Mansfield Community Partnership

Domestic Homicide Review

EXECUTIVE SUMMARY

'Angela'

Died 28th August 2015

Paul Johnston
Johnston and Blockley
April 2017

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EXECUTIVE SUMMARY

1 Introduction

1.1 This executive summary outlines the process undertaken by the Mansfield Community Partnership in reviewing the circumstances of the homicide of 'Angela', who was assaulted by her partner, Adult A, on 6th August 2015. Despite the best efforts of doctors and nurses, Angela died in hospital on 28th August 2015, after her life-support machine had been turned off. Angela was just 43. Criminal proceedings have been completed; Adult A appeared at Derby Crown Court on 11th May 2016, where he pleaded guilty to murdering Angela. He was sentenced to life imprisonment and he must serve 20-years and ten-months before he becomes eligible for parole.

1.2 'Angela' is a pseudonym chosen by her sisters; they both kindly participated in the review and their support was invaluable in allowing the panel to view events through Angela's eyes. Two of Angela's friends also took part in the review and their input also added very helpful context to the way Angela lived her life.

1.3 Adult A was asked whether he would be prepared to participate in the review, but he did not respond to the letter. Two of Angela's previous partners, one of whom had been violent towards her, were also invited. Neither took up the offer.

1.4 On 1st September 2015, the police notified the Safer Derbyshire Community Partnership of the circumstances of Angela's death, including that she had died of a stroke 22-days after she had been assaulted. There were complex medical and legal issues to be considered about the causation of Angela's death and once they were resolved, the Mansfield Community Partnership commissioned the domestic homicide review.

1.5 The following agencies were asked to give chronological accounts of their contact with Angela and with Adult A, between 25th November 2011 and 28th August 2015:

- Mansfield and Ashfield Clinical Commissioning Group (CCG) (representing GP independent contracted services)
- Nottinghamshire Healthcare NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust (SFHT)
- East Midlands Ambulance Service NHS Trust (EMAS)
- Nottinghamshire Police
- The Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC)
- Nottinghamshire Women's Aid
- Nottinghamshire Independent Domestic Abuse Service (NIDAS)
- Mansfield District Council
- Nottinghamshire County Council
- Nottingham Community Housing Association

1.6 Each agency was required to report the following:

- A chronology of interaction with Angela and with Adult A.
- What action was taken and to provide an analysis of what was done
- Whether internal procedures were followed and if those procedures were appropriate, in the light of Angela's death
- Conclusions and recommendations from the agency point of view.

1.7 Angela

Angela had contracted meningitis when she was only three-months old, which significantly affected her. She developed mild learning difficulties and suffered with bouts of depression and complex health issues. Her lack of understanding and/or willingness to comply with her prescribed medication and dietary requirements led to her having complex physical health issues.

1.8 Because of her various medical conditions, Angela became well known to the health professionals who supported her over many-years and they were shocked and saddened by her death. They described her as being fiercely independent and determined and someone who knew exactly what she wanted. She could be assertive to professionals when it came to deciding on her health needs and care plans but she could also be charming and funny. They added that Angela was a very kind person, who was gregarious by nature, but her naivety, passive approach to life and vulnerability exposed her to risky situations and sometimes to people who took advantage of her.

1.9 Adult A

Adult A and Angela met around June or July 2015. He had assaulted previous female partners and in March 2013, he was sentenced to 16-months imprisonment for assault and for breaching a restraining order. He was also a petty thief and among other things, he would steal alcohol from shops to satisfy his dependency on it. Angela allowed him to move in with her on the very day they met. That was only a few weeks before he murdered her.

1.10 Angela's friends said that within a few-days of him moving in, Angela's cheerful and happy-go-lucky demeanour changed dramatically. They added that Adult A immediately began to control her every move. Angela soon had Adult A's name tattooed on her forearm and a few-days later, uncharacteristically, she had love bites all over her neck. Adult A told Angela's friends that the love bites were a signal that she belonged to him and no-one else. On the last occasion, they saw Angela, the friends noticed that she was being very careful to keep her arms covered up. She physically flinched if anyone nearby made a sudden move and they were both convinced that Angela was hiding injuries to her arms, but they did not actually see any.

