DOMESTIC HOMICIDE REVIEW

TEST VALLEY COMMUNITY SAFETY PARTNERSHIP

Nicole

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May 2020

Executive Summary

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1 INTRODUCTION

1.1 This report of a domestic homicide review examines agency responses and support given to Nicole, a 30-year-old British woman, prior to her death on REDACTED following injuries she suffered at her home that day.

1.2 In addition to agency involvement, the review examines the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to minimise the risk of such tragedies occurring again.

1.3 The subjects of the review are[1:]

Victim	**Name**	Nicole
	Age	30 yrs.
	DOD	Redacted
	Address	Andover

Perpetrator	**Name**	Ryan
	Age	28 yrs.
	Address	Anna Valley, Hampshire
	Relationship to Victim	Husband (recently separated) In relationship with deceased 2010 - 2019
	Charge(s)	Murder

Others

Name	**Age**	**Relationship to Victim/Suspect**	**Address**
Max	13 yrs.	Child of Nicole and Andrew	Andover
Oscar	7 yrs.	Child of Nicole and Ryan	Andover
Sophie	5 yrs.	Child of Nicole and Ryan	Andover
Lily	12 yrs.	Child of Nicole and Robert	Southampton
Ethan	10 yrs.	Child of Nicole and Robert	Southampton
Robert	NA.	Ex-partner of Nicole (2005 – 2008 & 2008 – 2010)	Winchester
Andrew	NA	Ex-partner of Nicole (2003-2005 & 2008)	Andover (separate address)

[1] All names of parties subject to the review and those connected with them are pseudonyms.

1.4 On 11 July 2019, the Test Valley Community Safety Partnership (CSP) decided, based on the police referral dated 26 June 2019, that the criteria for a domestic homicide review were met. Consequently, they commissioned this review.

1.5 The review considered agencies' contact and involvement with the subjects of the review as listed between 1 January 2013 when Nicole moved back to Hampshire) and 23 June 2019 (the date of the murder) to reflect what was known regarding agency contact with the family.

1.6 Initially, the following agencies were required to submit Summaries of Involvement to allow the panel an opportunity to understand the nature and scope of their involvement with any of the parties during the time period under review.

- Andover Crisis and Support Centre
- Hampshire Constabulary
- Hampshire County Council Children's Services
- Hampshire Hospitals NHS Foundation Trust
- West Hampshire Clinical Commissioning Group
- Primary Care Surgeries
- South Central Ambulance Service
- Test Valley Borough Council Housing
- Test Valley Borough Council Revenue and Welfare

1.7 Having reviewed the Summaries of Involvement, and following discussions at the initial panel meeting on the 4 September 2019, the following agencies were required to submit Individual Management Reviews and Chronologies:

- A Medical Centre
- B Health Centre
- C Surgery
- Dorset Police
- Hampshire Constabulary
- Hampshire County Council Children's Services
- Hampshire Hospitals NHS Foundation Trust
- Secondary School
- Infant School
- Junior School
- South Central Ambulance Service
- S Surgery
- Sussex Partnership NHS Foundation Trust

1.8 Each of those agencies were required to:

- Provide a chronology of their involvement with the subjects of the review during the relevant time period using the provided template.
- Search all their records outside the identified time periods to ensure no relevant information was omitted.

- Provide an Individual Management Review (IMR): identifying the facts of their involvement with the subjects of the review critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency. Agencies were provided with an IMR template and asked to confirm the independence of the IMR authors.

1.9 Research was carried out to ascertain if Nicole was registered at a dentist in case they held relevant information, but it seemed she was not.

1.10 Interviews were held with Nicole's mother, one sister and brother in law (with their Victim Support advocate). Following a review of all the relevant witness statements provided by the police, a work colleague was interviewed. Ryan's father was interviewed as was Ryan in HMP Bullingdon. It was not felt appropriate to interview anyone else given the material provided.

2 THE REVIEW PANEL

2.1 Mr Graham Bartlett was appointed to chair the Domestic Homicide Review panel and be the author for this review. He is the Director of South Downs Leadership and Management Services Ltd. He Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards and was previously the Independent Chair of Brighton and Hove Local Safeguarding Children Board. He has completed the Home Office on line training for independent chairs of Domestic Homicide Reviews and the Social Care Institute for Excellence Learning Together Foundation Course. He has experience of chairing and writing numerous Domestic Homicide Reviews, Serious Case Reviews and Safeguarding Adults Multi agency reviews. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the Force's approach to Child Protection, Domestic Abuse, Multi Agency Public Protection Arrangements (MAPPA), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for any policing in Hampshire or the Isle of Wight nor, other than as the independent reviewer on another Domestic Homicide Review, any connection with Test Valley Community Safety Partnership.

