Mansfield Community Partnership

Domestic Homicide Review

'Angela'

Died 28th August 2015

Paul Johnston
Johnston and Blockley
April 2017

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1 Introduction

1.1 This domestic homicide review overview report is about 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 was turned off.

1.2 'Angela' is a pseudonym chosen by her sisters; they have kindly participated in this review and the panel would like to extend its sincere condolences to them. The panel is extremely grateful to them for supporting the review process at such a difficult time.

1.3 Angela

Angela was only 43 when she died. She was a vulnerable woman who had 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.

1.4 Because of her various medical conditions, Angela became well known to the health professionals who supported her over many-years. Those spoken to during this review were shocked and saddened by her death and the manner of it. They described Angela as a 'larger than life lady' who had a lovely personality. They said she was a 'real character' and someone who knew her own mind. They added that she 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.

1.5 Angela did not like to be on her own and the understanding of the professionals who got to know her well, was that she had grown apart from her family and had no immediate support from them, which was possibly why she sought the close company of several male partners over time.

1.6 That view is supported by Angela's sisters and by two of her friends who have been interviewed during this review. They explained that Angela left home about 11-years ago, having fallen-out with her mother and her step-father.

1.7 In their opinion, Angela missed having a family of her own and she just wanted to have people around her. The friends said she considered their friendship group to be her family.

Comment: *More detail of what Angela's sisters and friends said about her will be provided later in this report.*

1.8 A feature of this review is that Angela's two sisters and her friends were aware that she had been involved with several men who had been physically and

emotionally abusive, coercive and controlling towards her. They had all resigned themselves to the fact that Angela was determined to lead her life in the manner she chose - and that there was nothing they could do about it without greatly upsetting Angela and ultimately alienating her from them.

1.9 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.

1.10 This review has highlighted above all, the need to raise awareness among the public of the avenues available to them to report abuse without compromising their anonymity – and ultimately therefore, to be able to intervene without putting themselves in peril of damaging their relationships with the victim.

1.11 Rather than waiting for the review process to run its course, the review panel strove to address the issue of awareness raising immediately. 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. More will be said of this initiative later in this report.

1.12 **Adult A**

Adult A was a local man and was slightly younger than Angela. They 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. Having nowhere to live, Angela allowed him to move in to her home. Angela's friends say he moved in with her on the very day they met. That was only a few weeks before he murdered her.

1.13 Adult A appeared at Derby Crown Court on 11th May 2016, when he pleaded guilty to murdering Angela. He was sentenced to life imprisonment with a recommendation that he must serve 24-years before the question of his parole can be considered.

Comment: *The term of imprisonment he must serve before he becomes eligible for parole was later reduced on appeal to 20-years and ten-months.*

1.14 When sentencing Adult A, the judge remarked, *"The facts of this case are both depressing and horrifying…. A 43-year-old woman died because of a stroke prompted by the injuries she suffered…. [Angela] was a vulnerable woman, her final misfortune was to get involved with you…. It was a terrible thing that you did."*

Adult A has been written to in prison asking if he would be prepared to participate in this review, but to date, he has not responded.

1.15 In addition to the two friends of Angela who have taken part in this review, the chair has written to two of her former partners, one of whom (Adult B) was violent towards her. Adult B did not respond and the other former partner gave his apologies and said he was too ill to participate.

1.16 ## The Mansfield Community Partnership

Mansfield is situated in the heart of Nottinghamshire in the East Midlands and is a largely urban area covering 78 square kilometres. The area currently serves a population of just over 105,300 residents and has 47,300 domestic households.

1.17 Mansfield Community Partnership (MCP) is the strategic community safety partnership for Mansfield. The work of MCP in relation to domestic violence and abuse is supported by the Nottinghamshire Domestic Violence and Sexual Abuse Executive, which is chaired by the Chief Executive for Mansfield District Council and the Nottinghamshire theme lead for domestic violence. The work of the group is overseen by the Safer Nottinghamshire Board. The executive group provides strategic governance of domestic and sexual violence and abuse activity in the district and across the county.

1.18 Domestic abuse is one of the priorities for MCP and this is set out in the Joint strategic needs assessment. The executive ensures strategic delivery against the following themes:

- Prevention of domestic and sexual violence
- Protect and support survivors
- Reducing the risk of harm and repeat offending by working in partnership
- Improving education, understanding and awareness of domestic and sexual abuse
- Improving integration and effectiveness of partnerships

1.19 These themes provide focus to the sector's work in encouraging victims to disclose the abuse and in the longer term reduce repeat victimisation. Domestic abuse remains a critical priority for the police and partner agencies because the level of threat, risk and harm presented. Mansfield District Council employs a full time domestic violence and prevention officer to drive preventative work forward within the district. The district has also achieved the 'White Ribbon Status', which is a global movement to put a stop to male violence against women and girls.

1.20 ## Establishing this Domestic Homicide Review

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. The potential for conducting a domestic homicide review was realised straight-away, but there were complex medical and legal issues to be considered as to whether Angela's death had been brought about through an act of homicide. Once

those issues had been resolved and a decision had been made to charge Adult A with Angela's murder, the Mansfield Community Partnership commissioned this domestic homicide review. The Home Office was formally notified of the decision on 3rd February 2016.

Comment: *There was regular liaison between Derbyshire Constabulary, Nottinghamshire Police, Safer Derbyshire Community Partnership and Mansfield Community Partnership while the decision was pending in respect of the cause of Angela's death. Because most of the agency contact with Angela had taken place within the Mansfield area, it was jointly agreed that the Mansfield Community Partnership was the most appropriate body to conduct the review.*

1.21 All agencies were asked to undertake a review of the information in their possession to identify any relevant contact they may have had with Angela and with Adult A. They were also asked to secure their records.

1.22 **The purpose of a Domestic Homicide Review**

A Domestic Homicide Review should:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including their dependent children

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result

- Apply those lessons to service responses including changes to policies and procedures as appropriate

- Identify what needs to change to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children, through improved intra and inter-agency working

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case

- Determine whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

1.23 **Terms of reference for the review**

The review has:

- Invited responses from agencies or individuals identified through the process and requested Individual Management Reviews (IMR's) from each one that was involved with Angela, and/or Adult A (See 'Individual Management Reviews' section below)

- Considered each agency's involvement with Angela and Adult A between 25th November 2011 and the date of Angela's death on 28th August 2015, subject to any information emerging that prompted a review of any earlier incidents or events that were relevant. (See 'Scope of the Review' below)

- Sought the involvement of Angela's family and of Adult A, to provide a robust analysis of what happened

- Determined how matters concerning family, the public and media should be managed before, during and after the review and who should take responsibility for it

- Taken account of coroners or criminal proceedings (including disclosure issues) in terms of timing and contact with Angela's family to ensure that relevant information could be shared without incurring significant delay in the review process or compromise to the judicial process

- Considered whether the review panel needed to obtain independent legal advice about any aspect of the review

- Ensured that the review process took account of lessons learned from research and previous domestic homicide reviews.

1.24 They addressed whether:

- The incident in which Angela died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence

- Whether there were any barriers experienced by Angela or family/friends/colleagues in reporting any abuse in Mansfield or elsewhere, including whether they knew how to report domestic abuse should they have wanted to

- Whether Angela had experienced abuse in previous relationships in Mansfield or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died

- Whether there were opportunities for professionals to be 'professionally curious' as to any domestic abuse experienced by Angela that were missed

- Whether Adult A had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Angela and Adult A or to dependent children that were missed

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the county

- The review will also consider any equality and diversity issues that appear pertinent to Angela, 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

- To what degree could Angela's death have been accurately predicted and prevented?

1.25 **Scope of the review**

After discussion, the review panel agreed to extend the scoping period back to 25th November 2011, the date from which it was known that Angela had been the victim of domestic assault from her previous abusive partner, Adult B. Between then and December 2014, the police were called to over 20 incidents involving them, most of which related to abuse.

1.26 As well as the IMR's, each agency provided a chronology of interaction with Angela and Adult A, including what decisions were made and what actions were taken. The IMR's considered the terms of reference and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from the perspective of their own agency and to make recommendations, if appropriate.

1.27 Because Angela and Adult A were known to services prior to the scoping period, agencies were also asked to provide summaries of any historical information that may have been relevant to the review.

1.28 **Methodology**

This overview report has been compiled from analysis of the multi-agency combined chronology, the information supplied in the IMRs, supplementary reports from some agencies, interviews with Angela's two sisters and her two

best friends, consideration of previous reviews and findings of research into various aspects of domestic abuse.

1.29 In preparing the overview report the following documents were referred to:

- The Home Office multi-agency statutory guidance for the conduct of Domestic Homicide reviews 2013
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers 2012
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Call an End to Violence Against Women and Girls – HM Government (November 2010)
- Barriers to Disclosure – Walby and Allen, 2004
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006
- 'If only we'd known': an exploratory study of seven intimate partner homicides - July 2007
- What is domestic violence and how common is it? In Intimate Partner Abuse and Health Professionals: New Approaches to Domestic Violence - Hegarty 2006
- The Lancet – Feder, 2011
- Gender differences in the prediction of problem alcohol use in family factors and childhood maltreatment. Wonderlich et al, 2001
- The Neurophysiology of Dissociation and Chronic Disease – Scaer, 2001
- Agency IMR's, reports and chronologies

1.30 **Participating agencies**

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

1.31 **DHR Panel Chair and Overview Report Writer**

The Mansfield Community Partnership commissioned Paul Johnston of Johnston and Blockley to undertake the role of Chair and report writer. He is a specialist independent consultant in the field of homicide investigation and review. He has senior management experience in many aspects of public protection and created a comprehensive domestic abuse policy, linked to forced marriage and so-called 'Honour-based violence', harassment/stalking and interviewing children and other vulnerable witnesses. He has been a special advisor to an organisation that provides domestic violence and sexual abuse services, including an IDVA service for high-risk victims and a male perpetrator programme and is currently a member of a multilateral human rights investigation facility which seeks international cooperation in sexual and gender based violence investigations in conflict zones.

1.32 **The DHR Panel**

The Partnership agreed the formation of a review panel as follows:

Panel members:

Name	**Organisation**
Paul Johnston	Johnston and Blockley
Paul Theed	Nottinghamshire Health Care NHS Foundation Trust
Tina Hymas-Taylor	Nottinghamshire Health Care NHS Foundation Trust
Zoe Rodger-Fox	East Midlands Ambulance Service (EMAS)
Carmel Hopkinson	Nottingham Community Housing Association (NCHA)
Debbie Pridmore	Nottingham Community Housing Association (NCHA)
Mandy Green	Nottinghamshire Women's Aid Ltd
Lucy Binch	Nottinghamshire Women's Aid Ltd
Claire Thornley	Nottinghamshire County Council
Wendy Adcock	Nottinghamshire County Council
Michelle Turton	Mansfield District Council
Chris Fisher	Mansfield District Council
Sarah West	Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC)
Val Simnett	Mansfield and Ashfield Clinical Commissioning Group
Lisa Haydon-Bennett	Nottinghamshire Independent Domestic Abuse Service (NIDAS)
Julie Smith	Sherwood Forest Hospitals NHS Trust

Craig Walker	Derbyshire Police
Malcolm Bibbings	Derbyshire Police
Leigh Sanders	Nottinghamshire Police
Anthony Webster	Nottinghamshire Police

IMR authors:

Name	**Organisation**
Paul Theed	Nottinghamshire Healthcare NHS Foundation Trust
Sarah Langley	Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC)
Julie Smith	Sherwood Forest Hospitals NHS Trust
Lisa Haydon-Bennett	Nottinghamshire Independent Domestic Abuse Service (NIDAS)
Chris Fisher	Mansfield District Council
Anthony Webster	Nottinghamshire Police
Lucy Binch	Nottinghamshire Women's Aid Ltd
Lucy Spencer	East Midlands Ambulance Service (EMAS)
Carmel Hopkinson	Nottingham Community Housing Association (NCHA)
Wendy Adcock	Nottinghamshire County Council
Val Simnett	Mansfield and Ashfield Clinical Commissioning Group
Jane Brady	Mansfield and Ashfield Clinical Commissioning Group

1.33 The review panel met on the following dates:

26th February 2016
17th August 2016
4th October 2016
10th January 2017

1.34 The agenda for each meeting was appropriate; there was a good level of debate and appropriate challenge; themes were identified and recorded as they emerged and the minutes and actions were promptly circulated and the latter closely monitored.

