NOTTINGHAM COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Tom'

Date of death: February 2022

FINAL VERSION

February 2025

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

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1. INTRODUCTION

1.1 Nottingham Community Safety Partnership and the Domestic Homicide Review Panel offer their sincere condolences to Tom's family.

1.2 This report of a Domestic Homicide Review (DHR)[1] examines how agencies responded to, and supported, Tom, a resident of Nottingham, prior to his murder in February 2022. The review has been completed following Home Office Domestic Homicide Review statutory guidance (2016).[2]

1.3 Tom had been in a relationship with Mary. The relationship had ended in August 2020. There had been domestic abuse within their relationship. At the time of Tom's death, they lived in a house of multiple occupancy; however, they were the only occupants – each having their own room. Mary had been in a previous relationship with Jim. There was domestic abuse within that relationship. Tom, Mary, and Jim were friends, and Jim was a regular visitor to Tom and Mary's accommodation.

1.4 Jack was the nephew of Mary. In February 2022, Tom was assaulted by Jack, who claimed that Tom had been 'bullying' Mary. The assault occurred over a sustained period of time and was 'live streamed'. Tom was conveyed to hospital and placed in intensive care. Jack was arrested and charged with an offence of grievous bodily harm and remanded into custody.

1.5 Tom did not regain consciousness from the assault and later died from his injuries. Jack was charged with the murder of Tom. A Home Office post-mortem determined that the cause of death was: severe trauma, with head, chest, and spine injuries consistent with being kicked and stamped to a severe level.

1.6 In May 2023, Jack was found guilty of the murder of Tom and sentenced to a life sentence – with a minimum term of 21 years and 272 days. Speaking after the court result, the Senior Investigating Officer stated: 'This was a truly horrifying attack, almost defying belief in its brutality and utterly senseless nature. Not only was Tom beaten unconscious over a prolonged period of time, but Jack was lucid enough to live stream the attack on his mobile phone showing no mercy throughout. Today's sentence will not bring Tom back but it does mean that Jack will spend a considerable part of his life behind bars and I hope this gives his family some comfort'.

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

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

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

1.8 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.9 It is not the purpose of this DHR to enquire into how Tom died: this is determined through other processes.

1.10 Following the trial, the Senior Coroner reviewed the case. A decision was made to close the case, as the death had been dealt with at Crown Court.

2. TIMESCALES

2.1 Following Tom's death, the Victim Support Homicide Service sent a referral to Nottingham Community Safety Partnership. The referral was sent in August 2022 and was made in accordance with paragraph 21 of the Home Office statutory guidance, which allows for any professional or agency to refer such a homicide to the Community Safety Partnership (in writing) if it is believed that there are important lessons for inter-agency working to be learned.

The referral documented that the case met the criteria as defined in Section 2 of the guidance, under the definition specified at paragraph 13 (a): 'a person to whom he was related or with whom he was or had been in an intimate personal relationship'.

2.2 A meeting was held on 10 October 2022, where it was agreed to conduct a Domestic Homicide Review. Information on the case was provided to the meeting by Nottinghamshire Police. The Home Office was notified of the decision.

2.3 The first panel meeting was held on 20 June 2023. There was a delay in the review starting because of the criminal investigation and court processes. The Review Panel set the period of review at this meeting and agreed to review events from 1 January 2019 to February 2022. This timescale was used to capture events within the two years prior to Tom's death – to inform analysis around contemporary and current practice. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.

2.4 The Domestic Homicide Review was presented to Nottingham Community Safety Partnership Chair on 17 May 2024 for sign off, and concluded on 10th June 2024, when it was sent to the Home Office.

3. CONFIDENTIALITY

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

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim, perpetrator and significant others: these were chosen by the panel.

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

Name	Relationship	Age	Ethnicity
Tom	Victim	63	White British Male
Jack	Perpetrator and the nephew of victim's partner	23	White British Male
Mary	Partner of victim and aunt of the perpetrator	53	White British Female
Significant Other			
Jim	Previous partner of Mary	63	White British Male

4. TERMS OF REFERENCE

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

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

4.2 **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, were your agency aware of that could have identified Tom as a victim of domestic abuse, and what was your response?
2. What knowledge did your agency have in relation to Tom, Mary, Jack, and Jim's relationship? Did this include evidence of domestic abuse, and if so, what was your response?
3. What knowledge did your agency have in relation to Jack's offending behaviour, and what was the response?
4. Was there sufficient focus on reducing the impact of Jack's offending behaviour by applying an appropriate mix of sanctions (arrest/charge) and other interventions?
5. How did your agency identify, assess, and manage the level of risk faced by Tom from Jack? What risk assessments did your agency undertake, and what was the outcome? Were risk assessments accurate and of the appropriate quality?

6. What consideration did your agency give to any mental health issues and/or substance misuse when engaging with the subjects of the review?

7. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed? Are the procedures embedded in practice, and were any gaps identified?

8. What knowledge did family, friends, and employers have around Tom, Mary, Jack, and Jim's relationship? Did this identify domestic abuse, and if so, did they know what to do with that knowledge?

9. Were there any issues in relation to capacity or resources in your agency that impacted on its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? Please consider if Covid-19 related work practices affected your response?

10. Were there any examples of outstanding or innovative practice?

11. What learning did your agency identify in this case, and how will this be embedded into practice?

12. Was the learning in this review similar to learning in previous Domestic Homicide Reviews commissioned by Nottingham Community Safety Partnership?

5. METHOD

5.1 On 9 December 2022, Carol Ellwood-Clarke was appointed as the Independent Chair and Author. The Chair was supported in the role by Ged McManus. There was a delay in the review commencing due to the ongoing criminal investigation.

5.2 The first meeting of the DHR panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews (IMRs)[3]: the other agencies were asked to produce short reports.

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

5.4 The review gathered a significant amount of information from all agencies on their contact and engagement with Tom, Mary, and Jim. There was limited information known to agencies about Jack, and/or his relationship with Tom. The Review Panel reviewed all the information provided and made a decision to analyse only those events which fell within the Terms of Reference; however, the panel would include a summary of the remaining contacts.

5.5 The Review Panel agreed that information in relation to Jim would only be included where it could be evidenced that there was a connection between the subjects of this review. The Review Panel agreed that agencies would not undertake extensive research of Jim's records, as consent had not been obtained.

5.6 The Chair wrote to Jack to invite him to contribute to the review. The letter was delivered by Jack's Prison Offender Manager, who explained the content of the letter and the review process. Jack declined to be involved in the review process.

5.7 Thereafter, a draft overview report was produced: this was discussed and refined at panel meetings before being agreed.

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

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

6.1 The Chair wrote to Tom's family to inform them of the review and to invite them to participate in the review process. The letter included information on advocacy support and was delivered by the Senior Investigating Officer for the criminal investigation and the Police Family Liaison Officer. Tom's family initially agreed to speak with the Chair and participate in the review process.

6.2 The Chair undertook a range of methods to contact the family to progress their involvement in the review process: this included telephone calls, voicemails, and text messages. The family agreed to meet the Chair but cancelled the appointment on the day it had been arranged. The family did not respond to further contact from the Chair.

6.3 The Chair contacted the Victim Support Homicide Worker – who had been allocated the case during the criminal investigation – to seek assistance for engagement with the family. The Chair was informed that the family had chosen not to engage with the Victim Support Homicide Worker and that contact during the criminal investigation had been undertaken by the police.

6.4 The Chair contacted the Senior Investigating Officer to seek access to information gathered during the criminal investigation – to assist the Review Panel in gathering information about the subjects of the review. The Senior Investigating Officer agreed to release relevant statements from the criminal investigation to assist the DHR process. These have been captured throughout the report where necessary.

6.5 Towards the end of the review process, the Chair wrote a further letter to the family, which detailed the review timeline, anticipated date of completion, and how the family could still be involved within the review process. The Chair received no response from the family.

Mary

6.6 The Chair sought advice from agencies who were currently engaged with Mary. This was to gather information about the appropriateness of Mary being involved in the review process. The Chair was informed by a keyworker – currently working with Mary around her alcohol dependency – that due to her vulnerability, it would not be in Mary's best interests, nor conducive to her emotional wellbeing, to speak with the Chair or contribute to the review process.

6.7 The Chair was provided with a copy of the information provided to the police (during the criminal investigation) around the potential detrimental impact on Mary's mental health in the event that she be called as a witness during the court proceedings. Mary did not attend court during the criminal trial.

6.8 The Review Panel considered the information provided. The panel concluded not to contact Mary and to just use information provided by the police. Whilst the whereabouts of Mary were known, it was not felt appropriate for the Chair to write to her directly – due to the risk of affecting her current alcohol recovery.

Jim

6.9 The Chair spoke to Jim, who provided the Chair with information about his friendship with Tom and Mary. This has been captured within the report where relevant.

Landlord

6.10 The Chair spoke to Tom's landlord, who provided the Chair with information in relation to Tom and Mary's tenancy and engagement that the landlord had with agencies, particularly the police, to address incidents of concern and anti-social behaviour. This has been captured in the report where relevant.

Employer

6.11 None of the subjects of the review had been in employment, either prior to, or within, the review's timescales.

7. CONTRIBUTORS TO THE REVIEW

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

Agency	IMR	Chronology
Nottinghamshire Police	✓	✓
Nottingham Recovery Network	✓	✓
The Probation Service	✓	✓
East Midlands Ambulance Service	✓	✓
Juno Women's Aid	✓	✓
Adult Social Care	✓	✓
Housing Aid[4]	✓	✓
Nottingham Healthcare NHS Foundation Trust	✓	✓
Nottingham University Hospitals NHS Trust	✓	✓
Equation		✓
DHU Healthcare		✓
Children's Social Care		✓
Nottingham CityCare Partnership		✓
Crown Prosecution Service		✓
Department for Works and Pensions		✓
The Friary		✓
The YMCA		✓
Nottingham City Homes[5]		✓

7.2 The IMRs contained a declaration of independence by their authors, and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained that they had no management of the case nor direct managerial responsibility for the staff involved with this case.

7.3 Nil returns were received from:

- Nottingham Women's Centre[6]
- Nottingham Sexual Violence Support Service[7]
- St Ann's Advice Centre[8]

[4] Since September 2023 known as Housing Solutions.
[5] Now known as Nottingham City Council Housing Services.
[6] https://www.nottinghamwomenscentre.com/
[7] https://nottssvss.org.uk/
[8] https://stannsadvice.org.uk/

- Nottingham Trent University
- Nottingham University
- Nottingham Fire and Rescue Service
- IMARA[9]
- Nottingham City Council Whole Life Disability Team
- POW[10]

7.4 Below is a summary of contributors to the review.

7.4.1 **Nottinghamshire Police**

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

7.4.2 **Nottingham Recovery Network (including Clean Slate)**

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

Clean slate (under the umbrella of Framework) is based at the Wellbeing Hub. It works with individuals on mandatory attendance through licence conditions aimed at reducing offending – due to alcohol and drug dependencies – through engagement and treatment.

7.4.3 **Probation Service**

The Probation Service is a statutory criminal justice agency that supervises all offenders (in the community) subject to statutory supervision.

7.4.4 **East Midlands Ambulance Service**

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

[9] https://www.imara.org.uk/
[10] https://pow-advice.org.uk/

7.4.5 **Juno Women's Aid**

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

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

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

7.4.7 **Housing Aid – Nottingham City Council**

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

7.4.8 **Nottingham Healthcare NHS Foundation Trust**

Nottinghamshire Healthcare is positive about providing integrated healthcare services, including mental health, intellectual disability, and community health services. Almost 9,000 dedicated staff provide these services in a variety of settings, ranging from the community through to acute wards, as well as secure settings. The Trust also manages two medium secure units: Arnold Lodge in Leicester and Wathwood Hospital in Rotherham; and the high secure Rampton Hospital near Retford.

7.4.9 **Nottingham University Hospitals NHS Trust**

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

7.4.10 **Equation**

Equation is a Nottingham-based specialist charity that works with the whole community to reduce the impact of domestic abuse, sexual violence, and gender inequality.