2.2 The panel comprised the following members:

- Graham Bartlett – Independent Chair
- Michele Ennis – Adult Safeguarding & Quality Nurse. West Hampshire Clinical Commissioning Group
- Colin Matthews – Review Officer. Hampshire Constabulary
- Andrew Lund – District Manager. Hampshire County Council Children's Services and Safeguarding
- Keith Sutcliffe – Housing Manager. Test Valley Borough Council Housing
- Allan Appleby – Senior Probation Officer. National Probation Service
- Yvonne Bradbury – Manager. Andover Crisis Support Centre
- Carl Whatley – Head of Revenues. Test Valley Borough Council Revenue and Welfare
- Andrew Pilley – Community Engagement Manager: Community Safety. Test Valley Borough Council Community Safety Manager
- Cheryl Chalkley – Independent Domestic Violence Advisor

- Julie Yalden – Named/Lead Nurse for Safeguarding Children Hampshire CAMHS (Child and Adult Mental Health Service). Sussex Partnership NHS Foundation Trust
- Dave Growcott – Community Manager. Test Valley Borough Council Communities Team
- Steve Lincoln – Chair of Governors. Infant School
- Beth Trenchard – Designated Safeguarding Lead. Infants School
- Emma Stott –. Designated Safeguarding Lead. Junior School
- Lisa Hodgkinson – Head Teacher. Junior School
- Claire Davis – Adult Safeguarding Lead. Hampshire Hospital NHS Foundation Trust

2.3 Whilst all represent their own agencies, none were directly involved in the services provided or the supervision of those providing services to any of the subjects of the review and are independent of the matters under review.

3 TERMS OF REFERENCE

3.1 The specific terms of reference for this domestic homicide review were agreed as follows:

1. To review the history of domestic abuse involving Nicole and Ryan or any of their previous partners during the time period and assess whether there were any warning signs of escalation or vulnerability.
2. Whether there were opportunities for professionals to refer any reports of domestic abuse or sexual violence experienced or committed by either the victim or the alleged perpetrator, (towards each other or any other partner) to other agencies and whether those opportunities were taken.
3. Whether the quality of risk assessments undertaken were of a suitable standard and whether the thresholds for referral into Domestic Violence Multi Agency Risk Assessment Conference (DV-MARAC) were appropriate.
4. Whether the services available for victims who are assessed as being below the threshold for DV-MARAC are accessible and suitable for their needs and effective at reducing or preventing escalation of risk.
5. Whether there were opportunities for professionals to ‘routinely enquire’ as to any domestic abuse or sexual violence experienced by the victim or committed alleged perpetrator that were missed.
6. Whether there were opportunities for agency intervention in relation to domestic abuse or safeguarding between Nicole and Ryan (or any of her previous partners) or regarding Nicole’s children that were missed or could have been improved.
7. Whether there were any barriers or disincentives experienced or perceived by Nicole or her family/ friends/ colleagues in reporting any abuse including whether they knew how to report domestic abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.
8. Whether family, friends or colleagues were aware of any abusive behaviour towards the victim by Ryan or any of her previous partners prior to the homicide and what they did or did not do as a consequence.

9. Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.
10. Whether any previous services provided to Nicole relating to domestic abuse or safeguarding during the period under review, and her experience of them impacted on the likelihood of seeking further support or interventions.

In addition:

- The review will consider any equality and diversity issues that appear pertinent to the victim, perpetrator, previous partners and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
- The review will 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 Test Valley Borough Council area.

4 BACKGROUND INFORMATION

4.1 Nicole, her partners and children were well known to both Hampshire Constabulary and Hampshire Children's Services. She moved back from Wiltshire to Hampshire in early 2013 having been subject of investigation and in receipt of services in that area. Max and Oscar were subject of Child Protection Planning (CPP) in Hampshire in 2013 when their cases were transferred in from Wiltshire following a proven allegation that Nicole had burned Lily on their back. Nicole was convicted of Assault Occasioning Actual Bodily Harm (ABH) as a result and received a community sentence.

4.2 Nicole had a previous history of being a victim, and, some who knew her say, a perpetrator, of domestic abuse with former partners - including having to live in a refuge in Dorset in 2010. There were a number on incidents in the months leading up to Nicole's death.