1.35 **Parallel processes**

There was a thorough police investigation into the circumstances of Angela's death and subsequent court proceedings, which resulted in the conviction of Adult A for her murder.

1.36 Although Angela's death was referred to the coroner, no inquest will take place because all the evidence and information about her death was aired during the criminal proceedings against Adult A.

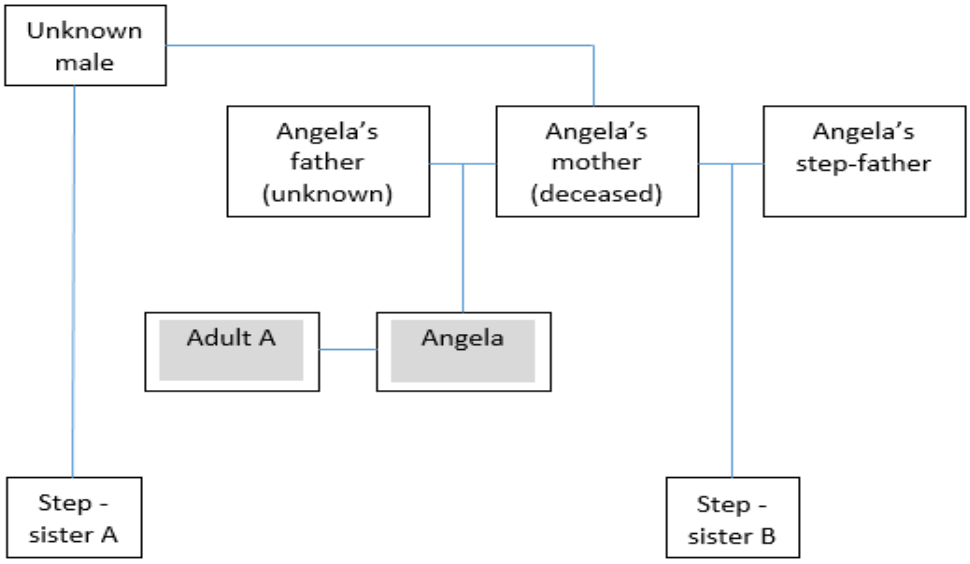
1.37 As a matter of policy and good practice, the Nottinghamshire Healthcare NHS Foundation Trust completed a serious untoward incident review. Information gathered during that process has been used to inform this report.

1.38 The Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (CRC) undertook a serious further offence review in May 2016 and again, information gathered during that process has been included in this report.

Comment: *CRC's were established on 1st June 2014 to manage low and medium-risk offenders in the community. Together, the National Probation Service (who manage high-risk offenders) and the CRCs have replaced the former 35 Probation Service Trusts.*

1.39 ## Engagement with Angela's family

Genogram:



1.40 Angela's two sisters explained that she contracted meningitis when she was only three-months old, which affected her development. They said that when the time came for Angela to leave school, she had the mental age of a 12-year old. Unlike her sisters, Angela had attended special schools, but nevertheless they were all close while they were growing up.

1.41 They lived with their mother and step-father and they recalled that Angela particularly liked going on holiday to the coast with the rest of the family. They also talked about Angela's good sense of humour and that her imitations of television characters were hilarious.

1.42 They added that despite her difficulties, Angela had a good network of friends. She had a very caring nature and liked to help other people. Together with some friends, she volunteered to work at a homeless centre about 11-years before her death. She was a very trusting person who couldn't see the harm in anyone, but her voluntary work brought her into contact with other people and very soon she began to distance herself from her sisters and the rest of the family.

1.43 She left home and lived on her own for a while, but then she started going out with men and it didn't take long before the sisters found out that one of them had 'beaten her up'. They said they were worried about Angela because she was vulnerable and didn't like her being on her own, but she was adamant that she could manage and was insistent that she would associate with whoever she wanted.

1.44 Over the years, the sisters became aware of a least four men who had physically assaulted Angela, in particular Adult B. They were also aware that she had suffered several strokes in recent-years, which they assumed were associated with the meningitis.

1.45 They added that their mother died four-years before Angela's murder and since then, Angela had drifted even further apart from the rest of the family. They had no idea what she was doing day-to-day, and generally, they would only hear from her if she needed something, for example, the last time they saw her was about four-weeks before her murder, when she came to the house to ask their step-father if he could mend her washing machine.

1.46 The sisters said they never considered reporting the abuse their sister was suffering to the police or to any other agency. 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 now, they regret not having been closer to Angela and feel they may have let her down by not involving the caring agencies, but they are sure that had they done so, Angela would have been furious with them.

1.47 ### Angela's friends

One of Angela's friends had known her for over 11-years and the other had been in the same class as Angela in junior school. They both said that Angela was a lovely and lively person who was full of fun and mischief; she was always the 'life and soul' of their friendship group, which consisted mainly of women with mild learning difficulties. They added that of the group, Angela was probably the most impressionable.

1.48 They said Angela had told them that her mother had died and that she had fallen out with her step-father about 11-years ago. Because of the fall out, she left home and at the time her only possessions were the contents of a carrier bag.

1.49 As far as the two friends were aware, Angela did not have anything to do with any relatives she may have had; they said they had no idea she had sisters, because she had never mentioned them.

1.50 In their opinion, Angela just wanted to ‘fit-in’ and to be part of ‘the gang’; she viewed their friendship group very much as being her family. She would always put her friends first, even if it meant she would have to go without something, for example, if someone needed money, she would lend it to them even if it was all she had.

1.51 An example of her desire to fit-in with ‘the gang’ was when Angela would buy cigarettes just because others were smoking. She didn’t enjoy smoking – she never inhaled and the friends said she appeared uncomfortable even holding a cigarette.

1.52 Angela didn't like alcohol either, but she would pretend she did, especially if she was with a male friend. Occasionally, if she thought it would endear herself to a man who was a heavy drinker, she would even act as if she had a drink problem.

1.53 They knew that Angela had been the victim of violence and abuse from men all her adult life, so much so that she thought it was normal behaviour. They said she did meet someone once who did not abuse her; he didn’t like to go out drinking and instead he preferred to stay at home watching television. He was not prone to violence or abuse, but according to the friends, Angela found him boring and ‘couldn't cope with it’; she told them he was not exciting enough and she would rather be in town ‘with the gang’.

1.54 The friends said that information in the media about Angela and Adult A having known one-another for several months was not correct. They had been with Angela when she met him, which was in Mansfield town centre only a few weeks before he murdered her. They added that Angela did not know Adult A beforehand. He had joined their group uninvited and had made a beeline straight for her, in their opinion, because she looked vulnerable. He was drunk, but Angela was clearly excited by him. Everyone else in the group took an immediate dislike to Adult A, mainly because they thought him arrogant.

1.55 The friends were worried when they realised that Angela had agreed that Adult A could move in with her; that had happened the very day they met. Over the following few-days, just about everyone in the group told Angela to be careful because no-one seemed to know very much about Adult A. She just laughed as she usually did when anyone tried to give her advice; the more she thought her friends were interfering, the more stubborn she became.

1.56 The friends said that also within a few-days, Angela’s cheerful and happy-go-lucky demeanour changed quite dramatically, especially when she was with Adult A, which was just about all the time. He would not allow her to smoke and he appeared to be controlling her every move; Angela said she was not allowed out without him. Within a week, Angela even had Adult A’s name tattooed on her forearm (please see comment below).

1.57 A few-days later, she was with Adult A when they joined the rest of the group. She appeared to be embarrassed and was covering herself up in her 'hoodie', but Adult A pulled the hood clear to reveal her neck, which was covered in love bites. The friends were shocked and asked her what she was playing at. Adult A said it was a sign of their love for one-another and a signal that she belonged to him and no-one else. When she had the opportunity, Angela whispered to the friends that she hadn't wanted him to do it, but he had insisted.

Comment: *Although Angela never specifically talked to her friends about the tattoo, their firm belief is that, just like the 'love bites', it was something Adult A had made her have as a means of exerting his coercive control over her.*

1.58 The last time they saw Angela was when she arrived in town with Adult A. They noticed that she was being very careful to keep her arms covered up. She had never done that before, in fact, she was known for wearing sleeveless tee-shirts even in cold weather. She refused to show them her arms when they challenged her and they said that she physically flinched if anyone nearby made a sudden move. Both friends were convinced that Angela was hiding injuries to her arms, but they did not actually see any.

1.59 The review chair asked the friends whether they thought Angela would have reported abuse to the police, or to any other agency – and whether she would have known how to do it. They said that Angela knew through experience that the police would respond swiftly to any calls she would make and that she had in the past used it as a tactic to stop immediate violence or threats of it, while ignoring the long-term consequences. Once a volatile situation had been diffused, despite support that was offered to her, Angela would usually go back to her abusive partner. In Angela's eyes, calling the police to come to her aid in times of crisis and then not supporting a prosecution, was a safer option than not involving them at all.

1.60 They said that other than to stop an immediate threat of violence, Angela would not have reported abuse to the authorities. They added that they had encouraged her to do just that when she had been with previous abusive partners and she had been adamant that she did not want to. She would become quite irritated when they pressed the issue and on occasions she would 'storm-off' and not speak to them for even suggesting it.

1.61 When asked whether either of the friends would have considered taking matters into their own hands by reporting their concerns to agencies, irrespective of Angela's wishes, they were both adamant they would not have done. They said that had they done so and Angela had found out about it, she would have been very upset and would have considered it a betrayal. In any event, they said, Angela would have denied that anything had happened and would have done whatever she could to avoid discussing it with anyone. She valued her privacy and her independence and although she was vulnerable, she was nevertheless more than capable of making decisions for herself.

1.62 As mentioned previously, a letter has been sent to Adult A, care-of his prison, asking whether he would participate in this review; but there has been no

response. The Chair has also written to two of Angela's former partners, one of whom had been violent and abusive towards her, but neither has taken up the request to be involved in the review.

2 Summary of what agencies knew about Angela

The next section of this report will detail what each agency knew about Angela and Adult A before the dreadful events of 6th August 2015, which led to Angela's death three-weeks later. An analysis of the involvement of the agency will also be included.

2.1 GP Primary Care Health Services

Angela was registered with a local GP in the Mansfield and Ashfield CCG locality throughout the period of this review. The GP practice involved is a large surgery consisting of general practitioners, registered nurses, care assistants and administrative staff.

2.2 What GP Services knew about Angela

Angela had a history of long-standing significant and complex health needs, for which she was in contact with a range of health services both primary and secondary. The GP records reflect over 100 contacts with the practice during the scoping period and almost twice as many non-attendances at appointments. There is a significant amount of correspondence from a large range of services including:

- Dermatology
- Specialist diabetic services
- Physiotherapy services
- Learning disability services
- Neurology services
- Speech and language therapy
- Emergency department
- GP out-of-hours' service

2.3 Angela's main health problems included uncontrolled type 1 diabetes and cerebral vascular incidents (minor strokes). These conditions were life limiting and required on-going medical management and treatment to prevent significant complications. Unfortunately, non-compliance with prescribed treatment had resulted in a range of associated conditions, including:

- Dizziness
- Headaches
- Joint pains
- Nerve damage resulting in poor co-ordination
- Speech impairment

2.4 Practice staff knew Angela very well because of the numerous health contacts they had with her over the years. They described her as being fiercely independent and determined. She reportedly knew what she wanted and could be assertive to professionals when it came to deciding on her health needs and care plans. She could be charming and funny, but her outward impression of self-confidence appeared to hide vulnerabilities, particularly around her need to be in a relationship. She appeared to be lonely and dependent on a partner for emotional and practical support.

