Executive Summary
of the Domestic Homicide Review

In respect of the homicide of Nicky (pseudonym)

In July 2020

Report produced for West Cumbria Community Safety Partnership by
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Independent Chair and Author

Contents

A note on confidentiality

In order to protect the identity of the homicide victim, her family and significant others, pseudonyms have been chosen. The homicide victim will be referred to by the name, Nicky[1], and the alleged perpetrator by the name Mark[2].

[1] The family were consulted on the use of a pseudonym and agreed that pseudonyms be chosen from names that were popular in the year that the individual was born as featured in official records, in this case Nicky and Mark: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/babynamesenglandandwalestop100babynameshistoricaldata

[2] ibid

1. The homicide

1.1. This domestic homicide review has considered the nature of the domestic abuse that was perpetrated against Nicky by her partner before her death at the age of 43 in July 2020. A post-mortem revealed that Nicky had died from head injuries which were consistent with punches to the head. Her partner was charged with her murder and remanded in prison where he was found deceased five days later. He is thought to have killed himself. An inquest into both deaths is due to be heard following the completion of this domestic homicide review

2. Background

2.1. Before meeting Mark, Nicky had been in a relationship for over 20 years during which she was subjected to high-risk domestic abuse and was referred to MARAC and Children's Services. She suffered from a significant lack of confidence and the degree to which her mental ill-health and substance misuse was caused by her long-term experiences of domestic abuse did not appear to have been explored. Her stress and anxiety were thought to contribute to eczema and alopecia, and she would wear a wig when this occurred.

2.2. Her two children went to live with family and thereafter she had little contact with them. Nicky's ex-husband continued to be abusive towards her even after the end of the relationship and threatened to kill her when he knew that she was in a new relationship. After being evicted from her social tenancy for rent arrears, she was assisted by the local authority in gaining a privately rented property. She began a relationship with the alleged perpetrator in August 2018 when she was in a particularly vulnerable position.

2.3. Mark had an extensive background of criminality over the last 25 years, including domestic abuse against his parents and previous partners. Two of his previous partners were taken to MARAC as a result of the high threat of harm that he posed to them. Much of his offending was accompanied by problematic alcohol use and attempts had been made by services to encourage his engagement with alcohol treatment.

3. Chronology

3.1. In September 2018, Nicky attended the hospital Emergency Department where she disclosed feeling suicidal, was in poor physical health and was socially isolated. She went on to disclose ongoing domestic abuse from her ex-partner to the community mental health team who were unable to maintain engagement with her.

3.2. In December 2018, Mark was convicted of harassment against his previous partner having left hundreds of messages and repeatedly calling her. Thereafter, he repeatedly breached restraining orders; assaulted a female family member; received a community order and then a suspended sentence; was treated by police as one of the top 10 domestic abuse perpetrators in the area and was heard at MARAC. However, his relationship with Nicky was not known to any of the agencies at the time.

3.3. Mark had poor physical health and worsening alcohol misuse. However, aside from a couple of appointments, alcohol treatment services were largely unable to engage with him. As his physical and mental health worsened over time, he regularly attended his GP Practice and received treatment in various hospital departments as well as nine visits to the Emergency Department as a result of various falls and possible assaults.

3.4. The first call to the police concerning Mark's domestic abuse towards Nicky came in December 2019 from neighbours who were alarmed at the screaming which they heard regularly. Later that month, on Christmas Day, Nicky was taken to hospital with slurred speech and a period of unresponsiveness, but she left the hospital before treatment.

3.5. In March 2020, the national lockdown period to control the Covid pandemic occurred and in coming months neighbours reported to the police their increasing concerns about the domestic abuse they were hearing. On the first police response she was found to have a lump on her forehead which she said had been accidental. However, on the second response in June 2020, neighbours had witnessed Mark kicking Nicky and punching her in the ribs and Mark was charged with 'assault by beating' and remanded in custody in HMP Durham.

3.6. Although Nicky denied domestic abuse and declined the DASH, the risk she faced was determined to be high and she was referred to MARAC. Mark's prior offending was disclosed to Nicky under the Domestic Violence Disclosure Scheme by the safeguarding police officer that was allocated to her, but Nicky spoke about how she was happy for Mark to come home when he was to be released from prison and that their relationship was going to continue. She denied experiencing domestic abuse and declined the mobile phone and referral to alcohol services that she was offered.