4.3 In September 2018 Nicole was subject of a domestic incident in a hotel in Bournemouth where it was reported that she and Ryan had been fighting and that she had blood on her. She was spoken with and said that they had been arguing and that she had not been deliberately assaulted but had sustained a nose-bleed by Ryan accidently striking her. The incident was assessed as a standard risk domestic incident. It transpired that Ryan had assaulted her and this matter is subject to investigation by the Independent Office for Police Conduct (IOPC)[2].

4.4 In the early hours of 18 May 2019 Nicole was reported to have been the victim of an assault outside a nightclub in Andover; described as her being on the floor with ten people kicking her. Nicole was spoken with and said she did not know what had happened and did not care. No further police action was taken.

4.5 On 30 May 2019 Nicole's brother reported that she had been raped by her ex-partner, Ryan, and that he had physically assaulted her over the previous five months. Police spoke with Nicole and she denied that she had been the victim of any offences. No further police action was taken. This matter is also subject to investigation by the IOPC.

4.6 At 05.33 on 23 June 2019, police were called Nicole's home in Andover by the

[2] Between the submission of this report in May 2020 and feedback from the Home Office QA Panel in May 2021, the IOPC notified Hampshire Constabulary and Dorset Police that there was no misconduct and some officers should receive 'non misconduct management advice.' Neither IOPC report has been shared with the review. The body of this report remains as it was when approved by the CSP given the lack of more detailed information.

Ambulance Service. Paramedics arrived at the scene to find Nicole in cardiac arrest. Police attended and established this as a suspicious death and Ryan was identified as a suspect.

4.7 Late in the afternoon, officers who were searching the address found Ryan in a bedroom cupboard. He was arrested for murder and in interview he answered 'no comment' to all questions put to him. He was charged with Nicole's murder.

4.8 A post mortem examination of Nicole found that she had died as the result of numerous blunt force injuries to her face, neck, trunk and limbs. She had suffered twenty-six broken ribs on the right side of her chest and eleven on the left. She had a fractured sternum and both of her lungs had collapsed. She also had lacerations to her liver. The pathologist found that this was indicative of a prolonged attack, probably from punching and sustained non-survivable crushing injuries from repeated stamping or jumping down on the front of her trunk whilst she was lying face up on the floor.

4.9 Background enquiries revealed Nicole had disclosed to a number of friends that she suffered a history of serious domestic physical and sexual abuse by Ryan and that she feared that he may kill her. Despite being urged, she was reluctant to get police involved for fear of getting Ryan into trouble which she thought would adversely affect their custody of the children.

4.10 Others say that she subjected Ryan to domestic violence and that he played that abuse down so as to protect the children. The evidence gathered by the police suggest both accounts are true, painting a troubled and abusive relationship on both sides, the full truth of which did not emerge as far as agencies were aware until after Nicole's death.

4.11 Following Ryan changing his plea from not guilty to guilty towards the end of his murder trial, on 20 December 2019 he received a life sentence with a minimum tariff of seventeen years in custody.

5 FINDINGS AND CONCLUSIONS

5.1 Nicole's history, both past and more recent, was troubled. She grew up amid domestic violence, fell pregnant at an early age and had a series of partners who subjected her to domestic abuse.

5.2 It is clear from the evidence that she could be prone to violence herself, being convicted of harming one of her children. She also came to notice for her excess use of alcohol. Her children reported the domestic abuse they witnessed and this was sometimes heard and followed up, sometimes not. At least one of her children had exhibited behavioural issues that escalated in the months leading up to his mother's death.

5.3 Two incidents of domestic abuse were reported to different police forces by third parties; once a member of the public in a hotel in Bournemouth and once by Nicole's brother. On both occasions the police investigated and on both the investigations was curtailed due to Nicole's denials that the reports were true. In the first case there was CCTV evidence to show the contrary but no one looked for it until Nicole was dead. In the second case there was photographic evidence to support the report but these did not sway the decision-makers that the investigation should cease, despite the very serious nature of the reports. It is not known why Nicole denied the reports and provided 'innocent explanations' for injuries but this is not unusual and services should be equipped to overcome that barrier.

5.4 The first of these cases was inadvertently closed by CRT. The second was not

referred to CSD at all. This meant that when the infants' school referred their concerns of domestic abuse, CSD considered there to be no history so took no action after the assessment. The infants' school, however, omitted a very serious overheard comment of domestic and child abuse. Had they not, then almost certainly a Section 47 Children Act investigation would have followed.

