Nottingham Crime & Drugs Partnership

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

Domestic Homicide Review

Executive Summary

'Lottie'

Died: November 2017

Johnston & Blockley

Paul Johnston
Independent Domestic Homicide Review Chair and Report Author
December 2018 (amended May 2019)

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1 INTRODUCTION

1.1 This summary outlines the process undertaken by the Nottingham Crime and Drugs Partnership domestic homicide review panel in reviewing the events that led to the death of 'Lottie' in November 2017. Indications are that Lottie deliberately placed herself onto railway tracks at the back of the house she jointly owned with Adult A. She was struck by a train and died instantly. A post-mortem examination revealed that she had 58 foreign objects in her stomach, including several coins, jewellery, a medal and 16 batteries.

Comment: *'Harmless', a national self-harm and suicide prevention support service informed the review that self-harm by ingestion is often associated with trauma. Ingesting items is a secretive and personal type of self-harm in that it can't be seen by others and the sort of items ingested by Lottie were not unusual because they are usually passable through the body with no or little intervention.*

1.2 Lottie is a pseudonym that was chosen by her mother to protect her identity. Lottie's partner has been referred to as Adult A throughout the report to protect his identity. Both identified themselves as being 'White European'.

1.3 No criminal proceedings have been instigated in connection with Lottie's death, although Adult A was arrested on suspicion of being involved in coercive and controlling behaviour towards her. He strenuously denied any suggestion that he had acted inappropriately and was subsequently released without charge.

1.4 Her Majesty's Coroner has adjourned the inquest proceedings into Lottie's death until such time as this domestic homicide review has been authorised for publication by the Home Office.

1.5 The domestic homicide review process began with an initial meeting of the Nottingham City Adult Safeguarding Partnership Board (NCASPB) Safeguarding Adult Review Subgroup on 16th January 2018, when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Lottie and with Adult A were contacted and asked to confirm whether they had been involved with them. Thirteen agencies confirmed contact with Lottie and/or Adult A and were asked to secure their files. The review commenced on 27th March 2018 and concluded on 10th December 2018. It was delayed twice, once until the Crown Prosecution Service determined there would be no criminal charges against Adult A, and then after the review had identified two key witnesses who had not been interviewed during the criminal investigation.

2 CONTRIBUTORS TO THE REVIEW

2.1 Lottie's mother, Adult A and two of Lottie's friends participated in the review.

2.2 The following agencies were asked to give chronological accounts of their contact with Lottie and with Adult A. Those submitting Individual Management reviews were:

- NHS Nottingham City Clinical Commissioning Group
- Nottingham City Council Adult Services
- Women's Aid Integrated Services (WAIS)
- Nottinghamshire Healthcare Foundation Trust (NHCFT)
- Nottingham Hospitals University Trust (NUH)
- Nottinghamshire Police Public Protection and East Midlands Special Operations Unit (EMSOU)
- DHU Healthcare CIC
- Nottingham City Council - Children's Services
- Equation Men's Domestic Abuse Service

The following submitted summary reports:

- CityCare
- East Midlands Ambulance Service (EMAS)
- National Probation Service – Nottinghamshire

The British Transport Police supplied a copy of their report to the coroner about the circumstances of Lottie's death.

2.3 In addition to the above, 'Harmless' kindly participated in the review process and added valuable insight about various aspects of suicide.

2.4 All of the report authors were suitably experienced and were independent in that they had no significant involvement with the individuals subject to the review or the line management of the case.

2.5 **THE REVIEW PANEL**

2.6 The review panel, all of whom were independent, consisted of:

Paul Johnston	DHR Independent Chair & Author
John Matravers	NCC – Safeguarding Partnerships
Hester Litten	CityCare
Lizzie Birch	Equation Men's Services
Jane Lewis	Crime and Drugs Partnership
Julie Gardner	Nottinghamshire Healthcare Trust
Gareth Davies	British Transport Police
Karen Barker	British Transport Police
Rhonda Christian	NHS Nottingham City Clinical Commissioning Group
Paula Bishop	Crime and Drugs Partnership
Jennifer Allison	WAIS
Julie Burton	National Probation Service, Nottinghamshire (NPS)
Zoe Rodger-Fox	EMAS
Lucy Chambers	CityCare
Anna Clark	Equation Men's Service

Adrian Thorpe	Equation Men's Service
Leia Robinson	NCC Adults Services
Bella Dorman	NUH
Clare Dean	Nottinghamshire Police
Ana Silver	Harmless
Julie Tomlinson	DUH Healthcare CIC

