUSE

4.3.1 There were occasions when Julie's partner made allegations that she was abusive to him, and she was, on occasion, arrested. This review has sought to understand, from the information available, what part the counter allegations made by Julie's partner played. Put simply, the review has looked at the different types of domestic abuse to try and understand this relationship.

4.3.2 Johnson (2008)[13] sets out four types of domestic abuse:

- *Intimate Terrorism* – The individual is violent and controlling, the partner is not
- *Violent Resistance* – It is the partner who is violent and controlling. The individual is violent, but not controlling
- *Situational Couple Violence* – Although the individual is violent, neither partner is both violent and controlling
- *Mutual Violent Resistance* – Both individual and partner are violent and controlling.

4.3.3 Johnson made the point that intimate relationships inevitably involve some sort of conflict and, in some relationships, one or more of these arguments escalate into arguments that may then escalate to violence. This violence may be singular, or the violence may be a chronic problem, with one or both partners frequently resorting to violence. This violence is circumscribed and deployed to express resentment, to resolve a dispute, or to dissipate stress. These partners do not use violence to isolate or erode their partner's sense of personhood. Nor is this violence used as part of an ongoing campaign to intimidate or strictly regulate their partner[14].

[13] Johnson Michael P, A Typology of Domestic Violence, Northeastern University Press, 2008
[14] ibid. cited in Websdale, Familicidal Hearts, Oxford University Press, 2013

4.3.4 Websdale (2013)[15] notes that a growing number of researchers emphasise that male and female intimate partners can deploy similar levels of violence in their relationships. He too, drawing on Johnson's work, describes how much of this violence can be routine, sporadic, and not linked to broader campaigns of coercion, domination, and terror.

4.3.5 One of the most difficult challenges in this case is that it is highly possible that Julie only disclosed part of the abuse that she was experiencing. The reasons that might exist for this will be explored later in the report; however, there was a distinct change in her reporting when she had left prison in April 2020. She now began to speak of being isolated from her friends and her child being used to cause emotional distress. Therefore, it is highly probable that coercive control was a significant factor in this relationship but was not verbalised by Julie as such. This may be because she did not recognise it as abuse earlier in their relationship.

Whilst the review cannot be certain, it is highly probable that coercive control was a significant factor in this relationship but was not verbalised by Julie as such. This may be because she did not recognise it as abuse earlier in their relationship.

4.3.6 As we look at the incidents of abuse that were reported to the police, there is evidence of Julie's partner making counter allegations when she had called the police.

4.3.7 It is recognised that a perpetrator of domestic abuse may use counter allegations to further perpetrate their abuse. Nottingham Community Safety Partnership (NCSP) has acknowledged the importance of exploring all counter allegations and has recognised that it can be very difficult, if not sometimes impossible, to identify who is the perpetrator and who is the victim.

4.3.8 This is an area of learning that has been highlighted in previous Domestic Homicide Reviews. These DHRs identified the importance of professional curiosity and not taking the counter allegations at face value. In response to this learning, a *Domestic Violence and Abuse Counter Allegations Framework and Guidance*[16] has been produced. This provides guidance for practitioners to further examine and question events and circumstances.

The review recognises this as an example of good practice.

[15] Websdale, Familicidal Hearts, Oxford University Press, 2013

[16] https://equation.org.uk/product/counter-allegations-framework-final-26-march-2021/ and https://equation.org.uk/product/counter-allegations-considerations-final-march-2021/

Section Five – Understanding Julie's Vulnerability

5.1 It is important that this DHR explores the vulnerabilities that Julie experienced: as understanding these, helps us to understand her challenges.

5.2 The professionals who carried out her psychological assessment in October 2019, described Julie as maintaining good eye contact and good levels of conversation with, at times, humour. She displayed appropriate emotions and was tearful when discussing certain topics.

5.3 This assessment gives a good insight into her early life. Julie experienced significant trauma as a child[17], and research demonstrates that trauma is known to affect how survivors relate to others, particularly when the trauma was caused by another person rather than a natural disaster. Being violated by someone you should be able to trust can evoke a strong sense of betrayal, which is something that Julie verbalised in her assessment[18]. This may well have led to her mistrusting professionals and those that sought to support her.

5.4 Julie said that, at the age of 17, she had been diagnosed with a personality disorder, elements of bipolar, schizophrenia, and depression and anxiety. In 2009, she had been diagnosed with post-traumatic stress disorder.

5.5 The review recognises that Julie's adverse childhood experiences may have contributed to her mental health, particularly PTSD.

5.6 Julie said that she used drugs and alcohol to cope with her life and the challenges that she faced; therefore, in October 2019, she did not see that her use of drugs and alcohol was a problem. This should not be a surprise to us. Research shows that between 25 – 75% of people who have survived abusive or violent traumatic experiences, report problematic alcohol use, compared with 10 – 30% of people who experienced accident, illness, or disaster-related trauma[19].

5.7 In the assessment, Julie said that she had tried counselling in the past but found it difficult to talk about the traumatic events of her past. She presented with some insight into the struggles relating to past trauma but had limited knowledge about the impact that this had on her anger. She often became angry when talking about these experiences but was reluctant to engage with talking therapies to aid this. These angry outbursts were probably a result of the trauma that she had faced[20].

5.8 Julie presented as a woman who wanted to change her life. When she was assessed at Trent PTS in December 2019, she spoke of 'low mood' 'crazy thoughts' lifelong problems and finding things very difficult currently'. She wanted to overcome her past and become a better person.

[17] The review panel is aware of the trauma that Julie disclosed; however, for the sake of her family, it is not right that this is shared in detail within this report.
[18] Complicated Matters, AVA, 2018
[19] International Society for Traumatic Stress Studies (ISTSS) (2001). Traumatic Stress and Substance Use Problems. Northbrook: ISTSS cited in ibid.
[20] ibid.

5.9 **CHILDREN TAKEN INTO CARE**

5.10 As set out above, the trauma that Julie had experienced may have led her to mistrusting professionals. In her assessment, Julie disclosed that she was feeling stressed and that this was associated with her worry that her child would be taken into care. Julie had four older children who had all been taken into care, and the distress that this had caused her, and still did cause her, heightened this fear, and discouraged her from allowing information to be shared with those very agencies that could help her. When Julie did make the report to the police in April 2020, she did not give permission for the information to be shared with agencies because she was worried how, if CSC were aware, this would affect her child.

5.11 So many women refer to the distress of having their children taken into care and how this is something that never really leaves them. This review is not, in any way, criticising the work of CSC, whose duty is to safeguard children, but rather pointing the lens onto the impact that this has on the mothers.

5.12 Research by Lancaster University found that over 11,000 women had more than one child removed between 2007 and 2014. One in four women who has a child removed through the family courts, is likely to have another removed, and that number increases to one in three if they are a teenage mother. Four out of ten women who have had multiple children removed, have been in care themselves. A further 14% lived away from their parents, in private or informal arrangements, while many more have experienced disruptive or chaotic childhoods[21].

5.13 Where the state intervenes to remove children, birth mothers experience loss. However, this is magnified where this is repeated, yet there has been little research into understanding the experiences of these women. Broadbent's research found that, for birth mothers who have their children removed from their care, the interval between one set of care proceedings and the next may constitute a vital window for recovery. However, the timeframes were out of sync with what is known about realistic recovery from problems such as mental health or addiction – the problems that frequently characterise the lives of women whose children are removed (Sidebotham and Heron, 2006; Brandon et al., 2008; Bockting et al., 2015[22]). Broadhurst et al. noted that a sizeable percentage of women reappear in the family court, sometimes multiple times, because their problems are *repeated* not *resolved.*

5.14 When a child is taken into care, there is no statutory obligation for support to be offered to the mother. Furthermore, as has been suggested by some, once the child has been removed, the mother's need does not meet adult services' threshold for intervention and support (Ashley, 2015[23]). Interviews undertaken by Dr Karen Broadhurst, of Manchester University, with over 60 birth mothers in five local authority areas in a study for the Nuffield Foundation, found that 'mothers feel completely abandoned after their child has been removed. There would be more attention paid to your rehabilitation if you were a criminal'[24].

[21] https://www.pause.org.uk/why-pause/the-data/
[22] Cited in Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England, Broadhurst et al., 2015
[23] https://www.theguardian.com/society/2015/apr/25/are-we-failing-parents-whose-children-are-taken-into-care
[24] Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England, Broadhurst et al., 2015

Section Six – Suicide and Domestic Abuse

6.1 PREVALENCE

6.1.1 The Office for National Statistics estimates that 27 women per week die as a result of suicide. The rate of females who die by suicide has increased by 8.9% (from 4.5 to 4.9 deaths per 100,000 women) between 2016 and 2019[25]. Extrapolating from various statistics, Walby (2004) estimates that a third of female suicides are women who have experienced domestic abuse – between 4 and 10 per week[26]. Suicidality is more prevalent amongst women who are domestically abused than those women who are not abused[27].

6.1.2 Analysis undertaken by Kent and Medway Suicide Prevention Team of the 93 nationally published DHRs, found that 26% contained suicide of either the victim or the perpetrator.

6.1.3 The most recent report from the National Confidential Inquiry into Suicide and Safety in Mental Health[28], found that between 2015 and 2019, there were 532 patients who were known to have experienced domestic violence – 9% of all patients during this time, 104 deaths per year. The average number in 2016 – 17 was 101 per year but in 2018 – 19, this had increased to 149 per year. The majority (73%) were female – an average of 76 per year.

6.1.4 Women with a history of domestic violence were more likely to be younger than other women, and be single or divorced, living alone, and unemployed. The majority (81%) had a history of self-harm and previous alcohol (61%), and/or drug (47%) misuse was common. Nearly a third (29%) had been diagnosed with personality disorder.

6.1.5 More women with a history of domestic violence had experienced adverse life events in the previous 3 months (115, 50% v. 351, 32%) – the most common relating to family issues (21% v. 6%), serious financial problems (22% v. 11%), and loss of job, benefits, or housing (19% v. 12%).

6.2 CONSIDERATION OF LEARNING FROM JULIE'S EXPERIENCE

6.2.1 The review is grateful to Sarah Kessling, from Harmless CIC, for her input into this review. Much of this section is taken from the paper and presentation that she provided to the panel.

6.2.2 For a coroner to reach a conclusion of suicide, the *intent* to kill oneself needs to be proved to the relevant standard in law. There are often difficulties in determining the intent of a person who dies. In England and Wales, it has been customary to assume that most injuries and poisonings of undetermined intent, are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to take their life.