2.5 The practice was aware of at least two violent relationships in the past. One, (Adult B), spanned several-years. He was registered as Angela's next of kin in 2011. It was known that she was not in contact with her family and lacked family support. The practice was not aware of Angela's relationship with Adult A.

2.6 The individual management review prepared by the CCG to support this DHR emphasises that the Mental Capacity Act 2005 requires assessment of capacity around medical treatment; assessments were undertaken on numerous occasions and Angela was assessed as having capacity, despite her learning difficulties.

2.7 The practitioners exercised professional curiosity about domestic abuse but rarely elicited a positive response. It was described how on one occasion when asked about it, Angela responded *"It's none of your business."* This was a typical response Angela would make when intrusive questions were asked about what she considered to be her private life.

2.8 Staff felt that Angela's private life appeared to impact on her attendance at appointments and the non-attendance pattern appeared to deteriorate when social crises or relationship problems arose or new relationships were being established.

2.9 Angela attended the surgery on 28th August 2014, saying her leg was bruised because she had been kicked by her boyfriend, Adult B. This had resulted in a referral to Nottingham Independent Domestic Abuse Service (NIDAS). The NIDAS worker told the GP that Angela had previously declined the service, but agreed to follow up the referral.

2.10 There were three safeguarding referrals made to the Nottinghamshire Multi-Agency Safeguarding Hub (MASH) during the period of this review. The first, on 12th March 2013, was in relation to Angela's vulnerability, the violent relationship with her partner and her learning difficulty. The other two were in relation to medical matters and a lack of carer support.

2.11 **What GP Services knew about Adult A**

Adult A was registered with a different GP practice to Angela. He attended the practice on a regular basis complaining of low mood, anxiety and depression. He was prescribed medication throughout the scoping period and this was reviewed on a regular basis by the GP.

2.12 He appeared to engage with his GP in terms of compliance with medication, but having been referred by the GP for counselling services and having discussed the importance of attending throughout, Adult A did not engage fully.

2.13 Attendances in relation to low mood and anxiety appear to have been linked to attendances where Med3 (sickness) certificates were requested.

2.14 Adult A attended the surgery on 23rd July 2015, smelling of alcohol. He had inconsistent contact with alcohol support services despite his verbal commitment to engage. The GP discussed engagement with drug and alcohol services over the scoping period. There is a note on his medical file that because he had failed to engage with the alcohol team, no more sick notes would be issued.

2.15 **Analysis of the involvement of GP Services**

The GP practice for Angela is part of the Identification and Referral to Improve Safety scheme (IRIS) which means that all members of the practice have received training on domestic abuse signs and indicators and routine questioning/the exercising of professional curiosity and referral routes. Staff were aware of Angela's history of being in violent and abusive relationships and confirmed that she was asked on numerous occasions about injuries and possible domestic abuse.

Comment: *The IRIS scheme is a general practice-based domestic violence and abuse training support and referral programme. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is aimed at women who are experiencing domestic violence and abuse from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.*

2.16 There were some excellent examples of reviewing records and sharing of information across primary healthcare workers, for example, at a multi-disciplinary health meeting on 4th November 2014, concerns had been raised about Angela staying at Adult B's home and associated risks of domestic abuse. Angela had not been to see the NIDAS worker and had been discharged. Having regular multi-disciplinary meetings to discuss safeguarding concerns is in line with best practice and is essential to be able to co-ordinate and plan effective healthcare provision.

2.17 The practice clearly recognised that Angela had additional vulnerabilities including learning difficulties, self-neglect (which was likely to result in significant health problems) and increased risk of domestic abuse. The practice followed local procedures by referring her to the local authority for safeguarding assessment on three occasions. A letter of confirmation of the outcome of the May 2014 referral notes that Angela had been referred to the learning disability team. It is not known what assessments were undertaken by the local authority in relation to safeguarding concerns.

2.18 At one consultation, Adult A linked his low mood to a lack of contact with his daughter. The records do not indicate whether this was explored any further.

Comment: *The GP appropriately referred Adult A for counselling, which would have explored contributory factors and provided a deeper understanding of his emotional health, but he did not take up the referral.*

2.19 Most of Adult A's attendances at the practice were linked to requests for sick-notes. This makes it difficult to predict whether he engaged with the GP in relation to management of his low mood and anxiety or whether this was an example of disguised compliance to secure long term provision of sick-notes.

2.20 ## Nottinghamshire Healthcare NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust is an integrated NHS Foundation Trust. The Trust's portfolio includes mental health, intellectual (learning) disability and specialist mental health services, forensic mental health and criminal justice liaison, community physical health, prison health and their low, medium and a high-risk secure hospital. The Trust is also involved in several collaborations in research and innovation with the Institute of Mental Health, the University of Nottingham and with other partners.

2.21 The Trust provides specialist health services for people with intellectual disabilities, focusing on those whose needs cannot wholly be met by mainstream provision. It works to improve both mental and physical wellbeing of its service users, providing a tiered service offering consultation to mainstream services on the less complex needs, specialist time-limited care to those with more complex difficulties and intensive intervention and care coordination to those with the most severe and complex needs. At the time of Angela's murder, the Trust had separate divisions. Health Partnerships provided mostly community facing services and their staff were predominantly based in Health Centres and GP surgeries. The Local Services Division predominantly provided inpatient services and specialised tier three and four services.

2.22 ## What Nottinghamshire Healthcare NHS Trust knew about Angela

Angela accessed the following services from Nottinghamshire Healthcare NHS Trust variously between September 2008 and August 2015:

Health Partnerships

- Community Diabetes Nursing Team
- Adult Community Services Integrated Care Team
- Podiatry

Local Services

- Adult Mental Health Services
- Psychology (Learning Disability)

- Psychiatry (Learning Disability)
- Community Learning Disability Teams
- Occupational Therapy (Learning Disability)
- Community Assessment and Treatment Teams (CATT)
- Health Facilitation Team (Learning Disability)
- Community Diabetes Nursing Team
- Adult Community Services Integrated Care Team
- Podiatry

Comment: *The following paragraphs focus solely on engagements between Angela and the Trust that may have related to issues around domestic abuse.*

2.23 On 18th October 2011, Angela's notes show a MARAC referral form was completed. It stated that Angela had been a victim 'many times in the past' and that she 'chooses not to engage with professionals'. An alert was put on RIO on 25th October 2011.

Comment: *RIO is an electronic patient record that operates across the mental health arm of the Trust. Health partnerships use SystmOne. Both systems support professionals in the consistent and timely delivery of care for patients and service users.*

2.24 Throughout November 2011, Angela's notes were endorsed with the outcome of the MARAC, that the local CATT had been very active in helping her, that liaison had been made with other agencies and that Angela was still seeing Adult B and another man who she wanted to live with.

2.25 There were further entries in Angela's notes in December 2011 and January 2012, documenting numerous pro-active attempts to engage with her. Twice in January it was recorded that there had been a domestic incident between Angela and Adult B and her psychiatric notes state she had talked about her mother's death three or four-months previously.

2.26 On 15th June 2012, a discharge letter from CATT mentioned Angela's risk of living with her partner, but that she felt low and suicidal if she lived on her own. Angela's history of poor engagement with services was also mentioned.

2.27 A Community Nurse made a telephone call to Angela on 11th July 2012, to remind her of the home visit scheduled for that afternoon. Angela said she did not want a visit; Adult B could be heard in the background shouting *"Tell her the real reason."* The phone then went dead. The Community Nurse sought immediate advice, culminating in a 'safe and well' check being carried-out by the police.

Comment: *This was an excellent example of good communication and multi-agency cooperation and support.*

2.28 Angela was unhappy that the Community Nurse had called the police. The Community Nurse wrote to Angela on 12th and 31st July 2012 to explain why she had done so. Angela's response was she did not want to see the

Community Nurse again. The Community Nurse discharged Angela, but she made a referral to the Health Facilitation Team to continue Angela's mental and physical health promotion work.

2.29 Angela's notes were updated on 23rd April 2013 to the effect that the police had received a call from a friend of Angela who she was staying with. The caller had said that Angela was threatening to kill herself after her split-up with Adult B three-days previously.

2.30 On 21st July 2015, the records indicated that Angela was 30-minutes late for a podiatry appointment. She was with a man and the notes state that 'as she was intoxicated' she was not seen. (It not clear who the man was, but staff who have been interviewed as part of this review process say they have heard from others that it was Adult A).

2.31 **What Nottinghamshire Healthcare NHS Foundation Trust knew about Adult A.**

Records show that Adult A's care began on 25th June 2014, while he was incarcerated in HMP Nottingham. He was seen separately by a mental health nurse and a doctor. It was noted that he had a chronic alcohol problem and a mental health problem of depression, anxiety and stress.

2.32 He was referred to substance misuse services and an assessment was that he required a complete alcohol detoxification. He was also referred to mental health services.

2.33 Notes dated 3rd July 2014, record that a mental health assessment was completed, which stated he had a history of depression. There followed a discussion with his GP about his prescription, which was then changed.

2.34 Substance misuse services follow-up was completed and plans were made for his discharge. An appointment was made for him for his date of release, 13th August 2014.

2.35 **Analysis of the involvement of Nottinghamshire NHS Foundation Trust**

Angela received numerous services from the Trust. She was well liked by staff who were committed to trying to keep her mentally and physically healthy and enable her to live as full a life as possible. Due to her various health conditions, Angela needed to attend a significant number of appointments with different services, all of whom were endeavouring to improve her overall health. However, despite proactive and concerted efforts to ensure she understood the importance and need for these appointments, it may have been a daunting task for her to manage and attend them all; there were in fact many missed appointments.

2.36 There is ample demonstrative evidence of persistent attempts by Trust staff to positively engage with Angela over the many-years they worked with her. There were occasions when she was asked specific questions about her

domestic situation, including physical domestic violence. She was advised to contact the police if she felt threatened and there were questions asked about her personal safety, for example when she said she was staying at a friend's house. There were times when Angela would 'open up' a little, but often, she tended to keep herself to herself. A common theme to come out of conversations with her was that she felt 'low and lonely' when she was on her own. She was offered 'female only' accommodation but she declined it.

Comment: *There was also evidence that Angela's capacity was assessed, albeit not on a frequent basis.*

2.37 Angela was specifically asked if she felt at risk by staying with Adult B, which is evidence of continued proactive practice and of questioning around her personal safety. This demonstrates that professional curiosity was used when talking about her partner's behaviour. However, the name of partner was not recorded.

2.38 There were also some examples of when there was an apparent lack of professional curiosity around Angela's lifestyle or consideration of the potential risks facing her. For example, some entries in the notes indicate that Angela was seeing or was wanting to see several men, but there is no evidence within those entries of questioning about her interactions with them.

2.39 During appointments, Adult B would often make inappropriate comments about his sexual relations with Angela, who would just laugh them off. It was reported that he liked to be the centre of attention. He would try and turn conversations around to him and his (quite significant) needs. There was no evidence within the notes to indicate whether Angela was spoken to on her own about her relationship with Adult B or how, if at all, Adult B's needs and behaviour impacted upon Angela.

2.40 In abundance were examples of proactive engagement with other agencies, for example with the probation service who informed the Trust on 24th April 2012, that Angela had sustained a black eye, apparently when she had tripped up the stairs. There was concern that Angela hadn't been since the previous week, so a joint welfare visit was made that afternoon.

