



Domestic Homicide Review Executive Summary

Name: Kiddo

Month and Year of Death: May 2023

Independent Chair: Carolyn Carson

Independent Author: Allison Sandiford

Final Draft – May 2025

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Kiddo was a man of quiet resilience and service. A former Army veteran of 12 years and a skilled engineer, he was a loner who was nonetheless friendly to all. Though he lived a solitary life in a ground-floor flat in Nottingham, he remained a devoted brother and uncle, valuing regular phone calls and football matches with his family. Having once been a registered counsellor, he possessed a degree of self-awareness and he openly acknowledged his struggles with grief and alcohol following the death of his ex-wife. He was a man who found purpose in helping others, a trait that unfortunately left him vulnerable to exploitation. At his core, Kiddo was a gentleman seeking connection in the isolating wake of a pandemic, whose inherent kindness was ultimately used against him.

1. The Review Process

1.1. To protect the identity of the individuals involved, the subject of this review (who was 74 years old at the time of his murder), is referred to under the pseudonym of Kiddo. The perpetrator, (who at the time of the murder was aged 44 years) is referred to under the pseudonym of Barbara. Both individuals are White British.

1.2. Following multiple police interviews, Barbara admitted to the murder of Kiddo and to carrying out a fraudulent withdrawal on his bank account (whilst disguised as him).

1.3. A Judge subsequently sentenced Barbara to life imprisonment, with a minimum of 25 years.

1.4. The review process began with an initial meeting of the Domestic Homicide Review Screening group in August 2023 where the decision to hold a Domestic Homicide Review was agreed. All agencies that potentially had contact with Kiddo/Barbara prior to the point of death were contacted and asked to confirm any involvement. 20 agencies out of 27 contacted, confirmed contact and were asked to secure their files.

2. Contributors to the Review

2.1. The following have contributed to the review by way of agency reports.

- Nottinghamshire Police
- Nottingham University Hospital
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham City Housing Solutions
- Nottingham Recovery Network
- Prostitution Outreach Team
- Nottingham County Probation Service
- Nottingham City Community Safety Slavery and Exploitation Team
- NHS Nottingham Integrated Care Board
- Department for Work and Pension
- Adult Social Care
- Nottingham City Anti-Social Behaviour Team
- Community Protection Team
- Nottingham Women's Centre
- Juno Women's Aid
- Jericho Road Project
- Nottingham Fire Service
- Equation

2.2. All agency report authors have confirmed their independence with the exception of the Jericho Road Project. Only a small number of staff are employed by the Jericho Road Project, and all have worked directly with Barbara.

2.3. The following have contributed to this review by way of further communications.

- Kiddo's Housing Manager/Landlord

3. The Review Panel Members

3.1. Membership of the Domestic Homicide Review panel is;

Carolyn Carson	Independent Chair
Allison Sandiford	Independent Author
Rachel Street	Community Safety Partnership
Jemma Whitworth	Slavery and Exploitation Team
Jo Elbourne	Nottinghamshire Police
Helen Pritchett	Nottingham Healthcare NHS Foundation Trust
Debbie Richards	Housing Solutions
Nick Judge	Integrated Care Board
Katy Pearson	Department for Work and Pensions
Jane Paling	Slavery and Exploitation Team
Maggie Westbury	Nottingham University Hospitals Foundation Trust
Karen Turton	City Care Partnership
Fiona McVey	Nottinghamshire Police
Ishbel Macleod	Integrated Care Board
Rachel Daley	Equation
Kerry Jackson	Department for Work and Pensions
Laura Shelton	Nottingham County Probation Services
Martin Illingworth	Age Concern
Julie Stevens	Adult Social Care
Debbie Dyson	Nottingham Recovery Network
Julie Hitchen	Nottinghamshire Healthcare NHS Foundation Trust

3.2. The panel met on four occasions. Two occasions included discussions with key frontline practitioners from the agencies¹ involved, and the agency report authors:

- 7th of October 2024
- 14th of January 2025
- 11th of March 2025
- 6th of May 2025

3.3. All panel members have confirmed their independence with the exception of the Jericho Road Project who has been directly involved with Barbara. As mentioned, only a small number of staff are employed by the Jericho Road Project, and all have worked directly with Barbara.

4. Independent Chair and Author of the Overview Report

¹ Housing Solutions, Integrated Care Board, Slavery and Exploitation Team, POW, Nottingham Recovery Network, Equation, Jericho Road Project, Nottingham Healthcare NHS Foundation Trust, Nottingham Police, Probation Services, Department for Work and Pensions, Adult Social Care, and Nottingham Community Safety Partnership.

4.1. The review commissioned Carolyn Carson, an independent safeguarding reviewer, to act as Independent Chair. Carolyn is a retired Police Superintendent who specialised in Safeguarding, retiring whilst holding the post of Safeguarding Lead at Her Majesty's Inspectorate of Constabulary, in 2011. In 2014 Carolyn completed the SILP Lead Reviewer Course² and post-retirement Carolyn has conducted a number of adult safeguarding reviews, and Domestic Homicide Reviews both independently and with SILP.

4.2. The report has been authored by Allison Sandiford. Allison gained experience in domestic abuse and safeguarding both adults and children whilst working for a police service. Allison was part of a team responsible for the force's contribution to delivering Early Help, preventive support and problem-solving interventions for adults and children, in partnership with other key local and regional agencies. She represented the force at strategy meetings and protection conferences to assess risk and negotiate actions with other agencies to instate interventions to safeguard individuals' lives. She also gained experience in chairing meetings, conferences, and partnership initiatives such as daily management risk meetings and Multi-Agency Risk Assessment Conferences.

4.3. Allison left the police force in 2019 and after also completing the SILP Lead Reviewer Course, began to conduct serious case reviews in both children's and adults safeguarding, and Domestic Homicide Reviews.

4.4. Both Allison and Carolyn have completed the Home Office online learning with regard to conducting Domestic Homicide Reviews and have recently completed the AAFDA³ Domestic Homicide Review training (in 2024). Both have a positive attitude to continuing professional development and regularly attend training and seminars.

4.5. Neither Allison nor Carolyn have any links to Nottingham City Council or any of its partner agencies.

5. Terms of Reference

5.1. Whilst applying the principles of proportionality, learning from good practice, and engagement with families, the Independent Chair and Author have followed the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, as amended in December 2016.

5.2. Following the Independent Chair and Author being in receipt of the agency screening reports, an initial scoping and first panel meeting was held on the 7th of October 2024, where agency representation, terms of reference, the scoping period and the project plan were agreed.

5.3. This was followed by the completion of further agency reports, and the panel met on three further dates to monitor the review process and contribute to the analysis and learning.

5.4. The panel identified the following key lines of enquiry for the review:

- What was known about the circumstances of Kiddo's living arrangements and dynamics within this arrangement? Did agencies consider that Kiddo and Barbara lived in the household?
- What was known about the impact of their relationship on Kiddo's health and well-being? Were risks to Kiddo from that relationship identified where evident?
- What was known about Barbara's substance misuse. How did this impact on Kiddo?

² SILP is an approach to reviewing cases in the context of Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews and any other form of learning activity.

³ Advocacy After Fatal Domestic Abuse (AAFDA) are a Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support.

- Were there opportunities to spot potential indicators of abuse and/or to identify risk of harm to Kiddo any stage?
- Were there opportunities to identify Barbara's offending background and previous risk assessments for violence that may have flagged concerns for Kiddo's welfare?
- Were there opportunities to support Kiddo to remove Barbara or support Barbara to live away from Kiddo?
- How would Kiddo have perceived his situation? Would Kiddo have identified as being a victim of abuse?
- Were there opportunities to identify Kiddo as vulnerable and/or opportunities to reduce his vulnerability? Did Covid have an impact on Kiddo's vulnerability and support?
- Were support services available for Kiddo in his situation and if so, what barriers existed that prevented Kiddo accessing support?
- How well known are these services to the public or other potential victims in Kiddo's situation?
- What was professionals' approach to / recognition of abuse, in particular, where there is no known familial or intimate relationship?
- Were issues of slavery and exploitation considered by agencies through the lens of coercive and controlling behaviour? If so, were they identified as such?
- Did the fact that Kiddo was male contribute to agencies not identifying Kiddo as a victim?
- Did agencies consider that Kiddo may have been affected by trauma and consider how this may have affected his decision making in relation to Barbara?
- Did any barriers exist to prevent the reporting of abusive incidents in the home?
- Could communication and information sharing, within and between agencies have been improved during the scoping period?
- Did any opportunities exist for multi-agency referrals by professionals for vulnerability and/or risk management/ professionals' meetings?
- Did professionals have an opportunity to exercise professional curiosity? Were there any barriers to professionals having an opportunity to exercise professional curiosity, if so, what were they?
- Identify examples of positive practice, both single and multi-agency.