3.7. Whilst in prison, there were no communication restrictions on Mark, but HMP Durham staff monitored his communications nonetheless and they observed his repeatedly abusive and controlling calls to the victim. They were also aware that he had disclosed to a fellow prisoner that he had head-butted Nicky. As a result, they shared this information with the police, but this was followed by internal delays within the police in getting the information to the relevant safeguarding team

3.8. Mark was sentenced to 60 days in prison for his assault of Nicky, but due to the 40 days already served on remand, he was released immediately after the court appearance. This unexpected release meant that no arrangements had been put in place to manage the threat that he posed to Nicky and on the day of his release, he assaulted Nicky in the street. Despite visible facial injuries, Nicky denied being

assaulted and the officers initially left the couple as they felt that they did not have sufficient evidence to take action. However, the Duty Inspector instructed that he be arrested for common assault. In the absence of corroborating evidence from witnesses, he was later released on bail whilst enquiries continued, with conditions not to contact or approach Nicky. The police made numerous unsuccessful attempts to contact Nicky but later that night, she suffered the fatal assault

4. Key Findings

4.1. Experiences of domestic abuse

4.1.1. By the time Nicky was beginning a relationship with Mark, she had experienced significant and high-risk domestic abuse for most of her adult life; suffered from mental ill-health and problematic alcohol use and lost her children. Her vulnerability and need for specialist support to help her to recover from her experiences was evident and Children's Services offered to refer her to a range of specialist services without success.

4.1.2. She went on to experience physical violence and coercive control from Mark and this was witnessed by neighbours and third parties. Evidence from third parties in respect of domestic abuse is vital. It can take responsibility away from the abused, who for so many reasons, may not be able, or feel able, to provide a statement themselves. Had witness statements been taken from third parties, the alleged perpetrator would likely have been held on remand for assault at the time of the homicide.

4.1.3. Despite presentations to health, it was not evident that any agency had been able to meaningfully engage with Nicky and engage her in addressing the trauma that she was continuing to experience. Nicky experienced male violence and abuse throughout most of her adult life and her substance misuse and mental ill-health should be seen as legitimate responses to this long-standing trauma. Domestic abuse victims often do not recognise the link between their own experiences of trauma and the difficulties that they have with mental health and substance misuse and so practitioners need to enable victims to understand what is happening to them.

4.2. Routine enquiry and health pathways

4.2.1. At various times, Nicky displayed a range of indicators of domestic abuse including: anxiety and related conditions such as eczema and alopecia, isolation, depression, self-harm, suicidal thoughts and a fall. She also misused alcohol and women who have experienced domestic abuse have been found to be at least three times more likely to be substance dependent than those who have not, as alcohol can be used as a means to cope with violence and abuse and to self-medicate the trauma. Although

the opportunity for routine enquiry was not always present, indicators of domestic abuse were missed in most of these settings

4.3. MARAC and high risk

4.3.1. The effective running of a MARAC is a crucial element of the local, co-ordinated community response to domestic abuse. The MARAC was well attended by a broad range of agencies and considered Mark's previous history of domestic abuse and significant history of stalking and harassment previous partner. Indeed, stalking has featured in 94% of domestic violence related deaths and should always be considered a key indicator of serious harm. His previous history led to prompt decision making and disclosure to the victim by the Domestic Violence Disclosure Scheme panel.

4.3.2. However, there was a missed opportunity to make an effective referral to the Independent Domestic Violence Advisor and research has shown that the IDVA interventions often have the most impact in enhancing the safety of domestic abuse victims.

4.3.3. It was considered that the MARAC could have anticipated that Mark would make contact with Nicky by telephone whilst on remand and should have considered preventing his communications with the victim during this period. Nonetheless, the prison service were pro-active in their monitoring of his telephone contacts.

4.3.4. In the intervening time, Cumbria has also moved from monthly to weekly, virtual MARAC meetings covering the whole of the Cumbria area, ensuring a timely multi-agency response to high-risk victims.