Comment: *The Trust should be congratulated for their proactive engagement and collaboration with other agencies, which was both consistent and timely and demonstrated their commitment to caring for Angela.*

2.41 The team around Angela was large, which was good in terms of the support that was available to her, but it is not clear how she was able to cope with all the input. When interviewed as part of this review process, staff that had supported Angela said there was 'excellent multi-agency working and communication' in respect of her (including regular telephone conversations and meetings) and that this was an important factor that ensured there were continued attempts to engage with her. It should be noted however, that some of these meetings were not minuted or apparently documented in either her electronic patient record or her paper notes. There did not appear to be a multi-

agency meeting that related to Angela. It was never clearly established whether external issues, notably Adult B and then Adult A, were preventing or affecting Angela's attendance at appointments. They probably were, but there is no doubt also that Angela was a strong and determined woman who sometimes did things she knew were not in keeping with a healthy way of life.

2.42 Sherwood Forest Hospitals NHS Foundation Trust (SFHT)

SFHT is an acute NHS Trust that provides a wide range of health-care services.

2.43 SFHT involvement with Angela

On 9th and 18th January 2012, Angela attended the accident and emergency department with her partner for routine medical matters and was discharged after treatment.

2.44 She also attended on 7th April 2012, again with her partner and in respect of a minor medical issue. Hospital documentation indicated that Angela had learning difficulties.

2.45 Angela was back at the accident and emergency department two-weeks later, but this time she had an injury to her left eye and bruising to her cheek. She said she had fallen upstairs the previous night and had caught her eye on the carpet.

2.46 Between 20th April and 19th August 2012, Angela was treated at the same accident and emergency department on five occasions for relatively minor medical matters. On four of those, her partner was with her.

2.47 On 29th August and 16th September 2012, Angela attended the accident and emergency department with injuries to an ankle and shoulder respectively. On both occasions, she was discharged after treatment.

2.48 Between 7th October 2012 and 3rd March 2014, Angela visited the hospital for a variety of medical issues including chest pain, a stroke, diabetes, slurred speech, headache, fungal infection, diarrhoea and vomiting and pain in her upper legs. She was with her partner most of the time.

2.49 On 6th April 2014, Angela attended the accident and emergency department with her partner saying she had overdosed on tablets and had fallen out of the bath. She was seen in the psychiatry department but she was unwilling to be assessed. She said she regretted what she had done and she was discharged.

2.50 On 4th May 2014, Angela was back at the accident and emergency department, again with her partner. She had a problem with her right shoulder and said she had injured it a year previously following a fall.

2.51 On 2nd August 2014, Angela was on her own when she attended again, this time with a pain in her right leg; she said she had been kicked by her partner the week before and that the police had arrested him and he was in custody.

2.52 Angela was also on her own on her next visit, which was on 29th September 2014. She said she had tripped over the previous day and had struck her head on a wall. It proved difficult for medical staff to find out how it had happened; Angela couldn't recall, but did say someone may have hit her. She was later discharged.

2.53 Between 1st October and 13th January 2015, Angela made another ten visits to the hospital. She had problems with her diabetes, strokes, general pains to her body and pain in her left leg.

2.54 On 19th January 2015, Angela was alone when she attended the accident and emergency department. She had an injury to her right leg and said she had fallen two-weeks previously, whist going to her boyfriend's house. She was discharged after an X-ray examination.

2.55 On 10th March 2015, Angela was with her partner when she went back to hospital complaining of a swollen leg. She had previously seen her doctor due to a possible deep vein thrombosis.

2.56 Three-days later, Angela attended an appointment at the fracture clinic. She told the doctor that she had been under the influence of alcohol and had fallen over two-weeks previously. She said she didn't drink daily. X-rays indicated no bone fractures, but a follow up appointment was made for it to be re-checked (this was done on 27th March 2015 with the same result).

2.57 Angela intentionally took an overdose of prescribed drugs and went to the hospital on her own on 16th March 2015. She said she had done it because she had fallen out with her boyfriend and had emotional stress due to the breakdown of the relationship. Angela was seen by the psychiatry department who documented that she was abrupt and irritable and wanted to go home. She denied having untoward thoughts and was deemed psychologically fit for discharge once she was medically fit.

2.58 **SFHT involvement with Adult A**

On 31st October 2012, Adult A attended the accident and emergency department having deliberately overdosed on prescribed drugs. He had also consumed alcohol. He was assessed as lacking capacity due to his level of intoxication.

2.59 On 3rd December 2012, he was admitted in the same circumstances as on 31st October, but on this occasion, the police were with him. He said he was *"attention seeking"* after an argument with his girlfriend. He later said he had wanted to end his life.

2.60 He was back at the hospital on 18th December 2012, with a laceration to his brow/forehead. He was intoxicated and was unable to explain how his injury had been caused. He was drinking beer whilst in the emergency department waiting room.

2.61 **Analysis of the involvement of SFHT**

On Angela's attendance on 18th January 2012, due to the nature of her complaint, it was not appropriate to have anyone else with her during the examination. Her partner refused to leave, which should have prompted staff to consider domestic abuse, which did not happen. This represented a missed opportunity to speak to Angela in confidence about any issues she may have had.

2.62 Another missed opportunity occurred on 21st April 2012, when Angela had the injury to her eye. Again, her partner was with her. There was no evidence of questioning about how her injury had been caused or any apparent consideration of her vulnerability. Clinical enquiry should have been made and a DASH risk assessment should have been completed, if appropriate. There should also have been consideration of information sharing with a community learning disability worker and with Angela's GP practice.

2.63 Similarly, when Angela presented in August 2012 following what she said had been a fall, questions should have been asked about the cause of the incident. The same was the case when she attended the following month. It was also noted that her partner had been present throughout.

2.64 On 2nd August 2014, after Angela had told medical staff that she had been assaulted by her partner and that the police were involved, there was no DASH risk assessment or consideration of a safeguarding referral. There was no liaison with the police or apparent consideration about her vulnerability. There were similar examples of a lack of professional curiosity about the cause of injuries sustained by Angela in 2015, when she attended with a leg injury and later when she said she had fallen while under the influence of alcohol. These were all missed opportunities for professionals to probe whether Angela was being abused.

2.65 When Adult A attended the accident and emergency department on 31st October 2012 having self-harmed, he was lacking in capacity due to his level of intoxication and was referred to mental health services. There was also discussion about the need to refer him to the drug and alcohol team and the homeless support-worker.

2.66 In December 2012, when Adult A was admitted having taken an overdose and saying he had attempted to commit suicide, he was referred to the alcohol liaison service after a mental health assessment had shown him to be of low-risk. There is nothing to suggest his care was anything other than professional.

2.67 **East Midlands Ambulance Service NHS Trust (EMAS)**

EMAS provides emergency 999 and urgent care services for a population of approximately 4.86 million people within the East Midlands region. The region covers the counties of Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire, Northamptonshire and Rutland.

2.68 During 2008 and 2009, EMAS attended Angela on 19 occasions. Twelve were for medical reasons, six were due to mental health issues and one related to domestic violence and abuse.

2.69 During the period being examined by this review, EMAS had 11 contacts with Angela. All of them were for medical interventions and except for the last one, which led to Angela's death, none were in relation domestic violence or abuse.

2.70 All in all, Angela's requests for the ambulance service to attend to her related to back pain, stroke/trans-ischaemic attack, pain in her foot and head after a fall, abdominal pain, pins and needles in her arms and her chest, diabetes, general illness, a headache, feeling lethargic, an inability to stop coughing and dizziness.

2.71 **Analysis of the involvement of EMAS**

The patient report form completed by the crew that attended the incident from which Angela eventually died, clearly identified that Angela had said her injuries had been caused during a domestic incident. This, combined with her known medical history and disability increased her vulnerability and should have resulted in a safeguarding referral. EMAS did not offer any signposting in relation to domestic violence and abuse, however based on the level of injury Angela had sustained, their priority was to keep her stable, treat her injuries and take her to a local emergency department.

Comment: *The police had joined the EMAS at the scene and later they requested the CCTV recordings from the ambulance, so the crew will have known that the matter was being fully investigated and that the police would be supporting Angela.*

2.72 **Nottinghamshire Police**

Summary of the involvement of the Nottinghamshire Police with Angela

Between October 2006 and November 2011, the police recorded 68 incidents involving Angela and various boyfriends/partners, most which were domestic abuse related. There was 20 more between November 2011 and December 2014, when she was with a former partner, Adult B. Those too, were mostly related to abuse.

Comment: *Adult B had suffered a brain injury during a road traffic accident and had been diagnosed as having mental health issues as a result. He also*

had issues with alcohol abuse. He did not take up the request to be involved in this review.

2.73 Adult B was arrested seven times for assaulting Angela. He received formal cautions on three occasions after Angela had declined to support a prosecution and was charged with assault in respect of the other four. He was sentenced to community service and supervision orders and finally to a suspended prison sentence in December 2014. At that point, their relationship ended.

2.74 **Summary of the involvement of the Nottinghamshire Police with Adult A**

Between 1992 and 2015, Adult A was convicted on no fewer than 35 occasions for offences including assault, theft, fraud, criminal damage, public disorder and drugs.

2.75 Much of his offending involved his excessive consumption of alcohol. In October 2012, he was arrested for criminal damage, having broken a glass door at the home of a male drinking-partner. During the same month, he was assaulted by a female drinking-partner who had damaged his property.

2.76 In March 2013, having been drinking with a different female partner all day, they had an argument about the ownership of a bottle of cider, during which he punched her several times. He also kicked the male occupant of the flat. He was arrested and bailed with conditions that he should not contact the female victim.

2.77 A week later, he was arrested for breaching the bail conditions and was placed before the court. The court released him on bail with the same conditions as those previously imposed. On 13th May 2013, he pleaded guilty to the assaults and was given a community service order.

2.78 Adult A's then female partner ended her relationship with him after just under a year, because of his abusive and threatening behaviour towards her. Because he continued to 'harass' her, she took out a restraining order prohibiting him from contacting her or visiting her address. Within three-weeks, she had to contact the police because he kept telephoning and texting. He was arrested and was sentenced to 16-months imprisonment for breaching the restraining order.

2.79 He was released from prison on 14th February 2014, with licence conditions that he must not contact his former partner without the permission of his probation officer, that he keep away from a specified area and that he must notify his probation officer of any developing relationships with women.

2.80 On 24th June 2014, he was arrested for being in breach of the order after he had been seen within the specified area. He was remanded in custody and was sentenced to two-months imprisonment on 16th July 2014.

Comment: *While in police custody, he disclosed that he had been drinking two large cans of extra strength lager and two/three litres of cider every day.*

2.81 Adult A was released from prison on 13th August 2014, on licence that he complied with any requirements specified by his supervising officer to address problems relating to alcohol and drug misuse. The licence expired on 26th October 2014.

2.82 On 11th November 2014, a new female partner of Adult A called the police because he was drunk and argumentative. He had gone before the police got there.

2.83 On 29th November 2014, a different former partner telephoned the police because she was fearful that Adult A may attempt to take their child from her whilst he was under the influence of drink and drugs. There was no legal order preventing Adult A from speaking to his former partner and daughter and no offences were disclosed.

2.84 Between 27th March and 24th June 2015, Adult A was arrested four times for stealing alcohol from shops. On 25th June 2015, he was sentenced to a community order with an Alcohol Treatment Requirement (ATR).

2.85 On 20th July 2015, Adult A was drunk when he approached a 17-year-old male stranger and repeatedly slapped him across his face. He was arrested and later said he had no recollection of the incident because he had been so drunk. The victim ultimately declined to provide a witness statement and no further action was taken.