6. Summary Chronology

6.1. At the time of the murder, Barbara had been staying with Kiddo at his address. Their relationship is not confirmed to have been intimate.

6.2. On a day in May 2023, having become concerned that Kiddo had not been seen for about a week, Kiddo's Housing Manager contacted the police and reported him as missing. Later that evening, Police Officers attended his address and found Kiddo deceased. His body was badly decomposed, and he had suffered multiple stab wounds to his neck.

6.3. Barbara was declared a suspect and quickly arrested. As the investigation progressed, it became apparent that there had been fraudulent banking transactions on Kiddo's bank account since his death - one withdrawal had been successful and another had been declined. In addition, it was noted that a considerable sum of money had been withdrawn from Kiddo's bank account over the previous 18 months he had been alive.

6.4. A Home Office post-mortem concluded the cause of death to be 'stab wound to the neck'; one of the multiple stab wounds had injured the carotid artery which had led to rapid death.

7. Background of Kiddo and Barbara prior to the Scoping Period

7.1. Kiddo's ex-wife (with whom he had remained on friendly terms) passed away in 2020 and Kiddo struggled with his grief. Following her death, and parallel with the Covid pandemic, it is recorded that Kiddo self-reported increased alcohol use and loneliness during a healthcare appointment.

7.2. Barbara has reported drug use from the age of 20. She would 'work on the streets' to fund her drug habit.

7.3. Prior to the scoping period of this review, Barbara had been convicted of offences which include prostitution, dishonesty and assaults. Of particular note is an offence in which Barbara punched a 78 year old female in the face and used force to steal her handbag. Also relevant are the domestic incidents and assaults committed against her grandfather. Barbara had been convicted of assaulting her grandfather on four occasions and she received two custodial sentences; the most recent was a 39 month sentence imposed in 2019. These incidents stemmed from Barbara demanding money from her grandfather to pay for her drug habit.

8. Chronology of Events

8.1. Within months of being released⁴ from prison (subject to Multi-Agency Public Protection Arrangements Category 2, Level 1) for offences against her grandfather, Barbara was served a notice to quit the Approved Premises in which she had been housed, due to her having breached her curfew and tested positive for drugs. Hereafter Barbara moved into shared accommodation within a house opposite Kiddo's property.

8.2. Professionals attempted to support Barbara with her drug use and survival sex work but both continued. And following Barbara anticipating that she would again be evicted from accommodation due to her behaviours, she disclosed to Probation Services that she was looking at supported accommodation over the road and that she had '*befriended an elderly bloke*' who resided there. The '*elderly bloke*' was Kiddo.

8.3. A few months later Kiddo disclosed 'woman trouble' to his sister. He said that the woman was staying at his flat, but he wanted her to leave because he had given her all his money. Kiddo's sister and Kiddo's nephew attended Kiddo's address hoping to help Kiddo remove the female from his property, but Barbara was aggressive and, unable to gain entry to Kiddo's address, they had to leave.

8.4. In the same month, Kiddo's bank contacted the police under banking protocol rules. Kiddo had attended to withdraw more money having already withdrawn all his savings during the previous four months. After having established that Kiddo had been giving Barbara money for her drug habit, Police Officers escorted Barbara away from Kiddo's address. No offences could be pursued because Kiddo had capacity and had willingly given Barbara the money, but Officers submitted an Adult at Risk Public Protection Notice.

8.5. However Adult Social Care could not work with Kiddo because he did not meet the statutory requirements within the Care Act 2014. Kiddo was consequently referred to the Slavery Exploitation Team.

8.6. Barbara was soon recalled to prison by the Probation Service on the grounds that having failed to engage with the Probation Service, she had breached her sentencing and licence conditions. Thus when the Slavery Exploitation Team contacted Kiddo, he reported no further issues, and the Slavery Exploitation Team closed their case.

8.7. When Barbara was next released from prison, she was not automatically managed under Multi-Agency Public Protection Arrangements (having served her sentence), but because she had been served an additional sentence for a shop theft whilst in prison, she was now subject to Post Sentence Supervision.

⁴ Subject to Multi-Agency Public Protection Arrangements category 2 level 1

8.8. Barbara moved back in with Kiddo. Agencies (including Probation Services) were aware, but checks were not initially made in relation to the suitability of the accommodation. And when enquiries did commence, Kiddo was not identified as vulnerable.

8.9. Barbara soon disclosed to support services that she had recommenced heroin, crack cocaine and cannabis use.

8.10. Within weeks of Barbara's prison release, Kiddo stopped answering calls from the Social Prescribing Team (with whom he had been engaging since Barbara had been recalled to prison) and his phone went 'out of service'. Additionally healthcare professionals became increasingly concerned for Kiddo's health. He had been losing weight since the summer and now disclosed that he wasn't *eating that much nor very nutritional food* because he didn't have the money. Kiddo said that he was struggling with the rising cost of living, which was not being reflected in his benefits and pensions. Food parcels were arranged.

8.11. Barbara's engagement with drug support and Probation Services continued to be sporadic up until her Post Sentence Supervision ended - four months before the murder. From hereon she was not subject to any orders or licences

8.12. In May 2023, Kiddo attended a Police Station to report intimidation from Barbara stating that she had been demanding money from him to fund her drug habit. In the first instance Kiddo declined the offer of the Officer immediately attending his flat and removing Barbara but the following day, Kiddo changed his mind. Barbara was removed and Kiddo consented to an Adult Concern Public Protection Notice which was shared with Adult Social Care.

8.13. In response, an Adult Safeguarding Social Worker attempted to call Kiddo but the contact numbers provided weren't recognised. Unable to obtain any different telephone numbers, the Social Worker visited Kiddo's address. Barbara answered the door stating that Kiddo was visiting his sister, and she was at his flat to clean. The Social Worker entered the address to confirm Kiddo was not present and updated the police of the visit by email.

8.14. Four days later, when the Social Worker re-visited, Barbara said that Kiddo was still at his sister's. The Social Worker again updated the police by email in which she said *I feel as though he [Kiddo] should be treated as a missing person but of course, that's your decision.*

8.15. The following day, Barbara contacted the Social Worker to report that she was meeting Kiddo that afternoon and she would ask him to make contact. This was the same day that

- the Housing Manager entered Kiddo's address after a neighbouring resident had become concerned that Kiddo had not been seen for about a week
- the Housing Manager contacted the police reporting Kiddo missing after Barbara had called the Fire Service claiming that she had locked herself out and had left a pan on the stove, and the same day that
- Kiddo's body was found by the police.

9. Key Issues arising from the Review

Risk Assessment and Management of Barbara

9.1. Within months of Barbara's release from prison, her placement at the Approved Premises was terminated due to concerns regarding her engagement with the support offered by the Approved Premises, her drug use, and breaches of her curfew.

9.2. Probation Services have reflected that formal enforcement action could have been considered at this time - but the professional direction to work towards the Female Offender Strategy⁵, potentially influenced the decision not to.

9.3. The Strategy, which prioritised increased support for vulnerable women in the community, implemented measures to divert women from contact with the Criminal Justice System and aimed to reduce the female prison population. Consequently, the Female Offender Strategy sought to shift the focus from prison to community-based solutions, and this approach is what potentially effected professionals to prioritise supporting Barbara to resolve her issues in the community over adopting punitive measures.

Learning 1: The Female Offender Strategy influenced probation professionals to prioritise providing support to Barbara in addressing her problems within the community rather than utilising enforcement action.

9.4. This review has been assured that this influence would not happen now as professionals have developed a better understanding of how to balance the offer of support services against risk to the community.