2 Agency responses

None of the agencies involved with Angela had any idea that she was in a relationship with Adult A. Had they known, the dreadful events that led to her death may not have happened. They had only been together a short time, and there was no opportunity

for any agency to have established a link between them. On one occasion, Angela had reported to the police that her new partner had gone missing, but she could not recollect his surname (he was in police custody for assault). Adult A was also on prison licence, but he had told his probation officer that he was living with his parents; there was no reason to doubt him.

2.1 The review witnessed significant evidence of persistent attempts by agencies to positively engage with Angela over many years in respect of her challenging medical conditions and concerns about domestic abuse. There were many occasions when she was asked specific questions about her domestic situation, including physical domestic violence, but they rarely elicited a positive response; she would typically say it was none of their business. Although appropriate questions were regularly asked, there was sometimes a lack of consistency and a variation in the quality of record keeping about the exercise of routine enquiry/professional curiosity.

2.2 There were some excellent examples of the sharing of information across many agencies, regular multi-disciplinary meetings to discuss safeguarding concerns and onward referrals for safeguarding assessments. With few exceptions, the proactive engagement and collaboration between agencies, was both consistent and timely and demonstrated a commitment to caring for Angela.

2.3 Angela's sisters and friends were aware that many of the men Angela had formed relationships with had been physically and emotionally abusive, coercive and controlling towards her. They knew that Angela would sometimes call the police when she was being physically abused, but said it was merely a means to stop the immediate violence or threat of it. They added that once the volatility of the situation had been diffused, she would usually go straight back to her abusive partner.

2.4 Neither the sisters nor friends ever considered reporting to the police or any other agency the abuse Angela was suffering. They said they knew insufficient detail of any incidents and in any event, although Angela was vulnerable, she was, in their opinion, entitled and able to make her own life-style decisions and it was not their place to intervene. They added that had they done so, Angela would have been furious with them.

2.5 The review highlighted the need to raise awareness among the public of the avenues available to them to report abuse without compromising their anonymity. The panel chose to address the issue immediately and It embarked upon a programme to raise awareness of the Domestic Violence Disclosure Scheme (Clare's Law), to coincide with the White Ribbon campaign during November and December 2016.

2.6 The campaign was highly successful. Mansfield District Council shared a series of tweets and images and produced a leaflet about Clare's Law. Of the 20,000+ views of the White Ribbon campaign posts, nearly 5,000 were specifically targeted at Clare's Law.

2.7 The leaflet was also given to domestic abuse organisations for staff training purposes and for distribution to potential victims and other service users. It was also provided to family services, specialist parenting practitioners, primary and secondary schools and many other organisations.

2.8 To compliment the campaign, a bulletin was distributed to all GP practices in Nottinghamshire, highlighting Claire's Law and signposting to the White Ribbon campaign and other resources. The DHR panel also sought to tie their campaign in with a pre-existing pilot project that dealt with issues surrounding the barriers experienced by friends of victims in reporting abuse.

3 Key lessons learned

A recurring theme from domestic homicide reviews has been the non-engagement with services of vulnerable people who have capacity to make decisions for themselves, yet consistently engage in risky behaviours. Angela was such a person; her learning disability, coupled with her general health issues and sometimes her dogged independence, greatly diminished her ability to keep herself safe. There was certainly no shortage of people within statutory and voluntary organisations who tried very hard to support Angela and they were frustrated at their own inability to make a difference as far as abuse was concerned. The learning from the review across all the agencies, was the need to consistently focus upon and re-shape practice and policy as necessary, to better alert practitioners of behaviour that increases the risk for people who are vulnerable.

3.1 That Angela was unlikely to engage with services became well-known by most agencies. The review has served as a reminder that staff should not cease making referrals into the relevant agencies just because they believe a client will refuse to engage with the service offered. Policy should always be followed and information should be shared when a person has been identified as high-risk and/or vulnerable.

4 Conclusions

- Angela was a cheerful and engaging woman who was very much liked by the professionals with whom she came into contact. She was vulnerable, fiercely independent and strong-willed, which at times added to her vulnerability.

- Adult A was under probation supervision at the time he attacked Angela and although his offender manager knew he had previous convictions for domestic abuse, probation interventions were focused on his current offending for theft, which centred mainly around his alcohol abuse.

- None of the agencies knew of the relationship between Angela and Adult A - and there were no missed opportunities to identify it. It is the view of the review panel that Angela's sad death could not have been predicted or prevented. Although domestic abuse was known to have blighted her life, the nature and severity of it did not indicate that she was at imminent risk.