[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973935/fifth-suicide-prevention-strategy-progress-report.pdf

[26] The Cost of Domestic Violence, Walby S, 2004, London: Women and Equality Unit.

[27] Reviere, S., Farber, E., Tworney, H., Okun, A., Jackson, E. & Zanville, H. (2017) 'Intimate Partner Violence and Suicidality in Low-Income African American Women: A Multimethod Assessment of Coping Factors.' Violence Against Women 13: 1113-1129; Pico-Alfonso, M., Garcia-Linares, I., Celda-Navarro, N., Blasco-Ros, C, Echeburua, E. & Martinez, M.(2006) 'The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety and Suicide.' Journal of Women's Health 15(5): 599-611. Cited in Domestic abuse and suicide, Refuge and Warwick Law School, 2018.

[28] The National Confidential Inquiry into Suicide and Safety in Mental Health, Annual Report 2022: UK patient and general population data 2009-2019, and real-time surveillance data, University of Manchester, 2022

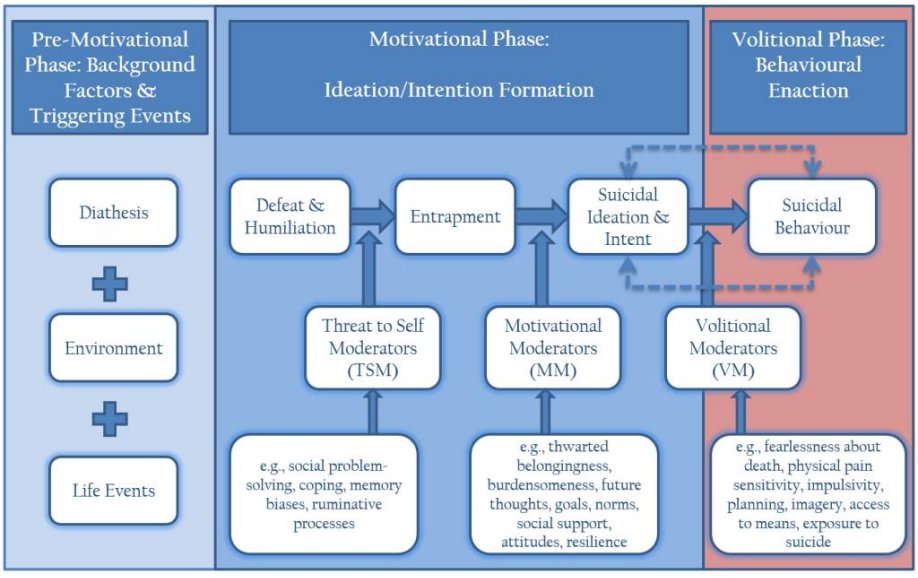
6.2.3 In 2018, the High Court determined that coroner's courts should move to the civil standard of proof (i.e., on the balance of probabilities) when returning a verdict of suicide. This change came into effect on 26th July 2018.

6.2.4 In this case, the coroner concluded that Julie's death was as a result of drugs and alcohol, and therefore the panel acknowledges that we cannot be certain that Julie intended to take her own life.

6.2.5 Given the circumstances, although Julie's death was not registered as suicide, there is benefit in reflecting on, and exploring, the factors that led to Julie's action, both of an intrapersonal and interpersonal nature, including suicidal intent.

6.2.6 Even with the new standard of proof, it can be challenging to ever fully know if a death was suicide or not. This can leave families with unanswered questions and little closure in understanding what took place that day. With that, it will bring a range of emotions to process from those affected by the loss of Julie (both family and professionals alike). This is an area of particular concern, given the vast body of evidence-based research that clearly shows that people bereaved, affected, or exposed to suicide, are at risk of suicide themselves.

6.2.7 Suicide is complex, and the journey of suicidal ideation to suicidal behaviours is not static but fluid and can be seen as being cyclical in nature. The Integrated Motivational-Volitional (IMV) model aims to synthesise, distil, and extend our knowledge and understanding of why people die by suicide, with a particular focus on the psychology of the suicidal mind.



6.2.8 This model can be an effective tool to help map a story of suicide and highlight specific points or factors, of which the review should take note. Sarah used this model to apply to the agencies' IMRs and summary reports provided to the review.

6.2.9 **Pre-motivational phase**

6.2.10 This first phase sets the context for suicidal ideation, and Julie experienced many vulnerability factors and stressors (some of which have been discussed in the previous

section), as well as environmental influences that should be noted when considering suicide risk:

- Relationship difficulties
- Substance misuse
- Domestic abuse (ongoing and historic)
- Self-harm (broader context alcohol)
- Criminal issues (including custodial time)
- History of suicide behaviour (attempted suicide nine years ago, when her child was removed)
- Severe mental health conditions (personality disorder, PTSD, bipolar, schizophrenia)
- Discussions of long-term physical health issues (chronic pain)
- Sexual abuse
- Adverse Childhood Experiences (ACEs)
- No employment and no qualifications.

6.2.11 **Motivational phase: Ideation/Intention formulation**

6.2.12 The centre column of the table highlights the key drivers: defeat, humiliation, and unbearable entrapment for the emergence of suicidal ideation. Whilst many of Julie's experiences will highlight these drivers, we focus on the incidents relating to the call to the police on 8th August 2020, the Domestic Violence Prevention Notice (DVPN) issued on 9th August, and the Domestic Violence Prevention Order (DVPO) issued on 11th August.

6.2.13 Positive action was taken by the police to protect Julie, and the review considers if more support and information sharing should have been in place to support Julie during this time.

6.2.14 By 8th August, it is clear that Julie wanted to end her relationship with her partner and remove him from her home. Julie expressed to the police that she was depressed and had suicidal thoughts. She disclosed that her partner had stopped her seeing her friends and was using their child to cause her emotional distress. This may already have been reinforcing emotions of defeat, humiliation, and most importantly entrapment.

6.2.15 As discussed earlier, previously Julie had not pursued or pressed charges; however, on this occasion, she engaged and consented to share information with Women's Aid and the local authority. She also provided details for a DASH risk assessment and said that she would support a prosecution.

6.2.16 Change, whether positive or negative, is change and brings with it, its own concerns and risks.

6.2.17 In her analysis, there are two pertinent questions:

- Were all necessary agencies informed of this so that they could support Julie thoroughly, especially with her mental health and wellbeing?
- Whilst the risk assessment remained at medium risk and therefore did not meet the threshold for a referral to MARAC, should cases, such as this, that have several services involved in providing support, involve a more consistent multi-agency approach?

6.2.18 Interestingly, this is a point raised by the author of the Probation Service IMR, who noted that there was no form of professionals' multi-agency meeting involving those working with Julie. Even though the threshold for MARAC was not met, there were many professionals involved with her (following her release), and it would have been possible to hold a meeting between those working with Julie – to discuss the issues and concerns regarding her and to ensure a full sharing of information and co-ordination.

The main gap that was highlighted was the lack of any co-ordinated multi-agency approach to supporting Julie. There is a danger that, if a case does not meet the threshold for MARAC, professionals do not feel empowered to call a meeting to discuss a case.

Dealing with the issue of information first. The local area has now added additional questions to the local DASH RIC, to supplement the suicide/depression area of questioning. Those questions are set out below:

- **Are you feeling depressed? Have you ever felt depressed and when?**
- **Have you ever had suicidal thoughts? If yes, when?**
- **Have you ever deliberately/intentionally self-harmed / significantly harmed yourself? If yes, when?**
- **Have you ever made a suicide attempt? If yes, when?**

The review believes that this will make a significant difference to the quality of information upon which decisions are made, and the additional questions put to a victim may encourage greater engagement on this aspect.

In relation to multi-agency meetings where initial thresholds do not appear to have been reached, we are aware of work going on in the area. This work encourages all professionals to take the step to, and be empowered to, call multi-agency discussions where concerns exist around a person who does not fall, necessarily, within a distinct area of high concern but about whom professionals have concerns.

New frameworks are being developed within a number of areas, and this review is being used to evidence the need for greater co-ordination.

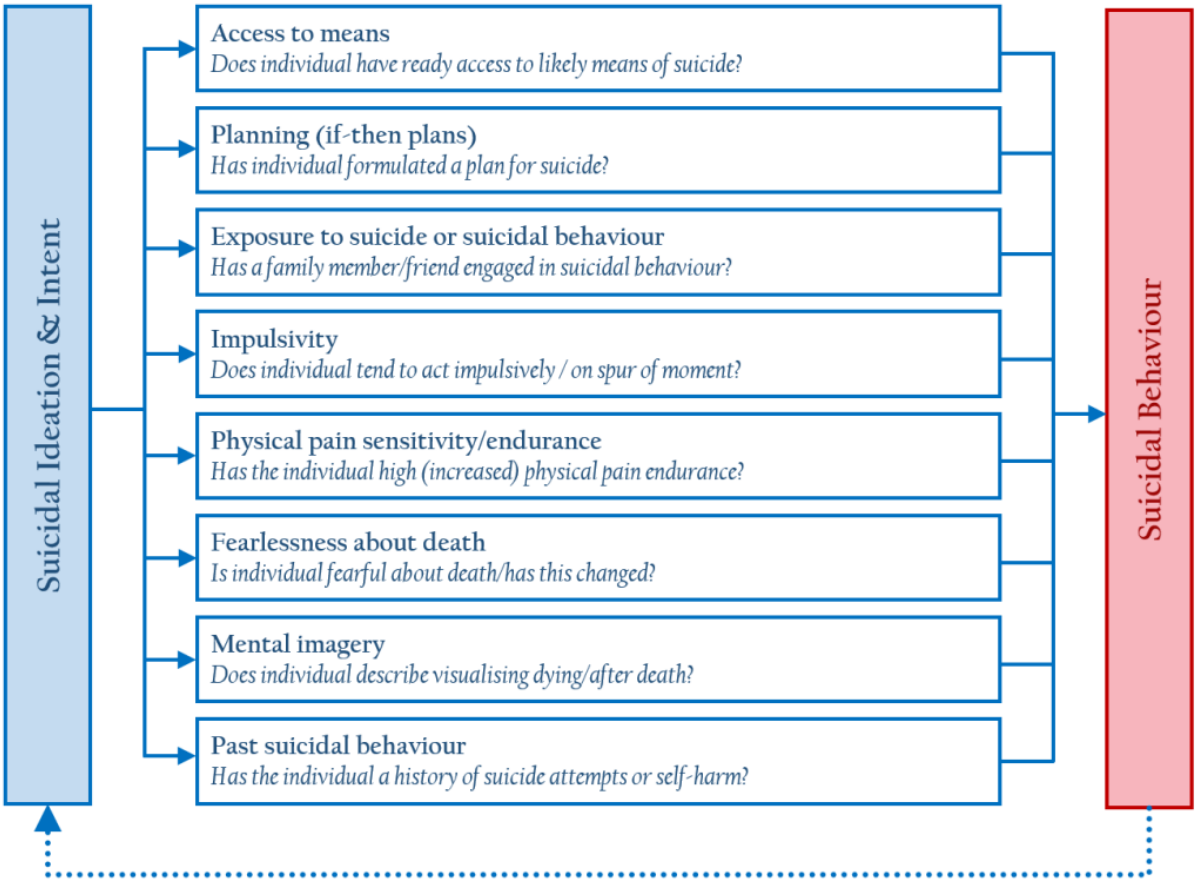
We believe this is exactly the sort of cross-agency work that will improve services for users and increase efficiency across organisations. We recommend this work continues and that this review is used as an example of where tangible differences could be made.