9.5. Nevertheless, at the time, a community-based solution for Barbara should have included a review of her Multi-Agency Public Protection Arrangements to consider whether Level 1 was still appropriate. Ordinary agency management Level 1 is appropriate where the risks posed by the offender can be managed by the lead agency in co-operation with other agencies but without the need for formal multi-agency meetings. As such, offenders should only be managed at Level 1 where the lead agency is confident that their Risk Management Plan is sufficiently robust to manage the identified risks.

9.6. Given that in order to manage Barbara's presenting Risks of Serious Harm her case now needed the active involvement and co-ordination of interventions from other agencies (for example, substance support, housing and the Jericho Road Project), level 2 active multi-agency management could have been considered. Level 2 would have demanded formal multi-agency meetings, and these would have supported information-sharing, and discussions between the agencies as necessary.

Learning 2: The Multi-Agency Public Protection Arrangements were not effectively reviewed which resulted in a lack of consideration as to whether Barbara's case management would have benefitted from Level 2 arrangements.

9.7. This review has been assured that this learning is now addressed as Probation Services have informed that monitoring has since improved and now includes

- flagging of eligible Multi-Agency Public Protection Arrangements cases and
- practitioners and the senior Probation Officer completing a form to determine the management level.

Additionally, systems are now in place to identify missing forms, which are reviewed every six months.

9.8. And additional assurance of improvement to the review of Multi-Agency Public Protection Arrangements has been provided by the police, who have also recognised a training need and have commenced developments⁶.

⁵ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719819/female-offender-strategy.pdf

⁶ In September 2024 the police created and began delivering a half day training session. This training is available to representatives from all relevant partner agencies which include Police, Probation, Prison, NHS, Youth Justice, Department for Work and Pensions, Adult Social Care, Children's Social Care, Housing and others. By March 2025 they had delivered 6 training sessions to a maximum of 240 people and had monthly sessions arranged with sessions being fully booked until July 2025, enabling a further 160 people to attend. In addition police had prepared a training session for Core

9.9. Drug Services and POW continued to work to support Barbara in the community. POW outreach workers often saw her on the streets but there was also a suspicion that Barbara might have been engaging in survival sex at the accommodation as the housing provider reported to Probation Services that a number of males were attending Barbara's property. The Probation Officer discussed this with Barbara, and it was during this discussion that Barbara first referenced Kiddo; when she stated that she had *befriended an elderly bloke* who lived in supported accommodation across the road. Case notes from this discussion suggest a lack of professional curiosity into this situation - there is nothing to evidence that the Officer asked for more information (in this appointment or in subsequent appointments) but further details should have been sought to understand any potential vulnerability of Kiddo. Theoretically, the information acquired could have then supported safeguarding and police enquiries being made.

Learning 3: A lack of professional curiosity regarding the 'elderly bloke' Barbara said she had befriended, equated to a missed opportunity to explore any potential vulnerability and identify risk.

9.10. Professional curiosity is considered in more detail later in this report.

9.11. In time Barbara informed her Probation Officers (Barbara now had two Probation Officers⁷) in a meeting that she had voluntarily left her accommodation and was staying with the *older bloke across the road*. One of the Probation Officers advised that the address would have to be approved, and Barbara confirmed the address (it was Kiddo's). There is no evidence of any further query into the address or its occupant.

9.12. Whilst there is evidence of the agencies involved with Barbara's support offer communicating with one another around this time, consideration could have been had to convening a multi-agency meeting. Notably, this course of action was open to every agency, but the information brought to this review suggests that not all professionals are confident to convene a professionals' multi-agency meeting. This is common learning in safeguarding reviews and not surprising when it is considered how professionals' meetings mean something different to each agency. But what all agencies should understand is that they:

- Can be a one off or regular meeting – called when a discussion with other professionals is needed
- Can be called at short notice in a crisis
- Can be used to discuss specific cases, care and treatment, incident, risk, professional challenge or disagreement etc.
- Can be called by any agency

9.13. Had any professional convened a meeting, agencies would have clearly recognised that Barbara

- was now using large amounts of drugs and not engaging with support,
- needed large sums of money to fund the drugs,
- was not engaging consistently with probation,
- had been accused of assault,
- Was a known risk to older people, and
- was potentially homeless but living with an *elderly bloke* she had *befriended*.

9.14. This information when pieced together would have supported professionals to recognise that the risk Barbara posed was not being effectively managed in the community and discussions around this should have

Panel Members, from all agencies who sit on the Level 2 and Level 3 meetings. This session is aimed at raising awareness of the role of a core panel member and their requirements.

⁷ In June 2021, Barbara's case started to be co-worked with another Probation Officer (in training) joining her current Practitioner. As part of the training process, staff are required to 'co-work' high risk cases to develop an understanding of this type of work. The new Probation Officer had been employed as a Probation Service Officer prior to commencing her training and was therefore experienced in working with individuals on Probation. All relevant safeguarding and domestic abuse training had been completed, and this Practitioner was a female member of staff who had a keen interest in working with Women on Probation.

led to Probation Officers seeking managerial oversight. And, as per the 2016 National Probation Service Effective Practice Team Guidance, a reassessment of risk, and the Risk Management Plan.

9.15. Instead agencies worked mostly in siloes and their focus remained upon Barbara's rehabilitation as opposed to the risk she potentially posed to the public.

Learning 4: Agencies focussed upon their own remit within Barbara's rehabilitation and in working predominantly in siloes, lost sight of the risk she posed to the community if rehabilitation wasn't proving successful.

Recommendation 1: Nottingham Community Safety Partnership should seek to review and re-issue guidance on all multi-agency meetings to support practitioners' to recognise a legitimate reason for getting together and to empower them to lead and convene professionals' meetings and/or refer to another meeting forum, as appropriate. Nottingham Community Safety Partnership must work with agencies to ensure that the information is thereafter known, and easily accessible, to all professionals.

9.16. Barbara soon disclosed to one of the Probation Officers, an incident with one of Kiddo's neighbours. Barbara denied any wrongdoing but told probation that she had agreed to a voluntary police interview. There is no evidence of Probation Services exploring the incident with the police.

9.17. Notably, had Probation Services already had shared their Level 1 intelligence with the police, the police would have known that Barbara, a level 1 offender was living within their community and could have updated Probation Services when she came to their attention. But regardless, there is no evidence of any Officer delving into Barbara's information, as an alleged perpetrator, and on account of her most recent criminal conviction, contacting Probation Services to see if she was known to them and to share the information.

9.18. This lack of communication and information sharing between Probation Services and the police resulted in missed opportunities to review Barbara's Risk Management Plan and to consider enforcement action.

Learning 5: There is an identified need for establishing a communication pathway between Probation Services and the police for sharing information concerning violent offenders and domestic abuse perpetrators.

9.19. This review has been informed that as a result of this review the police Multi-Agency Intelligence Team has already started to work with Probation Services to improve their information sharing systems and all information sharing between police and probation is currently under review to assess if the current arrangements are fit for purpose.

Recommendation 2: Nottingham Community Safety Partnership in collaboration with Nottingham Safeguarding Adults Board, must gain assurance and understanding of the continuing work between Probation Services and the police in relation to improving their communication and information sharing processes, and seek evidence of improvement.

9.20. In time, due to Barbara failing to reside as directed and failing to attend appointments, a decision was taken by Probation Services that she be recalled to custody under a standard recall⁸. This decision was correct as it was evident that the risks were not being successfully managed in the community.

⁸ A standard recall means that you are returned to custody for an undetermined length of time which could be until their sentence expiry date for determinate sentence prisoners.

9.21. During this period in custody, Barbara was further sentenced in relation to a shop theft and received an additional two months in custody. Consequently upon Barbara's automatic release on her Sentence Expiry Date⁹, though now not managed under Multi-Agency Public Protection Arrangements (having completed her sentence), she would be made subject to Post Sentence Supervision.

9.22. Prior to Barbara's release from prison, accommodation was identified, but Barbara declined the offer stating that shared accommodation was not appropriate for her and that she wished to stay with Kiddo. This was reported back to Probation Services.

9.23. It is notable that whilst Barbara was in prison, Probation Services reduced Barbara's Risk of Serious Harm from high to medium. This effected Barbara no longer being eligible for Approved Premises upon her release. But one of the requirements of Post Sentence Supervision is to reside at an address approved by the supervising officer. Therefore when Barbara said she would stay at Kiddo's property, his address should not have been approved, and positive practice would have seen Barbara being notified that her residence at the supported accommodation she had been offered was a direction until alternative accommodation was approved.