4.4 The "relentless pursuit and disruption" of domestic abusers

4.4.1 Mark's harassment of his previous partner led him to become one of the 'Top 10' domestic abuse perpetrators for the local police in 2019. The review argued that Mark should automatically have been considered a high risk to future partners, which was not consistently the case here. The review also recognised that there was a lack of research in this particular area that needed national attention.

4.4.2 Agencies were caught off guard when Mark was released immediately on conviction having served his time on remand and without the multi-agency perpetrator target plan in place, as would have been expected. Although email communication systems have since improved learning point for the local area was not to rely upon information sharing through email when there were immediate concerns over the threat from a domestic abuse perpetrator. However, the review has also sought a national steer about flagging offenders subject to immediate release for risk management as there appeared to be an increasing number of prisoners being released in this way as a result of the pressures arising from the Covid-19 pandemic.

4.4.3 Overall, there were deficits in offender management in relation his domestic abuse offending, 'out of area' referrals and in his court-mandated supervision.

4.4.4 Cumbria Constabulary had clearly been applying a perpetrator strategy in the pursuit and disruption of high-risk domestic abusers and the review heard how further developments in this management of high-risk abusers have been undertaken since by way of Operation Domestic Abuse Reduction Tactics (DART).

4.5 Engagement with alcohol services

4.5.1 Both parties experienced long-term problems with alcohol misuse and several attempts were made to refer them to alcohol treatment services. However, referral pathways and information sharing between alcohol treatment and both primary care and probation services needed strengthening

4.5.2 Nicky sometimes excused Mark's abuse because he was drunk. It is not uncommon for victims of domestic abuse to see their partner's drinking as a cause of their abuse and many abusers will have used their drinking as an excuse for their behaviour. Practitioners need to be dispelling these myths in order to hold perpetrators responsible for their abuse.

4.6 Role of social landlords

4.6.1 The social landlord was ready to take action against Mark for his domestic abuse and support the victim, shortly before the homicide. However, they had not been notified about previous abuse. Social housing providers have an important role to play in the co-ordinated community response to domestic abuse including: the early identification of domestic abuse; enabling safety planning and support to victims; finding alternative accommodation and taking enforcement action against perpetrators.

4.7 Impact of Covid-19 Pandemic

4.7.1 The homicide took place during the restrictions on movement and social interaction imposed as a result of the Covid-19 pandemic and Nicky considered that Mark's abusive behaviour had indeed deteriorated during this time. It was evident to the review that the local area had done much to seek to mitigate the impact of Covid-19 on domestic abuse victims and details of their initiatives are illustrated in the full report.

5. Recommendations

4.1 Overview Recommendations

Recommendation 1: Gender and trauma-informed services
Safer Cumbria Domestic Abuse Partnership Board to promote gender and trauma-informed practice in response to victims of domestic abuse experiencing multiple needs including adverse childhood experiences and mental health, alcohol and substance misuse.
Safer Cumbria Domestic Abuse Partnership Board to seek assurance from all affiliated agencies that gender and trauma-informed practice is embedded in their practice response to domestic abuse.

Recommendation 2: Selective and routine enquiry on domestic abuse in health settings
West Cumbria Community Safety Partnership should seek assurance and evidence that primary care, Emergency Department, mental health and substance misuse services in their area have implemented policies, pathways and staff training that have resulted in effective, selective, routine enquiry in domestic abuse, particularly where mental health and substance misuse are also involved.

Recommendation 3: Enabling access to Independent Domestic Violence Advisors
Cumbria Community Safety Partnership should seek evidence and assurance that agencies are consistently enabling high risk victim engagement with the Independent Domestic Violence Advisors in addition to their own services.

Recommendation 4: Preventing a perpetrator's contact from prison with high-risk victims of domestic abuse
In MARAC cases where the offender is held on remand, the police should alert the prison service to prevent, or if not possible, to proactively monitor telephone contact between the perpetrator and the victim.

Recommendation 5: Perpetrator's History of Violence
West Cumbria Community Safety Partnership should seek assurance from criminal justice agencies that they are able to accurately record and access records on an abuser's previous violent history and apply this to current risk assessments and responses

Recommendation 6: Serial domestic abusers

In the development of the national domestic perpetrator strategy, the Home Office considers commissioning research into whether a high-risk domestic abuser will be a high-threat domestic abuser to future partners and by virtue of their serial offending, are worthy of enhanced intervention, management and opportunities for change.