Recommendation Six
That the area continues its work to develop the ethos of multi-agency working for service users, including those who do not necessarily reach thresholds for existing safeguarding forums but who are known across services and about whom professionals have concerns about their safety. Specifically empowering professionals to have multi-agency discussions in those cases.

6.2.19 The review has already discussed the lack of monitoring of the DVPO, and the actions taken to improve this, but the continuation by Julie's partner to contact her would have increased his control of the situation and her isolation and sense of entrapment. These could have contributed to Julie's suicidal ideation and ultimately her feelings of entrapment.

6.2.20 **Volitional phase: Behavioural enaction**

6.2.21 This third phase of the model is most important, as it considers the transition from ideation to intent. It has been identified that there are eight volitional factors from suicidal ideation to suicidal behaviour.



6.2.22 If we apply what we know about Julie to these factors, we can begin to build a picture:

- *Access to means:* Julie had access to a range of illegal and prescribed drugs, as well as alcohol
- ***Planning:* was this explored every time Julie expressed suicidal ideation?**
- *Exposure to suicide or suicidal behaviour:* Julie self-harmed and was using alcohol to cope
- *Impulsivity*: personality disorder, anger, expressed worry that she would do something stupid
- *Physical pain sensitivity/endurance:* chronic pain, domestic and sexual abuse
- ***Fearlessness about death:* was this explored every time Julie expressed suicidal ideation?**
- ***Mental imagery:* was this explored every time Julie expressed suicidal ideation?**
- *Past suicidal behaviour:* Julie had attempted to take her life nine years earlier, when her child was taken into care.

6.2.23 As we can see, quite concerningly, Julie has evidence for five out of eight of the volitional factors.

6.2.24 Suicidal risk is not linear, it is constant and repeated.

6.2.25 A learning point for all agencies is that evidence-based practice suggests that *every time* someone mentions suicide, even if seemingly in passing, a conversation should be held. This conversation will allow the practitioner to assess an individual and mitigate the presented risk or share information with the relevant service for this to be continued.

6.2.26 The risk should then be reassessed at the next contact.

> The review does not have the evidence that this conversation was held every time Julie made a reference to suicidal ideation.
>
> There is no evidence that, even where this was recorded, it was shared with other agencies.

This review is aware that a previous DHR in the area, made a recommendation relating to the introduction of training around self-harm and suicide.

Recommendation Seven
It is recommended that the work commenced in the previous DHR, in relation to awareness training for front line staff on the impact of self-harm and suicide, be continued across the partnership.

6.2.27 **Key premises of the IMV model of suicidal behaviour**

Table 1. Key premises of the IMV model of suicidal behaviour.

	premise
1	Vulnerability factors combined with stressful life events (including early life adversity) provide the backdrop for the development of suicidal ideation.
2	The presence of pre-motivational vulnerability factors (e.g. socially prescribed perfectionism) increases the sensitivity to signals of defeat.
3	Defeat/humiliation and entrapment are the key drivers for the emergence of suicidal ideation.
4	Entrapment is the bridge between defeat and suicidal ideation.
5	Volitional-phase factors govern the transition from ideation/intent to suicidal behaviour.
6	Individuals with a suicide attempt or self-harm history will exhibit higher levels of motivational and volitional-phase variables than those without a history.
7	Distress is higher in those who engage in repeated suicidal behaviour and over time, and intention is translated into behaviour with increasing rapidity.

6.2.28 Having reviewed the details of the day of Julie's death, Sarah has noted that her child was sent to a friend's house for the day, and the dog was not barking when the police made their welfare check. Whilst it cannot be confirmed, such actions as these could have been part of a suicide plan.

6.2.29 It is not clear what information was gathered about Julie's suicide risk when the emergency services were called. However, given the points made above about the lack of information sharing, it is unlikely that they would have had a record of her suicidal ideation.

6.2.30 The police have rechecked their Command and Control system, that was in place at the time, and there was no 'flag' or other marker on their systems to indicate that Julie was suicidal. Whilst it is not possible to say whether this would have made a substantial difference to the decision of the officers not to enter the house earlier, it would have been an additional factor for consideration. The point, however, does have to be made that by the time the police were first notified of the concerns for her, she was almost certainly deceased. This can be reasonably assumed by the condition of Julie's body upon discovery.

6.3 CRY OF PAIN

6.3.1 Refuge[29], in their research, explain that Weaver, et al. and Williams developed understanding about suicidality through what they called a 'cry of pain' hypothesis. According to this theory, suicidal acts (completed or not) are understood as a cry of pain, rather than a cry for help, with suicide more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible. It is suggested further that this constellation of feelings and beliefs can lead anyone, irrespective of psychiatric diagnosis, to consider, and even enact, suicide. A key finding, observed across several studies, is that previous suicidal behaviour, regardless of cause, is one of the most robust predictors of future suicide, with some research indicating that completed attempt often follows an uncompleted attempt within an average of one year. Therefore, to dismiss suicidality and attempts as 'merely a cry for help', risks ignoring those who are in the greatest psychological pain and more likely to take their own lives in the future.

6.4 HOPE

6.4.1 Research undertaken by Refuge[30], states that: 'those trapped by domestic abuse can feel so hopeless that they believe the only way out is suicide'.

6.4.2 The power of hope has been studied by The Hope Research Centre at the University of Oklahoma. Domestic abuse victims can often only see the present – day-to-day survival – and are unable to see a future outside of the current situation.

6.4.3 Hope is defined as the ability to see beyond the immediate situation, and plan or visualise a future. Saleebey (2000) contends that hope is a cognitive set, essential to resilience and recovery. He said: 'Hope is about imagining the possible, the "untested feasible" as Frieire would have it. But more specifically, it is about thinking of oneself as an *agent*, able to effect some change in one's life, having *goals* that not only have the promise but also *pathways* to their accomplishment – pathways that may be short or long, full of ruts or smooth, well-lit or darkened'.[31]

[29] Domestic abuse and suicide, Refuge and Warwick Law School, 2018.
[30] ibid.
[31] The Relationship between Hope and Life Satisfaction among Survivors of Intimate Partner Violence: the Enhancing Effect of Self Efficacy, Munoz, Hellman and Brunk, Applied Research Quality of Life, 2017.

6.4.4 Friere, a pioneer in the study of individuals facing oppression, points to the importance of hope to resilience. He says: 'There is no change without the dream, as there is no dream without hope'.[32]

6.4.5 Julie's attitude to her abusive relationship had changed in recent times, and she was looking to leave that relationship and move on. She was attending the Healthy Relationships programme and having monthly contact with her OM. To professionals, her life at this time seemed stable. Unfortunately, as we know, her partner was not willing to allow her to move on and breached the DVPO that was intended to prevent him contacting Julie.

6.4.6 Whilst the review cannot be certain, it is possible that, because of her partner's unwillingness to allow her to move on, she had lost all hope for the future. She did not see how life could change.

6.5 UNANSWERED QUESTIONS

6.5.1 Kent and Medway Suicide Prevention Team has identified, from their analysis, that there are many unanswered questions remaining about suicide and domestic abuse. For example:

- How many victims of domestic abuse die by suicide nationally during abuse or during the months and years that follow?
- Are any groups at higher risk, e.g., gender, LGBTQ+, age?
- Do any types of abuse (financial, stalking, coercive control, etc.) pose a higher risk?
- Are there any high-risk points within the abuse cycle, e.g., when the victim is informed that the perpetrator is being released from custody?
- How strong is the link between domestic abuse and suicide? Can we see any evidence of correlation or causation? Does it differ between groups?
- What strategic and tactical interventions could reduce the risk of deaths by suicide?

6.6 LOCAL SUICIDE PREVENTION STRATEGY

6.6.1 The national suicide prevention strategy[33] was first published in 2012. Its key aims were to reduce the suicide rate in the general population in England and to better support those bereaved or affected by suicide.

6.6.2 To support this strategy, the NHS asked all Clinical Commissioning Groups to deliver local multi-agency suicide prevention plans.

6.6.3 Nottingham City and Nottinghamshire has a Suicide Prevention Strategy 2019 – 2023[34]. The overall aim of this strategy is to *reduce the rate of suicide and self-harm in the Nottingham City and Nottinghamshire population, by proactively improving the population's mental health and wellbeing, and by responding to known risks for suicide in the population.*

[32] The Psychology of Resilience: A Model of the Relationship of Locus of Control to Hope Among Survivors of Intimate Partner Violence, Munoz RT, Brady S and Brown V, Traumatology, 2016.
[33] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[34] https://committee.nottinghamcity.gov.uk/documents/s94904/Enc.%202%20for%20Nottingham%20City%20and%20Nottinghamshire%20Suicide%20Prevention%20Strategy%202019-2023.pdf

6.6.4 The strategy has the following key areas for local action:

- Priority 1 – At-risk groups
- Priority 2 – Use of data
- Priority 3 – Bereavement support
- Priority 4 – Staff training
- Priority 5 – Media

The review notes that this strategy recognises that suicide prevention goes hand in hand with addressing the well-recognised risk factors and at-risk groups for suicide.

6.6.5 Suicide and self-harm are often precipitated by recent adverse events across the life course. These include relationship breakdowns, conflicts, legal problems, financial concerns, interpersonal losses, and traumatic events.