9.24. Probation Services have reported that interviews with staff during this review suggest this was overlooked because of the influence of a Pilot scheme that had been introduced in the East Midlands Probation Area in respect of changing the way those subject to Post Sentence Supervision were managed. The interviews revealed that practitioners were, at that time, adopting a more passive approach towards enforcement when interpreting the Pilot scheme's guidance.

9.25. It is important to note that the Pilot scheme is no longer in place, and new guidance has re-emphasised the importance of enforcement.

Learning 6: A rehabilitative focus on Barbara lost sight of the risks she posed to others.

9.26. To respond to this learning, this report has already confirmed that in regard to overlooking risks when Barbara was

- subject to licence conditions; it was the influence of the Female Offender Strategy, which had led probation professionals to prioritise supporting Barbara to address her issues within the community rather than enforce penalties. This would not occur now as professionals have a better understanding of how to balance support services with community risk.
- under Post Sentence Supervision, it was the influence of the Pilot scheme which led to probation professionals adopting a more passive approach towards enforcement and the new probation reset guidance aims for a more balanced approach.

9.27. In line with the aforementioned Pilot Scheme guidance, following the *emerging risk concerns* (i.e., the problems concerning Barbara's engagement with agencies), Barbara's Probation Officer scheduled several enforceable (face-to-face) appointments, which Barbara failed to attend. These appointments could have been enforced but instead it was agreed with Senior Probation Officers that re-engaging Barbara was the priority but very soon after these failed appointments, Barbara had to be allocated a new Probation Officer.

9.28. This review has been unable to effectively analyse the handover as there are no notes to indicate what risks, concerns and next steps were highlighted to the new practitioner. But without doubt, the change in worker would have affected the continuity of Barbara's supervision and it is possible that Barbara's new

⁹ In respect of the custodial sentence she was serving for the offences against her grandfather - the shop theft sentence had run concurrently

Probation Officer did not realise that the previous Practitioner had been trying to arrange an appointment with Barbara *in light of emerging risk concerns* – rendering the appointment enforceable.

Learning 7: When a new Probation Officer is allocated a case, there should be a thorough documented handover to reflect what has been discussed.

9.29. Probation Services have informed that in relation to cases being allocated; under current standard practice the allocation would be clearly outlined, and it would be recorded on the system that before the case can be moved, a full handover is required and must be documented. In the event of an emergency, for example, where a practitioner has already left the service, the senior Probation Officer would be expected to record the suitability of the case to the newly allocated practitioner and to record the expectation that the incoming practitioner appraise themselves of the situation by reading the case notes. Probation Services have reported improvements in the recording and monitoring of recording.

9.30. Following the new Probation Officer managing an appointment with Barbara, the Probation Officer completed a safeguarding check in relation to Kiddo.

9.31. The safeguarding check revealed that Kiddo was not known to services, indicating that Adult Social Care had not previously engaged with Kiddo. This provided some reassurance to Probation Services as it suggested that Kiddo did not have care and support needs that rendered him vulnerable. However, considering his age, it was likely that Kiddo would have had an element of vulnerability and therefore, a case discussion with supervision would have been advisable to explore potential options for obtaining further information about Kiddo - to assess any vulnerability unknown to Adult Social Care.

Learning 8: Further risk assessment and professional enquiry was required to gather the knowable information and to support better identification of the risk of exploitation.

9.32. The safeguarding check was only the starting point of the enquiry. Improved and continuous professional curiosity would have seen further information being sought and triangulated from other sources. Professional curiosity is addressed within a recommendation later in this report.

Professionals recognition of Kiddo's increasing vulnerabilities

9.33. Prior to Barbara commencing her exploitation of Kiddo, he had been living alone for several years, and though he was friendly with a neighbour with whom he would regularly chat; it seems that Kiddo didn't know many people in the neighbourhood. Also at the beginning of the scoping period of this review Kiddo was grieving his ex-wife.

9.34. Police records identify that Officers learned much later in the scoping period from Kiddo that Barbara had told him early in their 'friendship' that she was homeless, and she had asked if she could stay for two nights. This is corroborated by Kiddo's family who have informed the review that Kiddo eventually confided that he and Barbara had gone for a drink, and he had started to feel sorry for her and had agreed to her staying for a couple of nights.

9.35. Following this 'offer', Barbara moved her belongings in to Kiddo's address and began to manipulate him into using his savings to fund her drug habit.

9.36. A key mechanism of this manipulation was the redirection of Barbara's benefits into Kiddo's account. By using his bank account (and his email address) for her Universal Credit, Barbara effectively merged their

financial identities and exploited him, taking advantage of his kind-hearted nature from the beginning by making him feel sorry for her. In light of Kiddo’s loneliness, it is reasonable to assume that he would have initially welcomed Barbara into his life as a friend.

Learning 9: Loneliness is a widespread experience; however, when it becomes prolonged and persistent, it can significantly impact an individual’s health and heighten their susceptibility to exploitation.

Recommendation 3: Nottingham Community Safety Partnership must seek assurance from agencies that loneliness is acknowledged as a feature of safeguarding within their guidance and training packages.

9.37. Professionals who initially became aware of a ‘connection’ between Kiddo and Barbara fell into two categories. They either knew the risk that Barbara posed but didn’t understand Kiddo’s vulnerabilities, or they knew of Barbara but knew nothing about her or the risk she posed. Both Barbara’s risks and Kiddo’s vulnerability was ‘knowable’ information but was not effectively sought – even when, as we move through the scoping period of this review, there is an increasing professional concern around the ‘friendship’ between Kiddo and Barbara, with some professionals reporting their concerns to the police and/or referring to safeguarding in line with practice protocol.

9.38. One of the subsequent barriers professionals faced in relation to supporting Kiddo, was that Kiddo was unable to maintain engagement with services. This is not unusual from a victim of exploitation, and behaviour whereby individuals seek support and then withdraw, follows patterns observed in relationships involving domestic abuse.

9.39. Professionals needed to employ robust professional curiosity to explore and understand situations whereby Kiddo withdrew his engagement with services.

Learning 10: Professionals needed to be ‘curious’ by asking questions and thereafter verifying information from alternative sources, as required to gain an effective understanding of the circumstances.

Recommendation 4: Agencies must evidence to Nottingham Community Safety Partnership that that they are prompting and encouraging their professionals to be professionally curious, and Nottingham Community Safety Partnership must gain an improved understanding of how to support agencies with this practice.

9.40. When during the scoping period of this review a safeguarding concern was shared with Adult Social Care, a member of the team established through enquiry that because Kiddo had no identified eligible Care Act needs, the criteria for a safeguarding enquiry was not met. Adult Social Care closed their case but did refer Kiddo to the Slavery Exploitation Team.

9.41. This was positive practice because adult safeguarding responsibility is broader than just those situations that can progress to a safeguarding enquiry; there is a shared responsibility across organisations to address risks to wellbeing and safety, whether through safeguarding responses or through alternative support pathways. And the Slavery Exploitation Team was the correct referral because the team has dedicated Officers who work with partners to identify and tackle exploitation, (and modern slavery and trafficking) and offer support to survivors.

9.42. However conversations with professionals involved with this review highlighted that many have not heard of the Slavery Exploitation Team and/or are unsure of what they do and/or how and when to refer.

Learning 11: Many professionals remain unaware of the Slavery Exploitation Team.

Recommendation 5: Nottingham Community safety Partnership in collaboration with the Slavery Exploitation Team must raise awareness of the Slavery Exploitation Team within partner agencies and support agencies to embed referrals into their guidance and processes.

9.43. In relation to signposting Kiddo for other support with Barbara's behaviours, whilst this review is a Domestic Homicide Review, agencies involved have highlighted that at no point during the scoping period would it have been appropriate to signpost Kiddo to domestic abuse services. This is because as previously mentioned, the relationship between Kiddo and Barbara¹⁰ did not fit the criteria within the Domestic Abuse Act 2021, and therefore incidents would not have been classed as domestic abuse incidents.

9.44. Nevertheless, professionals involved with this review identified that there are definite benefits to be had from looking at domestic abuse procedures and protocols and considering how domestic abuse practice could be adapted and applied to support victims of exploitation.