Recommendation 7: Managing offenders subject to immediate release

The Ministry of Justice to consider how those offenders who are subject to immediate release after serving a period on remand, are flagged for risk management, considered and their management resourced.

Recommendation 8: Managing Perpetrators and Harm Reduction

West Cumbria Community Safety Partnership to ensure that the evidence provided by criminal justice agencies in response to this review collectively demonstrates a robust multi-agency response to domestic abuse perpetrators and demonstrates effective harm reduction outcomes, particularly in regard:

- compliance with DASH
- positive action
- risk assessment
- supervision
- bail and responding to intelligence reports
- responding to victim minimisation and engagement
- 'Out of area' incidents
- Prison release

Recommendation 9: Alcohol/substance misuse and primary care pathway.

North Cumbria Integrated Care Board and Recovery Steps Cumbria to develop and embed pathways and relationships between primary care and alcohol treatment services in the area. Pathways to ensure that clinicians in primary care have access to clear and concise guidance for assessing and managing patients with alcohol concerns and have access to locally agreed information to enable them to make effective decisions, together with patients, at the point of care, particularly for those with whom practitioners would otherwise struggle to engage.

Recommendation 10: Alcohol/substance misuse and probation pathway.
Probation Service and Recovery Steps Cumbria to provide assurance to the Community Safety Partnership on the effectiveness of the criminal justice pathway between alcohol treatment and probation services and is able to address the issues over self-referral and information sharing

Recommendation 11: Social housing response to domestic abuse
West Cumbria Community Safety Partnership to secure the consistent participation of social housing providers in their area through multi-agency pathways in domestic abuse across areas of high risk and earlier intervention.

4.2 Individual Recommendations

Cumbria County Council Children's Services

- Mothers experiencing domestic abuse are enabled to access specialist domestic abuse support

Probation Service regarding the former Cumbria and Lancashire Community Rehabilitation Company

- Under the parallel Serious Further Incident review, the CRC were required to provide assurance to Her Majesty's Prison and Probation Service (HMPPS) that they were managing domestic abuse alleged perpetrators to a sufficient standard. The Probation Service to provide this evidence to the Community Safety Partnership

- To develop a criminal justice pathway within substance misuse services through which to address the issues over self-referral and information sharing between probation and substance misuse services.

- To strengthen management oversight of staff in order to ensure adherence to policy and practice standards in assessments, planning, implementation and review of interventions in the future.

Cumbria, Northumberland, Tyne and Wear NHS Trust

- To ensure professionals routinely enquire about domestic abuse when there are indicators of concern and staff need to understand their role when receiving disclosures of domestic abuse from perpetrators.

- To ensure staff consider history of domestic abuse and how this impacts on presenting risks at the time of initial assessments and future appointments.

- To promote the need to enable engagement with domestic abuse services, even when the police may be involved.

Home Group

- To review Home Group's internal procedure and ensure that the best practice highlighted above is captured and implemented. Mainly, that when DV and DA instances are reported or there are suspicions of DV/DA these incidents are reviewed by a Senior Manager (Operations Manager level).

- For Home Group to review their local procedures around outcomes and discussions at MARAC. Specifically focusing on; what visibility to Senior Managers have; What visibility do local Housing Managers have; How does the feedback process occur; What oversight and input do Senior Managers have.

Lancashire and South Cumbria Foundation Trust

- Liaison with other agencies, especially those that may be specifically addressing offending behaviours (such as the courts, probation services) assists in the wider understanding of the perpetrators' risks and actions that other services have implemented to address these. The requirement to notify partner agencies when an individual is discharged from the Liaison and Diversion service will be incorporated into the service wide Standard Operating Procedure (SOP) and introduced as standard practice.

- Communication with partner agencies including GPs should be strengthened by providing awareness about the Liaison and Diversion service to ensure an understanding of the service scope of practice. This will be achieved by sending a letter to GP's and partner agencies describing the Liaison and Diversion service.

- Information sharing and recording processes for MARAC for all LSCFT services to be consistent across all LSCFT localities.

- Current LSCFT processes regarding domestic abuse are correctly victim focussed, however, it is not clear regarding the expectations of staff when working with suspected perpetrators of domestic violence. This would be especially useful for Liaison and Diversion who are an offender focussed service.