Comment: *On that day, Angela reported to the police that her partner had gone missing; Angela told them that she was worried about him because he was late returning home. Angela also said she had only been in a relationship with him for two weeks and could not remember his surname. There was nothing to suggest any justifiable concern for his welfare, and with such scant information, there was little the police could do. Angela telephoned the police again during the early-hours of the following morning to say her partner had returned home drunk, but was otherwise safe and well.*

Due to the lack of detail provided by Angela and her partner's relatively early return home, his full name was not obtained by the police. It was only after Angela's death that it was established that her partner had in fact been Adult A.

2.86 ## Analysis of the involvement of the Nottinghamshire Police

In January 2012, Angela was assessed as being of high-risk of abuse from her then partner, Adult B and a MAPPA meeting took place. Those present heard that Angela was vulnerable, but refused to accept the support that had been offered to her. She had said she was determined that she was going to stay in the relationship with Adult B and would continue to live with him. The police did their best to monitor what was going on in the relationship by making

repeated visits to Angela's home, but she made it clear she did not want the visits to continue.

2.87 As mentioned previously, Adult B was arrested seven times for assaulting Angela. He received formal cautions on three occasions after Angela had declined to support a prosecution, but he was charged with assault in respect of the other four.

Comment: *On all four occasions that Adult B had been charged with assaulting Angela, he was bailed with conditions that he should not have any contact with her. On each occasion, Angela contacted him and he reported to the police that she had been in touch with him.*

2.88 When Angela reported her partner missing, there was nothing to suggest to the police that he was at risk or that his behaviour was out of character. Angela had only known him for two-weeks and couldn't remember his surname, so the connection between the person they had in custody for assault (Adult A), and Angela's missing partner was not made until after Angela's murder.

2.89 ### The Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC)

The Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company is working with the Reducing Reoffending Partnership to provide supervision and a range of interventions to enable offenders to successfully rehabilitate. Their mission is to 'Provide services to transform lives and reduce crime', with the vision, 'To create safer communities by giving people the opportunity to change and the skills to rebuild their lives'.

2.90 ### What the DLNR CRC knew about Angela

The DLNR CRC had no contact with Angela.

2.91 ### What the DLNR CRC knew about Adult A

Adult A appeared at Mansfield Magistrates Court on 25th June 2015 for an offence of theft and was sentenced to a 9-month Community Order (under the Offender Rehabilitation Act).

2.92 He was assessed by the National Probation Service as posing a low-risk of serious harm to the public and to known adults. Adult A did not disclose he was in a relationship with Angela at the time of the sentence and he said he lived with his parents. The report prepared by the National Probation Service did not refer to any previous involvement in domestic violence.

Comment: *It has not been possible to establish why Adult A's previous involvement in domestic violence was not mentioned in the report. It is usual and expected practice for such matters to be included. The Offender Manager was aware however, that Adult A had convictions for offences involving domestic abuse, having had sight of his antecedent record.*

2.93 On 2nd July 2015, Adult A attended his planned induction appointment with his offender manager. The conditions and requirements of his community order were explained to him fully. This included an Alcohol Treatment Requirement (ATR) for 6-months and a Rehabilitation Activity Requirement (RAR). The referral to the alcohol treatment provider was completed by the offender manager. Adult A confirmed he was in receipt of benefits and was unemployed. He also confirmed he was living with his parents and described his relationship status as 'Single'.

2.94 He attended his next appointment on 10th July 2015. He was extremely drunk, so the interview had to be concluded early because he was unable to engage in discussions. The offender manager contacted the alcohol treatment provider to confirm Adult A's next scheduled appointment with them on 15th July.

2.95 During the afternoon of 15th July, Adult A went to see his offender manager to say he had missed his appointment with alcohol services earlier that day. The offender manager contacted the treatment provider and the appointment was re-scheduled for 28th July 2015.

2.96 On 4th August 2015, Adult A failed to attend his planned appointment with his offender manager. He was sent a 'breach letter' telling him to attend his next appointment on 12th August. He was instructed to provide evidence to excuse his absence within five-working days. The offender manager also contacted the alcohol treatment provider. They confirmed that Adult A had failed to attend his appointment on 28th July.

2.97 On 12th August 2015, the DLNR CRC discovered that Adult A had appeared at court charged with seriously assaulting his female partner. He was remanded in custody. The supervision of the case was subsequently transferred to the National Probation Service as Adult A had been re-assessed as posing a high-risk of serious harm.

2.98 **Analysis of the involvement of DLNR CRC**

Adult A was seen by DLNR CRC within the required timescales following the imposition of his court order (within 5-working days). The induction process was completed as required and the offender manager made the appropriate referrals.

2.99 When he attended his second appointment drunk, he was given a warning in line with standard practice. The offender manager then contacted the alcohol treatment provider to confirm Adult A's next appointment with them, which was expected practice.

2.100 After Adult A had failed to attend his appointment with the alcohol treatment provider, his offender manager saw him even though he did not have an appointment. The offender manager then took the appropriate action by contacting the alcohol treatment provider and re-scheduling the appointment.

The offender manager properly sent Adult A a breach letter when he failed to attend his appointment on 4th August which also required him to provide the reason he had failed to attend.

2.101 **Nottinghamshire Women's Aid (NWAL)**

Nottinghamshire Women's Aid delivers a range of support services across north Nottinghamshire to women, children and young people who are affected by domestic and/or sexual abuse. The Independent Domestic Violence Advocate (IDVA) Service and Medium-risk Intervention Service is delivered as an integrated service in partnership with Nottinghamshire Police and Nottinghamshire Social Care. Referrals are received by the DASH risk assessment following a domestic violence and abuse incident that is reported to the police. The role of the IDVA Service and the Medium-risk and Intervention Service is to provide a range of safety interventions, support and signposting to other longer-term support services.

2.102 **Summary of the involvement of NWAL with Angela**

NWAL did not have any contact with Angela during the short time she was in a relationship with Adult A. Their involvement with her was almost exclusively when she was with Adult B, as follows:

2.103 In November and December 2011, NWAL had telephone conversations with Angela after she had contacted a social worker about an incident involving Adult B. Angela said they were still seeing one-another, but just as friends.

2.104 On 17th January 2012, NWAL again telephoned Angela. She said she and Adult B were back together and that she had given up her tenancy and moved in with him. She added that he was currently at the police station because he had pulled her hair during an argument. Apparently, he had been to see his probation officer that day and had admitted to it, so the police had been called. Angela was crying and said she loved Adult B and could not live without him.

2.105 NWAL telephoned the police who said that Adult B had been cautioned and released. They then telephoned Angela back and she said she wanted to stay with Adult B; she didn't think there would be any further violence because they had no money for alcohol and therefore he wouldn't be able to get drunk. Angela was offered various options to increase her personal safety, including refuge and the national 24-hour helpline number, but she declined it all. She was encouraged to telephone the police if she was frightened. A 'Place of interest' marker was also put on her address.

2.106 During another telephone conversation, Angela said there had not been any violence since Adult B had been arrested, but he had been shouting at her, which made her flinch. Angela was again told about her possible safety options, including refuge, which she said she would think about. She added that she still loved Adult B. A DASH risk assessment was completed and Angela agreed to be referred to the MARAC.

2.107 Angela telephoned NWAL on 25th October 2013, to say that Adult B had pulled her from the bathroom by her hair. She said she would be happy for the support-worker to look for a place of refuge for her. Suitable accommodation was found, but Angela then changed her mind, saying she was going to stay with a friend instead. Angela was reminded of the local 24-hour helpline and NWAL's out-of-hour's numbers. She was also reminded of her safety plan.

2.108 Following a domestic violence incident, the police passed a DASH risk assessment to NWAL on 15th August 2014, who telephoned Angela and arranged a joint visit with the police for 18th August. When the visit was made, Adult B said Angela had moved out and was staying in a hostel.

2.109 NWAL's last contact with Angela was on 2nd January 2015, when a support-worker completed a joint home visit with a Police Community Support Officer to put various safety interventions in place.

2.110 **Analysis of the involvement of Nottinghamshire Women's Aid**

Telephone conversations between NWAL and Angela were conducted in such a way as to ensure, as far as was possible, her safety. Asking questions which could be answered either with a 'Yes' or 'No' was good practice and professional judgement was used to determine whether any conversation was safe to have.

2.111 The placing of a 'Place of interest' marker on her address was also an example of good practice.

2.112 This review has identified occasions when it has not been possible to determine whether conversations with various people/organisations took place because of deficiencies in previous recording practices. NWAL has now migrated to an online case management system which allows staff to record detailed information that may have been left out when using hand-written paper files.

2.113 An issue has arisen since February 2016, when the police changed to a computer system that NWAL cannot access. This has proved somewhat difficult as staff now have no way of accessing information that may be relevant and significant to previous and ongoing individual cases.

2.114 NWAL's care of Angela and their commitment to her safety was evident throughout their engagement with her. They consistently provided her with multiple safety options, including refuge, the national 24-hour helpline service and NWAL's out-of-hour's number. Their communication with other agencies was also good, for example, the police, probation service, social services and children's services.

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

NIDAS delivers support and advocacy for survivors of domestic violence and abuse across Mansfield and Ashfield and has a 'whole-family' approach to support (this excludes the alleged abuser). NIDAS is a registered charity and a limited company. It is a non-directive service and support is dependent on the wishes of individuals to engage with it.

2.116 **NIDAS involvement with Angela**

On 11th August 2014, Angela was referred into the service and supported by the NIDAS Court Independent Domestic Violence Advocate with further support via the Court Team.

Comment: *Adult B had pleaded guilty to assaulting Angela. Angela was upset that she couldn't have contact with him and the reasons were explained to her by NIDAS. It was noted that Adult B had a significant history of offending against women.*

2.117 Angela's GP wrote to NIDAS on 4th September 2014, asking for support for her. The GP stated that Angela had recently left her partner of five-years who has been violent towards her. It also stated that she had an injury to her leg because of an assault and that she suffered from a mild learning disability, type-2 diabetes and had suffered a small stroke in the past. The doctor said that Angela was reasonably well at that time, but she felt emotionally distressed.

2.118 On 15th September, Angela self-referred to NIDAS following the letter from her GP. It was noted that she had mental health issues and was taking medication for it. The referral stated that Angela was happy to go to the NIDAS Safety Centre or have telephone support. It was noted that she was also receiving support from the police. Angela was placed on the waiting list for support (meanwhile, telephone support was to be provided).

2.119 Angela was telephoned regularly and she said she was not sure if she wanted one-to-one support, but would like to join 'drop-ins' and attend courses at NIDAS.

2.120 Angela was invited to a 'drop-in' session but was unable to attend. She was also invited to join the Freedom Programme, but she was unable to attend that because she was in hospital.

2.121 There was then a lengthy period when NIDAS was unable to contact Angela by telephone, during which they made enquiries with her tenancy support-worker, her disability social worker and other agencies to establish if Angela had changed her phone number.

2.122 They eventually established that Angela's case had been closed to Social Care on 13th April 2015. It was noted that Angela would engage when she wanted to, usually when she was in crisis. It was also noted that Angela had ongoing

support from a psychologist and had attended two sessions and that her social worker thought she was taking her medication and was 'In a better place'.

2.123 NIDAS was also told that Angela had stopped engaging altogether when she became involved with a new partner, because he was supportive and she therefore no longer needed it. The social worker said she didn't know whether Angela's new partner had a history of domestic violence. It was noted though, that there was a 'Place of interest' marker on her property and a restraining order against her former partner, Adult B.

2.124 Having established through other agencies that Angela had not changed her telephone number, a meeting was held at NIDAS on 29th April 2015, where a decision was made to close her case because of her lack of engagement.