- There was a determination by agencies to care for Angela as best they could. Multi-agency working and information sharing was generally of a high standard and Angela was regularly offered practical support on a one-to-one basis as well as additional services she could access, such as drop-in and the Freedom Programme.

- As soon as the issue of a lack of awareness about the domestic violence disclosure scheme became evident, the review panel decided to use Angela's

DHR as the catalyst to embark upon its own awareness raising campaign. This proved highly successful and plans are in place to build upon its achievements.

5 Recommendations

Nottinghamshire Police

- To consider the introduction of a quality assurance function in relation to the identification of risk and the completion of risk assessment forms now that the NICHE operational policing management system has been utilised.

5.1 Nottinghamshire Women's Aid

- NWAL staff should only populate information onto an NWAL electronic case management system.
- NWAL IDVA's should maintain the Leading Lights accreditation and uphold the standards as set out by SafeLives.
- The organisation should ensure that information is accessible to women with complex needs using Somerset symbols where appropriate.
- Care should be taken to make sure that all interventions are accurately recorded.

5.2 Sherwood Forest Hospitals NHS Trust

- Outdated paperwork should be updated to reflect current policy and practice.
- Patient information about vulnerable adults should be visible to all staff and should be shared with partner agencies where appropriate
- Consideration should be given to changing the practice whereby emergency department documentation about historical abuse attendances are only visible to staff if they occur in the present calendar year.
- Professional curiosity should become a matter of routine when anyone attends the accident and emergency department with an injury.
- GP's should be told within 24-hours of vulnerable patients who discharge themselves before being seen by a clinical decision maker or against medical advice.
- Training should be provided for senior staff in the emergency department regarding making routine enquiry/exercising professional curiosity, so that they can support and advise junior staff.
- Staff should be advised to ensure that the name and relationship of anyone attending with a patient is fully documented.

5.3 **Nottinghamshire Independent Domestic Abuse Service (NIDAS)**

- The NIDAS vulnerable adult's policy should be reviewed and updated to increase the focus around subsequent specialist interventions and joint working pathways in respect of vulnerable adults.

- Training in note taking and record keeping should be rolled-out to all current staff members with annual refresher training taking place.

- The NIDAS case closure form should be developed and expanded to give guidance to authors on special aspects of the case with attention given to actions for vulnerable adults.

- The NIDAS referral and assessment paperwork should be updated to provide a deeper focus on clients presenting with special educational needs and disabilities (SEND) and clear pathways for support

- NIDAS should disseminate findings from the new Young Peoples SEND project to the county-wide executive and wider partnership.

5.4 **Mansfield District Council**

- The effectiveness of the council's domestic violence policy and associated procedures should be assessed across all departments.

5.5 **Nottinghamshire NHS Foundation Trust**

- Managers must routinely ask for feedback from staff about their management of complex cases and the outcome of the discussions and any plans made/advice given must be explicitly recorded in the patient's notes.

- Outcomes of patient related discussions that occur in clinical supervision should also be recorded in a similar explicit way in patient's notes.

- Staff must ensure that all MDT/multi-agency meetings are fully documented (including actions and the review of previous meetings actions) either via scanned meeting minutes or a clear entry of meeting outcomes in the patients' records.

5.6 **Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company**

- The CRC should ensure that all checks are completed with the police domestic violence unit where an offender has a history of domestic violence (even in cases where the offender states they are not currently in a relationship).

5.7 **East Midlands Ambulance Service (EMAS)**

There are no recommendations in respect of EMAS.

5.8 **Clinical Commissioning Group**

There are no recommendations for the CCG, but it is of note that the good practice in relation to Primary Care Safeguarding Liaison Meetings has been cascaded to all GP practices in Nottinghamshire.

5.9 **Nottingham Community Housing Association**

- All staff involved in providing a service where domestic abuse is a factor, should receive training so that they have the necessary underpinning knowledge and skill in this area.

- Briefing sessions should take place with staff around the importance of recording information accurately and in a timely manner.

- Current assessment processes should be improved to ensure that relevant information is sought from other agencies involved with individuals.

5.10 **Nottinghamshire County Council**

- Training and awareness raising regarding DASH risk assessment and MARAC should be arranged either for NCC staff only or preferably through an inter-agency and multi-disciplinary approach.

- Safeguarding training should include consideration of other relevant processes (such as DASH or MARAC), where concerns or allegations include domestic violence or neglect.