9.45. Had Kiddo been a survivor of domestic abuse perpetrated by Barbara it is likely that following the police reports which indicated that Barbara could impact Kiddo's safety, Officers would have disclosed relevant information to Kiddo in relation to Barbara's offending history. And such a disclosure would have been accompanied by a robust safety plan tailored to Kiddo's needs which would have included detailing any protection orders available to him should he require support.

9.46. Part of a police response to a high-risk domestic abuse is also consideration of a panic alarm. Taking into account that later disclosures made by Kiddo highlighted Barbara's propensity to use physical violence and to take or damage his property, a panic alarm would have been a useful tool for Kiddo. Had Kiddo had a panic alarm; he would have been less dependent upon finding a phone when he required immediate assistance.

9.47. Additionally, when notified of a single or repeated occurrence of domestic abuse, many agencies will add a flag or domestic abuse warning marker to the case file of both the victim and perpetrator. This ensures that professionals are aware of the concerns and risks in future contacts and can incorporate appropriate safeguarding into their practice. This review has learned that there is no similar marker in relation to a victim of exploitation and/or a perpetrator of exploitation but that a Place of Interest Information Marker could have been placed on Kiddo's address to alert Police Officers attending incidents that Kiddo was a vulnerable victim, potential repeat victim, and the reasons why.

9.48. Had a marker been placed against Kiddo a more robust response may have been affected when Kiddo later went to the police station in May 2023 and disclosed intimidation from Barbara stating that she demanded money from him to fund her drug habit.

Learning 12: Marking Kiddo's address as a Place of Interest might have prompted a stronger response to later incidents.

¹⁰ Only Kiddo and Barbara can ever know the true dynamics of their relationship and whether it was intimate or not. Kiddo described Barbara as his friend, but on one occasion Barbara did tell Police Officers that they had had a sexual relationship. However there is nothing further to support this and it may have been an attempt by Barbara to justify her presence at the address.

Recommendation 6: Nottingham Police must review the criteria and use of their Place of Interest Markers in relation to repeat victims of crime and ensure that the updated criteria is implemented across the force and incorporated into training.

Learning 13: Valuable learning from the identification and protection of domestic abuse victims is not replicated in exploitation safeguarding processes which is allowing exploitation victims to remain unsupported and at risk.

9.49. This learning point (13) must be respected within the action plan in relation to Recommendation 7 later in this report.

The Professional Challenges

9.50. In order to identify learning for future practice, this review must consider why the practice around the two individuals didn't ever effectively come together and the crucial question for the learning of this review is - why didn't professionals recognise the potential risks and effect a multi-agency response to Barbara's exploitation of Kiddo which led to his murder?

9.51. An initial challenge for professionals started with the fact that financial abuse and exploitation are multifaceted areas of work for all agencies which examples why it is important to ensure that all agencies include financial abuse and exploitation within their training and as directed at Recommendation 6, embed the Slavery Exploitation Team support offer.

9.52. Another challenge professionals faced in relation to supporting Kiddo was that having allowed Barbara access to his property and having agreed to give her the money, Kiddo was seen as being somewhat 'complicit', and this led to missed opportunities to identify his vulnerabilities and needs. Additionally, Kiddo, like most victims, was reluctant to disclose his situation to professionals due to fear of repercussions. And furthermore the intricacy of the offender/victim relationship was not always understood by professionals.

9.53. All of this reflects historic practice attitudes to domestic abuse; it is only in the last 30 years or so, that there has been a change in how domestic abuse is understood and treated. Clearly professional practice around exploitation needs to follow similar guidelines to those outlined for domestic abuse

Learning 14: The challenges for professionals began with the complexity of exploitation work and lack of direct processes.

Recommendation 7: Nottingham Community Safety Partnership in collaboration with partner agencies must learn from domestic abuse practice to develop and promote a robust straightforward multi-agency resource (which should include referral to the Slavery Exploitation Team and reference the work they do) which will support professionals from all agencies to respond to concerns of financial abuse and exploitation effectively. This resource must thereafter be integrated into agency safeguarding training and processes.

Recommendation 8: The Home Office should consider reviewing and developing exploitation practice based upon the good practice standards exemplified within domestic abuse.

10. Conclusions

10.1. Barbara was a complex individual who struggled with substance addiction from an early age and she had been convicted of criminal offences relating to violent acts which she committed to obtain funds for her addiction.

10.2. In the community, Barbara funded her addiction with survival sex work and in time Barbara exploited Kiddo to give her his life savings. There is also evidence she assaulted him.

10.3. Barbara's exploitative behaviour was not properly identified by agencies. There was a lack of professional curiosity demonstrated, and no single agency identified Kiddo's lived experience. Notably there were no multi-agency professionals' meetings held in the scoping period. Consequently despite opportunities, Barbara's coercion of Kiddo was not interrupted.

10.4. Upon her release from prison, Barbara had been assessed as presenting a high risk of harm to vulnerable persons but although she was a Multi-Agency Public Protection Arrangements Category 2 Level 1 Violent Offender, this information was not passed to the police. The police therefore remained unaware, and this impacted their responses and information sharing when Kiddo, Kiddo's bank and Kiddo's family reported incidents/concerns.

10.5. The police referred Kiddo to the Multi-Agency Safeguarding Hub, but he was initially identified as not having eligible Care Act needs, and the criteria for a safeguarding enquiry was not deemed met (though he was referred to the Slavery Exploitation Team on one occasion).

10.6. Furthermore, Kiddo was not identified either by the Multi-Agency Safeguarding Hub or the police as a repeat vulnerable adult.

10.7. When Kiddo went to the police station just days before his homicide, financially distressed and unsure how to remove Barbara from his home, his previous reports were not taken into account. His report of theft and criminal damage was managed in isolation, and there was no consideration given to arresting Barbara – though a police Public Protection Notice was referred to Adult Social Care.

10.8. Furthermore, because there was no intimate relationship, when exploitation was identified the incidents did not meet the criteria to be managed as 'domestic abuse'. Therefore, although Barbara's offending behaviour and risk mirrored domestic abuse by way of coercive and controlling behaviour, financial abuse and ultimately homicide, domestic abuse processes could not be followed. This resulted in less robust protections, and it is evident that agency procedures for exploitation need to change and mirror those used in domestic abuse.

10.9. Overall, agencies worked mainly in silo, each managing different aspects and holding their own information without collaboration to assess the entire situation. Thus Barbara was able to continue her activities in support of her drug addiction without challenge.

10.10. Kiddo was failed by agencies and could, and should, have been protected. Instead, he was violently murdered by Barbara; a convicted high-risk abuser whose risks to Kiddo should have been identified.

10.11. Unless the recommendations of this review are implemented, the same outcome will be possible for future victims of exploitation in Kiddo's situation.

11. Lessons to be Learnt and Recommendations

11.1. Nottingham Community Safety Partnership, the Independent Chair and the Independent Reviewer would like to thank agencies for their single agency lessons learned from this Domestic Homicide Review which were outlined within their reports and are detailed at Appendix 1 of this report.

11.2. The review would ask that all the agencies/organisations provide assurance to Nottingham Community Safety Partnership of their action plans being monitored and outcomes being impact assessed.