6.6.6 Research has shown that, in terms of suicide prevention, it is important to note that the experience of sexual or domestic violence in adulthood is associated with the onset and persistence of depression, anxiety and eating disorders, substance misuse, psychotic disorders, and suicide attempts[35].

6.6.7 The governance structures have been strengthened and the Nottinghamshire and Nottingham City Suicide Prevention Strategic Steering Group now reports to the Health and Wellbeing Boards (for both Nottingham City and Nottinghamshire),the Nottingham and Nottinghamshire Integrated Care System (ICS), Mental Health and Social Care Partnership Board. Membership of this Group includes strategic representatives from local authorities, Clinical Commissioning Groups, health providers, Office of the Police and Crime Commissioner, universities, community, and voluntary sector.

6.6.8 The Steering Group has established the Nottinghamshire and Nottingham City Suicide Prevention Stakeholder Network. This provides a forum to engage, work with, and support stakeholders to implement the Nottingham and Nottinghamshire Suicide Prevention action plans and to deliver the required outcomes.

6.6.9 The review is advised that more than 60 organisations have signed up to this network. It is noted that there are organisations represented on the DHR panel that have not signed up to the network.

Recommendation Eight
It is recommended that all agencies represented on the DHR panel commit to the Suicide Prevention Stakeholder Network.

6.6.10 A guide has been produced for frontline workers and has been shared with all services in the city, as well as a poster for staff in primary care services. A suicide prevention and self-harm awareness and prevention pack is also being produced for primary care and pharmacies.

6.6.11 With funding from the NHSE Suicide Prevention Transformation Programme, the area will be using its three-year funding for:

[35] Hawton K, Van Heeringen K. The International Handbook of Suicide and Attempted Suicide. The International Handbook of Suicide and Attempted Suicide. 2008 cited in ibid.

6.6.12 **Communication** – Campaigns will raise awareness in the public about suicide. Through extensive consultation with partners, stakeholders, and people with lived experience, new suicide prevention branding and communications materials have been developed and widely disseminated, including to services working with people experiencing domestic abuse. The new branding and communications will be used for both population level and targeted communications campaigns over the coming year. Communications direct people to an updated suicide awareness webpage, to support access to the right help at the right time.

6.6.13 **Training** – A training needs' assessment has been completed, and a training provider has been appointed following a procurement exercise. The programme of training is being finalised and will be rolled out before the end of 2022. Services supporting people experiencing domestic abuse, and the community and voluntary sector, are included as target groups for training. Options for bespoke training for Nottinghamshire Police and East Midlands Ambulance Service, as 'first responders', are being explored.

6.6.14 **Real Time Surveillance System** – This area of work, being led by Nottinghamshire Police, will strengthen this system and will be exploring domestic abuse as a factor in suicide. The Terms of Reference have been revised and now include an objective to 'review learning from any Domestic Homicide Reviews shared by local Domestic Abuse Commissioning Leads where a suicide death is suspected or confirmed to identify any recommendations for action within the suicide prevention partnership'.

6.6.15 **DOMESTIC ABUSE AND SUICIDE**

6.6.16 Learning from Domestic Homicide Reviews in the area will be reviewed by the Real Time Surveillance Group and will report to the Steering Group.

6.6.17 Work is underway, with the Domestic Abuse Commissioner (led by the county council and across the Nottingham and Nottinghamshire footprint), to understand the issues for those experiencing domestic abuse and suicidal ideation. There is an intention to explore the feasibility of commissioning suicide prevention work in the domestic abuse services locally. This will be in addition to the worker from Nottinghamshire Healthcare Trust (mental health service), who already works within the domestic abuse service.

Section Seven – Lessons Identified

7.1 This review has identified a number of areas where lessons can be learned from the scrutiny of this case. These are set out below.

7.2 That staff at the Urgent Care Centre – to which Julie attended, self-reporting a dog bite – were unable to view the Safeguarding Information Node that would have alerted them to the multiple issues of domestic abuse within her relationship. Knowledge of this would have prompted greater professional curiosity as to the cause of the injury. This has resulted in a recommendation.

7.3 That routine questioning around domestic abuse is not always applied across different health settings. Whilst there was good practice noted within the emergency department, it was not always replicated elsewhere. This has not resulted in a recommendation, as discussions during the review, assured the panel that work was continuing in this aspect.

7.4 That professionals do not always feel empowered to have multi-agency discussions when individuals they remain concerned about, do not meet the threshold for existing safeguarding processes. This has resulted in a recommendation.

7.5 That the significance of a report to professionals of prior strangulation was not recognised for the specific indicator that it is. The review welcomes the work being done by Nottinghamshire Police in this respect but still feels a recommendation is appropriate.

7.6 That there was a lack of effective monitoring of protective injunctions, such as a DVPO. The review is aware of the work done by Nottinghamshire Police in this respect and thus has not made a recommendation.

7.7 That there is no single record that follows a detainee through the prison estate. This makes it difficult for those working with detainees within the prison, and upon release, to have a full appreciation of rehabilitation work carried out during their stay and can affect continuing rehabilitation. A recommendation is made in respect of this.

Section Eight – Recommendations

8.1 **Nottingham CityCare Partnership**

8.1.1 That Nottingham CityCare Partnership explores with the Integrated Care Board (ICB) and GP practice, the most appropriate way to ensure that any Safeguarding Information Notice (SIN) is easily visible to other services.

8.2 **Nottinghamshire Healthcare Foundation Trust**

8.2.1 That the NHCFT Safeguarding Team seeks assurance from senior colleagues in the Liaison and Diversion Service, that the referral mechanism is robust and allows for the appropriate assessment and care planning of patients in a timely manner.

8.2.2 That the NHCFT Safeguarding Team liaises with colleagues in the Information Assurance Team, to gain further understanding around the duplication of electronic files and the risk that this poses. A method of mitigating the associated risks should be explored.

8.3 **Nottinghamshire Police**

8.3.1 That consideration is given to ensuring that DASH risk assessments in which strangulation is a factor, are rated as high: regardless of the other answers given.

8.4 **Her Majesty's Prison and Probation Service (HMPPS)**

8.4.1 That the service explores the feasibility of one single record for a prisoner that follows them from prison to prison and records all the course and interventions with which they have engaged.

8.5 **Nottingham Community Safety Partnership**

8.5.1 That the work commenced in the previous DHR, in relation to awareness training for frontline staff on the impact of self-harm and suicide, be continued across the partnership.

8.5.2 That the area continues its work to develop the ethos of multi-agency working for service users, including those who do not necessarily reach thresholds for existing safeguarding forums but who are known across services and about whom professionals have concerns about their safety. Specifically empowering professionals to have multi-agency discussions in those cases.

8.6 **All agencies represented on the DHR Panel**

8.6.1 That all agencies represented on the DHR panel commit to the Suicide Prevention Stakeholder Network.

Section Nine – Conclusions

9.1 This has been a particularly sad case to review. It is based upon the death of a mother of five children. Despite the fact that four of those children were not within her care, they have still lost their mother. A mother who also had caring responsibilities for her long-term partner's young child.

9.2 Julie lost her life as a result of a drugs overdose. HM Coroner has not found sufficient evidence to enable them to come to a conclusion that she intended to take her own life. It is clear, however, that she was in emotional turmoil at the time of her death.

9.3 She and her partner had been in a long-term relationship that was consistent in ongoing reports of bidirectional domestic abuse. This, together with her complexities of previous trauma, drug and alcohol use – probably to cope with that previous trauma – meant that Julie was a vulnerable woman.

9.4 She had spent a period in prison during the months leading up to her death. Upon release, she seemed to want to make a change in her life and start again. Unfortunately, she and her partner rekindled their relationship, and reports of domestic abuse between them started once again. Both were arrested at different times in the months immediately prior to her death. At the time she died, her partner was subject of a Domestic Violence Protection Notice.

9.5 It seems likely, having reviewed what was known by all agencies in this case and having attended the inquest in this case, that Julie's multiple and compound issues, including the ongoing abusive relationship, had left her feeling at her lowest and that a combination of drugs were taken to null the pain. Unfortunately, that combination was fatal.

9.6 We have looked at this review through the lens of domestic abuse and its connection with suicide. Although suicide has not been proven in this case, many aspects of the 'cry of pain', made by Julie, are relevant.

9.7 There had been significant prior agency involvement with Julie, and we have identified a number of areas where we feel lessons should be learned from this case. We note and welcome the work that is ongoing in Nottingham to make others safer. We make a total of eight recommendations that we feel will support that work.

Appendix One – Terms of Reference

Domestic Homicide Review
(January 2021)
Terms of Reference Operation Berry (12924357)

Legal Basis of the Review:

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

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

1. Establish what lessons are to be learned from a domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

2. 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;

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

4. 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;

5. Contribute to a better understanding of the nature of domestic violence and abuse; and

6. Highlight good practice.

The guidance also states:

> 'It is, however, important to note that reviews should not simply examine the conduct of professionals and agencies. Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions'.

The Nottingham Community Safety Partnership (CSP) Board commissioned and then agreed its policy for conducting Domestic Homicide Reviews on 25th July 2011. The policy adopts the national guidance and sets out local procedures for ensuring that the principles of the guidance are adopted and followed through each Domestic Homicide Review.

Instigation of the Review:

Nottingham Community Safety Partnership was notified by letter, dated 9th October 2020, from East Midlands Ambulance Service (EMAS), regarding a suicide. The circumstances of the death fall within Section 9 of the *Domestic Violence Crime & Victims Act 2004,* which required consideration of conducting a Domestic Homicide Review.

The Chair of the Nottingham Community Safety Partnership considered the notification, and after having considered and consulted with Board members, the Chair agreed to invite (Christine Graham and Gary Goose), to write the overview report and chair the review panel. The rationale for this decision was:

1. To enable consistency in the oversight of Domestic Homicide Reviews within the city of Nottingham.

2. Christine Graham and Gary Goose are known to have the requisite skills, knowledge, and experience to take the responsibility. (As set out in paragraph 36-39 of the guidance).

3. The appointees had no known conflict of interest that would prevent them from writing the overview report / chairing the review panel and are not directly associated with any of the agencies involved in this review.

It is the responsibility of the Chair of the DHR Review Panel to ensure that he and the panel consider, in each homicide, the scope of the review process, draw clear Terms of Reference, and consequently report progress to the Chair of the CSP Board.