5.5 This section will focus on the conclusions and findings, organised according to the terms of reference. Where appropriate, some of the following paragraphs look at more than one of those terms of reference but all have been examined in detail.

1. To review the history of domestic abuse involving Nicole and Ryan or any of their previous partners during the time period and assess whether there were any warning signs of escalation or vulnerability.

5.6 Nicole had two relationships prior to Ryan and had five children. Whilst the reports of domestic violence and safeguarding concerns were relatively few, they were enough in terms of volume and severity to trigger concern.

5.7 Underpinning Nicole's return to Hampshire was her conviction for ABH where she was found to have deliberately harmed one of her children. The correct procedures followed and, on transfer, Hampshire CSD considering the progress made in Wiltshire stepped the children down from Child Protection Plans. Two of the children no longer lived with their mother.

5.8 This, and what was known about Nicole and her partners, should have heightened all agencies' awareness over any concerns that then came to light. The dispute at the party in September 2016 revealed no criminal offences, the children were not present and there was no suggestion they were at risk. CSD took no action on that basis.

5.9 From April 2018, the concerns around domestic abuse between Nicole and Ryan (and therefore the safeguarding of the children living at home) escalated. Specific disclosures were made regarding Lily and Ethan being physically abused during contact visits with Nicole and that Ryan physically abused his own children. Those children living with Nicole and Ryan did not support the disclosure when spoken to by social workers but Lily and Ethan maintained their accounts.

5.10 The case progressed to Child and Family Assessments but established that the children were safe, happy and well cared for at home. It found that no disclosures were made and no wider concerns were identified, despite the known history of domestic abuse. The case was closed.

5.11 These conclusions are at odds with Lily and Ethan being steadfast in their disclosures. Seemingly the assessment has only taken note of the outcome of the interviews with those children living with Nicole and Oscar. No action was taken regarding Lily and Ethan who remained consistent in their disclosures of physical abuse.

5.12 There appears to have been no consultation with the police in relation to this incident. Whilst they may not have added anymore to the picture, consideration of a strategy meeting to determine whether a Section 47 Children Act joint investigation should take place was missed. Whatever the outcome, had this been approached in a more multi agency fashion and in accordance with the 4LSCB[3] (as was) Safeguarding and Child Protection Procedures[4], further incidents may have been considered in a different light based upon the Hampshire and Isle of Wight Thresholds Document[5].

[3] An alliance of Hampshire, Isle of Wight, Portsmouth and Southampton Local Safeguarding Children Boards – Now Safeguarding Partnerships
[4] http://hipsprocedures.org.uk/
[5] https://www.hampshirescp.org.uk/wp-content/uploads/2019/08/Hampshire-IOW-Thresholds-Chart-July-2019-1.pdf

5.13 The failure to investigate properly and then recognise the incident at the Bournemouth hotel stands out as a missed opportunity at two levels. Firstly, had the attending officers examined CCTV at the time they would have seen Ryan assaulting Nicole. Not only would this probably have resulted in his arrest, notwithstanding her views, but also it would have highlighted Nicole's vulnerability. Her emphatic denials that she had anything other than an accidentally sustained injury and that Ryan had never deliberately harmed her, would then have been viewed as her minimising and denying the violence through fear, coercion or control. Because the case is subject to IOPC investigation, this review does not know whether efforts were made to locate the witness or background checks were carried out in Hampshire at the time but had they been, then Nicole's previous domestic abuse status should have been revealed, as would her conviction for assaulting her child. Lily and Ethan's disclosures from earlier that year would not have been shared as the police did not know about that.

5.14 The panel took the view, having heard a compelling assessment from one of its members who works day to day assessing cases for DV-MARAC, that this assault in itself would have been sufficient to place Nicole at high risk of DV. The absence of the CCTV footage and the witness account at the time precluded this option as the officers had a minimised explanation. Had they seen and reported what actually happened and a DV-MARAC held, a much richer multi-agency picture would have emerged which might have provided for a greater and more effective response from a variety of services. This is an investigative rather than a DV-MARAC issue.

5.15 Secondly, the administrative oversight that conflated the PPN referral with another to CSD meant that this incident was missed by them. By now they had a deeper knowledge of the potentially violent relationship between Ryan and Nicole because of the April 2018 disclosures, but this oversight meant the overall family dynamic and vulnerability of Nicole and the children could not be assessed. Recommendation 4 refers to these information sharing and handling issues.