11.3. The multi-agency lessons learned from this Domestic Homicide Review are highlighted in bold text throughout this report, but for reference, are repeated here alongside the relevant question if the learning has not been already addressed:

	Lessons/Learning	Has this learning been addressed?	Recommendation (where required)
1	The Female Offender Strategy influenced probation professionals to prioritise providing support to Barbara in addressing her problems within the community rather than utilising enforcement action.	This review has been assured that this influence would not happen now as professionals have developed a better understanding of how to balance the offer of support services against risk to the community.	
2	The Multi-Agency Public Protection Arrangements were not effectively reviewed which resulted in a lack of consideration as to whether Barbara's case management would have benefitted from Level 2 arrangements.	This review has been assured that this learning is now addressed as alongside the improvements to Probation Services practice (identified in paragraph 9.7), the police have already recognised a training need in relation to Multi-Agency Public Protection Arrangements and have commenced developments.	
3	A lack of professional curiosity regarding the 'elderly bloke' Barbara said she had befriended, equated to a missed opportunity to explore any potential vulnerability and identify risk.	Professional curiosity is addressed at Recommendation 4	
4	Agencies focussed upon their own remit within Barbara's rehabilitation and in working predominantly in siloes, lost sight of the risk she posed to the community if rehabilitation wasn't proving successful.		1 Nottingham Community Safety Partnership should seek to review and re-issue guidance on all multi-agency meetings to support practitioners' to recognise a legitimate reason for getting together and to empower them to lead and convene professionals' meetings and/or refer to another meeting forum, as appropriate. Nottingham Community Safety Partnership must work with agencies to ensure that the information is thereafter known, and easily accessible, to all professionals.
5	There is an identified need for establishing a communication pathway between Probation Services and the police for sharing information concerning violent offenders and domestic abuse perpetrators.	This review has been informed that as a result of this review the police multi-agency information team has already started to work with Probation Services to improve their information sharing systems	2 Nottingham Community Safety Partnership in collaboration with Nottingham Safeguarding Adults Board, must processes and understand the continuing work between Probation Services and the police in relation to improving their communication and information sharing processes, and seek evidence of improvement.
6	A rehabilitative focus on Barbara lost sight of the risks she posed to others.	In regard to overlooking risks when Barbara was subject to licence conditions; the review heard that it was the influence of the Female Offender Strategy which led probation professionals to prioritise supporting Barbara within the community rather than enforce penalties. This would not occur now as professionals have a better understanding of how to balance support services with community risk. And when Barbara was under Post Sentence Supervision, it was the influence of the Pilot scheme which led to probation professionals adopting a more passive approach towards enforcement and the review has been assured that the new probation reset guidance aims for a more balanced approach.	
7	When a new Probation Officer is allocated a case, there should be a thorough	Probation Services have informed that in relation to cases being allocated; under current standard practice the	

	documented handover to reflect what has been discussed.	allocation would now be clearly outlined, and it would be recorded on the system that before the case can be moved, a full handover is required and must be documented.		
8	Further risk assessment and professional enquiry was required to gather the knowable information and to support better identification of the risk of exploitation.	The safeguarding check was only the starting point of the enquiry. Improved and continuous professional curiosity would have seen further information being sought and triangulated from other sources. Professional curiosity is addressed at Recommendation 4		
9	Loneliness is a widespread experience; however, when it becomes prolonged and persistent, it can significantly impact an individual's health and heighten their susceptibility to exploitation.		3	Nottingham Community Safety Partnership must seek assurance from agencies that loneliness is acknowledged as a feature of safeguarding within their guidance and training packages
10	Professionals needed to be 'curious' by asking questions and thereafter verifying information from alternative sources, as required to gain an effective understanding of the circumstances.		4	Agencies must evidence to Nottingham Community Safety Partnership that that they are prompting and encouraging their professionals to be professionally curious, and Nottingham Community Safety Partnership must gain an improved understanding of how to support agencies with this practice.
11	Many professionals remain unaware of the Slavery Exploitation Team.		5	Nottingham Community safety Partnership in collaboration with the Slavery Exploitation Team must raise awareness of the Slavery Exploitation Team within partner agencies and support agencies to embed referrals into their guidance and processes.
12	Marking Kiddo's address as a Place of Interest might have prompted a stronger response to later incidents.		6	Nottingham Police must review the criteria and use of their Place of Interest Markers in relation to repeat victims of crime and ensure that the updated criteria is implemented across the force and incorporated into training.
13	Valuable learning from the identification and protection of domestic abuse victims is not replicated in exploitation safeguarding processes which is allowing exploitation victims to remain unsupported and at risk.	This learning point must be respected within the action plan in relation to Recommendation 7 later in this report.		
14	The challenges for professionals began with the complexity of exploitation work and lack of direct processes.		7	Nottingham Community Safety Partnership in collaboration with partner agencies must learn from domestic abuse practice to develop and promote a robust straightforward multi-agency resource (which should include referral to the Slavery Exploitation Team and reference the work they do) which will support professionals from all agencies to respond to concerns of financial abuse and exploitation effectively. This resource must thereafter be integrated into agency safeguarding training and processes.
			8	The Home Office should consider reviewing and developing exploitation practice based upon the good practice standards exemplified within domestic abuse.

Appendix 1 – Single Agency Recommendations
Probation Services:

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome	Audit
Probation Instruction 30/2014: Drug appointment and drug testing for licence conditions and post sentence supervision requirements to be re-issued to all staff.	The Probation Instruction will be recirculated via email to all staff. The lead Senior Probation Officer for substance misuse will attend all local team meetings to address key points and answer any staff queries. A sample of 20 cases with licence conditions relating to drug testing will be reviewed to ensure that testing and enforcement actions is in line with policy expectations.	Deputy Head of Service and Lead Substance Misuse Senior Probation Officer	Email to be circulated within 4 weeks. Follow up meetings to be attended within 8 weeks. Case sampling to take place 3 months after the initial activities have been implemented.	Ensure all staff are appraised of expectations around drug testing and that policy and guidance is being followed consistently	
A review to be undertaken to ensure that case allocation practices have been embedded, and that Senior Probation Officers have processes in place to review new allocations with Probation Practitioners	A sample of 3 cases per Sentence Management Senior Probation Officer allocated within the last 3 months will be reviewed to ensure that case allocation has followed guidance and that all new allocations have had a follow up case discussion. If the evidence indicates that practice has not been embedded, then further input will be delivered to the staffing group or individuals as required.	Deputy Head of Service	6 months	To confirm that process is fully embedded within practice	
A review to be undertaken to ensure that the Address Checks policy has been fully embedded within Probation practice	A sample of 20 licence cases across the Probation Delivery Unit will be reviewed to ensure that pre-release address checks have been appropriately completed, and checks have been completed in full ahead of any proposed address change. If the evidence indicates that practice has not been embedded, then further input will be delivered to the staffing group or individuals as required.	Deputy Head of Service	6 months	To confirm that process is fully embedded within practice	
Additional training to be provided to all staff around Professional Curiosity	Senior Probation Officers to re-deliver the Professional Curiosity 7 Minute briefing to all staff in a team meeting and reissue the document	Deputy Head of Service	6 months	To provide assurance that all staff have received relevant training and are aware of the importance of exercising professional curiosity in their roles	
To undertake a review in relation to case handover processes to ensure that processes are being followed	A sample of 20 cases will be reviewed across the Probation Delivery Unit to ensure that when management of a case is moved that a fully documented case handover takes place between the incoming and outgoing practitioner and that there is appropriate management oversight of the decision	Deputy Head of Service	6 months	To confirm that process is fully embedded within practice	

POW Nottingham

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome	Audit
Improve information sharing procedures with external agencies	Bring to Sex Worker Meetings to discuss procedure/protocol	Police Liaison Worker	TBC	Detailed review of those released from prison/returning to the area within meeting.	Minutes of Sex Worker Meetings

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Improve information sharing procedures internally	Briefing in team meeting of the information gathered from Sex Worker Meetings	Police Liaison Worker	January 2025	Increased awareness of arising issues and concerns	Minutes of team meeting
Train/encourage staff to show professional curiosity	Training session to staff to understand what is professional curiosity and the importance of it	Management	March 2025	More detailed understanding of the lives of the people we work with	More detailed information and notes

Equation

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome	Audit
Agencies to access 'Working with Men experiencing DVA' training	Circulate training details	Head of Service, Equation	By April 2025 when 2025/26 training dates are available	Learning outcomes for professionals <ul style="list-style-type: none"> • Understand the experience of men living with domestic violence and abuse in their intimate and family relationships • Develop skills in responding appropriately to men experiencing domestic abuse • Recognise the complexities of working with men experiencing domestic abuse • Understand how to use relevant tools to respond appropriately to men experiencing abuse, including risk assessment and screening tools and referral pathways • Recognise good practice points for responding to gay, bisexual and transgender men 	
Agencies to attend 'Recognising and Responding to Perpetrators of Domestic Abuse' training	Circulate training details	Head of Service, Equation	By April 2025 when 2025/26 training dates are available	Learning outcomes for professionals: <ul style="list-style-type: none"> - Build a safe alliance with a perpetrator of abuse, effectively building sufficient rapport to gain information crucial for possible behavioural change intervention - Use Equation's counter allegations tool to get closer to identifying a primary perpetrator - Use Equation's Perpetrator Assessment Tool to explore abusive behaviours with perpetrators in a therapeutic manner - Explore possible underlying issues related to domestic abuse - Identify risk factors when working with perpetrators and have knowledge of safer practice - Identify possible indicators of positive change in perpetrators of abuse - Complete an in depth referral to a voluntary Domestic Violence Perpetrator Programme (DVPP). 	