Prior to sending the final review to the Home Office Quality Assurance Group, a completed version of the review will be provided to the family. This will allow consideration of the other findings and recommendations. It is then possible to record any areas of disagreement.

Publication of overview reports and the executive summary will take place following agreement from the Quality Assurance Group at the Home Office and will be published on the local CSP web.

The initial stakeholder group has been identified as:

- The immediate surviving family members of the victim and, where appropriate, the offender.
- Nottinghamshire Police.
- Office of the Nottinghamshire Police and Crime Commissioner.
- The Crown Prosecution Service.

- Nottingham Coroner.
- Departmental Directors of Nottingham City Council.
- Senior management of voluntary sector services involved in delivering domestic violence services.
- NHS England.
- Nottingham City Clinical Commissioning Group.
- Nottinghamshire Healthcare Foundation Trust.
- Nottingham CityCare Partnership.
- Nottingham City (and where relevant, Nottinghamshire County) Council Public Health.
- The Crown Court.
- The Magistrates Court.
- HM Courts Service.
- The Chair of the Nottingham Community Safety Partnership.
- Nottingham Community Safety Partnership Board members.
- The Home Office.
- The Senior Investigating Officer (SIO), Nottinghamshire Police.
- The Family Liaison Officer, Nottinghamshire Police.
- Registered Social Landlords.
- HM Prison Nottingham.
- Probation Services – NPS Nottinghamshire and Derbyshire, Leicestershire, Nottinghamshire, and Rutland Community Rehabilitation Company (DLNR CRC).

It is the intention of the Chair of the DHR, that the Review Panel shall engage with the stakeholder group. It is from the stakeholder group that representatives of the panel will be selected, in accordance with the CSP policy. The Independent Chair and Author of the panel will visit the designated family contact of the victim and offender to outline the purpose of the Review Panel and ensure that the final outcomes are shared with the family prior to publication. Any contact with the family will be in consultation with the SIO and Family Liaison Officer.

An advocate for the family will be arranged to ensure they are considered as key stakeholders throughout the review process.

The Chair of the Nottingham Community Safety Partnership has made available some resources to undertake the review and will receive the final overview report from the Chair of the Review Panel. Partners may be approached to provide funding for a report author to be commissioned by the CSP on behalf of the Partnership. The Nottingham Community Safety Partnership accepts responsibility, including the preparation, agreement, and implementation of an action plan, to take forward the local recommendations that emerge from the Review Report.

The review will follow the key processes that are outlined in the multi-agency statutory guidance for the conduct of DHRs, as supported by the recently agreed 'DHR Practice Guidance'.[36]

[36] Ratified by the Nottingham City Crime and Drugs Partnership on the 11th December 2017.

The Terms of Reference are a live document and will be reviewed at panel meetings.

Scope of the Review:

Persons Covered by the Review:

Full anonymity of those subject to the review will be applied throughout. The principal focus of the review will be the victim, and she will be referred to as 'Julie'. The DHR panel sends its sincere condolences to the victim's family.

The partner of the victim in this case will be referred to as 'Julie's partner'. Should the panel consider it necessary, on evidence and reflection, to extend the scope of the review to cover other relevant persons, the Terms of Reference may be amended by the panel at a future date.

Review Period:

The scoping period covered by the review will cover events from 19th August 2019 as one month prior to Julie's death.

If the panel considers it necessary, on evidence and reflection, to extend or shorten the period, the Terms of Reference may be amended accordingly. Authors of independent management reviews will provide, in any event as part of the IMR, a summary of any relevant information prior to that date.

Terms of Reference of the Review:

Matters for Authors of IMRs:

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

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

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

5. Consider the efficacy of IMR authors' agencies' involvement in a multi-agency / multi-disciplinary team meetings regarding the victim's mental health.

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

7. 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.

8. To what extent were the views of the victim and offender (and where relevant, significant others), appropriately considered to inform agency responses.

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

10. 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, in Nottingham City, where domestic violence is a feature.

11. 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, her family, and the wider public.

12. 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.

In addition to the detailed IMR, authors should ensure that they include at least one paragraph in response to each of the Terms of Reference above. This will assist in the writing of the final report.

IMR authors should use DD/MM/YYYY format for dates to assist with the writing of the final report.

Ownership of IMRs:

Clearly identify the purpose of the IMRs and who owns them.

Where an agency has commissioned its own IMR, that agency will own that IMR. Where an IMR has been created that is not owned by an agency, e.g., MARAC IMR, the ownership of such an IMR will be determined on a case-by-case basis.

Matters for the Review Panel to Consider:

Identify, on the basis of the evidence available to the review, whether there were any modifiable circumstances that could have prevented the homicide, with the appropriate improving policies and procedures in Nottingham City, and if applicable, in the wider county of Nottinghamshire.

Identify, from both the circumstances of this case and the homicide review processes adopted in relation to it, whether there is learning that should inform policies and

procedures in relation to homicide reviews nationally in future, and to make this available to the Home Office.

Identify areas of good practice from single agency, multi-agency, or individual work.

If the coroner has an interest in this DHR, the CSP lead officer, the Independent DHR Chair, and Author will agree the process with the coroner for a copy of the Home Office approved DHR overview report, as part of the inquest disclosure bundle. The CSP and DHR Author will inform the coroner of any delays with the process, such as criminal proceedings. The DHR Author may be called as a witness at the Coroner's Inquest.

The overview report can only be submitted to the coroner once it has been approved as adequate by the Home Office. The Home Office understands the need for the Coroner's Inquest – to avoid unnecessary delays – and will aim to have the overview report considered by the DHR Quality Assurance Panel, as soon as possible. To assist with this, the CSP will inform the Home Office of any Coroner requests and timescales to help with forward planning.

Where a DHR has criminal proceedings, the agency information submitted for this should suffice, and to prevent further delays to the Coroner's Inquest, the DHR overview report may not be requested as part of the disclosure bundle.

Excluded Matters:

The review will exclude examination of how the victim died or who was culpable: these are matters for the coroner and criminal courts, respectively, to determine.

Family Involvement:

The family will be given the opportunity to be involved in this review throughout the whole process. This should be from helping determine the Terms of Reference to actions and recommendations from the review. The family will be invited to meet all the panel members. Family members will be provided with an independent advocate if they wish to be involved in the review process.

However, contact with the parties will not be undertaken without prior discussion and agreement with the Senior Investigating Officer in Nottinghamshire Police, due to the ongoing criminal process.

Again, in consultation with the SIO, the panel may designate that significant other persons may also be invited to contribute to the review and be interviewed by the DHR Author and DHR Chair.

All information obtained from third parties will be shared with the prosecution team.

Previous DHR Recommendations and Actions

To identify any recommendations and actions from previous Domestic Homicide Reviews that are recurring / reappearing in this review. Taking into account if, and when[37], these actions were implemented within the agency and how to address any repetition.

Document Security, Preparation of Individual Management Reviews, and Interviewing of Staff:

Agencies should arrange for all records connected with the individuals, covered by the review, to be secured.

Agencies will be required to submit chronologies of their involvement with the individuals who are subject to the review, together with their individual management reviews.

Agencies should immediately consider which staff they wish to engage with as part of their individual management review and prepare to forward their names to the Chair of the Review Panel on request.

Local IMR guidance will be issued to all agencies undertaking an IMR: this includes guidance on interviewing staff and draft letters for use.

Media Strategy

The development of the media strategy will be led by Nottingham CSP to provide an effective joint handling of the media tailored to the circumstances of the DHR. Taking into consideration what information can be shared and when, and where criminal and coroner's proceedings are still taking place. Please refer to the DHR Berry Media Strategy for further information.

Membership of the Review Panel:

Christine Graham,	Christine Graham Consultancy Ltd – Independent Author
Gary Goose,	Christine Graham Consultancy Ltd – Independent Chair
Jane Lewis,	Nottingham Community Safety Partnership
Paula Bishop,	Nottingham Community Safety Partnership
Karen Turton,	Nottingham CityCare Partnership
Kerry Jackson,	Department of Work and Pensions (DWP)
Sue Parker,	Derbyshire, Leicestershire Nottinghamshire, Rutland Community Rehabilitation Company (DLNR CRC)

[37] The recommendation / action from the previous DHR may not have been specific to that agency when the action plan was agreed / the agency was not involved in that DHR Review.

Lucy Gascoigne,	East Midlands Ambulance Service (EMAS)
Adrian Morgan,	East Midlands Special Operations Unit – Regional Review Unit (EMSOU)
Lisa Del Buono,	Framework Housing Association
Nick Judge,	Greater Nottingham Clinical Commissioning Partnership
Nat Cunningham,	National Probation Service – Nottinghamshire
John Matravers,	Nottingham City Council Children's Services
Heather Fry,	Nottingham City Homes (NCH)
Apollos Clifton-Brown,	Nottingham Recovery Network (NRN) & Clean Slate
Maggie Westbury,	Nottingham University Hospitals
Julie McGarry,	Nottinghamshire Health Care Foundation Trust
Clare Dean,	Nottinghamshire Police (Public Protection)

Document Marking:

All matters concerned with the review process, will be considered to be confidential. The transport and transfer of these documents should be in accordance with property marking schemes security guidance.

All agencies involved are reminded of the sensitivity of the information that they will become familiar with and have access to during the conduct of the review panel work. All matters coming into the possession of the panel will potentially be disclosable in any criminal or civil proceedings, which may be associated with this case.

The Chair will take personal responsibility to ensure the SIO / Disclosure Officer are informed of the findings of the Review Panel – for them to then liaise with their CPS colleagues to assess and guide the likely impact on any criminal proceedings.

Version: 1 (4th January 2021)

Appendix Two – Ongoing Professional Development of Chair and Report Author

2.1 Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
- Ensuring the Family Remains Integral to Your Reviews - Review Consulting (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
- Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
- Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
- Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
- Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
- Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
- Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
- Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
- Suspicious Deaths and Stalking, Professor Jane Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
- Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
- Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)
- Giving children a voice in DHRs – AAFDA (November 2021)
- Cross Cultural Training Webinar – Incels and Online Hate – HOPE Training (November 2021)
- Male victims of domestic abuse, Buckinghamshire DHR Learning Event (January 2022)
- Older victims of domestic abuse, Dr Hannah Bows, DHR Network (February 2022)
- Enhancing the cancer workforce response to domestic abuse – Standing Together and Macmillan (April 2022).

2.2 Christine has completed the Homicide Timeline Online Training (Five Modules), led by Professor Jane Monckton-Smith of University of Gloucester.