7.4.11 **DHU Healthcare**

Offers a range of service across the Midlands, providing services for around 15 million people a year. Working in collaboration with partners and colleagues across NHS systems – GP federations and other private provider companies – it offers innovative, integrated solutions that ensures all its patients and communities can access the right care, in the right place, at the right time. As part of the NHS frontline, it leads urgent care within Emergency Departments, Urgent Treatment Centres, GP and Primary Care Surgeries, and out in our communities. It offers a full range of both 'in and out of hours' clinical specialist services – provided by a diverse workforce made up of medical, nursing, allied health, and support teams. Its business offer includes community nursing, urgent treatment, primary care streaming, urgent on-day primary care, GP home visiting, phlebotomy, community hospital medical cover, telephone consultation support, and weekend palliative care home visiting.

7.4.12 **Children's Social Care – Nottingham City Council**

Children's Social Care teams work with families who need support. This ranges from the point of a referral being made, through to a single assessment, and, where necessary, into longer-term working relationships for ongoing advice, support, guidance, and interventions to keep children safe.

7.4.13 **Nottingham CityCare Partnership**

Nottingham CityCare is an award-winning community health service provider, dedicated to improving long-term health and wellbeing. It is a social enterprise delivering a range of healthcare services tailored to the needs of local people and free at the point of delivery.

7.4.14 **Nottingham and Nottinghamshire Integrated Care Board (ICB)**

The Nottingham and Nottinghamshire ICB is a unitary board, with all partners having shared responsibility. It is a governing body locally responsible for the oversight and co-ordination of integrated healthcare services. This integrated care approach to healthcare delivery provides comprehensive and co-ordinated services to patients by breaking down traditional silos between different healthcare providers, e.g., acute hospitals, primary care, mental health services, and social care.

The Primary goal of the ICB is to improve quality of care, enhance patient outcomes, and optimise the use of healthcare resources by ensuring that services are well co-ordinated and patient-centred.

The Nottingham and Nottinghamshire ICB Adult Safeguarding Team represents GP and primary care services where a statutory review is required to provide independent scrutiny and share lessons learnt to inform changes and improvement to practices.

7.4.15 **Crown Prosecution Service**

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

7.4.16 **Department for Works and Pensions**

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

7.4.17 **The Friary**

The Friary is a well-respected registered charity with a distinctly Christian foundation that operates in the Nottingham area. The Friary's mission is to empower homeless and vulnerable adults to rebuild their lives by offering practical services, advice, and emotional support. It is determined to cater for the needs of the most vulnerable in our society by supporting people into recovery and advocating for those without a voice. Every year the charity caters for 15,000 visits from local people who are suffering the effects of homelessness, substance misuse, financial destitution, and social isolation.

7.4.18 **The YMCA**

The YMCA provides housing services to support homeless young people and vulnerable adults across Nottingham, Mansfield, and Goole (East Riding of Yorkshire). Furthermore, it delivers a residential Settled Care provision, offering emergency accommodation for children at risk.

7.4.19 **Nottingham City Homes**

Provides advice and resources to secure accommodation and help with housing issues.

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Marie Bower	Head of Service: Survivors and Perpetrators	Equation
Liz Cudmore	Safeguarding Lead	East Midlands Ambulance Service
Jo Elbourn	Detective Chief Inspector	Nottinghamshire Police
Carol Ellwood-Clarke	Independent Chair and Author	
Amanda Garnett	Service Manager for Safeguarding and Public Protection	Nottinghamshire Healthcare
Louise Graham	Sexual Violence and VAWG Lead	Nottingham Community Safety Partnership
Sonya Hand	Deputy Head	Nottingham City Probation Delivery Unit
Ishbel Macleod	Designated Professional for Safeguarding Adults and Domestic Abuse and Sexual Violence Lead	Nottingham and Nottinghamshire ICB
John Matravers	Head of Safeguarding, Quality and Assurance	Children's Social Care
Ged McManus	Independent Reviewer	
Corenna Olivero-Nosakhere	Domestic Violence and Abuse Policy Lead	Community Safety Partnership Specialist
Helen Pritchett	Trustwide Service Manager for Public Protection and Safeguarding	Nottingham Healthcare NHS Foundation Trust
Rebecca Radage	Operations Manager	Nottingham Recovery Network/Clean Slate/Health Shop-Harm Reduction and Sexual Health

Yasmin Rehman	Chief Executive Officer	Juno Women's Aid
Debbie Richards	Head of Housing Solutions	Housing Aid/Solutions, Nottingham City Council
Julie Stevens	Service Manager and Principal Social Worker – Adult Social Care Safeguarding and Quality Assurance	Adult Social Care
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospitals NHS Trust
Anna Wetherburn	Operational Risk Manager	Nottingham Recovery Network

8.2 The Chair of Nottingham Community Safety Partnership was satisfied that the Panel Chair/Author was independent. In turn, the Panel Chair believed that there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report. The panel members from Equation and Juno Women's Aid were experienced in working with older victims of domestic abuse. Other panel members, including Nottingham Recovery Network and Clean Slate, were experienced in working with individuals with severe multiple disadvantages, through a multi-agency approach.

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

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

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

9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not Nottinghamshire) in 2017, after 30 years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to safeguarding and family liaison. In addition, she is an Associate Trainer for SafeLives.[11]

9.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not Nottinghamshire). He served for over 30 years in different police services in England (not Nottinghamshire). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

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

9.5 Both have previously completed DHRs for Nottingham Community Safety Partnership.

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

10. PARALLEL REVIEWS

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

10.2 Nottinghamshire Police completed a criminal investigation following Tom's death. Jack was charged with the murder of Tom. Following a Crown Court hearing, he was found guilty of Tom's murder. In May 2023, Jack was sentenced to life imprisonment, with a minimum term of 21 years and 272 days.

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

11. EQUALITY AND DIVERSITY

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

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

A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

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

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

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

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[12]

<u>Tom</u>

11.3 Tom had been diagnosed with chronic obstructive pulmonary disease (COPD)[13], emphysema, and arthritis. In December 2021, the police held information that Tom had told them that he suffered with sleep apnoea.

11.4 Tom had contact with health professionals, including the ambulance service. Tom attended at hospital with conditions linked to his health and at times whilst under the influence of alcohol.

11.5 Tom was not registered with a GP. Tom was not known to mental health services. [14]

11.6 Tom had alcohol dependency. Tom had two separate treatment episodes with Nottingham Recovery Network. The first was between September 2019 and September 2020 because of an Alcohol Treatment Requirement as part of licence conditions imposed by the court. In November 2021, Tom was seen by Nottingham Recovery Network's hospital liaison team following an admission for health reasons. Tom was noted to be alcohol dependent and prescribed medication for alcohol withdrawals. Tom was advised to self-refer to Nottingham Recovery Network on discharge.

11.7 Tom was not in employment. From June 2020, Tom was in receipt of Employment and Support Allowance (ESA) and had been awarded severe

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

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

[14] Many adults are not registered with a GP, as unlike children who have to be registered with a GP at birth, there is no mechanism for identifying adults across the population who are not GP registered. Across the area clinical points of contact e.g. walk in centres and Accident and Emergency encourage those attending who had no GP to register with a GP. The ICB provides details upon request of GP surgeries who are taking on new patients, and where and how to register. In addition, there is a GP+, which is a service people can access out of GP core hours, if they cannot get a GP appointment and need to see someone. A further service is provided for patients who have been 'banned' from GP practices due to aggressive or threatening behaviour. The NHS continues to deliver a range of campaigns aimed at getting people to access GP services, including services people can receive from pharmacies, who will then advise when to seek GP support.

disability premium (SDP). From March 2021, Tom had been in receipt of Personal Independence Payment (PIP).

Jack

11.8 Jack had no contact with a GP in the two years prior to the murder of Tom.

11.9 Jack was not known to mental health or drug and alcohol services as an adult.

Mary

11.10 Mary was alcohol dependent. Between December 2018 and July 2019, Mary was engaged with Nottingham Recovery Network for community treatment for alcohol dependency. Between December 2020 and September 2021, Nottingham Recovery Network completed several assessments with Mary.

11.11 Mary had contact with health professionals, including the ambulance service. There were records of Mary having attended at hospital due to levels of intoxication and injuries sustained whilst intoxicated.

11.12 Mary had no contact with mental health services.

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

11.14 All subjects of the review are white British. There is nothing in agency records that indicated that any subjects of the review lacked capacity,[15] in

[15] The Mental Capacity Act 2005 established the following principles:
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".
Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".
Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".
Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

accordance with the Mental Capacity Act 2005. Professionals applied the principle of Mental Capacity Act 2005:

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

Research

11.15 The panel recognised that domestic abuse is a gendered crime, with women being more likely to be victims than men. Men are much more likely to be killed by a stranger than their partner or family member. Tom was not murdered by a family member, but by a person whom he had been related to during his relationship with Mary. Tom had also been a victim of domestic abuse during his relationship with Mary. The Review Panel agreed that the following research was of relevance for this case.

11.16 According to the Office for National Statistics homicide report 2021/22,[16] there were 134 domestic homicides in the year ending March 2022. Of the 134 domestic homicides: 78 victims were killed by a partner or ex-partner; 40 were killed by a parent, son, or daughter; and 16 were killed by another family member.

Almost half (46%) of adult female homicide victims were killed in a domestic homicide (84). Of the 84 female victims, 81 were killed by a male suspect.

Males were much less likely to be the victim of a domestic homicide, with only 11% (50) of male homicides being domestic related in the latest year.

11.17 In April 2021, Mankind Initiative published the document: 'Male victims of domestic abuse and partner abuse: 55 key facts'.[17] This included the following statistical data:

- One in six/seven men and one in four women will be a victim of domestic abuse in their lifetime. In 2019/2020, 757,000 men and 1.56 million women said that they were victims that year.

Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".
Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".

(Mental Capacity Act Guidance, Social Care Institute for Excellence)

[16] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022#the-relationship-between-victims-and-suspects

[17] https://www.mankind.org.uk/wp-content/uploads/2021/04/55-Key-Facts-about-Male-Victims-of-Domestic-Abuse-and-Partner-Abuse-Final-Published-April-2021.pdf

- From April 2015 to March 2020, on average, 12 men per year had been killed by a partner or ex-partner (74 women per year).
- In 2019/20, 1.9% of men who were 60 – 74 stated that they had suffered domestic abuse (4.4% women), and 1.1% had suffered from partner abuse (3.4% women). The peak for men and women is 16 – 24.
- In 2019/20, 7.5% of men who were disabled stated that they had suffered domestic abuse (14.7% women), and 5.1% had suffered from partner abuse (11.5% women). The rate of domestic/partner abuse is double that of those who are not disabled.

11.18 The Review Panel was cognisant of research in relation to the gender bias of male victims of domestic abuse. In 2021, Dr Elizabeth Bates, University of Cumbria, published a paper following a review of 22 Domestic Homicide Reviews.[18] The research identified that society still did not readily recognise male domestic abuse victims, and that some may have lost their lives as a result. The research looked at homicides featuring male victims of domestic abuse and found that opportunities to help them were missed due to gender bias and outdated stereotypes. The bias dually inhibited male victims from reporting their abuse, and public support services, such as the police and health care, from recognising them as victims. Half of the reviews showed support services lacked guidance to help identify and treat male victims, and a considerable number of men's injuries (from domestic abuse) were dismissed by the police and other services, as well as friends and family.

11.19 The Review Panel also reflected on Tom's age and disability and took cognisance of the following research:

In the report, Safe Later Lives,[19] published by SafeLives, it highlights that victims aged 61 years or over are more likely (44%) to experience abuse from an adult family member or current intimate partner than those victims under 61 years old. Furthermore, on average, older victims experience abuse for twice as long before seeking help – compared to those aged under 61 – and nearly half have a disability. Whilst the age range in this report is not that of the victim in this case, the Review Panel felt that the findings in this report were of significance for this case because their medical conditions made them more vulnerable.

[18] https://www.cumbria.ac.uk/about/news/articles/articles/homicide-research-reveals-society-blind-to-male-victims-of-domestic-violence-.php

[19] https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

12. DISSEMINATION

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

- Tom's family
- Nottingham Community Safety Partnership
- All agencies that contributed to the review
- Nottinghamshire Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, CHRONOLOGY AND OVERVIEW

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the subjects of the review and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, and material gathered by the police during their criminal investigation.