2.7 The review panel met on the following dates:

27th March 2018	21st August 2018
3rd July 2018	3rd October 2018
31st July 2018	21st November 2018

2.8 REVIEW CHAIR AND AUTHOR OF THE OVERVIEW REPORT

The Nottingham Crime and Drugs Partnership appointed Paul Johnston to chair the review and to author the overview report. He is a former senior homicide investigator who led more than 70 murder investigations, many of which were domestic homicides, before becoming head of homicide review and then head of the criminal investigation department in West Yorkshire. He then worked in Northern Ireland supporting families who lost loved-one's during 'The Troubles', before independently reviewing more that 50 domestic homicide reviews. He is a member of an international investigation facility into sexual and gender-based violence in conflict zones and is an expert witness for a European human rights advocacy service in cases before the European Court of Human Rights involving abduction, murder and domestic abuse femicide.

2.9 Paul is not a member of the Nottingham Crime and Drugs Partnership and is not associated with any of the agencies involved in the review. He retired from the West Yorkshire Police 14-years ago and has not been employed by the police in any capacity since that time.

3 THE SCOPE AND TERMS OF REFERENCE FOR THE REVIEW

3.1 After careful consideration, the review panel opted to examine each agency's involvement with Lottie and Adult A between 1st November 2013 and the date of Lottie's death in November 2017, subject to any information emerging that prompted a review of any earlier incidents or events that were relevant. The panel decided that the review should also include any information that came to light after Lottie's death which may assist in identifying key learning points for the future.

Comment: *There had been significant contacts between Lottie and agencies in 2006 and 2007, but then very little contact until 2017. However, on 1st November 2013, Lottie and Adult A had been staying together at a local hotel when staff reported their concerns over alleged abuse from Adult A to Lottie.*

3.2 The Terms of Reference for the review were set to determine whether:

- *The incident in which Lottie died was related to domestic violence or abuse including coercive and controlling behaviour in her relationship with Adult A, whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse*
- *There were any barriers experienced by Lottie or her family/friends/colleagues in reporting any abuse in Nottingham or elsewhere, including whether they knew how to report domestic abuse should they have wanted to*
- *Lottie had experienced abuse in previous relationships in Nottingham or elsewhere and whether this experience impacted on her likelihood of seeking support in the months before she died*
- *here were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Lottie that were missed*
- *Adult A had any previous history of abusive behaviour to an intimate partner, a relative or a co-habitee and whether this was known to any agencies*
- *There were opportunities for agency intervention in relation to domestic abuse regarding Lottie and Adult A or to dependent children that were missed*
- *Anyone considered Lottie to have been at risk of taking her own life and whether those concerns were shared and acted upon*
- *Training or awareness raising requirements are necessary to ensure a greater knowledge and understanding of the risk of suicide in respect of victims of domestic abuse were identified*
- *There were any equality and diversity issues that appear pertinent to Lottie and Adult A and any dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.*

4 REVIEW SUMMARY

4.1 2013 – 2014

Late on New Year's Eve of 2013, Lottie told staff at an hotel that she had been assaulted by Adult A, but when the police arrived, she told them that nothing had happened. Lottie went to the hospital emergency department on New Year's Day, saying she had fallen down the stairs at home and had injured her face and her arm. The description of the incident matched her injuries and there was no suggestion at that time that domestic abuse might have taken place.

4.2 Lottie received psychological therapy in April 2014 for anxiety, low self-esteem and difficulties with interpersonal relationships. Domestic abuse was not highlighted as an issue at any time by counselling services or by Lottie's General Practitioner.

4.3 There was then an extended period to April 2017, during which agencies had no significant or relevant contact with ether Lottie or with Adult A.

4.4 **2017**

Lottie telephoned the Women's Aid Integrated Services (WAIS) helpline in early April 2017. She said she had suffered abuse from Adult A over the past 12-years. Lottie was asked to call the helpline back when she had considered her options, including leaving Adult A and going into refuge.

4.5 Lottie telephoned again the following day. She repeated a lot of what she had already said but she also insisted the abuse was 'just' financial and emotional. Lottie agreed to have a face-to-face conversation to discuss her options and she was given advice about contacting the police.

4.6 There followed a series of telephone calls to Lottie which remained unanswered and when Lottie called the service again to ask why she hadn't been called back, it became apparent that she had not answered the calls because they had been made from a withheld number (for personal security reasons).