2.125 **NIDAS involvement with Adult A**

Adult A was known to NIDAS as the perpetrator of domestic violence and abuse to a different woman, between 26th February 2014 and 9th February 2015.

2.126 **Analysis of the involvement of NIDAS**

The service provided by NIDAS went above and beyond what could reasonably be expected of them. Their approach to supporting Angela was consistent and there were determined attempts to maintain contact with her. There were good examples of multi-agency working and information sharing with various agencies.

2.127 The court support was also of a high standard. It provided Angela with additional guidance and prepared her with safety telephone numbers to ensure she could access support later, if she wished. The telephone support service was new and had been introduced because risk levels can change whilst women wait for support. The service is highly dependent on individuals wishing to engage with it.

2.128 NIDAS policies and procedures were adhered to, but this review has highlighted the need to ensure that more detailed, accurate, objective and concise notes are recorded.

2.129 The key decision to close Angela's case was a difficult one, but NIDAS is a non-statutory and non-directive organisation and has no legal rights to make sure clients do engage. Their policy is to avoid leaving messages unless otherwise agreed and their numbers are withheld for safety reasons. It is increasingly common for individuals to not answer withheld numbers, which creates an ongoing barrier to making positive contact.

2.130 **Mansfield District Council**

Mansfield Council is a local District Authority delivering a range of public sector services across Mansfield District.

2.131 **What Mansfield District Council knew about Angela**

The council's Housing Solutions Team offered Angela safe accommodation with additional support on 12th March 2013 and on 1st August 2014.

2.132 Angela did not take up the offer made in 2013, but did eventually accept the one made 2014, after she had spent a few-days staying with friends; she also said she was waiting to give the police a statement about being assaulted by Adult B. Angela moved in on 5th August 2014. On each occasion that Angela approached the council, she was advised of options/choices available to her to enable her to make her own informed decisions.

2.133 On 11th August 2014, a homeless person's interview was arranged for Angela, but she did not attend it. It took place two-days later and the council accepted a full homelessness duty. A 'Band 1' homeless priority card for Homefinder was issued to allow Angela to bid for properties of her choice that were advertised each week. She was successful in bidding for a property and commenced a tenancy on 25th November 2014.

2.134 **What Mansfield District Council knew about Adult A**

Adult A was not known to Mansfield District Council

2.135 **Analysis of the involvement of Mansfield District Council**

Each approach made to the council by Angela was dealt with in accordance with their policies and procedures in respect of domestic abuse. Appropriate offers of advice, assistance and guidance were given to Angela to enable her to make an informed decision. She appeared to be a very vulnerable person, but she was clear that she did not wish to take up the council's temporary accommodation on 12th March 2013. MDC is going to undertake an assessment of the effectiveness of its policies and procedures to identify any gaps in awareness raising and responses where domestic abuse is identified.

2.136 During the time, Angela resided in the council's temporary accommodation, the support-worker assigned to her told the homelessness officer that she had not been staying in her unit and during August and September 2014, she had only stayed in the scheme for two-nights.

2.137 When moving out of the temporary accommodation scheme, Angela was provided with resettlement support and was then offered ongoing tenancy sustainment support by the council's Housing Needs Service. Angela declined the support and said she was being supported by another agency.

2.138 **Nottingham Community Housing Association (NCHA)**

Nottingham Community Housing Association provides care and support to 1,689 people across the East Midlands. Its work covers mental health, learning disabilities, domestic violence, Asian elders, vulnerable young people, homelessness, teenage parents and older persons, whether they need a place to live or support in their own homes.

2.139 **Summary of the involvement of Nottingham Community Housing Association with Angela**

The NCHA Personalised Support Team was commissioned from 23rd January 2012 to 2nd July 2015, to provide support to Angela around social inclusion and emotional wellbeing at her home. Her partner (Adult B), would no longer allow Angela to access support whilst in his home, so the focus of support was around social inclusion.

2.140 Angela rarely engaged with the support and at times her reluctance to engage with NCHA appeared to be instigated by Adult B. When Angela did access the support, she often chose to receive it at Apollo Bingo in Mansfield.

2.141 On 7th March 2012, NCHA supported Angela to attend a care programme approach through a Community Assessment and Treatment Team, but she did not readily accept support from them. On 23rd March, a visit was made to Angela at home. Adult B said they did not want any support from NCHA; he appeared angry and agitated, so the visit was aborted. A social worker from Nottinghamshire County Council was told about the situation; they had also met with the same response, so the police were contacted because Angela had not been seen during the visits.

2.142 Three-days later, on 26th March 2012, NCHA again visited Angela at home. Adult B said, *"We don't want you lot coming anymore."* On this occasion, Angela was seen; she was abrupt and appeared frustrated; she said Adult B could get angry and physical with NCHA staff if they visit the house.

2.143 Kings Mill hospital contacted NCHA on 29th January 2013, to say that Angela had been admitted to hospital on 27th January. She discharged herself having agreed to support being put in place, but she later contacted the office to say she did not want any support. NCHA immediately visited Angela at home, but Angela asked them to leave, saying the support was not welcome.

2.144 The next involvement NCHA had with Angela was on 12th March 2013, when she was being interviewed by the police at home regarding a complaint she had made of domestic abuse involving Adult B. She was later supported by Mansfield District Council to find alternative accommodation.

2.145 On 22nd August 2013, Angela met with NCHA and discussed her wish to leave Adult B; she said that she had had enough of Adult B being aggressive and violent. Angela was told that NCHA had services she could access and she said she would think about her options. The following week, Angela was seen

again; she said she still wanted to leave Adult B. She was told about some refuges that NCHA had found for her, but she said they were too far away. Angela added that she was no longer concerned for her safety because Adult B was no longer violent.

2.146 On 31st July 2014, Angela disclosed that 'her partner' had kicked her; she had severe bruising to her leg. Angela was advised to report it to the police. The following day, a member of NCHA staff supported Angela to provide a written statement to the police. Angela said she would be willing to attend court. She was then supported to leave her property and to go to a friend's house. Angela contacted the NCHA on 5th August 2014, to say she had moved to an address in Mansfield.

2.147 NCHA telephoned Angela on 19th August 2014 to ask if she would accept some support. She said she didn't want any on that day, but would like some help on Thursday at her new boyfriend's house.

2.148 On 9th December 2014, a member of NCHA staff telephoned Angela to complete a 'well-being' check, because she had not engaged in support that had been offered. Angela said that Adult B had 'beaten her up' and that she had telephoned the police to arrest him. Adult B could be heard in the background shouting. Angela was asked if she wanted NCHA to come to her home and she said she did. When they got there, they found Angela outside the property. The police had arrested Adult B.

2.149 The last occasion NCHA had any contact with Angela was on 20th January 2015, when she was visited at home to find out why she had not been accessing any support. Angela said she only wanted certain staff to support her and that she was currently staying at her new boyfriend's house.

2.150 **Summary of the involvement of Nottingham Community Housing Association with Adult A**

Adult A was not known to NCHA

2.151 **Analysis of the involvement of Nottingham Community Housing Association**

Once NCHA was commissioned, appropriate support plans were put in place but Angela did not engage with them effectively. NCHA made a point of keeping Angela's social worker updated about the situation.

2.152 When concerns were raised by Angela and/or disclosures made to NCHA about domestic abuse, NCHA regularly liaised with Angela's social workers, but there is no record of them referring the potential domestic abuse to the safeguarding team. However, Angela was supported in her dealings with the police when she disclosed domestic abuse and was also helped to leave her property and seek refuge elsewhere.

2.153 There is no doubt that on occasions, NCHA staff felt threatened by Adult B's behaviour and it is to their credit that they continued to find ways to support Angela despite the interference of Adult B.

2.154 **Nottinghamshire County Council (NCC)**

Nottinghamshire County Council delivers a range of assessment services across Nottinghamshire and commissions support services. It serves adults, their families and communities throughout Nottinghamshire in relation to eligible needs of adults who are affected by physical disability, learning disability, mental health or Asperger's. The service to adults with learning disabilities is delivered as a co-located service alongside staff from Nottinghamshire Healthcare Trust.

2.155 **Summary of the involvement of Nottinghamshire County Council with Angela**

In April 2008, Angela moved into a tenancy with tenancy support, but during that year she failed to attend appointments with Adult Social Care.

2.156 On 16th October 2009, the police told NCC that Angela had reported being assaulted by her boyfriend the day before. Attendance at day services was offered to support Angela, but she did not attend them. She was provided with other support, for example, the provision of household goods and equipment.

2.157 In June 2010, Angela told NCC that she had been assaulted by her boyfriend but she did not want to report it to the police. She added that she just wanted her relationship to work and that she did not want to pursue options offered in terms of domestic violence and abuse, for example a referral to Women's Aid, homelessness, alternative accommodation or MARAC. Angela was offered Relate counselling and several visits were made to her to discuss her concerns and the level of risk she faced.

2.158 On 28th November 2011, Angela said she was keen to move to another address. She indicated that she was lonely and found living alone to be depressing. On 3rd January 2012, Angela gave notice on her tenancy saying she was going to move in with Adult B.

2.159 On 17th January 2012, NCC received a telephone call from the police who said that Adult B had told his probation officer that he had assaulted Angela. The following day, a MAPPA meeting was held to discuss Adult B and concerns about Angela moving in with him. On 23rd January, NCC visited Angela to discuss how she could minimise the risks she faced. She said she was happy living with Adult B and that he did not want to leave her.

2.160 Following a referral by Angela's GP to the multi-agency safeguarding hub on 22nd May 2014, regarding concerns about Angela resuming her relationship with Adult B, a NCC safeguarding strategy meeting was held. A decision was made to offer Angela an appointment and to arrange an assessment of her needs. Angela declined to undertake the assessment and said she didn't want

anyone to visit her as she had no issues with the relationship and she did not want anyone to 'spoil it'.

2.161 At a multi-disciplinary team meeting on 4th October 2014, it was mentioned that Angela had attended Reach fitness-day activities and that she appeared to like having friends and having fun. Health staff reported that when too many questions are asked of Angela, the 'barriers come up'. It was also reported that Angela had been asked if she had a new boyfriend, but she had not given a clear answer.

Comment: *Further multi-disciplinary team meetings were arranged by NCC for 14th and 22nd October and 3rd November 2014.*

2.162 On 8th October 2014, Angela was admitted to hospital following a stroke. When she was discharged a few-days later, she said she was going back to Adult B and that she would engage with social care support.

2.163 On 20th October 2014, a review of community care assessment indicated that Angela had been the victim of domestic abuse on several occasions. She had retracted statements made to the police and usually returned to live with Adult B, but her relationship with him was now over. It was suggested though, that Angela was not accepting of the situation and that she would likely continue to visit Adult B. Her 'support-hours' were increased to seven per-week, plus three half-day sessions with Reach.

2.164 The following day, NCC was told by the police that Angela had been removed from Adult B's home. She was moved to a new address on 27th November 2014. On 9th December 2014, their emergency duty team out-of-hours' service was told that Angela had been assaulted by Adult B, who had subsequently been arrested.

2.165 On 5th January 2015, the Nottingham Community Housing Association advised NCC of the name of a man that Angela was now living with (not Adult A). NCC telephoned Angela on 26th January; she said she was still with her new boyfriend and that all was well. A home visit was arranged for 30th January 2015.

Comment: *Angela was not at home when the visit was made on 30th January.*

2.166 On 5th February 2015, Angela was reported to be more accepting of support now that she was with a new partner. A visit was made to see her on 19th March 2015 and it was noted that she looked well and was accepting support from NCHA. Her medication was discussed and she was told she would be receiving a letter from a psychologist who would be able to help her with strategies for managing when she became upset. She was also provided with help and advice about claiming benefits.