There was no contact between Tom and Jack (known to agencies) prior to the murder of Tom. As detailed in Section 5, the Review Panel agreed to provide a summary of events (only within this section) to provide an overview of agencies' involvement with the subjects of the review prior to Tom's murder.

13.1 Tom

13.1.1 Tom was born in Lincolnshire and was one of six children born to his mother and father. Tom's parents' relationship ended when he was a young child, and he and three of his siblings were brought up by their father.

13.1.2 After leaving school, Tom worked for his father, as a painter, before moving away from Nottingham, where he then worked as a lorry driver. Tom met and married a woman. The marriage ended after several years, and Tom remained living away from Nottingham. Tom had no children. Tom returned to live in Nottingham around 2001/2002.

13.1.3 Tom's family described him as a hard worker, who was always sociable – the life and soul of the party – and as a family, they had a great relationship. Tom was generous and funny – he loved singing, dancing, and partying. Tom was a happy man and lovely with his nephews and nieces, who called him 'stupid Uncle Tom' because he would be silly with them and entertain them.

13.1.4 Tom had been known to criminal justice agencies since 1974. Tom was a perpetrator and victim of domestic abuse. Tom had three convictions for domestic abuse, which related to assaults on Mary:

- Common Assault (February 2015) – 12 months, conditional discharge, costs, and victim surcharge.
- Common Assault (February 2018) – sentenced to 9 weeks' imprisonment, suspended for 12 months, costs, and victim surcharge.

- Common Assault (September 2019) – sentenced to 12 weeks' imprisonment, suspended for 12 months, costs, and victim surcharge. A rehabilitation activity requirement was also imposed, with a requirement to attend alcohol treatment.

In two of the above offences, Mary stated that Tom had grabbed her throat or tried to strangle her.

13.1.5 Between 2015 and 2021, Tom was arrested on 11 occasions for assaulting Mary. These offences were not prosecuted.

13.2 Jack

13.2.1 Jack had been known to Children's Social Care since 2012. Concerns had been raised regarding Jack's alcohol use and the ability to focus on Jack's wellbeing, which was linked to neglect. Due to the concerns raised, there was period of involvement by Children's Social Care: this was managed at Child in Need level and Common Assessment Framework, with the case being closed after identified risks were reduced.

13.2.2 Jack had been known to criminal justice agencies since 2015. In February 2015, Jack was identified as being involved in an aggravated burglary – no further action was taken. Later the same year, Jack was arrested for the theft of a motor vehicle and later convicted for offences relating to this incident. Further contact with the police related to an offence of robbery and anti-social behaviour.

13.2.3 In 2016, Jack was engaged with the Youth Offending Team and was accessing support for cannabis use. At this time, Jack was reported to be completing an apprenticeship, and appointments were made around his working hours.

13.3 Mary

13.3.1 The Review Panel had little information about Mary. Tom's family believed that Mary had two adult children, with whom she did not have any contact.

13.3.2 Nottingham Recovery Network provided the review with the following information that Mary had provided to them during engagement with their service:

'Mary reported she had started drinking alcohol at the age of 11 and classed herself as a social drinker at weekends until 10 years ago when her father passed away, she ended a 26-year relationship, and she lost her job.

Within a few months of this her alcohol use escalated to daily drinking of 3 litres of cider and 9 bottles wine daily. Mary's brother died 2 years ago. Mary acknowledged at the time of presentation all her current social group were all heavy drinkers. Mary had periods of homelessness and sofa surfing after this. Mary has two daughters and a grandchild'.

13.3.3 Mary has been known to criminal justice agencies since 1998. Mary was a perpetrator and victim of domestic abuse.

13.3.4 In 2015 and 2021, Mary was arrested for assaulting Tom. These offences were not prosecuted.

13.4 Jim

13.4.1 Jim was a friend of Tom and Mary's. Jim had known Tom for over 30 years, after they had started working together in the flooring/tiling business. Jim had no knowledge of Jack and told the Chair that he had never seen him or heard his name mentioned whilst in Tom and Mary's company.

13.4.2 Jim stated that he met Mary through Tom, who introduced her to him. Jim stated that he had previously been in a relationship with Mary, but that they had not been intimate since around 2016, when they had moved in together at that time. Jim stated that after this time, Tom and Mary lived together, and he would see them about 3 or 4 times a day.

13.4.3 Jim told the Chair that he had previously had a drug/alcohol addiction and had previously been in detox.

13.5 Tom, Mary, and Jim's relationship

13.5.1 Tom and Mary had been in a relationship since 2012. Tom's family stated that they met in a local off-licence. Tom and Mary's relationship was not stable and was described in agency records, and by Tom's family, as being 'on and off'. The relationship was understood to have ended in August 2020; however, they continued to live in the same home in multiple occupancy (HMO), where they shared communal facilities, but each had their own bedroom. During the investigation into Tom's death, Mary stated that she was not in a relationship with Tom.

13.5.2 Tom and Mary led a transient lifestyle. They were known to consume alcohol, often to excess, and were often seen drinking alcohol with other

people described as 'street drinkers'. Tom and Mary would often allow people who were homeless into their home to consume alcohol.

13.5.3 Tom and Mary's contact with the police tended to occur whilst they were under the influence of alcohol. It was during these times that domestic abuse occurred and was reported to the police.

13.5.4 Tom, Mary, and Jim reported to the police that they had been assaulted by each other. A breakdown of the allegations is provided below:

- Tom was the victim of 22 assaults by Mary.
- Tom was the victim of 9 assaults by Jim.
- Mary was the victim of 20 assaults by Tom.
- Mary was the victim of 18 assaults by Jim.

Alcohol was a feature in every call made to the police. The nature of the assaults included hair pulling, slapping, throwing paint, punching, being hit with a plastic bottle, throat grabbing, and strangulation. The allegations made were often withdrawn upon the arrival of the police, and when the police recontacted the identified victim, they were informed that they could not recall the incident, or that the victim no longer supported a prosecution.

Events within the Terms of Reference

During the review's time frame, there were 172 contacts with the police. These are not repeated in chronological order here. The Review Panel determined that only those of relevance would be documented below.

13.6 2019

13.6.1 In January, Tom was living in accommodation provided by the YMCA. Mary was living in separate YMCA accommodation. Mary was spending time staying with Tom. The police and the YMCA responded to incidents involving Tom and Mary's behaviour towards residents and members of staff. Tom was advised to adhere to the accommodation terms and advised that if the behaviour continued, he would be issued with a visitor ban and notice to quit.

13.6.2 On 28 March, Jack was identified by the police as being responsible for a theft of a motorcycle.

13.6.3 On 10 May, Tom presented as homeless after being evicted from his accommodation. A homeless person application was taken, and Tom was advised about the remit of the Street Outreach Team and homeless policies. By the end of May, Tom had been referred to the Independent Living Support (ILS) service for support. Tom's application proceeded – in accordance with legislation and policy – over the following weeks.

13.6.4 Throughout June, Mary had contact with Juno Women's Aid due to domestic abuse that had been assessed as high risk. The perpetrator was Jim. The case was referred to MARAC. An IDVA continued to seek engagement with Mary over the following months, including a move out of the area. The case was closed in November 2019.

13.6.5 On 25 June, The Wellbeing Hub submitted a referral to MARAC, following disclosures from Mary about Jim. The case was heard at MARAC on 31 July.

13.6.6 On 5 September, Mary contacted the police and reported that Tom had threatened to hit her and had caused damage to a bedroom door. Mary stated that she did not wish to make a complaint. A crime of damage was recorded, and a DAPPN (Domestic Abuse Public Protection Notice) was submitted as medium risk.

13.6.7 On 7 September, the police received two calls from Mary. In the first, Mary stated that Tom had been abusive and had prevented her leaving his room. This was recorded as a verbal argument. In the second contact, Mary stated that she had been assaulted by Jim. Jim was arrested and later released from custody, as Mary did not support a prosecution.

13.6.8 On 12 September, Mary contacted the police and reported that Tom had spat in her face, and four days earlier, Tom had tried to strangle her. Mary stated that she was five months pregnant. The Review Panel has found no evidence to support this. Mary stated that Tom was jealous of her current partner, Jim. Tom was arrested and charged with two offences of common assault. A DAPPN was submitted as medium risk.

13.6.9 On 13 September, Tom appeared at court and was sentenced for an offence of assault by beating. A restraining order was not awarded because Mary had resumed her relationship with Tom, and they were living in the same household. Probation completed a Short Format Report (SFR) to assist the court with sentencing. Tom was assessed as posing a medium risk of serious harm to Mary.

13.6.10 On 17 September, Tom's case was allocated to a probation practitioner, (formerly known as a probation officer). Tom did not attend his initial appointment. Tom was issued a warning letter, which was later withdrawn.

13.6.11 At the beginning of October, at an appointment with his keyworker at Nottingham Recovery Network, Tom discussed his alcohol use, accommodation, finances, health, and previous drug use. Tom told his keyworker that he had a co-dependent relationship with Mary, and that Mary was also in a relationship with a long-standing friend he had known for over 25 years. The Review Panel determined that this was Jim.

13.6.12 On 11 November, Tom told his probation practitioner that he had been given notice to vacate his accommodation.

13.6.13 On 23 November, Mary contacted the police and stated that Tom had assaulted her and threatened to kill her. Tom was arrested. A DAPPN was submitted as medium risk. No further action was taken. The incident was shared with Probation and discussed with Tom on 11 December.

13.6.14 On 26 December, Tom contacted the police and reported that Mary was refusing to leave his flat. Tom described Mary as his ex-partner. A DAPPN was submitted as standard risk and recorded as a verbal argument.

13.6.15 On 29 December, Tom contacted the police and reported that he and Mary had been assaulted by Jim. Tom described Mary as his partner. Jim was arrested. A DAPPN was submitted as medium risk. Mary stated that she did not wish to make a complaint. Tom provided a statement. Jim was released on bail, and a file was submitted to the Crown Prosecution Service. Jim was charged with assault. In January 2021, the charges were dropped, as Tom and Mary withdrew their complaints.

13.6.16 The following day, Mary attended at hospital with a head injury sustained in the incident on 29 December. Medical staff were not aware that Mary had been a victim of domestic abuse.

13.7 2020

13.7.1 On 7 January, Tom told his probation practitioner that he had recently found out that his daughter had died. Tom cited Mary as a source of support and reported a deterioration in health due to increased consumption of alcohol. Tom reported no contact with Nottingham

Recovery Network. Information provided by Tom's family, as part of the criminal investigation, stated that Tom had no children.

13.7.2 By the end of January, Tom had been issued with a warning letter by Probation for failure to attend appointments with Nottingham Recovery Network. Tom told the probation practitioner that he had been served an eviction notice.

13.7.3 On 17 February, Tom was issued with a final warning letter by Probation – after he had failed to attend five appointments in the past four weeks with Nottingham Recovery Network – due to noncompliance in the treatment element of work. Tom continued to miss appointments, and a further final warning letter was issued on 27 March.

13.7.4 On 27 February, Tom contacted the police and reported a domestic incident with Mary and Jim, during which Mary had smeared paint on Tom. Tom did not support a complaint. A crime of common assault was recorded, and a DAPPN was submitted as standard risk. Mary and Jim were issued with notices under Section 35 Crime and Policing Act 2014.[20] This prevented them from returning to Tom's address. Later that day, Mary was taken into custody for failing to adhere to the Section 35 notice.

13.7.5 On 12 March, Tom's Alcohol Treatment Requirement terminated.

13.7.6 By April, Tom was engaging with Nottingham Recovery Network on a voluntary basis. Contact between Tom and his probation practitioner had moved to telephone contact due to the Covid-19 pandemic. Tom reported an increased consumption of alcohol.

13.7.7 On 8 April, Tom contacted the police and stated that he had been assaulted by Mary. Tom stated that he did not want to make a complaint. Mary was taken to an alternative address. A crime of assault was recorded, and a DAPPN was submitted as medium risk.

13.7.8 Later on 8 April, Mary contacted the police and reported that Tom had assaulted her. Mary stated that she did not want to make a complaint. A crime of assault was recorded, and a DAPPN was submitted as medium risk.