North East and North Cumbria Integrated Care Board

- To further promote with GPs the need for targeted routine enquiry about domestic abuse when indicators are present and to strengthen the disclosure pathway

North Cumbria Integrated Care NHS Foundation Trust

- to continue to improve awareness and responses to domestic abuse through the A&E and Domestic Abuse Improvement Plan, to include increased use of DASH and MARAC referrals and the 'think family' screening tool

- Domestic abuse and substance misuse to continue to be included in mandatory training updates for all staff, with particular focus on routine enquiry and referral to support services.
- To complete a review to be completed of current pathway and follow up for patients who leave A&E prior to completing treatment.

Appendix: The Review Process

i. Summary

The decision to undertake a domestic homicide review was made by the Chair of West Cumbria Community Safety Partnership in consultation with partner agencies. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

The review panel members are listed below and included senior managers and designated professionals from the key statutory agencies, and all were independent of the case, with the exception of Home Group[3].

Wider matters of diversity and vulnerability were considered when agreeing panel membership. Victim Support provided the local domestic abuse service and therefore brought particular expertise on domestic abuse and the 'victim's perspective' to the panel. Unity provided expertise on drugs and alcohol and Cumbria, Northumberland, Tyne and Wear NHS Trust provided expertise on mental health, each of which were issues particularly pertinent to this review.

The process began with an initial meeting of the review panel in October 2020 but was delayed in its conclusion as a result of national arrangements to contain the spread of the Covid-19 pandemic. Terms of reference were drawn up and incorporated key lines of enquiry as featured below Agencies participating in this review are featured below as well as those who had no contact.

The review panel met on six occasions and the Independent Chair communicated with victim's family with the assistance of the Victim Support Homicide Service. Family members were able to contribute to the terms of reference and offered the opportunity to consider the overview report before it was concluded.

The Overview Report was endorsed by West Cumbria Community Safety Partnership on 06.12.22 before being submitted to the Home Office for approval.

[3] Home Group's panel member had responsibility within his portfolio for the geographical area in which the homicide took place. However, he also carried the national lead for tenancy enforcement and this specialism was seen as integral to the review. His membership of the panel was therefore encouraged.

ii. Review Panel Members

Name	Role/Organisation
Paula Harding	Independent Chair
Alison Knight	Department for Work and Pensions, Senior Safeguarding Lead
Amanda Boardman	North East and North Cumbria Integrated Care Board, GP Lead for Safeguarding
Andrew Donnelly	Cumbria Constabulary, DI North Crime and Safeguarding Team
Clare Stratford	North Cumbria Community Safety Partnership Co-ordinator
Daniel McAllister	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust, Safeguarding and Public Protection Lead
James Varah	Home Group Operations Manager
Janine Weatherington	Cumbria and Lancashire Community Rehabilitation Company, Senior Probation Officer Lead for Risk and Public Protection
Lisa Handley[4]	Cumbria County Council Children's Services, Service Manager Safeguarding Hub
Louise Cavanagh	Cumbria County Council, Domestic and Sexual Abuse Co-ordinator
Pat Graham	Copeland Borough Council, Chief Executive
Ruth Higgins[5]	Lancashire and South Cumbria NHS Foundation Trust, Specialist Safeguarding Practitioner
Sarah Edgar[6]	Cumbria Constabulary, Domestic Homicide Review Co-ordinator
Sarah Place	Victim Support
Sheona Duffy	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Sioux Nealings	HMP Durham, Head of Offender Management
Susan Mein	North Cumbria Integrated Care NHS Foundation Trust, Safeguarding Lead

[4] Lisa Handley was a panel member until the final meeting when she left the service

[5] replaced Helen Hargreaves

[6] replaced Angela Rush

iii. Key Lines of Enquiry

The review should address both the 'generic issues' set out in the Statutory Guidance, in Appendix 1 below, and the following specific issues identified in this particular case. Individual Management Review Authors were asked to provide a chronology and respond to the following questions, where relevant, in respect of their involvement in key episodes with the couple during the period specified above.