4.7 A 'Drop-in' session was booked for Lottie for late April 2017 and calls were made to identify a refuge that Lottie may have been able to access, despite her saying that she didn't feel ready for it, but no refuge space could be found.

4.8 During early June 2017, Lottie had said that she did not want ongoing support, but she added that Adult A was controlling and that she felt trapped financially. She confirmed that she would approach the Women's Centre for a drop-in if she decided to leave Adult A.

4.9 On 21st October 2017, Adult A telephoned 999 to say that Lottie was going to stab him. Adult A had some superficial injuries and said that Lottie needed help and that recently she had suffered a mental health breakdown. He also said that she had recently shaved her own hair off and that since then, she had become anxious and had been behaving irrationally; only the day before he had received a telephone call from her stating that she had stabbed herself in the stomach and that she wanted to die.

4.10 Lottie was arrested, and she told the police that she had acted in self-defence after Adult A had grabbed her by the throat.

4.11 Lottie told the police that she had been raped by Adult A about five-years previously and that on another occasion he had punched her in the face. She mentioned the incident at

the hotel on New Year's Eve 2013 and said that what really happened was that Adult A had pushed her down some stairs.

4.12 Adult A was arrested on suspicion of rape and assault. He vehemently denied the allegations and was later released without charge.

4.13 The WAIS worker later discussed refuge again with Lottie, but she declined it saying that she and Adult A had a joint mortgage and that he received her welfare income, the inference being that she did not want to vacate the house and that she had no access to her own money.

4.14 Around a week later, Lottie telephoned to say that she had contacted her GP and that she wanted to go into refuge and that she could do it that day. She was told that a check would be made about refuge availability and that she would be called back.

4.15 Initially two refuge spaces were found for Lottie and she said that she was willing to go to either, but during the time it took to contact Lottie by telephone, the spaces were no longer available. The same thing happened in respect of another refuge place that had been found for Lottie.

4.16 On 6th November 2017, Adult A telephoned the NHS 111 Service saying that Lottie had telephoned him to say she had cancer and that she wanted him to kill her. She had also told him that if he didn't kill her, she would kill herself, (although Adult A told the call handler that he did not know whether she would do it).

4.17 A Clinical Advisor telephoned Adult A back and told him to call NHS 111 again when he was with Lottie so that a full assessment with her could be undertaken. The Clinical Advisor also told Adult A to call for an ambulance if the circumstances were to change and if he felt that Lottie was at risk. The call was not viewed as an extraordinary event or an emergency and the Service notified Lottie's GP practice of the call the same day.

4.18 Lottie later called for an ambulance and was taken to the hospital emergency department. She said that Adult A had pushed her down the stairs and had banged her head against the floor. She had bruises and cuts and was also found to have a small stab wound to abdomen and broken teeth.

4.19 Lottie telephoned the police from the hospital to tell them what Adult A had done to her. They then telephoned Adult A and asked him to come to the police station to be Interviewed. He said he had pushed her which made her bang her head, but he had only done that because she had lunged at him. He added that she then went downstairs only to come back with facial injuries. He was reported for summons.

4.20 The following day, Lottie telephoned WAIS to tell them what had happened. She asked for a worker to visit her at home because she was bruised, and her hair had been shaved off. She added that Adult A had left the home and was not coming back and that she was

worried about how she would be able to pay her bills. Due to the risk, WAIS staff told Lottie that they would not visit her at home.

5 KEY ISSUES ARISING FROM THE REVIEW

5.1 Whether Lottie was a perpetrator of domestic violence and abuse, a victim of it or both, there is no doubt that the awful spectre of domestic abuse subsumed her. The review however, did not uncovered any clear causational link between the abuse and Lottie's death.

5.2 The dynamics of the relationship between Lottie and Adult A are far from clear. There is conflicting evidence with on the one-hand Lottie being the perpetrator, maybe while suffering mental-health issues and on the other hand, documented complaints from Lottie that she was abused by Adult A, something he strenuously denies.

5.3 Lottie had long-standing mental-health issues and was well supported by her GPs until she stopped accessing the service in June 2014. Sustained efforts were made to obtain the most appropriate psychological support for Lottie between April 2012 and June 2014, but despite those efforts, Lottie never undertook a prolonged period of counselling and the reasons why are not clear.

5.4 At times, Lottie was clearly reaching out for help, but there was sometimes an imbalance between Lottie accessing support and it being available when she needed it most; she tried to access refuge, counselling and she engaged with WAIS, but barriers prevented her from engaging face-to-face. Lottie signalled a willingness to go into refuge and the fact that that did not happen must represent a missed opportunity. Currently there is no national referral mechanism, so refuges are contacted individually. If a refuge has a bed space and there is more than one woman wanting it, the refuge will call the first referral and if they cannot contact her, they will work down the list.