[20] https://www.legislation.gov.uk/ukpga/2014/12/part/3/enacted

Details of this incident were shared with Adult Social Care. Over the following month, Adult Social Care attempted to contact Mary. This was unsuccessful, and the case was closed on 11 May.

13.7.9 On 13 April, Tom contacted the police and reported that he had been assaulted by Mary. Tom did not provide further details of the assault. A crime was recorded, and a DAPPN submitted as standard risk. The incident was emailed to the Neighbourhood Policing Team to work with the landlord around housing.

13.7.10 On 5 May, Mary contacted the police. She stated that Tom had tried to choke her, and she said that he was going to kill her. A crime was recorded, and a DAPPN was submitted as standard risk. Later that day, Mary contacted the police and reported an incident with the landlord, who had been banging on the door trying to evict her.

13.7.11 On 18 June, Tom told his probation practitioner that he had ongoing issues with accommodation, his relationship with Mary was strained, and that he was drinking three times more due to boredom. The probation practitioner agreed to refer him to the housing team for support.

13.7.12 On 10 July, Mary reported to the police that she had been assaulted by Tom. Tom was arrested. A crime of assault was recorded, and a DAPPN was submitted as medium risk. Mary declined to provide a statement. Tom admitted to pulling Mary's hair in self-defence after Mary had attacked him. Tom was released without charge. Details of the incident were shared with Adult Social Care, who were unable to contact Mary, and the incident was closed. The incident was shared with Probation.

13.7.13 On 13 July, Tom's probation practitioner telephoned Tom and discussed the incident from 10 July. Tom stated that he was trying to sort out accommodation and that his alcohol consumption had increased due to lockdown stress.

13.7.14 On 1 August, Jack completed an application for housing. This was not approved, as he was living in private rented accommodation and was adequately housed.

13.7.15 On 12 September, Tom's order terminated.

13.7.16 On 19 October, Mary contacted the police and reported that she had been assaulted by Tom. Tom was arrested. Mary declined to make a statement.

A crime of assault was recorded, and a DAPPN was completed as standard risk. Tom denied assaulting Mary and was released without charge.

13.7.17 On 31 December, Mary attended Nottingham Recovery Network for alcohol assessment. During this appointment, efforts were made to secure a refuge space due to domestic abuse concerns. As no spaces were available, a referral was made to Housing Aid. The referral documented that Mary lived in a house of multiple occupancy and there were issues with the accommodation. The referral was allocated to a case worker. Initial contact was made with Mary via Nottingham Recovery Network, and a telephone assessment was started. A break in the assessment was requested by Mary. Attempts to re-establish contact with Mary were unsuccessful, and the case was closed in April 2021.

13.8 2021

13.8.1 On 13 February, Tom contacted the police and reported that he had been assaulted by Mary. Mary was arrested. Tom was not able to make a statement when first seen by the police due to his level of alcohol consumption. When he was seen later, he declined to make a statement and stated that he would not support a prosecution. A crime of assault was recorded, and a DAPPN was submitted as medium risk. Mary was released without charge. Mary was given information concerning her alcohol consumption.

13.8.2 Whilst in custody, Mary was seen by the Liaison and Diversion Service. No mental health concerns were identified. Mary reported issues with her current accommodation. The outcome of the contact was to refer Mary to Changing Lives, to contact the Wellbeing Hub, and to refer to Adult Social Care regarding housing concerns. Adult Social Care forwarded the concerns to the environmental health department. Mary did not respond to any contact from Changing Lives.

13.8.3 On 30 March, Tom was arrested by the police after Mary reported that she had been assaulted by Tom three days earlier. Mary declined to support a prosecution. Tom was released without charge. A crime of assault was recorded, and a DAPPN was submitted as standard risk. The police considered issuing Tom with a Domestic Violence Protection Notice (DVPN).

13.8.4 On 25 April, Tom was assaulted by Jim. Mary had been present during the incident. A crime of assault was recorded. Tom provided a witness

statement. Jim denied assaulting Tom and stated that he had intervened to stop Tom and Mary arguing. Jim was released without charge.

13.8.5 On 23 June, the police prepared a case summary of events to be shared with agencies in support of a civil action being taken by the landlord.

13.8.6 On 5 July, Tom and Mary reported to the police that they had been assaulted by Jim. Jim was arrested. A crime of assault was recorded, and a DAPPN was submitted as standard risk; however, this was raised to medium following a review by a Domestic Abuse Risk Assessor (DASU). Jim was released on bail, with conditions not to contact Tom and Mary. The case was referred to the Crown Prosecution Service for a charging decision. Tom and Mary were not supportive of a prosecution. No further action was advised by the Crown Prosecution Service.

13.8.7 On 20 July, Tom received severe disability payment arrears – to the sum of £8,686.35.

13.8.8 On 31 July, Tom and Mary were staying in a hotel in Skegness, Lincolnshire. Mary contacted Lincolnshire Police and reported that she had been assaulted by Tom. When the police arrived at the hotel, Mary stated that she had not been assaulted. Mary was taken to another hotel. The incident was recorded as standard risk.

13.8.9 During the early hours of 1 August, Lincolnshire Police received several calls from the hotel regarding Mary's behaviour. Mary was taken to the train station by the police.

13.8.10 During August, Housing Aid had contact with Mary. She had asked for support due to the current situation with her accommodation, which was described as being in disrepair and having no electricity. Contact was made, and Mary advised that the property did have electricity and that the landlord had resolved the other disrepair issues. Attempts to contact Mary on a later date – to complete a housing assessment – were unsuccessful, and the case was closed.

13.8.11 On 17 October, Tom contacted the police and reported that Mary had assaulted him. Tom had no visible injuries, and he told the police that he did not want to make a complaint. Mary was taken to an alternative address. A crime of common assault was recorded, and a DAPPN was submitted as standard risk. No action was taken against Mary.

13.8.12 On 22 November, Nottingham Health and Care Point, which is part of Adult Social Care, received a referral from the ambulance service for Tom. The referral detailed concerns regarding the state of Tom's accommodation. A Health and Social Care Officer made contact with Tom, who stated that he wanted Mary to be his carer. Mary was described as Tom's ex-partner. Mary told the Health and Social Care Officer that she did not want to be Tom's carer. Tom declined social care support. An environmental health and safer places referral was completed.

13.8.13 On 1 December, Nottingham Health and Care Point received another referral from the ambulance service. This referral cited the same concerns as those raised on 22 November. Enquiries were undertaken by the Adult Safeguarding Team Social Worker in relation to Tom's accommodation. The enquiries undertaken did not identify any safeguarding concerns, and the referral was closed.

13.8.14 During contact with the Chair, Jim stated that Tom and Mary's living conditions were diabolical: there were rats in the flat, the fridge and cooker did not work, and there was damage to the windows that had not been replaced. In addition, there was no heating, and the flat was very cold.

13.8.15 The landlord told the Chair that he had tried to undertake civil action in relation to Tom and Mary's tenancy, and following the death of Tom, he had had to spend a considerable amount of money completing repairs to damage within the property.

13.9 2022

The below information was gathered as part of the homicide investigation.

13.9.1 On 9 February, Jack went to Tom and Mary's address. Jack assaulted Tom over a sustained period of time. The assault was live streamed. Mary was present during the assault.

13.9.2 On 10 February, the police were informed of the assault and attended at the address. Tom was taken to hospital and placed into intensive care. Jack was arrested for the offence of grievous bodily harm. Jack was charged and remanded into custody.

13.9.3 Staff at Nottingham University Hospital completed a DASH, which was graded as high and sent to MARAC. A referral was sent to Equation's High

Risk Domestic Violence and Abuse Service. Contact with Tom was not able to take place due to him being sedated and ventilated on the adult intensive care unit. The case was listed to be heard at MARAC at a later date.

13.9.4 At a later date in February, Tom died. Jack was charged with Tom's murder. The police made a policy decision that Mary was a witness to the incident. The MARAC had not been heard at the time of Tom's death.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

What indicators of domestic abuse, including coercive and controlling behaviour, were your agency aware of that could have identified Tom as a victim of domestic abuse, and what was your response?

14.1.1 There were no incidents that identified that Tom was a victim of domestic abuse, including coercive control from Jack, prior to the assault on Tom in February 2022.

14.1.2 Tom had been a victim of domestic abuse from Mary. The police were the only agency who held this information.

14.1.3 Tom and Mary had been in relationship since 2012. This relationship was understood by the Review Panel to have ended in August 2020; however, after this time, there were incidents when Tom and Mary told professionals that they were in a relationship. Tom's family described his relationship with Mary as being 'on and off'.

14.1.4 The definition of domestic abuse[21] in place at the start of the review's time frame, stated that domestic abuse was:

'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- Emotional'.

Following the introduction of the Domestic Abuse Act 2021, the definition of domestic abuse was expanded, but it still included those individuals who are, or had been, intimate partners.

14.1.5 The police received 22 reports from Tom that he had been assaulted by Mary. Tom was first recorded as a victim of domestic abuse in 2015. Alcohol consumption by Tom and Mary was recorded as a factor in all of the incidents. Tom did not to support a prosecution for any of the

[21] https://www.gov.uk/government/publications/new-government-domestic-violence-and-abuse-definition

assaults, and it was recorded that Tom either withdrew his initial complaint or declined to provide a statement that detailed what had occurred. On some of the incidents, Tom sustained no visible injuries from the assaults. The police submitted DAPPNs on 14 occasions, and with the exception of one incident in which the risk was assessed as medium, all other incidents were risk assessed as standard risk.

14.1.6 Tom did not consent for the police to share information with other agencies; therefore, the details of the assaults and domestic abuse were not shared with partner agencies. Tom did not consent to be referred to support services for male victims of domestic abuse, and the case was not referred to MARAC.

14.1.7 In February 2020, consideration was given by the police to refer Tom to Equation, following him being assaulted by Mary. However, this did not take place because Equation did not accept referrals from agencies where the risk had been assessed as standard and consent from the victim had not been provided. Equation told the Review Panel that they would have accepted a self-referral from Tom.

14.1.8 Between September 2019 and September 2020, Tom was being managed by Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC), who was responsible for managing low- to medium-risk people on probation at that time. The DLNR CRC had limited information that Tom was a victim of domestic abuse during their involvement.

14.1.9 The Review Panel discussed the volume of incidents of domestic abuse that Tom had reported. Mary was arrested on two occasions – April 2020 and February 2021. Mary was not charged with committing any offences on Tom, either following her arrest or following a criminal investigation. The offences reported were closed, and it was recorded that no further action was being undertaken.

14.1.10 The Review Panel discussed the challenges that the police faced in undertaking a criminal investigation when there was a lack of available information, including evidence of injuries sustained, such as photographs, medical evidence, independent witnesses, and the support of the victim to progress a prosecution.

14.1.11 Mary contacted the police and reported that she had been assaulted by Tom on 20 occasions. Within the review's time frame, Tom was convicted of assaulting Mary. This incident occurred in September 2019. Tom was arrested on a further four occasions (November 2019, July and October 2020, and March 2021) for assaulting Mary. Tom was not charged with

any further criminal offences against Mary. The police considered issuing a Domestic Violence Protection Notice (DVPN)[22] to Tom; however, based on Mary's reluctance to engage with any form of prosecution, this was not supported by a senior police officer.

14.1.12 A DVPN is an emergency non-molestation and eviction notice that can be issued by the police to a perpetrator (when the police are attending to a domestic abuse incident). As the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. A victim's consent is not required. Within 48 hours of the DVPN being served on the perpetrator, an application (by the police to a magistrates' court) for a DVPO must be heard. A DVPO (Domestic Violence Protection Order) can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options, with the help of a support agency. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim.

14.1.13 The Review Panel discussed the incidents of domestic abuse reported to the police and agreed that the domestic abuse within Tom, Mary, and Jim's relationship appeared to be entrenched. It was often the case that individuals were under the influence of alcohol. Therefore, due to their presentation and the information that they provided, it would have been difficult to establish, at that time, who the primary victim and perpetrator were.

14.1.14 The Review Panel member from Equation informed the review about the Your Choice Project (YCP)[23] – a voluntary domestic violence and abuse perpetrator programme. Referrals to the project are made with the consent of the individual, and had either Tom, Mary, and/or Jim consented to a referral, then an assessment to identify the primary perpetrator and primary survivor would have taken place. If this proved inconclusive, then it may have resulted in recommendations for parties to access support in other areas in an attempt to reduce risk and re-refer to the Your Choice Project at a later date.