Nottinghamshire Healthcare NHS Foundation Trust

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome	Audit
Routine enquiry to be added to the templates used for podiatry documentation	Review templates used on Sys 1 to ensure it makes documentation regarding routine enquiry clearer	Manager for Podiatry		Routine enquiry is embedded within the service and recorded appropriately	

Nottingham Women's Centre

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome	Audit
Amend case review proforma	As well as assessing and monitoring arising risk, include routine review of original risk assessment from referral to take into account changes in circumstances -during support plan reviews with case workers	Sara Garton	January 2025	Line managers routinely check on risk factors, are more able to mitigate risk and ensure professional curiosity in all caseworkers.	April 2025
Training for casework team - Multi Agency Working	Train caseworkers at induction and in training sessions – ensuring knowledge of importance and application of multi-agency working	Sara Garton	March	All caseworkers are able to appropriately convene multi-disciplinary meetings, information share and minimise risk of missed information/action taken	June 2025
Training - women perpetrators domestic abuse	Source training for caseworkers awareness	Sara Garton	February 2025	Caseworkers awareness is raised, bias is addressed, risk correctly identified.	May 2025

Nottinghamshire Police

<p>Recommendation 1 It is recommended that Nottinghamshire Police identify the best process to ensure that officers attending incidents where vulnerability is identified are aware of their responsibility to consider and implement safeguarding measures. This is in addition to any support provided following the submission of a Public Protection Notice.</p>
<p>Recommendation 2 from the Independent Office for Police Conduct report. 'If the initial decision by the reviewing officer is not to share a Public Protection Notice with Social Care, then the reviewing officer will review the last 3 months previous Public Protection Notice's linked to that nominal on Niche to ensure that there is no relevant further information or repeat concerns that may influence that decision. When we document the decision on Niche not to send a Public Protection Notice to social care, we include the statement 'I have reviewed the last 3 months Public Protection Notice's linked to this nominal and there is no relevant information that influences this decision'.</p>
<p>Recommendation 3 From Independent Office for Police Conduct Comments. Nottinghamshire Police to consult with Social Care to consider how to improve information sharing around the outcome of any safeguarding interventions adopted following referrals by the MASH team to the local authority.</p>
<p>Recommendation 4 Attending officers and supervisors should be reminded to identify Repeat Vulnerable Victims using information available within Force systems. The qualifier facilities available within Niche should be populated so that such individuals can be readily identified and safeguarding interventions considered. The use of such qualifiers would assist in identifying repeat vulnerable victims for any subsequent tasking process as identified within Recommendation 5.</p>
<p>Recommendation 5 Nottinghamshire Police to consider implementing a formal tasking process to identify repeat vulnerable victims identified as Adults at Risk and identify the most appropriate resource to provide safeguarding interventions.</p>
<p>Recommendation 6 Nottinghamshire Police to consider amending the Adult at Risk Public Protection Notification Report (Public Protection Notice) on Niche; to include questions to remind the submitting officer of their responsibilities around safeguarding, and to identify if the individual is a repeat vulnerable victim.</p>

DHR Haiku Report Recommendations and IMR Action Plan April 2025

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

DHR Haiku Report Recommendations:

	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)	Nottingham Community Safety Partnership should seek to review and re-issue guidance on all multi-agency meetings to support practitioners' to recognise a legitimate reason for getting together and to empower them to lead and convene professionals' meetings and/or refer to another meeting forum, as appropriate. Nottingham Community Safety Partnership must work with agencies to ensure that the information is thereafter known, and easily accessible, to all professionals.	Agencies focussed upon their own remit within Barbara's rehabilitation and in working predominantly in siloes, lost sight of the risk she posed to the community if rehabilitation wasn't proving successful.	Local	<p>Prepare a One-Slide Briefing for ALIG Dissemination.</p> <p>Create a concise briefing to be shared via ALIG and cascaded to partner agencies. This briefing should:</p> <ul style="list-style-type: none"> • Reference relevant existing frameworks and policies. • Provide clear guidance on when and how to convene multi-agency meetings. • Outline who the appropriate and relevant partners are to involve. 	<p>Input required by ALL Assurance, Learning and Implementation Group partners to capture information required.</p> <p>NCSP and Equation to create the one-slide briefing document.</p>	Sept 2025		All agencies passing this information out will demonstrate completion.	

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to Take	Lead Agency	Target Date	Date of Completion	Evidence: <ul style="list-style-type: none"> • 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
				<ul style="list-style-type: none"> • Emphasize that this applies not only to established meetings and pathways, but also to ad hoc multi-agency meetings convened for specific cases. All partners have a responsibility to initiate a multi-agency professionals meeting whenever a case requires collaborative discussion.					
2)	Nottingham Community Safety Partnership in collaboration with Nottingham Safeguarding Adults Board, must gain assurance and understanding of the continuing work between Probation Services and the police in relation to improving their communication and information sharing processes, and seek evidence of improvement.	There is an identified need for establishing a communication pathway between Probation Services and the police for sharing information concerning violent offenders and domestic abuse perpetrators.	Local	<ol style="list-style-type: none"> 1. Police and Probation will work together to facilitate improved working with CAT 2/3 MAPPA nominals by creating a new CAT2/3 Police team and ensuring that all MAPPA nominals are on Visor and Probation staff vetted and trained to access the system 2. Police and Probation will work to ensure that all PPNs are shared directly from the Police to Probation on the next working day to ensure a timely exchange of domestic abuse information 3. Police and Probation will review the wider information sharing protocol to improve the request for and nature of 	Probation Nottinghamshire Police	May 2026		14/08/2025 <ol style="list-style-type: none"> 1. The formation of the new MAPPA Cat 2/3 is almost at completion – the recruitment for this team sits with the Police and I understand this process in now at the onboarding stage. Probation continue their program of vetting and training staff on Visor and nominals are being added to the system regularly to ensure that information can be shared via this route. <ol style="list-style-type: none"> 2. Significant progress has been made in the area of sharing all PPNs directly from the Police to Probation. This action is awaiting final information assurance and final operational detail before rolling out. 3. Discussions have commenced in relation to wider information sharing between both agencies outside of the areas above – this is a longer and more complex piece of work which will build upon the systems and work already being undertaken between both agencies. 	

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to Take	Lead Agency	Target Date	Date of Completion	Evidence: <ul style="list-style-type: none"> • 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
				information sharing between agencies					
3)	Nottingham Community Safety Partnership must seek assurance from agencies that loneliness is acknowledged as a feature of safeguarding within their guidance and training packages.	Loneliness is a widespread experience; however, when it becomes prolonged and persistent, it can significantly impact an individual's health and heighten their susceptibility to exploitation.	Local	<p>Integration of Learning from Recommendation 1.</p> <p>The initial briefing developed under Recommendation 1 will include this learning, presented within the same slide.</p> <p>Partner agencies are encouraged to embed this information into their future training packages and internal briefings.</p> <p>The learning will be presented to the Adult Safeguarding Board for wider dissemination.</p> <p>Equation will incorporate the content into their multi-agency training programme for both City and County partners.</p> <p>Additionally, the Slavery and Exploitation Team will receive the learning to integrate into their own training materials.</p>	NCSP Equation	November 2025		<p>06/08/2025</p> <p>Recruitment for a full-time Childrens and Adults Training Officer is underway, and the recruitment process has been undertaken. The Training Officer will be in post from 1st of September 2025.</p>	