2.167 On 9th April 2015, NCC contacted Nottinghamshire Police to ask them to put a 'Place of interest' marker on her address to ensure the police were aware of

potentially vital information about past events involving Adult B, should Angela contact them in an emergency.

2.168 In response to an enquiry from NCC about the level of Angela's engagement, NCHA emailed NCC on 10th April 2014, to say she had stopped engaging. She had either turned staff away or she had not kept appointments.

2.169 On 13th April 2015, a Community Care Review was completed. Because of her non-engagement with NCHA, it was decided to end the support-hours Angela received. NCHA was to make a referral to their Nottinghamshire Adult Support Services Team so that they could deal with any future issues, such as with tenancy and benefits. Angela was told that the multi-disciplinary team was to be notified that her case was to be closed, but that she could contact the Mansfield Community Learning Disabilities Team if she had any worries, questions or concerns.

2.170 **Summary of the involvement of Nottinghamshire County Council with Adult A**

Adult A had no direct contact with Adult Social Care.

2.171 **Analysis of the involvement of Nottinghamshire County Council**

There is substantial evidence that NCC staff were sensitive to Angela's needs and that they were experienced in dealing with safeguarding issues. Staff spent time getting to know Angela and trying to understand her views and wishes. They offered her support, including a behaviour management plan; it was in an 'easy to understand' format to help both Angela and Adult B manage their behaviours and minimise risks. The support also included help with her personal care and to meet her general health needs as well as the Community Learning Disability Team helping her to find alternative accommodation and to move in.

2.172 NCC took a prominent role in facilitating multi-disciplinary meetings to look at ways of providing Angela with ongoing support and to ensure her engagement with services. There is significant evidence that NCC 'sought-out' opportunities to engage with Angela without Adult B being present, in case he was the reason for her non-engagement.

2.173 Angela was regularly given advice as well as being provided with information and signposting to a variety of services, for example with the Mansfield and Ashfield safety centre, NIDAS and Women's Aid. There was also evidence of the completion of safeguarding referrals, the recording of safeguarding manager's decisions, recording the outcomes of safeguarding and of the two safeguarding strategy meetings that were held. Both safeguarding and MARAC processes were used and referrals were made to the safer Mansfield Forum. There was also good inter-agency working with Learning Disability Specialist Nurses at the local hospital and the GP surgery. NCC made appropriate referrals to other agencies including Psychology, and NASS (Nottinghamshire Adults Support Service).

3 Addressing the Terms of Reference

- **Involvement of family and friends**

Angela's two sisters have participated in this review and have been of great assistance, although they did not see Angela regularly. They had been close when they were growing up and they all lived with their mother and step-father. As she grew older, Angela developed her own network of friends through her voluntary work at a centre for the homeless. She moved away which distanced her from the rest of the family even more.

3.1 They soon discovered that Angela had started going out with men and that some had 'beaten her up'. They said they were worried about Angela because she was vulnerable and they didn't like her being on her own, but she was adamant that she could manage and was insistent that she would associate with whoever she wanted.

3.2 The sisters chose not to report the abuse to the police or to any other agency. 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 interfere.

3.3 The review identified two friends of Angela who provided helpful information about the way she viewed life, particularly her relationships with men and her determination not to involve agencies in her private affairs.

3.4 They said their friendship group consisted mainly of women with mild learning difficulties and that of them all, Angela was probably the most impressionable; she just wanted to be part of 'the gang' and she considered the group to be her family. The friends didn't even know that Angela had sisters.

3.5 They knew that Angela had been the victim of violence and abuse from several men and that she considered it to be part of normal life. They added that she would sometimes call the police to diffuse a situation, but would then go back to her abusive partner. The friends encouraged Angela to report assaults to the police, but she was determined not to do so and would become quite irritated with them when they pressed the matter.

3.6 Both friends were sure they would not have taken it upon themselves to report abuse on behalf of Angela; she would have been furious with them and would have considered it a betrayal.

3.7 Although Angela's sisters and her two friends were aware that she had been involved with several men who had been physically and emotionally abusive, coercive and controlling towards her, they consciously chose not to do anything about it. They did say though, that had they known about the Domestic Violence Disclosure Scheme, they would have at least considered using it anonymously (see paragraph 3.21).

3.8

- **Determine how matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for it.**

The panel decided that the Mansfield Community Partnership would handle all media and communication matters. The findings of the review have been shared with Angela's sisters and friends who are content for the partnership to retain responsibility for managing any media interest. The partnership will prepare a press release in case of any enquiries and a briefing will be delivered to senior council officials prior to the publication of the final report.

3.9

- **Take account of coroners or criminal proceedings (including disclosure issues) in terms of timing and contact with Angela's family to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?**

As mentioned previously, there will not be an inquest into Angela's death because all the matters relevant to the coronial proceedings were aired during the criminal proceedings against Adult A.

3.10 There were no issues around sharing information with Angela's sisters without incurring delay in the review process or compromise to the judicial proceedings.

3.11

- **Consider whether the review panel need to obtain independent legal advice about any aspect of the proposed review.**

No conflicts or issues have been identified that would suggest that independent legal advice will be required about any aspect of this review.

3.12

- **Ensure that the review process takes account of lessons learned from research and previous DHRs.**

Previous DHRs conducted locally and nationally have been scrutinised by the chair during this review to take account of lessons learned.

Comment: *Angela's case is typical of many where there is non-engagement with services of vulnerable people who have capacity to make decisions for themselves, yet consistently engage in risky behaviours. There was no shortage of people within statutory and voluntary organisations who tried very hard to support Angela, but they were frustrated at their own inability to make a difference as far as abuse was concerned. There is a 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 like Angela.*

3.13

- **The incident in which Angela died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence.**

All agencies were aware that Angela had been in relationships blighted by domestic violence and abuse and in particular a long-standing one with Adult B. They knew also that she had been the subject of a MARAC. The incident that brought about Angela's death was therefore not a 'one off', but there is no doubt that had Angela wanted to, she could have secured support in respect of domestic violence and abuse.

3.14 None of the agencies knew of the relationship between Angela and Adult A. She had reported to the police that her partner of two-weeks had gone missing, but his identity was not established until after Angela's death.

3.15 It was difficult for professionals to be clear as to whether Angela understood what a positive relationship looked like, but her two sisters and her friends say she did. They add though, that from time to time Angela did have male partners who respected and cared for her, but she would make conscious decisions to be with the type of men who she described as 'exciting'. They all felt that although Angela had learning difficulties, she was fully aware of the dangers she placed herself in by being with abusive men; to her it was an acceptable part of life and she was determined to do as she wanted and not listen to anyone else.

3.16 Over the years and especially while she was with Adult B, Angela availed herself of numerous domestic violence and abuse services, such as Nottingham Women's Aid, their IDVA's and intervention workers plus NIDAS and the Mansfield and Ashfield Safety Centre. She was also supported by her GP and the health services and the police, to whom she would sometimes report abuse. No matter which agency Angela turned to, it was usually to resolve an immediate and pressing issue and almost as soon as the issue passed, she would distance herself from the agency again.

3.17 There is a strong possibility that when Angela was not with her friends, she was at times lonely. It has been speculated during this review that if she was lonely, it may have had some bearing on the decisions she made and that had some agency focus been made on integrating her socially within different circles, she may not have so readily been drawn to men who targeted her vulnerabilities. Her friends are confident that Angela would not readily have varied her social circle beyond her established friendship group, save only for attending bingo sessions, which was something she did on a regular basis. Their view is that Angela's attraction to men was not due to loneliness, but rather a desire to be in a physical relationship.

3.18

- **Whether there were any barriers experienced by Angela or family/friends/colleagues in reporting any abuse in Mansfield or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.**

Sadly, Angela had not received much in the way of family support for most of her adult life; her friends speculate that to have been the reason she craved their company. The friends knew that Angela had been the victim of abuse from male partners for a long time, but also knew how much she objected to anyone else knowing about it or interfering. They said that although Angela was very much the 'life and soul' of the party and was usually pleasant, she did have an unattractive side to her nature, and on some occasions, she would be verbally abusive to them and would then 'sulk' for several-days if they had offended her in any way.

3.19 The friends said that they had never reported any of the abuse Angela suffered because they did not want to upset her. They talked about how much they disliked and distrusted Adult A from the time they first met him and they also described how he controlled Angela from the very outset. Within a week, Angela had Adult A's name tattooed on her arm. She then turned up 'covered in love bites' and Adult A told them he had done it because it was a sign to anyone else that she was his. The friends then noticed that unusually, Angela was keeping her arms covered up and that she 'flinched' whenever anyone nearby made a sudden move.

3.20 Both friends conceded they were sure that Angela was being physically and mentally abused by Adult A, yet neither had considered reporting it to anyone. Both readily accepted that they knew to whom abuse could be reported, but said they would never have done so because Angela would have been furious with them if she were to find out. As mentioned previously, neither friend was aware that an anonymous report would have been acted upon – and both said they were under the impression that if they made a report to the police, they would be required to make witness statements and to give evidence in court.

3.21 Angela's two sisters also knew about her being repeatedly at risk of domestic violence and abuse, but they too chose not to report it for fear of upsetting her. Neither Angela's friends or sisters had any knowledge of the Domestic Violence Disclosure Scheme (DVDS – (Clare's Law)) and when told about it by the review chair, they said they would have at least considered using it had they known of the scheme, especially with the knowledge that their anonymity would have been guaranteed had they done so.

Comment: *The DVDS has two processes which can generate a disclosure to a potential victim; the Right to Ask and the Right to Know routes. The former is initiated by the potential victim or someone associated with them and the latter is initiated by the police when they become aware that a person is at risk of harm from someone they are in a relationship with.*

3.22 The review panel decided to use Angela's DHR as the catalyst to embark upon their own awareness raising campaign about the DVDS. They decided to run

it alongside the White Ribbon Campaign UK, a global movement to put a stop to male violence against women and girls. Sixteen-days of activism began on 25th November 2016 and the panel's awareness raising campaign began the same day and finished on 10th December 2016.

3.23 Mansfield District Council shared a series of tweets and images, (including a leaflet they created about Clare's Law) and issued a news release and wrote a blog for the campaign. There were 549 views of their web page during the campaign and of the 20,000 who viewed the White Ribbon campaign posts, nearly 5,000 viewed those specifically targeted at Clare's Law.

3.24 The leaflet on Clare's Law was also distributed to Nottinghamshire Women's Aid and NIDAS. NIDAS gave them to their staff together with a refresher briefing about the origins and purpose of Clare's Law and a reminder that it is a resource that could be offered to victims. Since then, a member of the team identified a new case where utilising Clare's Law was a possible option and the client was receptive to it. NWAL routinely discuss Clare's Law with all service users and the leaflet is provided as additional information, particularly if a client discloses that they are in a new relationship.

3.25 The CCGs in Nottinghamshire have distributed a bulletin to all GP practices in Nottinghamshire, highlighting Claire's Law and signposting to the white ribbon campaign and other resources.

3.26 New avenues for distributing the Clare's Law leaflet are being identified and the information will be distributed to all Children's Centres in Mansfield. The leaflet has also been shared with the Family Service at Nottinghamshire County Council, Mansfield District Council's Specialist Parenting Practitioner, CAMHS (Mansfield), Mansfield Area Partnership (covering all primary and secondary schools in Mansfield) and family workers from Mansfield schools.

3.27 The panel also sought to tie-in to its awareness raising efforts, an existing Friends and Family pilot project which was delivered in a specific geographical area in Mansfield. The project dealt with issues surrounding the barriers experienced by the victim's friends in reporting abuse. The campaign was aimed at non-professionals who may have first contact with survivors of domestic abuse (friends and family), providing information on signs of abuse and how to respond safely to disclosures. The campaign ran between 5th and 19th September 2016.