5.16 In February, March and May 2019 the infants school heard escalating concerns from Sophie that all was not well at home. The first was she and her brother were being baby-sat by their thirteen-year-old brother. His school and the police were well aware of Max's deteriorating behaviour both at school and in the community. These concerns resulted in advice to the school to speak to Nicole and re-refer if there was any concern. They did speak to Nicole and she denied Max was looking after the children.

5.17 In March, Sophie made it very clear that she had witnessed domestic abuse – including criminal damage – at home. She suggested that her parents were separating. This added factor should have been a red flag as research consistently points to separation being a factor that significantly heightens risk[6]. However, the school did not share that information with CSD or anyone else for nearly three months.

5.18 In May, two days before half term, Sophie again revealed that she was living with domestic abuse. She said 'my mum stabs my dad. Once she stabbed him in the bathroom, there was blood. She keeps hitting me, I don't know why. I want to be with my dad.' This was a clear sign of escalation yet the school, again, did not refer this to CSD. This was an overt and extremely serious child protection concern that potentially put Sophie, her siblings and parents at risk of significant harm.

5.19 The infants' school was subject to an independent safeguarding audit in January 2020. The reviewers observed a much stronger and compliant culture of

[6] http://www.safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

safeguarding in the school.

5.20 Between the disclosure and the referral, Nicole's brother made a third party report of serious domestic – including sexual – violence to the police. This cannot be analysed fully as it is currently being investigated by the IOPC but, despite photographic evidence of injuries and apparently non-consensual sexual photographs, the only police response was to speak to Nicole. She revealed that she and Ryan were separating which should have triggered added concern. This incident was not fully investigated; Ryan was not interviewed and no safeguarding referral was shared with CSD. It is unclear, at the moment, whether the matter was ever subject of risk assessment or safety planning within the police.

5.21 On return from half term, Oscar told the school that his father, Ryan, might be coming to live back home as he and Nicole were not arguing so much. Four days later Ryan told the school Nicole was drunk with the children. They were not in school that day. This was referred to CSD. In a telephone conversation the school told MASH about the disclosure surrounding the damage to the car but not the 'stabbing.' MASH spoke to Nicole who described how her break-up was causing acrimony that the children were struggling with. The matter was closed by CSD for the school to monitor.

5.22 There was a clear escalation in domestic abuse that, had the information been assessed, explored and understood more deeply would have been apparent. The information came in to a school and two different police forces but never was it brought together effectively to develop a common picture of that escalation. If it had, perhaps more would have been done to help support the family and address the behaviour but, instead, each case was considered in isolation so those opportunities were not taken.

Recommendation 1

The Hampshire Safeguarding Children Partnership and CSD should work with schools to reinforce expectations, processes and good practice around raising safeguarding concerns, with the aim of achieving full and timely referral processes to enhance the safety of children.

Recommendation 2

Hampshire Safeguarding Children Partnership should incorporate the learning from this review into the annual Safeguarding in Education Assessment that is undertaken in all schools, especially focussing on recognising signs and symptoms of abuse, local referral pathways and record keeping.

Recommendation 3

Subject to the outcome of the IOPC investigations, Hampshire Constabulary and Dorset Police should review the impact of their training and supervision of domestic violence and abuse to ensure that their officers and staff are applying it to undertake full and broad investigations that do not hinge on the co-operation and/ or support of victims. In so doing both police services should ensure the signs and symptoms of coercion and control are well understood and applied.

2. Whether there were opportunities for professionals to refer any reports of domestic abuse or sexual violence experienced or committed by either the

victim or the alleged perpetrator, (towards each other or any other partner) to other agencies and whether those opportunities were taken.

5.23 Nicole, generally, would deny or minimise any concerns expressed about her, be that to the police, CSD or her children's school. To professionals, she was adamant that she was safe and that Ryan presented no threat to her. That appeared to satisfy all of those agencies and mostly resulted in enquiries or investigations being shut down.

5.24 The sharing of information between agencies was not good, so far as this review has seen. The infants' school held on to several pieces of information which were clear indications of domestic violence. When they did refer they did not always do so in a timely fashion and their referrals were incomplete. Other than on one occasion they were asked to monitor the situation and refer back if needed.

5.25 Dorset Police did not refer the Bournemouth incident to Hampshire Constabulary for nearly a month. Whilst at that time Dorset were of the view there had been no domestic abuse taking place between Ryan and Nicole, the fact that they completed and eventually shared a report about it must have meant that the possibility existed. That period of time to inform the parties' home force – and therefore their partners – was too long and denies the home area's agencies the opportunity to safeguard the victim. The College of Policing[7] promotes the timely sharing of information for this purpose but that did not happen.