14.1.15 The YCP offers a range of services for male and female perpetrators of domestic abuse and support for male and female survivors of domestic

[22] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

[23] Worried about your own behaviour? | Equation
The YCP works in partnership with Equation's Domestic Abuse Service for Men, Juno Women's Aid, and Nottinghamshire Women's Aid, who provide the support services for partners, ex-partners, and family members of perpetrators accessing interventions.

abuse. The project is available for residents within Nottinghamshire, who are over 18, and who have not:

- been involved in any criminal justice proceedings relating to their use of violence/abuse.
- been involved in any private law family court proceedings relating to Children Act orders or non-molestation/occupation orders,
- worked with CAFCASS during family court proceedings,
- been involved in any public law proceedings relating to children safeguarding, and
- completed a perpetrator programme within the last six months, i.e., Building Better Relationships.

14.1.16 The Review Panel acknowledged that a referral to the project could have been considered for Mary or Jim; however, this would have required their consent before a referral could have been made. The Review Panel has seen no information that the role of YCP was discussed with either Tom, Mary, and/or Jim. The panel has identified this as an area of learning and made a relevant recommendation.

14.1.17 The panel member from Juno Women's Aid informed the Review Panel that it can be incredibly difficult for the police to continue with investigations and criminal justice processes when victims of domestic abuse return to relationships, especially when those individuals lead complex/chaotic lifestyles. Furthermore, in order to respond to those circumstances, that there is a need to ensure a co-ordinated community response is delivered in keeping individuals safe. During the review period for this case, there were added challenges to all agencies due to the impact of the Covid-19 pandemic. The panel member stated that in their opinion, safe accommodation and access to drug and alcohol treatment services may have rendered a more positive outcome for both Tom and Mary.

14.1.18 The Review Panel reflected on the comments from Juno Women's Aid and recognised that the nearest accommodation for male victims of domestic abuse was located outside of Nottingham, in Lancashire and Birmingham. Moreover, further access to spaces for individuals who have complex needs, such as drug and alcohol use, were limited.

14.1.19 The panel member from Housing Aid informed the Review Panel that had Tom presented or been referred to Housing Aid, emergency accommodation would have been provided in accordance with statutory requirements. Housing Aid had also remained open throughout the Covid-19 pandemic. The panel member from Equation informed the Review Panel that they have a member of staff, based within the Housing Aid, who

provides additional support. They are a point of contact for victims of domestic abuse who are seeking alternative accommodation.

14.1.20 In terms of access to drug and alcohol treatment services, Tom was engaged with these services; however, it was recognised that this was due to a court order. Nottingham Recovery Network operates a same day walk-in assessment service (6 days a week). Mary had been in treatment numerous times (voluntarily) over the years and had successfully completed treatment on two occasions: reaching controlled drinking on the first occasion and achieving abstinence on the second occasion. Mary is currently in treatment and is abstinent. She is also completing a peer mentorship course. The multi-agency response to the domestic abuse is analysed under Term 7.

14.1.21 The Review Panel considered whether there were any additional barriers that may have prevented Tom from reporting the abuse. The report 'Surviving justice'[24] (2017) by Victim Support, contains the following information.

Barriers to reporting, as cited by Victim Support caseworkers

Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear that they would not be believed or taken seriously	42%
Fear, dislike, or distrust of the police/criminal justice system (CJS)	25%
Concern about their children and/or the involvement of social services	23%
Poor previous experience of the police/CJS	22%
Abuse normalised, not understood, or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish the perpetrator	14%
Cultural or community concerns	9%

[24] https://www.victimsupport.org.uk/wp-content/uploads/documents/files/VS_Survivor%E2%80%99s%20justice.pdf

Barriers to reporting	Percentage of respondents citing barrier
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

14.1.22 An internet search using variations of 'male domestic abuse victim' found several services that provide help to male victims of domestic abuse in Nottingham. Their services appear to be easily accessible.

14.2 Term 2

What knowledge did your agency have in relation to Tom, Mary, Jack, and Jim's relationship? Did this include evidence of domestic abuse, and if so, what was your response?

14.2.1 Jack was the nephew of Mary. The Review Panel has no record of any incidents or agencies' contact that involved Mary and Jack. The Review Panel has no evidence of any contact or incidents between Jack and Tom, and/or Jim, with the exception of the assault on Tom in February 2022.

14.2.2 Tom's family did not know Jack; they did not know that he was related to Mary and had not heard his name mentioned during contact with Tom. The first the family knew of Jack was following the assault on Tom, which subsequently led to his death.

14.2.3 Tom and Mary had been in an intimate relationship since 2012. The relationship was understood to have ended around August 2020. After this date, there were entries in agencies' records that documented that Mary and Tom had told professionals that they were in a relationship. The exact timings of these relationships starting and ending were not known. It was evident to the Review Panel that there was an element of co-dependency within their relationship.

14.2.4 At some time prior to, and during, the review's time period, Mary and Jim had been in an intimate relationship. In contrast to agencies' records, Jim told the Chair that he had not been in a relationship with Mary since 2016.

14.2.5 Tom and Mary lived together in a house of multiple occupancy. Whilst they had separate bedrooms, they shared living facilities. Jim was a frequent visitor to this address.

14.2.6 The police had an extensive knowledge of Tom, Mary, and Jim's relationship, which included 127 contacts within the review's time period.

Contact with the police occurred whilst Tom, Mary, and Jim were reported to be under the influence of alcohol, and it was during these times that domestic abuse occurred. The Review Panel agreed that alcohol consumption and level of intoxication should not be seen as an excuse for domestic abuse; however, the Review Panel acknowledged that alcohol consumption was a key factor in this case and created a challenge for the police in responding to calls for service.

14.2.7 Paragraph 13.5.4 documents the extent of the assaults between Tom, Mary, and Jim that had been reported to the police, which included hair pulling, slapping, throwing paint, punching, being hit with a plastic bottle, throat grabbing, and strangulation. The allegations made were often withdrawn upon the arrival of the police, and when the police recontacted the identified victim, they were informed that they could not recall the incident, or that the victim no longer supported a prosecution.

14.2.8 Tom was the only person to be convicted of an offence within the review's time frame. This was in September 2019, for an assault on Mary.

14.2.9 Tom and Mary's living conditions were reported to be unhabitable, with rat infestation, damage, and a lack of electricity. Referrals were made to Adult Social Care and the environmental health services. The property was privately rented. The landlord told the Chair that they had experienced a number of issues whilst Tom and Mary were tenants, which included:

- Volume of visitors to the property
- Damage
- Maintenance issues
- Noise.

The landlord stated that on two occasions, they had initiated civil action and had issued Tom and Mary with a notice of eviction. The landlord said that they had sourced information from the police to support their civil action. The landlord stated that the property was above a shop/takeaway and that there had been thefts and takeaways ordered and then not paid for. Employees in the shop had, on occasions, heard arguing and shouting from the property.

14.2.10 Mary had contact with Housing Aid; however, attempts to contact Mary to complete a housing assessment were unsuccessful.

14.2.11 Mary accessed support from Nottingham Recovery Network. [This is analysed in Term 6]. During an assessment at the Wellbeing Hub on 31 December 2020, Mary disclosed that she had been a victim of domestic abuse whilst in a relationship with Jim. During the same conversation, Mary said that she was fearful of her ex-partner, Tom, who lived in the

same shared house. Mary said that she did not feel safe in her accommodation. The worker telephoned several refuges but was unable to find any availability. Housing Aid was also contacted, and a telephone assessment was commenced with Mary. Mary left the Hub after around 40 minutes due to frustration at the length of time the assessment was taking. She did not return. A DASH was completed, which indicated medium risk. The DASH was submitted to MARAC on the grounds of professional judgement, due to concerns around the risk posed by Tom and Jim. This risk was not increased to high.

14.2.12 At an appointment on 6 January 2021, Mary reported feeling safe and that issues only arose in situations where Tom and Jim were together and intoxicated. Mary stated that this was less problematic since she had told Jim to stay away from the property. Mary was given advice around prioritising her own safety, including contacting the police if there were any issues or conflict.

14.3 Term 3

What knowledge did your agency have in relation to Jack's offending behaviour, and what was the response?

14.3.1 The response to this will be addressed in Term 4.

14.4 Term 4

Was there sufficient focus on reducing the impact of Jack's offending behaviour by applying an appropriate mix of sanctions (arrest/charge) and other interventions?

14.4.1 Jack was never identified as being a perpetrator against any crime in which Tom was the identified victim.

14.4.2 Prior to the time frame for the review, the police had contact with Jack when he committed criminal offences. The police dealt with these through arrests and interviews under caution: the outcomes of these were appropriate for the offences committed.

14.5 Term 5

How did your agency identify, assess, and manage the level of risk faced by Tom from Jack? What risk assessments did your agency

undertake, and what was the outcome? Were risk assessments accurate and of the appropriate quality?

14.5.1 There were no records of any contact between Tom and Jack prior to the assault in February 2022, which led to Tom's death. Therefore, there was no opportunity for any agency to assess and/or manage any risk that Tom faced from Jack.

14.5.2 The management of risk faced by Tom from Mary has been captured in Term 1 and 2.

14.6 Term 6

What consideration did your agency give to any mental health issues and/or substance misuse when engaging with the subjects of the review?

Tom

14.6.1 In September 2019, Tom was made subject to an Alcohol Treatment Requirement (ATR) for six months, as part of a court order. Tom indicated to his probation practitioner that he was using alcohol problematically.

14.6.2 During his assessment as part of his Alcohol Treatment Requirement, Tom was assessed as experiencing low mood at times. It was recorded that Tom was not receiving mental health support from external agencies, and that he did not require further support in this area at that time.

14.6.3 In January 2020, Tom reported increases in his level of alcohol consumption to his probation practitioner, which he cited was due to bereavement and pending homelessness. Tom also reported increased use of alcohol during contact after March 2020, when Covid-19 restrictions were in place. The IMR author for the Probation Service stated that the factors raised in January 2020 should have prompted a home visit and liaison with the police to gather information on the police call-outs to the property. This did not take place and has been identified as a single-agency area of learning, with action taken to address the learning.

14.6.4 Tom's engagement with Nottingham Recovery Network was inconsistent, and he was eventually discharged from the service prior to the six-month requirement for engagement. Tom had also been issued with several warning letters in relation to potential breach action regarding his compliance with the court order. There was an option at the point of the Alcohol Treatment Requirement ending to take the case back to court and request an extension, but this did not occur. The IMR author from the

Probation Service stated that had the breach been instigated sooner or an application made to extend the ATR, then the contact with Nottingham Recovery Network could have continued.

14.6.5 Tom had further contact with Nottingham Recovery Network. Firstly, through voluntary engagement after his Alcohol Treatment Requirement had ended, and secondly, during two contacts from the hospital liaison team who saw Tom during hospital admissions. Tom was given harm reduction advice on these occasions and given information to help him self-refer upon discharge.

14.6.6 In a statement provided to the criminal investigation, Tom's brother stated that there had been times over the years when they had spoken to Tom about his alcohol use. Tom's brother said: 'I think he had always been a functioning alcoholic, but he never accepted this'.

14.6.7 Jim told the Chair that it was his opinion that Tom would not accept support, if offered, as he (Tom) did not see that he needed help in relation to his lifestyle and relationship with Mary. Jim stated that Tom would never approach or reach out to agencies for support.

Mary

14.6.8 Mary accessed Nottingham Recovery Network for support to reduce her alcohol intake, with a view to becoming abstinent. During both treatment episodes, Mary engaged sporadically. Mary was discharged from support in July 2019, when Mary was recorded as maintaining a controlled intake of alcohol. Mary engaged in a further treatment episode in 2021, for support with alcohol use. She was discharged following a short period. During which, Mary was offered advice around safe reduction of alcohol intake. Mary was discharged because she had achieved abstinence. Mary had further contact with the hospital liaison team and was signposted back for future support should she want it. Mary's engagement was not unusual for people in alcohol treatment.

14.6.9 In her assessment with Nottingham Recovery Network, Mary reported a diagnosis of anxiety and depression, for which she was prescribed medication. Mary was not in contact with mental health services and was looking to address her alcohol consumption as a priority.