3.28 The 'signs of abuse' element of the campaign included posters, a social media strapline linked to an informative blog post and a social media optimised video. 'Warning signs' information was also distributed to every household in a specific area of Mansfield (1613 properties). The video was viewed nearly 9,000 times and there were dozens of views of the blog and the link.

3.29 The 'how to respond' element included a flyer with a peel-off card that had also been delivered to the 1613 households. A web-based resource was created which was viewed on 72 occasions. In addition, 'Just in time' printed tea-bags

were given to about 1000 women at an event. As a result, five disclosures of abuse were received.

Comment: *Equation has now shared the resources with two other district councils so the campaign can be delivered to a wider audience in Nottinghamshire. The resources have also been used to form the basis of an information point at a wellbeing event in Mansfield in March.*

3.30

- **Whether Angela had experienced abuse in previous relationships in Mansfield or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died.**

Angela certainly experienced physical abuse in previous relationships and had been supported by a host of services throughout. Precisely why the long-term relationship with the abusive Adult B finally ended is not known, but there must at least be a possibility that the support and intervention she received helped her to decide to move forward with her life without him.

3.31 Sadly, Angela (according to her friends), considered domestic abuse a part of normal life; she even sacrificed healthy relationships for unhealthy ones and there can be little doubt that her perception of what was normal will have influenced her decisions to seek support.

3.32

- **Whether there were opportunities for professionals to exercise 'professional curiosity' as to any domestic abuse experienced by Angela that were missed?**

Whilst there is evidence there was some 'professional curiosity' there were multiple opportunities to make more enquiries into domestic abuse related issues that were either missed or if they did happen, they were not documented. The fact that Adult B was often with Angela during many of the contacts she had with agencies would have made it very difficult in any event.

Comment: *A recommendation to come out of this review will be to remind practitioners of the need to speak with service users alone and the need to endeavour to do so on as many occasions as possible. Of course, this must be balanced with the requirement to complete comprehensive records around complex needs and it is not necessarily the case that documenting routine questions would have had any impact on the quality of care provided to Angela, or the outcomes for her.*

It is also recognised that the exercise of professional curiosity, although desirable, is simply not always possible or necessary in every case; there are many factors that could influence whether it is carried out, such as the presence of an abusive partner who is influencing and controlling the victim, the physical or mental condition of the victim, their demeanour, immediate medical needs and other factors such as volumes of patients in busy accident and emergency departments.

3.33 It is of note that GP practices involved with Angela and Adult A both implement the IRIS project, whereby all staff receive training on domestic abuse and routine questioning/the exercising professional curiosity. They also have close links with identified domestic abuse workers. Interviews conducted as part of this review process indicate that routine enquiry/exercising of professional curiosity did take place on a regular basis, and although the recording of the discussions was lacking, one disclosure resulted in a referral to NIDAS.

3.34

- **Whether Adult A had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.**

Adult A had a history of abusive behaviour towards intimate partners. He was convicted of assault and breaching a restraining order in March 2013 and was sentenced to 16-months imprisonment. He was released from prison on 14th February 2014 with licence conditions that he must not contact his former partner, but on 24th June 2014, he was arrested for being in breach of the order. He was remanded in custody and was sentenced to two-months imprisonment on 16th July 2014.

3.35 NIDAS had supported one of his previous partners, but that was quite some time before he and Angela formed a relationship. (When NIDAS supported Angela, she was with Adult B and she had not even met Adult A).

3.36

- **Whether there were opportunities for agency intervention in relation to domestic abuse regarding Angela and Adult A or to dependent children that were missed.**

There were no opportunities to intervene in any domestic abuse incidents involving Angela and Adult A, simply because no-one knew about the relationship soon enough. When Angela reported to the police that her partner was missing, she could not recollect his surname, so there was no opportunity for the police to make a connection between the two.

3.37 Had DLNR CRC known about the relationship at the time Adult A was under their supervision, his offender manager would have taken steps to discuss it with him and appropriate risk management interventions could have been implemented, including the monitoring of the relationship. On the three occasions he attended DLNR CRC, he had been drinking and was unable to engage properly with the service.

Comment: *The Offender Manager was aware that Adult A had convictions for offences involving domestic abuse, having had sight of his antecedent record. However, the interventions focused on his current offending, which was for an offence of theft, and consisted mainly of alcohol treatment.*

3.38

- **The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the county**

Most agencies identified the need for staff to receive explicit guidance and practical advice about how to work and communicate with hard to reach clients who find it difficult to engage with services.

3.39 A common theme across many DHRs is the lack of record-keeping around asking routine questions in relation to domestic abuse. Generally, records tend to lack detail around this issue and fail to evidence whether professional curiosity took place or was even considered.

Comment: *As mentioned previously, this must be balanced with the requirement to complete comprehensive records around complex needs. It is not necessarily the case that documenting routine questions would have had any impact on the quality of care provided to Angela, or the outcomes for her.*

3.40 Nottinghamshire NHS Foundation Trust staff who were interviewed as part of this review were clearly able to demonstrate they had received specific domestic violence training and/or awareness training. Domestic violence continues to be an area of focus for the Trust which intends to ensure that specific domestic violence training continues to be delivered. The Trust-wide Think Family Safeguarding induction training packages for new staff have also been strengthened in this area.

Comment: *Staff who have completed the domestic violence training are issued with a purple ribbon badge. There are posters displayed across the Trust explaining to staff and service users that the badge denotes someone who has been specially trained and who it would be 'safe' to talk to about abuse.*

3.41 NIDAS is aware it requires more training on working with individuals with special educational needs and disabilities and already it has secured funding to better understand the issues for children and young people with SEND (Special Educational Needs and Disabilities). Their plan is to share the findings with the wider partnership through the county-wide Domestic and Sexual Violence Executive Group.

3.42 Mansfield District Council identified the need to place awareness training on its induction programme for all new starters and to roll out ongoing training to all front-line service areas, in the same way as they do for Safeguarding in the District Council.

3.43

- **The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to Angela, 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.**

The fact that Angela was vulnerable was recognised by all the agencies with whom she came into contact. Her capacity to understand what support was on offer was regularly assessed, which concluded that she had the capacity to make appropriate decisions around her health needs. Angela usually made it clear what she wanted and when she intended to access a service.

3.44

- **To what degree could Angela's death have been accurately predicted and prevented?**

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, especially given that agencies did not know of her association with Adult A.

3.45 Angela was at risk of death from her significant ill-health and this appears to have been the prime consideration for the health professionals involved.

3.46 Adult A was a known perpetrator of domestic abuse during previous relationships. Perhaps unsurprisingly, he did not tell his probation officer that he was in a relationship with Angela during the period of his supervision.

4 Generic 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, but were frustrated at their own inability to make a difference as far as abuse was concerned; they were deeply saddened when they learned of Angela's death. The learning from this review across all the agencies, is 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.

4.1 Generic learning for agencies has also been about the need to 'spread the message' about the DVDS – and that the message will require reinforcing on a regular basis using a variety of means. Great in-roads have already been made during this review and the agencies concerned are keen to maintain the momentum.

4,2 **Agency key lessons learned**

Nottinghamshire Women's Aid

For Nottinghamshire Women's Aid, the review highlighted the importance of agency co-location working. It proved extremely effective in respect of agency referrals.

4.3 **Sherwood Forest Hospitals NHS Foundation Trust**

That Angela was unlikely to engage with services became a well-known fact within the Trust, but this 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. Trust policy should always be followed and information should be shared when a person has been identified as high-risk and/or vulnerable.

4.4 **Nottinghamshire Independent Domestic Abuse Service**

The key lesson learned by NIDAS is encapsulated in the generic lessons learned above, in particular there is a determination to increase their understanding of the increased risk to individuals who are more vulnerable because of a disability (or any other reason). At the point of referral, or if identified through the work, they feel there should be a specialist pathway to support, which is escalated both internally and externally. As with many agencies, they also reaffirmed their intention of making sure that very clear and detailed case notes are maintained which outline their intervention and the responses of others.

4.5 **Mansfield District Council**

Mansfield District Council recognised that they are not fully aware of the effectiveness of their domestic violence policy and associated procedures across other council departments and they wondered whether Angela would have received the same response had another department been in contact with her. Their plan is to undertake an assessment of the effectiveness of their policy and procedures across the council (including the housing teams) to identify any gaps in awareness raising and appropriate responses where domestic abuse is identified.

4.6 **Nottinghamshire Healthcare NHS Foundation Trust**

The Trust was unable to find evidence in Angela's notes of safeguarding management or professional supervision in relation to her. It would be expected that a complex case such as Angela's would be reviewed and discussed within either management and/or safeguarding supervision. In her case, there were complex issues that would have benefitted from further exploration and discussion from a safeguarding perspective. Staff said that her case was discussed both in their own supervision (and this would be recorded in their own notes) and at case discussions. If this was the case, then these

discussions should also have been recorded in her notes along with any plans/advice given.

4.7 There was other learning around the need to maintain accurate records, for example, it was unclear in some instances whether safeguarding referrals had been made and in others where a referral had been made, there was no record of the outcome.

4.8 It was noted that Angela was placed on the high-risk register after a MARAC, but it was unclear how it impacted on Trust professionals' interaction with Angela and Adult B. It would be expected that such an issue would be considered within care plans and strategies for care and intervention but there was no evidence it was.

4.9 There was evidence that domestic violence issues were considered during engagement with Angela and that appropriate questions were asked, but not on a consistent or co-ordinated basis. For example, when Angela was injured having apparently fallen, it was noted within the records that her partner (Adult B) often came to appointments with her after incidents where she sustained an injury but not always on others. This should have prompted some professional curiosity.

Comment: *This was also an issue for many agencies, for example the hospital emergency department. It is one of the general lessons learned from this review.*

4.10 **Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC)**

This review has highlighted the need to ensure that all checks are completed with the police domestic violence unit when supervising an offender with a history of domestic abuse.

Comment: *The Offender Manager had access to Adult A's antecedent record which documented his previous convictions. It is expected practice that previous convictions involving violence/risks to known adults are included in Pre-Sentence Reports prepared by the National Probation Service, but on this occasion, that did not happen.*

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

There was no specific learning to come out of Angela's case as far as EMAS is concerned, but it has re-enforced the need to maintain the programme of safeguarding training that is already in place.

4.12 **Clinical Commissioning Group**

Safeguarding multi-disciplinary team meetings are an excellent example of peer review of records and sharing of information across primary healthcare workers. It is in line with best practice and in Angela's case prompted follow-up and communication with key professionals.

4.13 The implementation of the IRIS scheme across the Mansfield and Ashfield CCG afforded optimum opportunity for identification and support for Angela as a victim of domestic abuse. The GP practice recognised risks and vulnerabilities of Angela and made three safeguarding referrals when she was considered to be at significant risk.

4.14 Monitoring and follow-up of patients with high numbers of emergency department and out-of-hours' attendances enabled concerns to be discussed with Angela and afforded her an opportunity to disclose domestic abuse.

4.15 **Nottingham Community Housing Association**

A lesson learned by NCHA is for them to have a clearer understanding of the roles/responsibilities and capabilities of other agencies involved with people like Angela and for their Personalised Support Team to receive specific training around identifying and acting upon allegations of domestic abuse.

4.16 They also identified the need to maintain their records in greater detail and in a timely fashion and to pay attention to documenting telephone conversations that take place with other professionals.

4.17 **Nottinghamshire County Council**

The interface between safeguarding and DASH needs to be more clearly defined to assist staff and organisations in working together to manage risk.

5 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.

6 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.

6.1 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.

6.2 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.

6.3 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 particular 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.

6.4 Mansfield District Council

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

6.5 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.

6.6 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).

6.7 East Midlands Ambulance Service (EMAS)

There are no recommendations in respect of EMAS.

6.8 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.

6.9 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.

6.10 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.