5.5 Added to all of these barriers, Lottie must have felt emotionally and physically overwhelmed. She must also have been in severe pain having swallowed the batteries and the other objects that were found in her stomach.

5.6 There was also a missed opportunity for the police to have arrested Adult A when they decided instead to allow him to voluntarily attend the police station for interview.

6 CONCLUSIONS

6.1 The dynamics of the relationship between Lottie and Adult A are far from clear. There is conflicting evidence with on the one-hand Lottie being the perpetrator, maybe while suffering mental-health issues and on the other hand, documented complaints from Lottie that she was abused by Adult A, something he strenuously denies.

6.2 Where there are mutual allegations, it is important for agencies to move away from an incident-based approach to a pattern-based approach, in an attempt to establish who is

instigating the abuse and to explore whether for example a perpetrator is exhibiting controlling or abusive behaviour that does not necessarily involve physical violence but is responded to by a survivor out of retaliation or self-defence.

6.3 Previous domestic homicide reviews have revealed many permutations of abuse between couples and the review panel is alive to the fact that Lottie may have been a perpetrator towards Adult A, which may even have been brought-on as a result of her living with abuse. Adult A could have been physically violent towards Lottie who retaliated, or Adult A may have been abusing Lottie at the same time as using her mental-health issues to hide what he was doing or to shift the blame onto her. Experience has shown that on occasions perpetrators use a victim's mental-health issues to hide the abuse, but it should be stressed that there is no evidence to show that Adult A was doing so.

6.4 Lottie had long-standing mental-health issues and was well supported by her GPs until she stopped accessing the service in June 2014. Sustained efforts were made to obtain the most appropriate psychological support for Lottie between April 2012 and June 2014, but despite those efforts, Lottie never undertook a prolonged period of counselling and the reasons why are not clear.

6.5 Good practice and adherence to NUH Trust policy was shown in relation to the contacts the Trust had with Lottie and Adult A. Staff showed good understanding of domestic abuse and the risks to the victim following a disclosure. There is evidence that staff continued to support Lottie and tried to get her to engage with the appropriate agencies to support her following the alleged assault.

6.6 Good practice was also shown in response to the disclosure of domestic abuse by Adult A with an appropriate risk-assessment and referrals being made.

6.7 It is apparent that latterly Lottie and Adult A were in a relationship that involved alcohol, violence and reported suicidal thoughts by Lottie. It is not known whether the sharing of this information directly with Lottie's GP and agencies such as Women's Aid would have prevented the tragic occurrence, but the panel is of the view that a MARAC was entirely appropriate in line with the Medical Centre and Public Protection Unit referrals.

7 SUMMARY OF LESSONS TO BE LEARNED

7.1 GENERIC

7.2 A point of learning for agencies was that if they are communicating with a GP practice with a view to action being taken by a GP, they must make that fact clearly apparent.

7.3 NHS NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP

7.4 Lottie completely disengaged from the GP (in June 2014) and from counselling services (in February 2015), which may have been because she felt she was being 'passed from pillar to post'. The learning is that the transition points and information available to Lottie was

unhelpful or unclear. Lottie may also have felt let-down by the GP Practice because, despite their best efforts and following agreed protocols they had not managed to source Lottie an appropriate service to meet her complex mental-health needs.

7.5 There had been issues around record keeping within the GP practice which have now been resolved.

7.6 **NOTTINGHAM CITY COUNCIL ADULT SERVICES**

7.7 The learning for Adult Services was around the need to explore with other agencies how best to communicate with a potential survivor who is living with the potential perpetrator without compromising the survivor's safety.

7.8 **WOMEN'S AID INTEGRATED SERVICE**

7.9 Learning for WAIS was that not only did Lottie minimise the abuse she was suffering, there were other obstacles preventing her from accessing support; her hair had been cut off which meant she didn't want to be seen in public, she was only able to access support when Adult A was at work and she was financially dependent on him.

7.10 Another learning point for the organisation was that if the staff had read Lottie's notes before speaking to her it would have meant that she wouldn't have had to repeat so much information. This issue has already been addressed through additional training.

7.11 **EQUATION MEN'S DOMESTIC ABUSE SERVICE**

7.12 Learning for Equation was that in a wider sense discussions and decisions need to be made about whether there should be a local response or support service designed specifically for referrals men who are identified as potential perpetrators.