5.26 Hampshire Constabulary should have shared the third party report made by Nicole's brother to CSD. Whilst they would not have known it at that precise point – because the infants' school had delayed their referral – this critical piece of information would have assisted CSD in undertaking a more meaningful assessment following the school's referral. In addition, had CSD recognised the Bournemouth hotel PPN for what it was, that would have added to their considerations.

5.27 CSD did not refer the disclosure regarding Lily and Ethan being physically abused on contact visits to the police. As the June 2019 referral from the school did not contain the most serious incident, CSD could not have been expected to refer it to the police as a child protection concern. If it was as detailed as it should have been, this would no doubt have resulted in a Section 47 child protection investigation and an investigation into domestic abuse between Ryan and Nicole.

5.28 There has been comment within this review of schools not sharing information or appreciating the context and the lived experiences of the children in their care. There is a systems issue here. The infant school told the review they had no idea of the history of abuse within the family, nor that the two on their roll had four siblings each. They thought they only had two. They say they rely on parental openness when gathering family information and, unless any of the siblings are open to CSD, they are unlikely to have information shared with them from that agency.

5.29 They say that, until they started to pick up the concerns, they had no reason to worry about Oscar and Sophie and their upbringing. It seems that when the disclosures were made by Ethan and Lily, information around the family set-up was not shared with the school as the assessment did not result in them being opened to CSD.

5.30 There was no information shared between CSD and CAMHS, either way. At the time the referral was made regarding Ethan and Lily being abused while at Nicole and Ryan's house, Ethan had been closed to CAMHS the month before. None of the children were open to CSD during the time Ethan was open to CAMHS. The review was told that with two-thousand referrals per quarter, it is impossible for CAMHS to

[7] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/partnership-working-and-multi-agency-responses/#sharing-information-with-relevant-agencies

speculatively request CSD provide information on each of those. Likewise, CSD told the review that they would be overwhelmed if they *speculatively* requested information from CAMHS – or anyone else - on every referral they received.

5.31 Both those positions are understandable but with families who may not always provide the full picture or without any additional information, the current positions risk that agencies are working in isolation and with limited information which can only be to the detriment of safeguarding. There are no easy answers to this but, rather like the absence of information held by the schools, it exposes a systems issue which means that unless a child is already subject to Section 17 or 47 Children Act intervention, they are left without the co-ordinated, multi-agency support they need to prevent them escalating to that level.

5.32 There is no suggestion seen by this review, that any professional or agency took a deliberate decision not to share information. However, on occasions they did not, despite HM Government's 2018 Guidance on Information Sharing for Safeguarding Practitioners[8] that to do so is both lawful and necessary to protect vulnerable people.

5.33 The Section, 'Assessment of a Child Under the Children Act 1989', in Working Together to Safeguard Children 2013[9], (P31); 2015 (*ibid)* (P34) and 2018 (*ibid)* (P35) – which cover this review period, stipulates that criminal offences that come to the attention of CSD should be referred to the police. The police maintain they should have been notified of Sophie mentioning criminal damage by Nicole to Ryan's car. CSD say they would only do so if the matter reached the threshold on Section 47 Children Act. These differing interpretations of Working Together are unhelpful and should be resolved.

5.34 There is a risk of verbally shared information being either missed of misunderstood especially between schools and CSD. This should not be the case as all referral should be followed up in writing, but it happened here so could be happening elsewhere leading to opportunities to keep children and vulnerable people safe being missed.

Recommendation 4

The Hampshire Safeguarding Children Partnership should develop a comprehensive Information Sharing Agreement between the safeguarding partners and all 'Relevant Agencies' which provides a shared commitment to what information is to be shared and how. This should be informed by the learning from this review and the outcomes of the biannual MASH Multi Agency audit which focuses explicitly on information sharing, assessment and decision making.

3. Whether the quality of risk assessments undertaken were of a suitable standard and whether the thresholds for referral into Multi Agency Risk Assessment Conference (DV-MARAC) were appropriate.

And

4. Whether the services available for victims who are assessed as being below the threshold for DV-MARAC are accessible and suitable for their needs and effective at reducing or preventing escalation of risk

8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

9 https://webarchive.nationalarchives.gov.uk/20130403204422/https://www.education.gov.uk/publications/eOrderingDownload/Working%20Together%202013.pdf

5.35 The quality of risk assessments undertaken by Hampshire Constabulary were appropriate at the time. Given that, those cases risk assessed (possibly with the exception of the third party report currently being investigated by the IOPC), would not have resulted in a DV-MARAC referral or any other safeguarding intervention without Nicole's consent.