- **Individual Practice: how effective were agencies in identifying and responding to the needs and risks faced by the victim?**
  Reflective Questions. In responding can you consider:
  - *A pen picture of how the individuals were known to you*
  - *What knowledge your agency had about the relationship between the victim and the alleged perpetrator?*
  - *What needs did your agency identify for either individual and how did your agency respond?*
  - *What specific support was made available to the victim as a result of her repeat domestic abuse victimisation?*
  - *What opportunities were there to engage and refer over substance misuse issues and how was substance misuse considered/responded to in the context of domestic abuse?*
  - *How were decisions made and actions taken by agencies to reduce risk and prevent harm, considering, for example:*
    - *indicators of risk; how risk was assessed and managed; attention to previous history; identifying pre-existing vulnerabilities; how were the individual's attitudes to risk perceived and understood, and how did this affect decisions made or actions taken;*
    - *How substance misuse impacted upon assessment and response to risk?*
    - *Safety planning; escalation; managing risk on closure of cases?*
    - *How the alleged perpetrator's repeat presentations impacted upon his risk profile?*
    - *What actions were taken to respond to and manage* the alleged *perpetrator's domestic abuse and how effective were they in harm reduction?*
    - *Whether the alleged perpetrator's serial abuse was considered in the context of 'violence against women' and, if so, how that impacted upon the response?*
    - *If domestic abuse was not known, how might your agency have identified the existence of domestic abuse from other issues presented to you? For example, were there policies and procedures for direct or routine questioning and how well were they implemented in this case?*
    - *What barriers to engagement did agencies face and how did they seek to overcome these barriers?*
    - *How did agencies recognise and respond to issues of equality and diversity for either individual? Was there any evidence of unconscious bias in the assessments, decisions or services delivered?*

- *How effective was record keeping?*
- *How effective was management oversight?*
- *Did resource issues impact upon services offered?*
- *How the Covid-19 pandemic impacted upon agencies' responses?*

- **Multi-Agency Practice: how effective were agencies in working together to prevent harm and to meet individuals' needs?**

  Reflective Questions. In responding can you consider:
  - *How roles and responsibilities were understood and multi-agency protocols adhered to?*
  - *Was there a shared ownership and approach?*
  - *How effective was the co-ordination of services?*
  - *How effective was communication, information sharing and sharing records?*
  - *How effective was escalation between agencies?*

- **Can you identify areas of good practice in this case?**

- **Improving services:**
  - *what lessons can be learnt to prevent harm in the future?*
  - *what recommendations are you making for your organisation and how will the changes be achieved?*
  - *what system-wide, multi-agency recommendations do you consider need to be made?*

As well as being asked to respond to the key lines of enquiry, certain agencies were also asked to respond to the following specific questions:

- Cumbria Constabulary to analyse how they responded to the intelligence report received from HMP Durham on 22.06.20 regarding an acrimonious telephone conversation between the victim and alleged perpetrator
- North Cumbria Integrated Care NHS Foundation Trust to also consider their responsibilities to patients leaving A&E before treatment and how they were followed in this case

iv. Agency Involvement in the Review

Agencies were asked to provide chronologies, information reports or Individual Management Reviews, dependent upon their degree of involvement. Individual Management Reviews were provided by:

- Cumbria and Lancashire Community Rehabilitation Company *(to incorporate whole probation response)*
- Cumbria Constabulary
- HMP Durham
- Lancashire and South Cumbria NHS Foundation Trust
- North Cumbria Integrated Care NHS Foundation Trust
- North-West Ambulance Service

The following agencies were asked to provide briefer information reports and chronologies to the review

- Copeland Borough Council Housing Options
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- North-East and North Cumbria Integrated Care Board[7] (for GP Practices)
- Cumbria County Council Children's Services
- Cumbria Health On Call (CHOC):
- Department for Work and Pensions
- Home Group
- HM Courts and Tribunals Service
- Impact Housing to access historic records from Let Go service in respect of the victim's potential engagement with the IDVA service following a MARAC referral
- Unity (Greater Manchester Mental Health NHS Foundation Trust)
- Victim Support

The following agencies were contacted but confirmed that the individuals had not been known to them or that their contact was not relevant to this review:

- Safety Net
- Gateway Women's Centre
- Freedom Project

[7] Formerly the Clinical Commissioning Group