14.6.10 Mary's contact with Juno's Women Aid identified alcohol use, domestic abuse, and a lack of stable accommodation. Mary self-referred to Juno's Women Aid when accommodation became a serious concern, either because she could not source her own accommodation, i.e., paying for hotels, staying with friends, or because she was rough sleeping.

14.6.11 Mary's accommodation needs were not met, as she was unable to access refuge, particularly during the periods of the Covid-19 pandemic and national lockdown. Juno Women's Aid informed the Review Panel that it provides a confidential service to survivors of domestic abuse who are living in an abusive relationship or who have left their abusive partner, and that its aim is to accompany a woman through her journey at a pace led by them. Juno Women's Aid offers non-judgmental perspectives and support – to give women back some of the control that may have been lost. The City Survivor Advocacy Support Service (City SASS)[25] and Response to Complexity (R2C) service are for women who are experiencing, or who have experienced, domestic abuse in Nottingham City. Support is tailored for women to enable them to sustain their accommodation, prevent homelessness, and assist with resettlement and safety planning.

14.6.12 The referral to R2C was not processed in line with policies and procedures. This service supports complex cases, where often engagement is sporadic and at the point of crisis. This has been identified as a single-agency point of learning.

14.6.13 During contact with the Liaison and Diversion Service in February 2021, Mary discussed that her main difficulty was alcohol related. Mary stated that she engaged in binge drinking behaviour, whereby she would be sober for one or two months at a time and then something in her life would trigger her – leading her to binge drink for one or two weeks. Mary was accessing support from the Wellbeing Hub in respect of her alcohol use, and she was receiving weekly support. Mary stated that when she abstained from alcohol, she suffered from low-mood and anxiety. Mary discussed her accommodation as a precipitating factor in her anxiety. Mary was not assessed to be suffering from acute mental health symptoms: her mood was described as euthymic, and she showed good insight into her current difficulties.

Jim

14.6.14 Jim was taking prescription medication to treat low mood. No concerns were reported about Jim's mental health while he was supported by Nottingham Recovery Network, and no other mental health services were involved. Jim was supported by Nottingham Recovery Network over a number of treatment episodes to address his alcohol use. Jim's engagement was sporadic during these periods, and he was discharged because of missed appointments.

[25] https://junowomensaid.org.uk/sass-city/

Jack

14.6.15 Jack was not known to services.

14.6.16 The police reported that alcohol had been a feature in the incidents of domestic abuse between Tom, Mary, and Jim. A report by the Institute of Alcohol Studies[26] – 'Alcohol, domestic abuse and sexual assault' – states:

Alcohol has been found to be associated with victimisation, with research finding victims of domestic assault to have higher alcohol consumption than non-victims, and that the risk of violence increases with levels of consumption.

There are many reasons why victims of domestic abuse may drink. Amongst those caught up in long-term domestic abuse, there is evidence that they may use alcohol to cope with the effect of domestic abuse. Indeed, one study found that women who suffered domestic abuse from their partners were twice as likely to drink after the abuse as their violent partner.[27]

14.6.17 The Review Panel considered a fact sheet published by Alcohol Change – 'Alcohol and Domestic Abuse':

The links between alcohol and domestic abuse

1. Drinking and domestic abuse often occur at the same time

Many abuse incidents occur when one or both people involved has been drinking, and alcohol is more commonly involved in more aggressive incidents. [28] It is not just being intoxicated that can increase risk; lack of access to alcohol can make someone irritable or angry which can, in turn, create a trigger point.

2. When alcohol is involved, abuse can become more severe

Alcohol can affect our self-control and decision-making and can reduce our ability to resolve conflict. Home Office analysis of 33 intimate partner domestic homicides in 2014 – 15, found that 20 of these involved substance use.[29]

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[26] https://www.ias.org.uk

[27] Galvani, S. 'Grasping the Nettle: alcohol and domestic violence'

[28] https://academic.oup.com/bjc/article/59/5/1035/5486457

[29] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

3. Controlling access to alcohol can become part of the abuse

A perpetrator may exert control over another person by withholding alcohol from them or preventing them from buying it. For someone who is dependent on alcohol, this could be extremely distressing and even dangerous, if they experience withdrawal symptoms.

4. People who experience domestic abuse may drink to try to cope

Living with domestic abuse can be extremely frightening, distressing or exhausting. This can cause some people to drink alcohol to try to cope with the physical and mental health impacts of domestic abuse. Research shows that women who experience extensive physical and sexual violence are more than twice as likely to have a problem with alcohol than those with little experience of violence and abuse. [30]

Alcohol use can also leave someone more vulnerable to further abuse, especially if drinking prevents survivors from accessing support or makes their mental health worse.

14.6.18 The Review Panel reflected on the presence of alcohol within Tom, Mary, and Jim's relationships and what multi-agency options there were within Nottingham for professionals who were trying to engage with Tom, Mary, and Jim. The Review Panel was informed that the co-author of Alcohol Concern's Blue Light project[31] set up the alcohol services in Nottingham City and that working with resistant drinkers in Nottingham was the first pilot for the project. The project formed an Intensive Case Management Service (ICMS) specifically to work with resistant drinkers in Nottingham City. The pilot was successful and then became the embedded practice within all the teams working now within Nottingham Recovery Network.

14.6.19 During comprehensive assessments, Nottingham Recovery Network uses specific tools to identity alcohol dependence, which consider: physical health, psychological health, presentation on assessment, substance use, treatment history, housing and finances, safeguarding, family and relationships, domestic abuse, criminal justice, strengths, and perception of ongoing need plan. Family involvement is encouraged, where appropriate.

[30] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/the-nature-and-impact-of-domestic-abuse/

[31] https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-light-project

The Blue Light approach is an initiative to develop alternative approaches and care pathways for drinkers who are not in contact with treatment services, but who have complex needs.

Multi-agency care planning and co-ordination is undertaken by Nottingham Recovery Network. Regular multi-agency meetings are undertaken, as well as formulation meetings with the psychologists in Nottingham Recovery Network. Fast-track treatment and planning for relapse is built into the strength-based care plans that are agreed with the service user, who is also provided with a copy of their plan.

14.6.20 The Review Panel agreed that the main focus of the Blue Light project work is a multi-agency co-ordinated approach and that the Blue Light principles need to be embedded in services wider than substance use treatment. The Review Panel was informed that since the timescales of this review, there are now multi-agency processes and defined referral processes in place, which respond to cases where there are identified severe multiple disadvantages. This is documented further at 14.12.2.

14.7 Term 7

Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed? Are the procedures embedded in practice, and were any gaps identified?

14.7.1 Tom's conviction and sentence in September 2019 did not qualify under MAPPA protocols.

14.7.2 Prior to the assault leading to Tom's death, the domestic abuse that Tom suffered had never been assessed as high risk; therefore, he was not referred to MARAC based on risk or on professional judgement.

14.7.3 The police received 22 reports from Tom that he had been assaulted by Mary; however, only 14 DAPPNs were submitted. This has been identified as a single-agency area of learning, and action has been taken to address this area of learning.

14.7.4 The Review Panel discussed whether the MARAC protocol within Nottinghamshire provided an option for Tom and Mary to have been referred to MARAC – due to the frequency of domestic abuse incidents over a set period of time, and where the risk on those incidents had been graded as standard and/or medium. The Review Panel was informed that the current MARAC protocol (November 2021) for Nottingham City provides guidance on the process for referring cases into MARAC, with the criteria being based on:

- Professional judgement,
- Visible high risk – 14 ticks or more within the DASH risk assessment, or

- Potential escalation – the number of police call-outs to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. Nottinghamshire Police consider three or more police call-outs in a six-month period.

14.7.5 The MARAC protocol mirrors the guidance[32] produced by SafeLives, who state:

'Before considering whether to raise the MARAC referral thresholds, we would suggest reviewing the quarterly performance data provided by SafeLives about your MARAC. Using this data, you can review the current volume of cases against the recommended volume of cases for your MARAC, as well as using regional, Most Similar Force and national performance data as a benchmark. We would suggest that the volume of cases referred to your MARAC should be within at least 80% of the recommended volume for your area before you raise the local referral threshold.

'If your MARAC is hearing more than the recommended number of cases and it becomes necessary to raise the local referral threshold, we would suggest you review which referral criteria are being used (and at what level) as this will enable you to identify the impact on your volume of raising the visible high risk or potential escalation threshold'.

14.7.6 The police informed the Review Panel that, historically, the police did refer to MARAC where there had been three cases of medium risk within a short time frame, but that now, each case assessed as medium risk is reviewed, and a decision is made on professional judgement, thereby removing the requirement for there to have been three cases. The criteria in place by the police, appeared to the Review Panel to contrast with the criteria documented in the MARAC protocol, which states three or more police call-outs, with no mention of the risk.

14.7.7 The Review Panel was informed that the MARAC process is overwhelmed with new cases being referred and panel meetings being held for repeat MARAC cases. The demand for domestic abuse services has increased

[32] https://safelives.org.uk/sites/default/files/resources/MARAC_FAQs_for%20MARAC%20practitioners_2013%20FINAL.pdf

exponentially, and the time for cases to be heard has increased due to case volume.

14.7.8 The Review Panel was informed that a MARAC review was currently taking place. The review was being undertaken as:

- Data from SaveLives showed that in 2022/2023, the MARAC case load for Nottinghamshire was 48% higher than the recommended levels.
- New referrals into MARAC had increased 50% in 2022 and 52% in 2023.
- The current demand was unsustainable and presented a risk to the continuing effectiveness of the process and the safeguarding of survivors and their children/families.

The following aims of the MARAC review had been identified as:

- To reduce demand on MARAC by improving referrals and Quality Assurance processes.
- Improve outcomes for survivors and families.
- Reduce the burden on MARAC Chairs, attendees, and MARAC research staff.
- Improve sustainability of the MARAC process.
- Reduce current waiting times of cases being heard at MARAC.
- Reduce length of meetings.

14.7.9 The Review Panel agreed that the learning identified in this case, in relation to MARAC processes, should be used to inform the MARAC review. The Review Panel made a relevant recommendation to address this area of learning.

14.7.10 The Review Panel considered whether there were opportunities for the case to be discussed within other multi-agency forums. The police informed the Review Panel about a new initiative, 'The Prevention Hub', which was established to specialise in sharing best practice, as well as the latest crime reduction measures and initiatives to address various types of crime, including business crime, theft, burglary, domestic abuse, and anti-social behaviour. The Prevention Hub delivers the National Policing Prevention Strategy[33] across Nottinghamshire: fewer victims, fewer offences, and less demand on policing. This is achieved by addressing underlying causes and using partnership orientated problem-solving.

[33] https://www.npcc.police.uk/SysSiteAssets/media/downloads/publications/publications-log/2022/npcc-prevention-strategy-1.pdf

14.7.11 The Review Panel agreed that the volume of contact from Tom, Mary, and Jim had had a significant impact on agencies' engagement and contact with the individuals, and yet despite this contact, the domestic abuse continued. The Review Panel agreed that the repeated calls to reported incidents of domestic abuse, which were later not supported, would have benefited from discussion and consideration of a multi-agency approach, and not be the sole responsibility of the police. The Review Panel discussed the role of The Prevention Hub in responding to cases of domestic abuse. The panel agreed that this was a positive process that would have been useful to have been implemented, had it been in place during this case. The Review Panel agreed that the details of how cases are identified and discussed with partner agencies, including what outcomes are considered, should be presented to Nottingham Community Safety Partnership.

14.7.12 In 2019, Mary had been referred to MARAC. The perpetrator in the case was Jim. The alert process within Nottingham University Hospital was not followed accurately, and the MARAC alert was placed in case notes. The Review Panel was informed that at that time, the system had recently changed. There is a standard operating procedure for all staff that describes the process for alerts: this ensures a standardised process is in place. This area of learning is now embedded into practice.