5.36 The incident in Dorset was risk assessed appropriately on the information to hand but had the initial investigation been undertaken effectively a different picture would have emerged which, in the view of the panel, would have resulted in a MARAC referral and probably a multi-agency risk management plan that might have enhanced Nicole's safety.

5.37 The way in which Hampshire Constabulary assesses and responds to domestic abuse now has changed significantly from the time this review commences. Changes have been made to the grading policy in terms of enhancing the risk assessment process for victims. This has included amendment of the questions asked and the 'weighting' of responses in terms of identifying levels of risk. There are also certain questions within the assessment which if answered in the positive (e.g. strangulation) mean that a risk assessment cannot be anything other than high.

5.38 Since the end of this review period, Hampshire Constabulary introduced some significant changes to practice in relation to the way in which victims of domestic abuse are supported and receive long term safety planning. All medium and high risk victims (who agree to services) are now referred to specialist domestic abuse support services.

5.39 These commissioned services will seek to engage with the victim providing wholly independent support and guidance to empower them to make decisions regarding their relationships and also seek support in other areas such as drug and/or alcohol misuse, housing issues, safety planning and long-term support for victims who wish to leave a relationship.

5.40 Following on from a pilot in Southampton, now extended to Hampshire, all high risk domestic abuse cases are considered from a multi-agency perspective within seventy two hours. Those that have a need for more strategic/complex interventions are discussed within the scheduled monthly DV-MARAC.

5.41 This case would be unlikely to have reached that threshold but may have been medium or high risk had investigations been fuller or more information been shared. This would have put Nicole in the scope of the new commissioned service, depending on her consent.

Recommendation 5

Hampshire Constabulary should review its revised domestic abuse risk management arrangements to assure themselves and partners that they are achieving the desired outcomes in terms of recognition of vulnerability and provision of services to reduce escalation of risk.

5. Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse or sexual violence experienced by the victim or committed alleged perpetrator that were missed.

5.42 The occasions that the police and CSD encountered Ryan, Nicole or their children were around overt child protection, safeguarding or domestic abuse concerns. Therefore, they were not required to 'routinely enquire' as such as they knew what they were dealing with.

5.43 The infants' school and Max's secondary school however encountered several

episodes which could have provided an insight in to possible domestic abuse. The disclosures by the younger children, the fluctuating attendance, the behavioural concerns and the ambiguous report by Ryan were all opportunities for the school to broach the possibility with Nicole that she or the children may be at risk. However, that might be difficult for a school to do that without risking the relationship they have with the parents. They are not trained to ask those questions and the pathways they would follow on a positive disclosure are those they occasionally took. Thought needs to be given to equip schools to become more knowledgeable and confident in recognising and addressing domestic abuse as part of their safeguarding approach. These considerations relate to Recommendations 1 and 2.

5.44 Hampshire Hospitals NHS Foundation Trust had five opportunities to enquire further. Nicole attended on three occasions with recently historical injuries and none were questioned beyond her initial explanation.

5.45 Ryan's presentation with a sword injury should have generated some curiosity over whether this indicated that he may present a risk to himself or others he lived with, given the unusual nature of how he said the injury was sustained. It was since emerged that Ryan's account may have been to cover up a very serious assault. It is not suggested that he would have revealed this if probed, it just illustrates what may underlie seemingly innocuous or innocent explanations.

5.46 When Andrew presented having been kicked by his daughter, there was no evidence that anyone asked him more about that. The records do not show the context of how the injury came about, how old his daughter was, whether she was injured or whether anyone was at risk. These questions should have been asked as it was possible that Andrew himself was a victim of domestic abuse or that he may have sustained the injury while perpetrating domestic or child abuse. As a result, no follow-up action or referral took place.

5.47 The GP surgery saw Nicole with a lip injury and with low mood/ depression. They also noted the hospital attendances. CAMHS knew that Robert was violent. Whilst notes are scant as to whether the domestic violence was still a feature in either Nicole or Laura's life, there is no mention of it. Therefore, it might be that these presentations may signify that either woman, or the children, were at risk of abuse but was not explored.