2.3 Gary and Christine have:

- Attended training on the statutory guidance update (May 2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended Conference on Coercion and Control (Bristol, June 2018)
- Attended AAFDA Learning Event (Bradford, September 2018)
- Attended AAFDA Annual Conference (March 2017, 2018 and 2019)
- Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)
- Attended AAFDA DHR Chair Refresher Training (August 2021)
- Commissioned bespoke training on DHRs and Suicide, Harmless (March 2022).

Appendix Three

DHR BERRY Overview Report Action Plan – June 2024

The action plan is a live document and subject to change as outcomes are delivered.

DHR BERRY – victim's death was recorded by the Coroner as a result of 'drugs and alcohol'. The victim experienced childhood trauma, PTSD and had diagnosed mental health illnesses. She had a long-term history of drug and alcohol addiction and was known to have been a victim of physical and verbal abuse from her partner of 25 years.

Recommendation	**Rationale**	**Scope of Recommendation - Local or National**	**Action to take**	**Lead Agency**	**Target Date**	**Date of Completion**	**Evidence:** • **Key milestones achieved in enacting recommendation** • **Outcome** Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?	**RAG**
1. That Nottingham CityCare Partnership explores with the Integrated Care Board (ICB) who should then explore with GP practices the most appropriate way to ensure that any Safeguarding Information	Information in Safeguarding Information Node (SIN) was not accessible to front line staff at the Urgent Care Centre. Information on this system could have provided vital information about known DV history	*Local*	Domestic abuse information is now recorded by the safeguarding team on SystmOne which is visible to all Nottingham CityCare Partnership services.	Nottingham CityCare Partnership	**Feb 2023**	**Feb 23**	Previously when there was a DAPPN or DASH Ric referral for an adult survivor, Nottingham CityCare Partnership shared the DASH RIC and DAPPN with the survivors GP. The GP was then responsible for documenting the relevant domestic abuse information onto the SIN on the survivors SystmOne record. At the beginning of 2023, the Nottingham CityCare Partnership service developed and launched a safeguarding unit on SystmOne for the exclusive use of the Safeguarding team. Since March 2023 when the Nottingham CityCare Partnership Service receive a DASH or DAPPN notification from the City MASH, the survivor is now registered into the safeguarding unit. The Nottingham CityCare Partnership safeguarding team document the domestic abuse notification onto	

Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence: • **Key milestones achieved in enacting recommendation** • **Outcome** Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?	RAG
Notice (SIN) is easily visible to other services.							the SIN and attached the DASH RIC and DAPPN onto the survivors SystmOne. All Nottingham CityCare Partnership services are now able to view the information recorded in the Safeguarding Unit on SystmOne, this includes the information in the SIN. This also means that if a survivor accesses a Nottingham CityCare Partnership service in the future which they were not open to at the time of the domestic abuse incident, the information recorded on the SIN would still be visible to them. This action has been completed by Nottingham CityCare Partnership; we no longer rely on the GP to record the domestic abuse incident on the SIN as this is now being undertaken by the Nottingham CityCare Partnership safeguarding team. **In summary** Nottingham CityCare Partnership have implemented a SystmOne Unit in which we document domestic abuse notifications in the Sin. This ensures the information is visible to all Nottingham CityCare Partnership services. Nottingham CityCare Partnership has also liaised with the ICB who have agreed to formulate guidance for GPs regarding recording domestic abuse notifications on the SIN. Nottingham CityCare Partnership staff no	

Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence: • **Key milestones achieved in enacting recommendation** • **Outcome** Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?	RAG
							longer rely on the GP to document this information onto the SIN, in order for it to be accessible to Nottingham CityCare Partnership services. It will ensure there is a consistent approach when recording domestic abuse notifications. The meeting in which this was agreed took place in May 2023.	
2. That NHCFT Safeguarding Team seek assurance from senior colleagues in the Liaison and Diversion Service that the referral mechanism is robust and allows for the appropriate assessment and care planning of patients in a timely manner.	In July 2021, the clinical lead of NHCFT Safeguarding Team circulated an email to staff in the Liaison and Diversion Team, reminding them to check correct patient identifiable information when meeting clients in custody, to ensure that they match with the	*Local*	The NHCFT Safeguarding Team will work with the Liaison and Diversion Service to review the referral and assessment mechanism in light of this recommendation.	Notts Healthcare Foundation Trust		**Final update completed November 2023**	Nottinghamshire Healthcare NHS Trust Safeguarding Lead explored this further with Liaison & Diversion Team Lead. There may be limits to this recommendation due to the Liaison & Diversion team being hosted by the Police. However, Safeguarding Lead explored this further in order to gain assurance that clients are seen at the time they present and have the appropriate assessments. Liaison & Diversion Team Lead Informed the Safeguarding Lead that a new referral pathway for women will be introduced in Sept 2021 which they promote all women referred to Liaison & Diversion will be assessed. Currently there is a health care professional in custody every day and each time a client is released they will have a release assessment.	

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	health records.						 Women's pathway flow chart.docx	

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3. That NHCFT Safeguarding Team liaise with colleagues in the Information Assurance Team to gain further understanding around the duplication of electronic files and the risk that this poses. A method of mitigating the associated risks should be explored.	Due to a lack of triage assessment, concerns about mental health were not provided to the GP, who was unaware that the Liaison and Diversion Service had provided an opt-in letter to access support. This resulted in the clinician not having an overview of Julie's past history, and the need to potentially safeguard Julie and others was not identified. A knowledge	*Local*	NHCFT Safeguarding Team liaise with colleagues in the Information Assurance Team to gain further understanding around the duplication of electronic files and the risk that this poses. A method of mitigating the associated risks should be explored.	Notts Healthcare Foundation Trust		**Final update completed November 2023**	In July 2021 a meeting took place between the Safeguarding Lead and the Information Governance Officer. There is recognition that duplicate files remain a concern In order to mitigate the risk, the Applied Information Team run a daily RIO check and merge any duplicate files which have been created using the sound index. If NHS numbers are not known then Applied information will marry up. Applied Information does keep a log of which teams in the Trust create most duplicate files The IG officer agreed to discuss the issue with her manager. To explore a method of reminding clinical staff to contact the Applied Information team if a duplicate clinical file has been created in error. This could potentially be communicated via the daily Trust briefing and in the planned information newsletter the team are planning to launch. A reminder was sent out in the Notts Healthcare Trust Line Manager's update which are disseminated to all staff :-	

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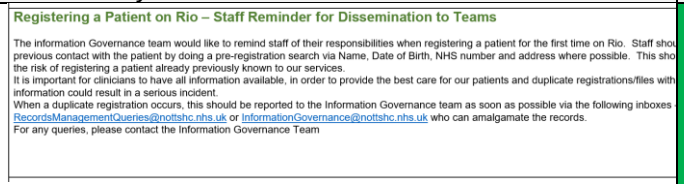
	of this history may have led to an alternative response from the clinician.						 **Registering a Patient on Rio – Staff Reminder for Dissemination to Teams** The information Governance team would like to remind staff of their responsibilities when registering a patient for the first time on Rio. Staff shou previous contact with the patient by doing a pre-registration search via Name, Date of Birth, NHS number and address where possible. This sho the risk of registering a patient already previously known to our services. It is important for clinicians to have all information available, in order to provide the best care for our patients and duplicate registrations/files with information could result in a serious incident. When a duplicate registration occurs, this should be reported to the Information Governance team as soon as possible via the following inboxes RecordsManagementQueries@nottshc.nhs.uk or InformationGovernance@nottshc.nhs.uk who can amalgamate the records. For any queries, please contact the Information Governance Team The Senior Information Governance Officer has since updated the Rio FAQ's page on Connect (internal intranet) which points staff in the direction of the IG team if they find a duplicate registration or if they make one in error. The IG Team have also held a few Records Management Bitesize training events, which are advertised on Connect and have been mentioned in the bulletin, where this is covered as part of the training.	
4. That consideration is given to ensuring that DASH risk assessments in which strangulation is a factor are rated as high regardless of	Following the introduction of non-fatal strangulation legislation, this review notes the additional information from the police regarding	*Local / National*	Notts police have a 2 tiered approach to assessing risk with Domestic Abuse reports. The initial assessment is mad eby the officer and is	Notts Police	**Oct 2023**	**Oct 2023**	Police hold a number of internal meetings to ensure that there is appropriate oversight regarding domestic abuse: 1. A quarterly domestic abuse standards group that meet to ensure standards across the force regarding domestic abuse which is chaired by the Head of Command - a Detective Superintendent. 2. A monthly Public Protection performance meeting which considers longitudinal trends, quality and performance within teams. 3. Auditing of specific teams to ensure compliance with procedures. 4. Team meetings conducted by the Detective Inspector to ensure that all	

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the other answers given.	training and awareness. Information was disseminated widely across Nottinghamshire Police, by way of additional guidance, and was provided to all officers and staff when the new legalisation was implemented. This included guidance that officers should consider victims of domestic abuse who have suffered non-fatal strangulation as high risk		subsequently reviewed by the DASU – Domestic Abuse Safeguarding Unit. The DASU assess the risk according to safe lives guidance and amend the risk grading according to need. If a case is raised to High Risk this will be picked up by Public Protection. Whilst the offence of strangulation is taken seriously, there is not an automatic grading of high risk and				staff understand the procedures of reviewing Domestic Abuse. The DASU team are an integral police team to ensure that offences are correctly graded and whilst there can be no direct improvement to comment on regarding the recommendation, it is important to state that Police are striving to ensure that all Domestic Abuse cases are graded correctly according to risk.	

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	for DA unless other factors reduce this risk.		the team will review a number of factors to ensure that high risk cases and highlighted.					
5. That the service explores the feasibility of one single record for a prisoner that follows them from prison to prison and records all the courses and interventions with which they have engaged.	Following release from prison, Julie's behaviour and acceptance of the abusive relationship changed. It has not been possible to establish whether this is a result of interventions delivered whilst in prison.	*Local*	For Nottinghamshire County Probation to feed recommendation up to the East Midlands Public Protection Manager	Her Majesty's Prison and Probation Service (HMPPS)		**November 2023**	The Probation Service is now joined with the Prison Service under the umbrella of Her Majesty's Prison and Probation Service. Also, the former CRC and The National Probation Service are unified. This means that all Services are using the same system platforms to record information. They are the Delius system and the OASYs assessment. The OASYs assessment record transfers to the Prison staff where someone is in custody and then transfers back the community probation officer during the persons' pre-release phase (8 months prior to release). Therefore, there is one common system for recording interventions completed in custody. However, this does not account for people who are held on remand who may not be known and therefore will not have an OASYs assessment created until after they are sentenced. The systems are available but what cannot be accounted for is the quality of information recorded on that record which may be impacted by a number of things including people on very short sentences and people who are immediately due for release at the point of sentence because they have spent a long period on remand.	