14.7.13 Mary was living in Nottingham City at that time of the MARAC, and a MARAC-to-MARAC transfer was made from Nottingham, to Nottingham City who listed the case. Although Juno Women's Aid made contact with Mary, no risk assessment was completed with her. The referring DASH had described evidence of coercion, (Mary felt it was her duty to sleep with Jim), obsession, and jealousy. The Review Panel was informed that as a minimum, the referring risk assessment should be reviewed with the survivor in order that additional information can be gathered, or a DASH assessment can be completed to assess risk. This has been identified as a single-agency area of learning and action taken to address this learning.

14.7.14 In February 2021, Mary had contact with the Liaison and Diversion Service after her arrest for assaulting Tom. There was recorded evidence that routine enquiry was utilised, with Mary denying that she was the victim of abuse. At this time, there was a Perpetrator of Domestic Violence and Abuse Pathway in place within Nottingham Healthcare NHS Foundation Trust: this prompts staff to refer a service user to perpetrator support services if they are wishing to engage. There was no evidence to suggest that the clinician explored known information indicating that Mary was the perpetrator of abuse.

14.8 Term 8

What knowledge did family, friends, and employers have around Tom, Mary, Jack, and Jim's relationship? Did this identify domestic abuse, and if so, did they know what to do with that knowledge?

14.8.1 Tom, Mary, and Jim were not in employment.

14.8.2 Tom's family had no knowledge of Jack, and his relationship to Mary was not known to them until after the death of Tom. There was no evidence that family members were aware of the intimate relationship between Jim and Mary.

14.8.3 In a statement provided for the criminal investigation, Tom's family stated that at the time of Tom's death, he had been living with Mary, and that their relationship had been 'on and off' for about five or six years. Tom had his own room in the flat where he lived, which the family understood to be a house of multiple occupancy, although they had never been to the property.

14.8.4 Tom's family described Tom and Mary's relationship as difficult and chaotic, as they both consumed alcohol, and that their relationship had driven a wedge between Tom and his family. At family gatherings, there had been arguments that resulted in family members not having contact with Tom or inviting him and Mary to family events.

14.8.5 Tom's family stated that Tom did not talk about his relationship with Mary, as Tom found it difficult, and as a family, they thought Tom and Mary's relationship was not healthy. Tom's family stated that they had, at times, been open with Tom and told him that he should end the relationship.

14.8.6 Tom's family did not engage in the review process. Therefore, the information on their knowledge around Tom's relationship with Mary and Jim, the domestic abuse, and what to do with this knowledge, is confined to the information gathered during the criminal investigation. Whilst the Review Panel acknowledges that this has limited the review with information, it was clear to the Review Panel that Tom's family were aware of the complexities within Tom's relationship and that this had resulted in the family's contact with Tom being limited.

14.8.7 The Review Panel sought information around the accessibility of information for family and friends around how they can report concerns of domestic abuse. An internet search for variations of 'Nottingham friend domestic abuse' finds multiple services with advice on what to do.

14.8.8 The Review Panel was informed that in partnership with Nottinghamshire Police, Equation is raising awareness about the Domestic Violence Disclosure Scheme – '**Right To Ask Campaign**' – highlighting that domestic abuse can happen to anyone, of any gender, sexuality, race, ability, or religion, and that everyone has the right to relationships that are free from abuse. Furthermore, that anyone can use their Right to Ask to help keep themself, or someone else, safe.

The Campaign includes:

- Equation website page: It's your Right to Ask, about their past | Equation
- Poster: Right to Ask – Domestic Violence Disclosure Scheme poster | Equation
- Article in Equation's Professional's News (March edition)
- Article in LeftLion Magazine (March edition)
- Social media posts.

Equation offers a DVDS service for men. As the DVDS is commonly referred to as 'Clare's Law', the campaign was undertaken to address concerns that people may therefore assume DVDS is only available for women.

14.9 Term 9

Were there any issues in relation to capacity or resources in your agency that impacted on its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? Please consider if Covid-19 related work practices affected your response?

14.9.1 Tom's contact with Nottingham Recovery Network was affected by the Covid-19 pandemic because face-to-face appointments changed to telephone appointments. However, it was recorded that Tom engaged well with the support offered and made positive changes during his six-month engagement as part of his Alcohol Treatment Requirement. A thorough assessment and care plan reflected the requirements, which Tom completed successfully.

14.9.2 Mary was initially offered a telephone assessment by Nottingham Recovery Network rather than an appointment in person, as outlined in the local Covid-19 standard operating procedure at that time. However, staff became concerned that Mary was not able to safely complete a telephone assessment due to the presence of Jim in her home, and she was asked to come in to the Wellbeing Hub for a face-to-face appointment the following

day. Mary complied with this request, and a thorough assessment was completed safely.

14.9.3 Tom was managed by DLNR CRC. This organisation worked with a large volume of less complex cases. The Covid-19 restrictions came into force during Tom's period of supervision. DLNR CRC moved to an emergency delivery model (EDM), which required contact to move from face-to-face to telephone contact for all but the critical few. Tom's supervision moved to remote telephone contact. Records indicate that his compliance actually improved during this period of remote contact; however, it is acknowledged that DLNR CRC was unable to rely on physical presentation and reaction as a means of monitoring any potential risk situation, including to Tom himself.

14.9.4 Housing Aid had an office-based presence throughout the Covid-19 pandemic, and customers could access the service either by telephone or in person. Mary was referred to the service on three occasions. On each of these occasions, contact was established, and initial advice was given. Contact was lost each time, although it was confirmed that Mary was in touch with other services, and requests were made of them to support her to contact Housing Aid if she needed assistance.

14.9.5 The period of the review covered the Covid-19 pandemic and national lockdowns, which impacted on all public services. Juno Women's Aid informed the Review Panel that the impact for services, and those who needed support, is still being addressed. For the most vulnerable and with complex needs, accessing specialist domestic abuse services during this time became increasingly difficult, despite initiatives. Refuge spaces for women with additional needs, e.g., disability and/or complex needs, are incredibly limited across the country and impacts on women such as Mary. The increased provision for domestic abuse victim-survivors with disabilities, and/or multiple complex needs, is a national Government action.

14.10 Term 10

Were there any examples of outstanding or innovative practice?

14.10.1 The Review Panel was informed that Mary's Nottingham Recovery Network worker demonstrated outstanding practice by taking immediate action to safeguard Mary: firstly, by assessing the risk to Mary; and secondly,

offering a face-to-face appointment during the Covid-19 pandemic. Efforts were then made to secure a refuge for Mary due to domestic abuse concerns, and when it became apparent that this was not a viable option due to a lack of bedspaces, her worker then contacted Housing Aid. Mary was then given an assessment straight away over the telephone. Rather than signposting Mary to appropriate services, action was taken quickly with Mary present – with a view to achieving a positive outcome and reducing risk.

14.11 Term 11

What learning did your agency identify in this case, and how will this be embedded into practice?

14.11.1 Nottinghamshire Police

- To ensure processes are in place to identify and investigate cases of domestic abuse flagged in partner agency DASH referrals.
- Feedback on responses to police officers regarding the identification of domestic abuse and completion of DAPPNs.

Action taken to address this learning –

- Tactical advice around the use of civil orders is added to all prisoners received into custody for domestic abuse offences.
- Nottinghamshire Police have revamped the DAPPN training, which will be delivered across the Force over the next 12 months.
- Nottinghamshire Police have a bespoke webpage dedicated to the use of DVPN/O – including when to consider them, how to complete them, and other operational advice. During the standard working week, there is also a dedicated SPOC to answer any queries relating to DVPN/O use.
- As part of the Prevention Hub, further training and advice around the use of all civil orders is planned to be delivered by the end of the 2023/24 financial year.
- A full systematic review of DASU and MARAC is planned for 2024 – this will include an escalation process for repeat domestic abuse cases.

14.11.2 The Probation Service

- Review of domestic abuse incidents to highlight any potential emerging risks.
- Home visits.

Action taken to address this learning –

- Since this case, the DLNR CRC and NPS have merged to form part of East Midlands Probation Service, and policies have changed.
- Home visits to cases with domestic abuse concerns are mandatory, and a clear and established process of obtaining information around domestic abuse from the police is embedded into practice.
- It is now mandatory for all cases to have a safeguarding and domestic abuse check at the start of supervision and a home visit within the first three months in a case that is medium risk and has domestic abuse concerns.
- It is now expected and embedded into practice that information regarding further offending is followed up with the police and other relevant agencies and that offence-focussed work is undertaken on all areas of risk to assess all areas of concern.

14.11.3 East Midlands Ambulance Service

- Promotion of future EMAS 'Learning from Events' session, around documentation and completion of Patient Referral Forms (PRFs), to include EMAS Safeguarding Team – so that learning around comprehensive documentation can be disseminated Trust wide and documentation requirements for domestic abuse referrals can be reiterated.

Action taken to address this learning –

- A 'Learning from Events' session is planned around completion of PRFs and documentation.
- EMAS has launched a pathway to refer into drug and alcohol support services across the East Midlands counties covered by EMAS. Consent is required to make the referrals unless a service user has required life-saving intervention, such as administration of naloxone or airway management due to overdose. This has been well received and is now an established referral pathway. Therefore, in future attendances to service users with alcohol dependency issues, there is now an option for crews to discuss alcohol use and raise a referral if consent is gained.

14.11.4 Juno Women's Aid

- Opportunities to attempt one-to-one contact and engagement with Mary.

- The referral to R2C that was not processed in line with policies and procedures. This service supports complex cases, often engagement is sporadic and at the point of crisis.
- Recruitment and retention of staff.

Action taken to address this learning –

- Juno Women's Aid has created service manuals for all services. This is service-specific guidance for staff covering processes – from referral into service stage to case closures. These are available to existing and new staff at induction stage to support practice, re-enforce policy, and to embed learning.
- Juno Women's Aid has overhauled their approach to recruitment of staff, which is delivering positive results, and has introduced a one-week corporate induction followed by three weeks in-service induction. In addition, a revised learning and development plan has been implemented for the whole organisation that ensures staff receive ongoing training to address a range of topics, including supporting survivors with multiple and complex needs, case note recording, etc. so that survivors can be assured that staff understand, can respond to differing needs, and are not reliant on specific specialist services, e.g., R2C alone.

14.11.5 Nottingham Healthcare NHS Foundation Trust

- Wider consideration and exploration of perpetrator behaviour and support is required by the Liaison and Diversion Service.

Action taken to address this learning –

- The Liaison and Diversion Service will receive perpetrator training from the Your Choice Project.

14.12 Was the learning in this review similar to learning in previous Domestic Homicide Reviews commissioned by Nottingham Community Safety Partnership?

14.12.1 Juno Women's Aid informed the Review Panel that it has conducted a review of all the DHRs it has had involvement with over the past 10 years – to ensure that the recommendations are implemented and the learning for all Juno Women's Aid services is embedded in order to improve practice and ensure survivors receive the service they need, when they need it.

14.12.2 The Review Panel also considered learning identified in a previous DHR[34] completed in Nottingham – around a multi-agency response to work with individuals who had identified vulnerabilities that met the needs of the individual's health and social needs. The Review Panel has seen the action plan from this DHR and the work to embed the learning, which includes:

- The Integrated Care Pathway and how clients can be referred.
- The development of a Women's Severe Multiple Disadvantage group.
- The implementation and roll out of a Trauma Strategy.

At the conclusion of this review, the action plan and learning have been embedded.

[34] DHR Hashtag

15. CONCLUSIONS

15.1 Tom died following a long and sustained assault perpetrated by Jack.

15.2 Jack was the nephew of Mary, with whom Tom had previously been in an intimate relationship. Tom and Mary lived in the same household.

15.3 As part of their victim impact statement, Tom's family stated: 'I can't accept what had happened to Tom – how unfair it is and how unnecessary. I don't know how to explain Tom's death to my youngest children who still ask when they will get to see their 'stupid uncle Tom'.

15.4 Tom had had a long-term relationship with Mary. Whilst the relationship was understood to have ended in August 2020, the Review Panel saw information that they did, at times, continue to describe themselves as being in a relationship.

15.5 Within Tom and Mary's relationship was another male, Jim. He was a long-term friend of Tom's, and a previous partner of Mary's. Together, all three of them had relationships that centred around friendship and alcohol consumption. At times, there was violence within their relationships – with incidents of abuse, including physical abuse being reported to the police. Where criminal offences had been identified, these did not always result in a criminal investigation and conviction, due to the lack of evidence and support from the identified victim.