7.13 **NOTTINGHAMSHIRE POLICE**

7.14 The key lesson learned by Nottinghamshire Police was the need for them to evaluate the use of voluntary attendance of a suspect for interview in respect of domestic abuse flagged crime.

8 RECOMMENDATIONS FROM THE REVIEW

The following recommendations were made:

8.1 **GENERIC**

- Agencies should undertake a training needs analysis in respect of domestic abuse related suicide and provide assurance that it has been done.

- The Public Health Suicide Prevention Group should consider whether something should be put in place similar to the MARAC regarding the impact of domestic abuse on suicide.

- The CSP should explore whether a structured and coordinated approach can be developed around the delivery of 'safe messages' by agencies to a survivor who is living with a perpetrator and to consider how the 'Change that lasts' project uses safe messages.

- That the national recommendations about maintaining or expanding refuge spaces and there being a centralised referral system Is supported by the CSP.

- That in complex cases where there are mutual allegations, partner agencies should map incidents rather than looking at them in isolation in an attempt to establish who is instigating the abuse.

- That Understanding and Responding to Domestic Violence and Abuse (URDVA) training includes more information about suicide and the impacts on it of domestic violence and abuse.

8.2 **NOTTINGHAMSHIRE POLICE**

- The force needs to evaluate the use of Voluntary attendance in respect of Domestic Abuse flagged crime, to ensure it is appropriately used and is effective.

Comment: *This has been covered in the recent vulnerability briefings given to all staff but is an on-going piece of work within the falling arrest rate review.*

8.3 **NHS NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP**

- Consideration should be given to the type of training GP's and primary health-care require in order to identify victims of abuse and address their holistic needs appropriately.

- That the NHS Nottingham City Clinical Commissioning Group recirculate the Primary Care Domestic Abuse Referral Team (DART) Notifications Good Practice Guidelines (by the Safeguarding Adult and Children Team) to all GP Practices across Nottingham City CCG/ Greater Nottingham Clinical Commissioning Partnership and that they are also made available on the Safeguarding Adult and Children Safeguarding Website.

- That the News Fact Sheet Safeguarding Newsletter is re-circulated to all GP Practices in Nottingham City CCG/Greater Nottingham Clinical Commissioning Partnership on the subject of domestic abuse and the risk of suicide amongst victims.

- That GP Practices ascertain the patients preferred method of contact (e.g. via telephone, text or letter), when patients register at GP Practices and also when any member of the GP Practice staff reviews patient personal details.

- That the IAPT services and Primary Care Mental-health Services are linked into the System One F12 project to ensure all GP's, including locums are aware of services are available in the city.

- Assurance is sought from primary care that all practice staff have access to domestic abuse training through the GP self-assessment checklist

- That the Mental-health strategy for the Nottinghamshire Integrated Care System (ICS), which is currently under review, takes account of the learning from this DHR.

8.4 **DHU HEALTHCARE CIC**

- The automated 'remote observer call' system should be reviewed so as not to give a misleading impression that a caller has terminated a call when it had ended naturally.

8.5 **NOTTINGHAM CITY COUNCIL ADULT SERVICES**

- That the regular action learning workshops continue for all DART/MARAC practitioners to share information and ideas about cases and the service provided.

- That training will be reviewed to increase the understanding of the risk of suicide and the impact of poor mental-health for domestic abuse survivors.

- Nottingham City Council should continue to explore different methods of contact with survivors and record why particular methods were not used.

- DART workers should contact the survivor's GP when a survivor has been assessed as 'High-risk' and telephone contact has been unsuccessful, to request that contact details of Adult Services and Women's Aid are provided at the patient's next consultation.

8.6 **WOMEN'S AID INTEGRATED SERVICE**

- All WAIS staff should have a process within their service handbook on how to gain information from case notes and staff members working with a woman to prevent too many staff members contacting the woman and her having to repeat her 'story'.

8.7 **EQUATION MEN'S DOMESTIC ABUSE SERVICE**

- The Men's Service should continue only to offer a service to male survivors and follow procedure to assess relationship dynamics.

- The Men's Service should identify how to improve timescales of referral checks and case notes.

- The Men's Service identify whether to engage with all referrals identified as perpetrators who acknowledge their behaviour to give advice on how to get support with their abusive behaviour.

- The potential for bringing more clarity to the engagement with the service of men where it is unclear whether they are a victim, or a perpetrator should be explored.

8.8 There are no recommendations to be made in respect of any of the other agencies involved in this review.