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							Therefore, it is not possible to offer an assurance that ALL cases will have this information recorded. However, wherever this is possible this is the expected level of practice. The use of Delius and OASYs is monitored by different functions in the prisons and in the community. As this recommendation relates to information not being recorded from her time in prison, consideration should be for prisons to remind their staff of the importance of using the Delius and OASYs systems to capture work undertaken by people in custody.	
6. That the area continues its work to develop the ethos of multi-agency working for service users, including those who do not necessarily reach thresholds for existing safeguarding forums but who are known across services and about	The main gap that was highlighted was the lack of any co-ordinated multi-agency approach to supporting Julie. There is a danger that, if a case does not meet the threshold for MARAC, professionals do not feel	*Local*	For the CDP to compile and circulate information about all existing multi-agency case management meetings (including referral criteria and pathways) and remind agencies of their responsibility	Nottingham Crime and Drugs Partnership	**Jan 2024**		SR to send out draft version to partner colleges. Agenda item for the ALIG meeting in April 2024.	

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whom professionals have concerns about their safety. Specifically empowering professionals to have multi-agency discussions in those cases.	empowered to call a meeting to discuss a case.		to take action in calling a case conference where no relevant meeting exists.					
7. That the work commenced in previous DHR in relation to awareness training for front line staff on the impact of self-harm and suicide be continued across the partnership.	A learning point for all agencies is that evidence-based practice suggests that every time someone mentions suicide, even if seemingly in passing, a conversation should be held. This conversation will allow the	*Local*	For the CDP to liaise with the Nottinghamshire and Nottingham City Suicide Prevention Strategic Steering Group to explore how we can influence policy and practice and	Nottingham Crime and Drugs Partnership	**April 2024**		**Nov 2023 –** contact made with the Chair of Nottinghamshire and Nottingham City Suicide Prevention Steering Group to explore how DHR learning is effectively shared and implemented. **Dec 2023 –** SR and CON met with Helen Johnson to discuss strengthening links with Notts and Nottm City. Ongoing representation within Suicide Prevention Strategic Steering Group and Suicide Prevention Network. Sharon to ask for a slot for presentation. **Suicide Prevention Strategy and Stakeholder Network in February 2024. SR to attend. To confirm next stage after attendance**.	

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	practitioner to assess an individual and mitigate the presented risk or share information with the relevant service for this to be continued. The risk should then be reassessed at the next contact. This review is aware that a previous DHR in the area, made a recommendation relating to the introduction of training around self-		embed the learning from this review through the work of the strategic partnership. CDP to provide a summary of the learning, and record how this is embedded in the action plans of the Strategic Steering Group.				Suicide Prevention Stakeholder Network have offered opportunity to present at future network meeting. SR to confirm.	

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	harm and suicide.							
8. It is recommended that all agencies represented on the DHR panel commit to the Suicide Prevention Stakeholder Network.	The Nottinghamshire and Nottingham City Suicide Prevention Strategic Steering Group has established the Nottinghamshire and Nottingham City Suicide Prevention Stakeholder Network. This provides a forum to engage, work with, and support stakeholders to implement the Nottingham	*Local*	**For all organisations represented on the DHR Panel to confirm to the CDP that they are signed up to the Nottingham City Suicide Preventions Stakeholder Network**	Nottingham CityCare Partnership, DWP, EMAS, EMSOU Regional Review Unit, Harmless, Juno Women's Aid, Nottingham and Nottinghamshire ICB, City Council – Children's Services, Nottingham City Homes, Nottingham Recovery Network, NUH, Nottingham Women's Centre, NHF Trust,	**April 2024**		**Nov 2023 -** Enquiries initiated to establish contact with the Suicide Prevention Stakeholder Network **Dec 2023 –** SR and CON met with Helen Johnson to discuss strengthening links with Notts and Nottm City Suicide Prevention Strategy and Stakeholder Network. Further meetings to be arranged to progress. **Jan 2024 –** Email sent to all panel members with information and details of how to sign up to the Stakeholder Network **8.01.24 DWP** confirmed sign up to Network and Katy Pearson attending next Network event **08.01.24 Juno** - I have signed Juno up to the network and have also shared information with my colleagues, Paula (Deputy CEO and Operational lead) and Sam (Head of Quality and Compliance) **11.01.24 NHFTrust** - , I can confirm that our Trustwide Lead for Suicide Prevention attends and participates in the Nottinghamshire and Nottingham City Suicide Prevention Steering Group on behalf of the Trust and is also involved in the Real Time Surveillance and stakeholder groups. This has included leading sessions	

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	and Nottinghamshire Suicide Prevention action plans and to deliver the required outcomes. The review is advised that more than 60 organisations have signed up to this network. It is noted that there are organisations represented on the DHR panel that have not signed up to the network.			Nottinghamshire Police, Probation Service			at the stakeholder network relating to responding to crisis and safety planning. **11.01.24 NRN –** I can confirm that I've contacted the team to sign Framework up, hopefully we can attend the next meeting in February. **15.01.24 Police -** Police are signed up to the Steering Group and DI Abi Goucher will be in attendance **17.01.24 – NWC –** confirmed sign up to the Network **18.01.24 EMAS –** As EMAS are a regional emergency service, and do not caseload hold it is not appropriate or manageable for us to engage with local networks. That said, the EMAS Mental Health Team engage with the Regional Suicide Prevention Network and attend the meetings. In addition, EMAS has a suicide prevention strategy (2023-2026) The strategy has been informed by stakeholder input and the undertaking of NHS and the Association of Ambulance Chief Executives health, wellbeing and suicide prevention frameworks and the outcomes arising from these assessments. **18.01.24 – Nottingham CityCare Partnership –** confirmed sign up to the Network and Karen Turton will be attending Network events going forward.	

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							13/02/2024 – ICB The ICB designated professional is a member of the 'Realtime surveillance group for suicide prevention' part of the Network. Recent GP practice Learning sessions have included suicide awareness training deliver by Harmless.	