15.6 Tom, Mary, and Jim were identified as victims and perpetrators of domestic abuse. The exact identification of the primary victim and perpetrator of domestic abuse was often difficult for professionals to establish.

15.7 Tom did not provide consent for information to be shared with partner agencies, including support agencies for domestic abuse and alcohol consumption.

15.8 The frequency of the incidents of domestic abuse were not discussed within a multi-agency forum; therefore, the domestic abuse continued to occur.

15.9 The review acknowledged the difficulty for agencies that respond to incidents of domestic abuse, especially where those involved have additional and often complex needs, and who decline support from agencies.

15.10 The Review Panel identified areas of learning, for all agencies, on responding to cases where there is a potential escalation in terms of frequency of incidents and contact with agencies.

16. LEARNING IDENTIFIED

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

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

Learning 1 [Panel recommendation 1]
Narrative
There was an opportunity for Mary and Jim to have been informed about the provision of a voluntary domestic abuse and violence project, to which, with their consent, they could have been referred. The programme, known as YCP, includes a support service for survivors of domestic abuse, alongside the intervention for perpetrators to monitor/manage risk and ensure survivor safety and wellbeing.
Lesson
Awareness of the role, remit, and referral process of YCP allows professionals to discuss with perpetrators of abuse, a service which can work with them to address their domestic abuse behaviour.

Learning 2 [Panel recommendation 2]
Narrative
The review identified that the volume of domestic abuse cases had increased exponentially, which impacted on cases being referred to MARAC. In addition, the threshold criteria to refer cases to MARAC was not being adhered to by agencies, and single-agency processes had been implemented for MARAC referrals where the risk had not been deemed as high.
Lesson
Understanding the current volume of domestic abuse cases, risk level, and – where that risk is high – the number of referrals to MARAC, will then inform if the current threshold criteria is valid or needs to be reviewed.

Learning 3 [Panel recommendation 3]
Narrative

The case identified that the domestic abuse continued over an extended period of time, and despite incidents of abuse being reported to the police and action being taken, including through criminal justice routes, the domestic abuse continued to occur and be reported to agencies. The implementation of The Prevention Hub will respond to cases of domestic abuse and utilise a partnership orientated problem-solving method.
Lesson
Understanding the role of The Prevention Hub in responding to repeated cases of domestic abuse, particularly where there is escalation in terms of frequency. Furthermore, agency contact will inform Nottingham Community Safety Partnership on the partnership approach to repeated cases of domestic abuse and seek to identify any gaps in the multi-agency working arrangements.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	That Equation shares the learning from this review in relation to the role of, and referral processes to, Your Choice Project. This should also include the options available to agencies on how they could disseminate the learning further within their agency by: 1. Inviting the YCP to attend internal meetings or learning events to provide an overview of their service. 2. That professionals can attend online webinars that are held on the role of YCP. 3. That professionals can attend Equation's Challenging Domestic Violence Abuse training.
2	That Nottingham Community Safety Partnership shares the learning around the MARAC process (identified within this report) with the MARAC review currently being undertaken. This can take place by sharing the relevant sections and analysis (within the report) with the review process.
3	That Nottinghamshire Police provide a report/presentation to Nottingham Community Safety Partnership that details how The Prevention Hub responds to repeated cases of domestic abuse, where there has been an escalation in frequency and agency contact, which are not being addressed through other processes, such as MARAC and criminal justice intervention. The report/presentation should detail: 1. How cases are identified. 2. How agencies are working together to respond to such cases. 3. How the outcomes of cases are measured. Upon receipt of the report/presentation, Nottingham Community Safety Partnership should then seek to consider if there remains any gap in the multi-agency response to such cases.

17.2 Single-agency Recommendations

17.2.1 Single-agency recommendations are contained within the Action Plan at Appendix A.

Appendix A

Action Plans

DHR Hassium 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	RAG
1	That Equation shares the learning from this review in relation to the role of, and referral processes to Your Choice Project. This should also include the options available to agencies how they could disseminate the learning further within their agency by: • Inviting the YCP to attend internal meetings or learning events to provide an overview of their service. • That Professionals can attend online webinars that are held on the role of YCP. • That Professionals can attend Equations Challenging Domestic Violence Abuse training.	To increase awareness of Your Choice Project, to provide Professionals with information on how to refer and the availability of support to individuals where domestic abuse has been identified.	Local	Invite the YCP team to attend internal meetings or learning events to provide an overview of their service. To promote the YCP service to professionals via online training/webinars/newsletter/ communication platforms. To promote Equations Challenging Domestic Violence Abuse training to professionals via to Equation's professional newsletter.	Equation	September 2024	August 2024	Equation's *'Challenging DVA'* training has been reviewed, re-designed and renamed as *'Recognising and Responding to Perpetrators of Domestic Abuse'* and dates for this training are advertised on Equation's website. The training is free to professionals across Nottingham(shire). Promoted through a variety of multi-agency partnerships Your Choice Project briefings are available to all agencies to book via Eventbrite throughout 2024. In depth Recognising and Responding to Perpetrators if Domestic Abuse are free to all professionals. Other agencies can invite the YCP team to team meetings to provide an overview of the Project. All sessions are being promoted through Equation Newsletters and Campaigns material.	**Green**
2	That Nottingham Community Safety Partnership shares the learning around the MARAC process identified within this report with the MARAC review currently being undertaken. This can take place by sharing the relevant sections and analysis within the report with the review process.	MARAC processes were not adhered to on this case. The MARAC processes were under review at the time of this review and the learning will inform the review taking place.	Local	The NCSP DHR Lead to share the learning from the DHR report with the NCSP MARAC Lead and MARAC Steering Group	NCSP	September 2024	October 2024	The DHR learning was shared with the NCSP MARAC Lead and MARAC Steering Group. The concerns in the report have been addressed and the NCSP are moving to a new model which better manage demand and ensure that only the appropriate cases are heard at the full MARAC.	**Green**

3	That Nottinghamshire Police provides a report/presentation to Nottingham Community Safety Partnership which details how The Prevention Hub responds to repeated cases of domestic abuse, where there has been an escalation in frequency and agency contact, which is not being addressed through other processes such as MARAC and criminal justice intervention. The report/presentation should detail: • How cases are identified. • How agencies are working together to respond to such cases. • How the outcomes of cases are measured. Upon receipt of the report/presentation, Nottingham Community Safety Partnership should then seek to consider if there remains any gap in the multi-agency response to such cases.	The review was informed that The CSP needs to understand the work of The Prevention Hub in responding to repeated cases of domestic abuse to ensure that the learning on this case is being addressed through this process.	Local	Nottinghamshire Police to create a report/presentation to share with the Nottingham Community Safety Partnership/DHR Panel, which details how the '*Prevention Hub'* responds to repeated cases of domestic abuse, where there has been an escalation in frequency and agency contact, which is not being addressed through other processes such as MARAC and criminal justice interventions.	Nottinghamshire Police	December 2024		NFA Required – Upon reviewing the incidents, the DA Policy at the time did not include 'person involved' which this relationship would have fallen into. Therefore, the professional judgement applied would have been in accordance with policy at the time.	**Green**

DHR Hassium IMR Agency Actions

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • **Key milestones achieved in enacting recommendation** • **Outcome**	RAG
Nottinghamshire Police							
1.1	To ensure processes are in place to identify and investigate cases of domestic abuse flagged in partner agency DASH referrals		As of the November 2023 tactical advice around the use of civil orders is added to all prisoners received into custody for DA offences during the core day. The aim of this is to raise awareness of consideration of the use of DVPN.	N/A	November 2023	As of the November 2023 tactical advice around the use of civil orders is added to all prisoners received into custody for DA offences during the core day. The aim of this is to raise awareness of consideration of the use of DVPN.	**Green**
1.2	Feedback on responses to Police Officers regarding the identification of domestic abuse and completion of DAPPN's.		Nottinghamshire police have a bespoke webpage dedicated to the use of DVPN/O – including when to consider them, how to complete them and other operational advice. During the standard working week there is also a dedicated SPOC to answer any queries relating to DVPN/O use. As part of the Prevention Hub, further training and advice around the use of all civil orders is	December 2024 March 2024		Nottinghamshire Police have revamped the DAPPN training which will be delivered across the force over the next 12 months. We continually work to improve our officers record and document crime and DAPPNs will be subject to an enhanced regime this year. Given the passage of time and the fact that our training regime has been enhanced the individual feedback will not be completed. There is a greater enhanced scrutiny by the force on recording of Domestic Abuse incidents and the force has put in post a new DCI dedicated to improving standards of investigations who will be focussed on improving Domestic Abuse investigations.	**Green**

			planned to be delivered by the end of the 2023/24 financial year. A full systematic review of DASU and MARAC is planned for 2024 – this will include an escalation process for repeat DA.	2024			
The Probation Service							
2.1	Review of domestic abuse incidents to highlight any potential emerging risks		Since this case the DLNR CRC and NPS have merged to form part of East Midlands Probation Service and policies have changed Regular checks are made to the police in order highlight any further concerns around domestic abuse, these are discussed with SPO's and come through to SLT if risk is considered unmanageable and are on licence.	**N/A**	**2023**	Regular checks are made to the police in order highlight any further concerns around domestic abuse, these are discussed with SPO's and come through to SLT if risk is considered unmanageable and are on licence.	**Green**
2.2	Home Visits		Home visits to cases with domestic abuse concerns are mandatory and a clear and established process of obtaining information around domestic abuse from the Police is embedded into practice.	**N/A**	**November 2023**	It is now mandatory for all cases to have a safeguarding and domestic abuse check at the start of supervision and a home visit within the first 3 months in a case that is medium risk and has domestic abuse concerns It is now expected and embedded into practice that information regarding further offending are followed up with the Police and other relevant agencies and that offence focussed work is undertaken on all areas of risk to assess all areas of concern.	**Green**
East Midlands Ambulance Service							
3.1	Promotion of future EMAS 'Learning from Events' session around documentation and completion of PRFs to include EMAS Safeguarding Team so that learning around comprehensive documentation can be disseminated Trust wide and documentation requirements for Domestic Abuse referrals can be reiterated.		A 'Learning from Events' session is planned around completion of PRFs and documentation. EMAS has launched a pathway to refer into Drug and Alcohol Support services across the East Midlands counties covered by EMAS. Consent is required to make the referrals, unless a service user has required life-saving intervention such as administration of Naloxone or airway management due to overdose. This has been well received and is now an established referral pathway. Therefore, in future attendances to service users with alcohol dependency issues, there is now an option for crews to discuss alcohol use and raise a referral if consent is gained.	**Q4 2023-2024** **2023**	**2024** **January 2023**	Session was cancelled due to demand and capacity at EMAS. Date not yet rescheduled however learning has been completed: incorporated into Safeguarding Brochure which has been issued to all staff during 2023-2024 also forms part of the bespoke Safeguarding eLearning package being delivered during 2024-2025 Drug and Alcohol referral process is now an established referral pathway. Therefore, in future attendances to service users with alcohol dependency issues, there is now an option for crews to discuss alcohol use and raise a referral if consent is gained	**Green**
Juno Women's Aid							
4.1	Opportunities to attempt one to one contact and engagement with victim		Juno Women's Aid have created service manuals for all services. This is service specific guidance for staff covering processes from referral into service stage to case closure. These are available to existing and new staff at induction stage to support practice, re- enforce policy and embed learning.	**N/A**	**April 2023**	Juno Women's Aid have created service manuals for all services. This is service specific guidance for staff covering processes from referral into service stage to case closure. These are available to existing and new staff at induction stage to support practice, re-enforce policy and embed learning.	**Green**
4.2	The referral to R2C that was not processed in line with policies and procedures and was the service that supports in complex cases, often						**Green**

	engagement is sporadic and at the point of crisis.						
Nottingham Healthcare NHS Foundation Trust							
5.1	Wider consideration and exploration of perpetrator behaviour and support is required by the Liaison and Diversion Service.		The Liaison and Diversion Service will receive perpetrator training from the Your Choice Project.	**April 2024**	**April 2024**	The Liaison & Diversion Service consist of approximately 22 staff members. 86% have undertaken the training through Equation. The Team Manager has assured the safeguarding team that the remaining staff undertake this training.	**Green**