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to Take	Lead Agency	Target Date	Date of Completion	Evidence: <ul style="list-style-type: none"> • 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
4)	Agencies must evidence to Nottingham Community Safety Partnership that they are prompting and encouraging their professionals to be professionally curious, and Nottingham Community Safety Partnership must gain an improved understanding of how to support agencies with this practice.	Professionals needed to be 'curious' by asking questions and thereafter verifying information from alternative sources, as required to gain an effective understanding of the circumstances.	Local	<p>Professionals to bring together learning from previous DHR action plans and recommendations and reissue previous training and guidance. The existing 7-minute briefing on professional curiosity which will be reshared.</p> <p>Professionals to ensure that this learning is reinforced internally within their own organisations amongst their workforces.</p> <p>Professionals to use DHR Haiku as a case study to send out to reinforce the impact of not being 'professionally curious.'</p> <p>Professional Curiosity is an ongoing point of learning which has continued to be highlighted through multiple DHR's and will be escalated up into the NCSP Board as an ongoing concern. A request will be made to add to the risk register for ongoing monitoring.</p>	All	November 2025		<p>Highlighting good examples of professional curiosity could be included within quarterly monitoring shared by partners to the NCSP through the relevant strategy groups.</p> <p>This could also be discussed within management supervision sessions with staff and made a specific point for discussion.</p>	
5)	Nottingham Community safety Partnership in collaboration with the Slavery Exploitation Team must raise awareness of the Slavery Exploitation Team within partner agencies and support them to embed referrals into their guidance and processes.	Many professionals remain unaware of the Slavery Exploitation Team.	Local	<p>Extending the Reach of the Slavery and Exploitation Team (SET)</p> <p>SET will explore opportunities to broaden their engagement with additional organisations by incorporating key information into staff CPD</p>	Slavery and Exploitation Team	November 2025		<p>SET has already developed and delivered a bespoke training package to frontline police officers. This training will now be extended to the Police Development Hub for wider rollout.</p>	

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to Take	Lead Agency	Target Date	Date of Completion	Evidence: <ul style="list-style-type: none"> • 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
				<p>(Continuing Professional Development) days. This will support increased awareness and understanding of their role across the sector.</p> <p>Relevant content can be included in a concise briefing slide, alongside learning points from other recommendations within this action plan.</p>					
6)	Nottinghamshire Police must review the criteria and use of their Place of Interest Markers in relation to repeat victims of crime and ensure that the updated criteria is implemented across the force and incorporated into training.	Marking Kiddo's address as a Place of Interest might have prompted a stronger response to later incidents.	Local	<p>Place of Interest (POI) Markers</p> <p>Nottinghamshire Police currently do not have a formal policy regarding the use of Place of Interest (POI) markers and do not consider their implementation beneficial at this time.</p> <p>The concern is that overuse in inappropriate cases may diminish their impact and effectiveness.</p> <p>The force will review the existing processes to ensure they are functioning as intended.</p> <p>Training on the use of POI markers has been delivered to frontline officers and will continue to be included in ongoing</p>	Nottinghamshire Police	August 2025			

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to Take	Lead Agency	Target Date	Date of Completion	Evidence: <ul style="list-style-type: none"> • 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
				professional development.					
7)	Nottingham Community Safety Partnership in collaboration with partner agencies must learn from domestic abuse practice to develop and promote a robust straightforward multi-agency resource (which should include referral to the Slavery Exploitation Team and reference the work they do) which will support professionals from all agencies to respond to concerns of financial abuse and exploitation effectively. This resource must thereafter be integrated into agency safeguarding training and processes.	The challenges for professionals began with the complexity of exploitation work and lack of direct processes.	Local	<ul style="list-style-type: none"> • Equation will incorporate relevant elements into their existing training programmes and update their website to include a link to the Slavery and Exploitation Team (SET). • SET will develop a comprehensive training package to be shared with all partner organisations. • Nottinghamshire Police currently deliver a three-slide presentation created by SET. This training is being rolled out to all new officers, including neighbourhood policing teams. • The presentation will be circulated to the ALIG group for further sharing within their respective organisations. • This information will also be included in a briefing slide, alongside other recommendations from the action plan, to 	NCSP Slavery and Exploitation Team Equation	November 2025		 Slavery Exploitation Team condensed.pptx	

	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
				support consistent messaging and awareness.					



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Loxley House
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NG2 3NG

15th January 2026

Dear Rachel,

Thank you for submitting the Domestic Homicide Review (DHR) report (Kiddo) for Nottingham City Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 3rd December 2025. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

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

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Kiddo
COMMUNITY SAFETY PARTNERSHIP	Nottingham City
DATE REVIEWED BY QA BOARD	03 December 2025
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	<ul style="list-style-type: none"> • It is good to see specialist input via services for older people on the panel. • Kiddo's family engaged in the DHR process and the Chair met with Kiddo's sister and his nephew, which was good practice. • The lived experience sections of the report are written with insight into how Kiddo is likely to have felt and are supported by evidence. • The professional challenges section offers a balanced understanding of the probation perspective. • The equality and diversity section is well considered. As well as an understanding of male victims of domestic abuse, there is broad consideration of factors relevant to survival sex and ways in which older victims of crime can be particularly vulnerable.
FEEDBACK FOR FUTURE DHRs	Please mark the documents as confidential until they have been through the quality assurance process.

	DHR SECTION	DHR QA BOARD FEEDBACK (improvements required before publication)
	Title Page	<ul style="list-style-type: none"> • Please rephrase the title in both the overview report and executive summary so that it doesn't say 'deceased person'. • Please mark the documents as confidential.
1	Contents Page	No amendments required.
2	Pen Portrait	There is no pen portrait for Kiddo within the report. If possible, please consider including this.
3	Condolences	No amendments required.

4	Confidentiality and Anonymity	No amendments required.
5	Terms of Reference	Please consider clarifying whether Kiddo's family helped shape the terms of reference.
6	Equality and Diversity	Sex and gender reassignment should be referenced rather than using the term cisgender.
7	Background Information	At section 4.39, the report states that it is more appropriate in this case to refer to sex work as survival sex. However, the term sex work is then used in sections: 4.38, 6, 6.10.7, 8.30, 8.85, 10.3.
8	Combined Chronology	Please address the accuracy of the following statement in section 6.12.4: 'When Barbara was next released from prison, she was not eligible for Multi Agency Public Protection Arrangements, but because she had been served an additional sentence for a shop theft whilst in prison, she was now subject to Post Sentence Supervision'. Please consider amending to: 'When Barbara was next released from prison, she was not automatically managed under Multi Agency Public Protection Arrangements...'
9	Overview	No amendments required.
10	Analysis	<ul style="list-style-type: none"> • This section is very thorough but the detail that Barbara's benefits were paid into Kiddo's bank account is not picked up. Please could this be addressed. • The hyperlink in section 8.3, footer 33: 'Voice of women on Probation' does not work. • Section 8.15 states, 'The reason why enforcement action wasn't taken has been discussed by the professionals engaging with this review and it has been concluded that it could potentially have been because Barbara was still waiting for her initial appointment with drug support services (following the referral made by Probation Services after she had failed her first test)'. From this description, it is a suggestion rather than a conclusion. • At section 8.15, the final sentence has a typo which makes the closing point unclear. Please consider removing the word had: 'and given that a link between substance misuse and offending behaviour had already been identified, consideration had as to whether the risks were escalating to a point where they could no longer be managed in the community.' • In section 8.41, the implication of frustration is understandable, however, it may be better to use 'very likely to' rather than 'clearly recognised' in: 'had any professional convened a meeting, agencies would have clearly recognised that Barbara...'
11	Conclusions	The detail above might have been relevant to how systems may have aided Barbara's abuse. Please consider including.
12	Lessons learnt and recommendations	In relation to the above please consider a recommendation in relation to benefits being paid into the account of someone else. An important theme of this review is the read-across between exploitation and domestic abuse. A recommendation like this would benefit the response to both issues.

13	Timescales	No amendments required.
14	Involvement of family / friends / community	No amendments required.
16	DHR contributors	No amendments required.
17	DHR Panel	No amendments required.
18	DHR Author	No amendments required.
19	Parallel Reviews	No amendments required.
20	Dissemination	<ul style="list-style-type: none"> • Please add a dissemination list that includes the family, the local Police and Crime Commissioner and the Domestic Abuse Commissioner. • Please clarify if any consideration been given to key dates on which to avoid publication and family support if needed. • It states that only the executive summary will be published. This section states that action plan will be shared with partner agencies. Please consider sharing the full report or providing reasoning for not doing this.
21	Action Plan	No amendments required.
22	<p>Has there been a request to withhold publication?</p> <p><i>If Yes, include the reason for the request. Is it proportionate and appropriate?</i></p>	No requests to withhold publication. However as above the QA Board notes that the report suggests only the executive summary will be published. If this is the case, please clarify the reasons for withholding the publication of the full report.
23	Any other comments	No amendments required.