DHR Berry IMR Agency Actions

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • **Key milestones achieved in enacting recommendation** • **Outcome**	RAG
Nottingham CityCare Partnership							
1.1	Guidance for Nottingham CityCare Partnership staff is reviewed and updated to ensure that it	Improve opportunities to explore issues, signpost and provide			Feb 2023 0ngoing.	Making every contact count, this message has been reinforced via: • The quarterly Safeguarding updates always includes a domestic abuse section to ensure key messages and learning is delivered across the workforce. • The Safeguarding Team have established a Safeguarding Champions Network. We encourage representation from every Nottingham CityCare Partnership team. In April 23 we have 45 Safeguarding Champions. They attend quarterly Safeguarding Champion Network meetings. These have been set up to	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • Key milestones achieved in enacting recommendation • Outcome	RAG
	emphasises the importance of making every contact count when staff interact with families where there are concerns regarding domestic abuse.	support around domestic abuse.				➢ reinforce that safeguarding is everyone's responsibility and to make every contact count, ➢ to reinforce a Think Family approach, ➢ to enhance and develop Nottingham CityCare Partnership safeguarding practices. Example of safeguarding updates see pages 25- 42 Safeguarding Update 2 Quarter 4 2021-22.(Example of presentation at Champions meeting of domestic abuse updates. Nottingham CityCare Partnership's Domestic Abuse Policy has been updated and was disseminated in March 2023. The policy sets out clear expectations for services / staff members in fulfilling their safeguarding responsibilities. This includes making domestic abuse enquiries and responding to disclosures. It provides a clear message to staff members to seek safeguarding advice when dealing with complex cases and or where there is any professional uncertainty. Domestic-Abuse-Policy-V10.0--1-.pdf The Mandatory Domestic Abuse training has been updated, it incorporates a slide in relation to making every contact count, a concept which underpins the whole training. A Think family case study is used to reinforce the need to consider the wider family within our safeguarding responsibilities which is not limited to the individual/s open to the service. Examples of slides used in the mandatory domestic abuse induction training and mandatory domestic abuse training	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • **Key milestones achieved in enacting recommendation** • **Outcome**	RAG
1.2	Further work is undertaken to clarify why information in the SIN was not visible to staff in the Mosaic service and Urgent Treatment Centre and ascertain whether this is a wider issue. When this evaluation has been completed action should be undertaken to address the issue	Ensure information relating to domestic abuse is visible / accessible to all services.			March 2023	The Safeguarding team in conjunction with our ICT provider have developed a bespoke Safeguarding Service Unit on SystemOne. This means that when a DASHRIC or DAPPN is received by our service from the City MASH/DART the victim is registered into the Safeguarding Unit. Relevant Safeguarding information is now always recorded within the Safeguarding Information Node and the Safeguarding template. This information will be accessible to all Nottingham CityCare Partnership Services even if they are referred into a service in the future.	**Green**
Probation							
2.1	Multi-agency meetings should be convened for	Lack of coordinated multi agency	Confirm arrangements for complex	**NA**	**2/5/23**	Since this DHR review was completed the probation service has unified. Previously the Mappa management of cases was exclusively held by the National Probation Service. The former Community Rehabilitation Company (DLNR) would also hold multi-agency meetings but without the formal structure of the MAPPA arrangements. Some domestic violence cases may meet the	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • Key milestones achieved in enacting recommendation • Outcome	RAG
	complex cases in which domestic abuse is evident particularly if there is Early Help intervention as well. These meetings should aim to discuss, understand and co-ordinate support to families.	approaches for the victim and her family and improved support and intervention.	cases where DV is evident and/or if Early Help Intervention is part of the multi-agency working plan.			criteria for MAPPA management, others may not. For those that do, the MAPPA level of management (1/2 or 3) will be determined by the need for a formal meeting where there are identified by gaps in the risk management plan. Where a level 1 meeting has been held and there is not the assurance that all risks are being managed the case can be escalated to a Level 2 or 3 meeting dependent upon the seniority of management required to resolve the issues. Level 3 meetings are held for the "critical few" cases which are deemed to be assessed as a very high risk of harm or where there is national media attention. For cases which would not ordinarily meet the MAPPA management criteria, but where there are significant concerns, a referral into L2 management can be made under (Category 3 criteria). This process ensures that the case will be subject to formal meetings, regardless of the MAPPA eligibility criteria where the case is particularly complex and where the risk management plan is not deemed to be sufficient. Therefore, the arrangements following unification are deemed to be more robust that with previous arrangements pre-unification.	
2.2	DLNR CRC to highlight to practitioners the complex issue of Mutual Allegation between perpetrators and victims of DV and to undertake and embed training provided by Nottingham City Council	Improve understanding and identification of primary perpetrators	Provide assurance that the probation service have shared the learning around mutual allegation cases between victims and	**NA**	**3.5.23**	The probation service is now unified and part of the mandatory training package for all staff, regardless of organisation, was to complete mandatory domestic abuse training as well as training to use the SARA risk assessment tool within their risk assessment of cases where domestic abuse is a feature. The learning shared via this DHR has been directly shared with staff alongside the Controlling and Coersive Behaviour in an Intimate or Family Relationship statutory guidance framework (December 2015) which includes guidance on how to consider counter allegations.	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • Key milestones achieved in enacting recommendation • Outcome	RAG
	in this subject area.		perpetrators.				
NHCFT							
3.1	NHCFT Safeguarding Team to develop a Safeguarding Matters brief around The Think Family Approach. This should include a reminder to clinicians to apply professional curiosity when meeting a client, who disclosures misusing alcohol and drugs and who has parenting responsibilities. At such times, professional curiosity may	Use this approach to help obtain correct information to assist providing the required level of support and refferrals.			**19/07/21** **06/08/21**	19/07/2021: Meeting took place between Trust S/G Lead and Team Leader in L&D service. Recommendation discussed and think family strategy provided for Team Lead to disseminate within the team Evidence embedded below  FW_ Domestic Homicide Review acti 20/07/2021: meeting took place between Trust S/G Lead and manager of DPM to discuss recommendation. Think Family strategy shared with Team Leader who will disseminate information in DPM team meeting today. In addition S/G Lead agreed to undertake some Think Family Training for staff in DPM. The above conversation backed up with email. 06/08/2021 email received from Team Lead confirming dissemination of learning in DPM. 2 think family training sessions planed for September 21:  RE_ DHR recommendations.m	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • **Key milestones achieved in enacting recommendation** • **Outcome**	RAG
	require a clinician to undertake enquiries re a child's status with the local authority to ascertain if a child is known, subject to Child in Need Status or Child Protection. On such occasion's, clinicians should also review the need for a new referral to children's social care, in order to fully safeguard children at risk.					07/09/2021 – S/G Lead completed x1 Think Family briefing with DPM. Power point presentation and resources provided. 21/07/2021 – email to manager in DPM and Manager in L&D reminder re safeguarding supervision for Band 7 and above.	
3.2	NHCFT Safeguarding Team to circulate a bulletin reminding staff in L&D to routinely check out	Ensure access accurate clinical history to help determine level of			**19/07/21**	X2 Trust S/G Leads, met with Team manager in the L&D team 19/07/2021: Shared recommendation from the report and L&D Manager has agreed to send out a reminder to all staff  RE_ Domestic Homicide Review acti in L&D re the need to check patient's identifiable information at the first contact.	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • Key milestones achieved in enacting recommendation • Outcome	RAG
	correct patient identifiable information when meeting clients in custody and ensure they match with any health care records.	support required					
3.3	NHCFT Safeguarding Team to seek assurance from senior colleagues in L&D that the referral mechanism into their team is robust and allows for the appropriate assessment and care planning of clients, presenting mental health difficulties, whilst in custody in a	Ensure access to information to determine support and make informed clinical decisions.			**09/21**	Re appropriate referral method. Trust S/G Lead agreed to explore this further with L&D Team Lead. There may be limits to this recommendation due to the L&D team being hosted by the police. However, S/G Lead thought this should be explored in order to gain assurance that clients are seen at the time they present and have the appropriate assessments. L&D Team Lead Informed S/G Lead that a new referral pathway for women will be introduced in Sept 2021 which will promote that all women referred to L&D will be assessed. Currently there is a health care professional in custody every day and each time a client is released they will have a release assessment.	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • Key milestones achieved in enacting recommendation • Outcome	RAG
	timely manner.						
3.4	NHCFT L&D team to review discharge arrangements to include routinely notifying GP following all discharged clients from the team whether successfully triaged or not.	Improve information sharing with GP				19/07/2021: Meeting took place between Trust S/G Lead and L&D Team Lead Shared recommendation from the report around discharge of clients and Team Lead has agreed to revise the discharge process to ensure that GP's are notified if client's do not opt in for assessment. Team Lead assured S/G Lead that when clients are successfully assessed GP's are always informed. In addition, L&D are soon to be provided with Smart cards and will have access to the clinical spine which can also be used as a method to be checking out correct GP details.	
3.5	NHCFT Safeguarding Team to liaise with colleagues in the Information Assurance team to gain a further understanding around the duplication of electronic files and the risk this poses. A method of mitigating the associated	Improve client information and access to those accurate records.				07/07/2021 MST meeting between Trust S/G Lead and Trust IG officer IG Issue discussed Duplicate files are an issue for the Trust. To mitigate the risk of a duplicate file having been generate the IA team run a daily RIO check and merge any duplicate files which have been created using the sound index. If NHS numbers are not known then Applied information will try and marry up. Duplicate files are generated by the Trust frequently, every day. The daily check does not capture them all. Clinical staff can contact the IA team to request duplicate files are merged. IA does keep a log of which teams in the trust create most duplicate files (incidences occur for a variety of reasons) We agreed that IG officer agreed to discuss the issue with her manager . To explore a method of reminding clinical staff to contact the IA team if a duplicate clinical file has been created in error. This could potentially be communicated via the daily Trust briefing and in the planned information newsletter the team are planning to launch. IG officer agreed to review the information re duplicate files currently on connect. IG officer agreed to explore with her manager if there should be a review of the data the team hold which may highlight if any individual team/s requires additional support in this area.	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • Key milestones achieved in enacting recommendation • Outcome	RAG
	risks to be explored.					 RE_ Duplicate files.msg 10/05/2022 – update from IG officer 18/05/2022 further email from IG officer following request for update:  RE_ Duplicate files.msg	
Nottingham Women's Centre							
4.1	In order for us to support women effectively and work in a trauma informed way we will be reviewing the referral form with the CRC and insisting it is fully completed before we accept a referral into our service.	Review referrals to ensure robust and all information provided to provide holist support.	Communicate with referring agencies to review risk and DVA information at referral, return incomplete referrals.	June 2021	June 2022	CRS contract began in June 2021 and a new Refer and Monitor system (RAM) was introduced. The quality of referrals is a standing agenda item and as such is reported on monthly, and discussed at quarterly Service Management Board Meetings with the service manager since 2021. DVA is not on probation's RAM as an area of need so there is no option for Probation Practitioners to select it (CRS providers have asked for this to be added to RAM a few times). Information about risk is unreliably reported at assessment (e.g. missing, out of date). We routinely send back incomplete referrals and request more information when missing. We also raise recurring issues as they arise- we do not wait for meetings to occur. We report monthly on the amount of referrals we have had to send back for extra/missing risk information. The percentage of those hovers around the 30% mark. We hold monthly drop ins for new and current probation officers to inform of our needs for referrals. We have escalated to the East Midlands Women's Lead and our Contract Manager. Routine enquiry is undertaken at assessment and throughout engagement at Nottingham Women's Centre and recorded on our systems. In house training and reflective practice to support staff to identify, monitor and act on all risk information.	

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • Key milestones achieved in enacting recommendation • Outcome	RAG
4.2	During initial assessment we will ask women if they are involved with any other support organisations.	Improve multiagency working and prevent duplication / repetition	Enquire about and record involvement with other agencies.			Caseworkers explore beneficiaries' support systems routinely at assessment and throughout engagement, communicating with other organisations as needed in interest of safety and limiting duplication. Professional contacts and involvement are recorded on our systems and multiagency meetings are facilitated and attended.	

Appendix Four

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Sharon Rose
Community Safety Partnerships Specialist (DVA)
Housing and Children's DVA Officer
Community Safety Partnership Team
Environment and Residents Directorate
Loxley House, Station Street
Nottingham NG2 3NG

11th April 2024

Dear Sharon,

Thank you for submitting the Domestic Homicide Review (DHR) report (Julie) for Nottingham Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21st February 2024. I apologise for the delay in responding to you.

The QA Panel felt that this is a strong report. Whilst there is some repetition (which can be difficult to avoid due to the requirements of the guidance), this is well managed by the author. The report is clear, well written, empathetic and despite little family involvement, the victim feels present in the review.

The report is not defensive and does not victim blame. It is well researched and cited. It should also be noted that the section on domestic abuse and suicide is one of the best the QA Panel have seen and the specialist presentation to the panel appears to have been very successful in supporting them to explore important considerations.

It is also very positive to see the section on the impact of children being taken into care and the exploration of this. This is a significant issue that is often not adequately addressed. The QA Panel would like to recognise the work of the Chair, Author and panel for their work on these particular sections – they stand out against many DHRs into deaths by (suspected) suicide/fatal self-harm.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The review is, at times, confusing in terms of the number of children that the victim had. Initially it states that she has four children (all removed) and a younger child living with her - so the victim has

five children, four of which were no longer living with her at the time of her death – this would be clearer if restated. At 9.1 however, there is reference to the victim having two children which is incorrect and should be amended.

- Whilst the service Harmless appear to have supported with input (and added real strength to the report), there does not appear to be a representative from Public Health/suicide prevention on this panel. This might have been a helpful input for learning in this case (and indeed for the recommendations). The CSP might consider inviting a suicide prevention representative to future DHR panels relating to (suspected) suicide.

- The rent arrears Julie had could have been explored as being a potential sign of economic abuse.

- The panel might consider clarifying within the report if Children's Social Care were involved with the child during the course of the temporal scope of this review. There is no submitted report to the review, and this seems odd in this case.

- The equality and diversity section is underdeveloped, and does not relate to protected characteristics specific to this review which would have benefited from further exploration/analysis.

- The CSP should consider adding Public Health/Suicide Prevention or the Nottingham City Suicide Prevention Strategic Steering Group to the dissemination list for this DHR.

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

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

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

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

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

Home Office DHR Quality Assurance Panel