Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Caroline
in April 2018

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Preface

Ashfield's Community Partnership (the statutory Community Safety Partnership for the area) wishes at the outset to express their deepest sympathy to Caroline's family and friends. This review has been undertaken in order that lessons can learned; we appreciate the support and challenge from families and friends throughout the process.

The review was commissioned by the Partnership on receiving notification of the death of Caroline in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

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Section One – The Review Process

1.1 Introduction and agencies participating in the Review

1.1.1 This summary outlines the process undertaken by the Ashfield Community Partnership Domestic Homicide Review Panel in reviewing the death of one of its residents. The death occurred in April 2018.

1.1.2 The victim in this case was Caroline, she was a 31-year-old woman who was killed by her partner, at the home they had shared together. They had been in a relationship for around six years and married for the last three. The couple had separated a few weeks prior to Caroline's death. They had a two-year-old child together. Caroline had two children from a previous marriage.

1.1.3 On the night of the incident that took Caroline's life, the couple's young child was asleep upstairs. The child was subsequently found upstairs by police after they had been alerted to the killing by this perpetrator who had left the child in the house with their now deceased mother.

1.1.4 Police arrested this perpetrator following the incident and he subsequently pleaded guilty to Caroline's murder. He is now serving a term of life imprisonment.

1.1.5 Ashfield Community Safety Partnership were notified on 6th May 2018.

1.1.6 A partnership meeting was held on 22nd May 2018 after an initial trawl had been undertaken to ascertain those agencies with knowledge of the victim and perpetrator. This meeting was chaired by the Chair of the Partnership and the decision was taken to appoint an independent chair and report author and proceed with a domestic homicide review.

1.1.7 The Independent Chair and Report Author were appointed in June 2018.

1.1.8 The Home Office were notified of the decision to carry out a DHR on 24th May 2018. The family were notified of the intention to hold a review.

1.1.9 The first panel meeting was held on 10th July 2018. The following agencies were represented at this meeting:

- Ashfield District Council
- Equation
- Mansfield and Ashfield Clinical Commissioning Group
- Nottingham University Hospitals
- Nottinghamshire County Council – Children's Services
- Nottinghamshire Healthcare Trust
- Nottinghamshire Police
- WAIS (Women's Aid)

1.1.10 Apologies were received from DLNR Community Rehabilitation Company.

1.1.11 At this first meeting, the panel considered its composition and agreed that it brought together the relevant expertise in relation to the circumstances of this case. The panel determined its strategy to progress the Review. This included family engagement as key stakeholders, the commission of IMRs and reports and any other such enquiries as were felt necessary.

1.1.12 The panel met again on 13th December 2018. The panel considered IMRs, reports and other information gathered during the review.

1.1.13 The panel met for a further meeting and the review was concluded in November 2019.

1.2 Purpose and Terms of Reference of the Review

1.2.1 The purpose of this Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.2.2 The Review Panel agreed that the specific purpose of the Review is to:

- Establish the facts that led to the incident in April 2018 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in April 2018; suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

Section Two –
Agency contact and information learnt from the Review

2.1 There was some knowledge held by agencies about this couple's relationship. None of those agencies had a volume or detail of information that could or should have indicated this awful outcome.

2.2 It is very clear that little was known by agencies of the abuse that Caroline experienced. Her family and friends had some knowledge but did not understand the full extent of the abuse she was experiencing. The review is indebted to her family and friends for helping us to understand Caroline's life so that we can endeavour to learn from her tragic death.

2.3 **Evidence of domestic abuse**

2.4 There is clear evidence in this case of prior domestic abuse in the couple's relationship. The evidence shows exclusively abuse from this perpetrator towards the victim. Abuse in this case is not only confined to physical abuse; there are clear examples of isolation, emotional and intimidating behaviour, economic abuse, coercion and control and gaslighting.

Section Three – Key issues arising from the Review

3.1 The single biggest issue arising from this review is that work has to continue to raise awareness amongst not only victims, but also family and friends and society in general of the dangers and insidious nature of domestic abuse.

3.2 This Review has looked at why this victim felt unable to seek support from those agencies charged with safeguarding her and her children. In part, a long-standing view that to involve agencies would put her relationship with her children at risk existed. Work needs to be done to demonstrate the positive nature of support available.

3.3 More needs to be done to enable friends and family or others concerned with a potential victim's safety to report or discuss concerns in a confidential setting.

3.4 There are some positive examples in this review of health visitors and midwives in particular taking the time to ask about domestic abuse. Whilst disclosures did not occur in this case, the positive engagement by health staff is to be welcomed and encouraged to become the norm.

3.5 The agencies involved in this review, together with family and friends of this victim have helped form a number of recommendations that we believe will help make potential victims of domestic abuse safer in the future.

Section Four – Conclusions

4.1 In this case a young woman's life was tragically cut short by an act of calculated violence. The fact that the violence was filmed by the offender and the victim was likely to have known what was going to happen to her makes it all the more appalling.

4.2 Added to the terrifying nature of the attack is the fact that this victim has left behind three young children and a family and friends who loved her dearly. She was killed in her own home by someone she had loved, trusted and was the father of her youngest child.

4.3 The motivation for this dreadful act of violence has never really been explained. It is reasonable though to conclude that jealousy, power and control all feature as factors and once again demonstrates that the point of separation is a time of high-risk in domestically abusive cases.

4.4 Little was known about Caroline to those agencies charged with the responsibility for safeguarding her. The fact that some of her friends and family had knowledge of what she may have been going through demonstrates yet again that more has to be done to afford people the confidence to speak to others about their concerns. Over and again, individuals will say that they would not report concerns for fear of social services involvement and the probability of the children being taken into care. Whilst professionals know that this is not the case, the general public still have this misunderstanding and fear.

Section Five – Recommendations

Nottinghamshire Schools

5.1 It is recommended that Nottinghamshire schools have a clear policy about how they will respond when they are made aware that parents have separated to ensure that there is clarity about how issues, such as collection of children and altercations in the playground, will be dealt with.

Nottinghamshire Police

5.2 It is recommended that Nottinghamshire Police raise awareness of the change in its policy in July 2018 which means that, in this case a risk assessment would have been undertaken. Awareness should be raised in order that officers understand that incidents where a relationship has come to an end or where complaints are withdrawn increase the risk to the victim.

GP practice

5.3 It is recommended that the GP practice reminds all practitioners of the importance of using their professional curiosity and asking about domestic abuse at every opportunity, especially when dealing with those who are pregnant or presenting with anxiety.

Ashfield Community Partnership

5.4 Whilst it is acknowledged that there is much work done to raise awareness, it is recommended that the partnership considers more innovative ways of getting the messages to young women, such as Caroline, who are not having contact with agencies.

5.5 It is recommended that publicity messages focus upon the support that social services can provide to women experiencing domestic abuse with a view to allaying their fears that their children will be taken away.

Nottinghamshire Safeguarding Children Board

5.6 It is recommended that the role of school safeguarding leads is reviewed and incorporates the opportunity for victims of domestic abuse and others who have concerns to have confidential conversations and make reports in a safe environment.