5.48 The decline in her mental health and her alcohol use could have been coping mechanisms against the abuse she was suffering. Seen in the round and now, with tragic hindsight, this was probably the case but never explored at the time.

5.49 HHFT maintain that, given what they regard as a reasonable explanation being provided for how each injury had occurred, further enquiry was not indicated by their interpretation of the guidance set out in the Hampshire Domestic Abuse Partnership *Domestic Violence and Abuse pathway for Health Services*[10] currently used by health agencies across Hampshire. They have considered the merits, or otherwise, of making enquiries into possible domestic abuse where they may not be obviously indicated and remain concerned that blanket requirements may dissuade staff from thinking for themselves about why they might be enquiring and the enquiry then becoming quite mechanical and process driven, removing professional judgment. They are also concerned regarding the resource implication of such routine enquiries.

5.50 They worry too around the potential for victims who do not want to access support to avoid attending hospital for medical treatment. For example, it may become known that staff will automatically ask if an injury is as a result of domestic abuse. This could work the other way and victims may see health settings as somewhere they will be

[10] http://www.hampshiresab.org.uk/wp-content/uploads/DVA-Questions-and-Pathway-FINAL-07_03_18.pdf

sensitively and safely asked if they are disinclined to otherwise tell.

5.51 HHFT report they are active in promoting awareness of domestic violence and abuse with staff. They have domestic violence health advocates working within the Trust who are raising awareness by delivering training, having a presence within the Trust and producing materials that can be used. Advice and support are available for staff who have concerns about patients as well as any staff that could be victims.

5.52 The *Domestic Violence and Abuse Pathway* identifies when enquiry should be made. In Nicole's case, this pathway was not applied as one of the criteria to enquire is delay in presentations. However, the guidance does not set out what constitutes a delay as many reasonable adults may put off seeking treatment or advice, for example if pain lingers beyond their expectation.

5.53 Most of these presentations, arguably, could have triggered additional enquiry aimed at identifying whether the patient was a potential victim or perpetrator of domestic abuse. Recommendation 6 of NICE Guideline PH50[11] sets out the standards for this and it appears that, with these patients, this was not applied.

Recommendation 6

The Hampshire Domestic Abuse Partnership should assure that guidance, policies and practice supporting routine and targeted enquiry for domestic abuse are fully understood and applied so that opportunities to identify abuse and signpost or offer services appropriate to need are taken.

6. Whether there were opportunities for agency intervention in relation to domestic abuse or safeguarding between Nicole and Ryan (or any of her previous partners) or regarding Nicole's children that were missed or could have been improved.

5.54 This has been covered under points 1 and 2 above.

7. Whether there were any barriers or disincentives experienced or perceived by Nicole or her family/ friends/ colleagues in reporting any abuse including whether they knew how to report domestic abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.

And

8. Whether family, friends or colleagues were aware of any abusive behaviour towards the victim by Ryan or any of her previous partners prior to the homicide and what they did or did not do as a consequence.

5.55 Nicole did not report any domestic abuse herself. The occasions when it was reported was by third parties such as her children, brother and a member of the public.

5.56 There are indicators that Nicole was reluctant to report or confirm offences to the police due to fears that her children would be removed from her care. Her brother told police it was unlikely that Nicole would speak with them as she was petrified of Ryan and of losing her children. She told him she would deny anything to the police.

5.57 Background enquiries into the murder revealed a number of Nicole's friends to whom she disclosed a history of serious domestic physical and sexual abuse by Ryan and that she feared that he may kill her. She was reluctant to get police involved for fear of getting Ryan into trouble which she thought would adversely affect their children.

5.58 Nicole's mother, whilst not saying she considered making a third party report

[11] https://www.nice.org.uk/guidance/ph50

regarding Ryan, said she had previously been put off doing so. She recalls, in 2010, trying to report domestic abuse towards her daughter to Family Mosaic via Test Valley Borough Council at Romsey. She says she was told that only the victim could do so, therefore she left and did not try again.

5.59 Nicole's work colleague, with whom she had a relationship, tried to raise his concerns – or at least receive advice – to the friend of a friend who was a police inspector. This advice seemed dissuasive, centring on all the problems and barriers that might arise rather than seeing it as an opportunity to keep Nicole and her children safe. This was a very serious error. Given the person who knew the inspector – the solicitor – is now dead, the colleague is unable to ascertain more details regarding this officer.

5.60 People both Nicole and Ryan knew reported and could evidence domestic abuse on both sides. Some of those who knew about the abuse Nicole suffered urged her to report to the police but she did not, in one case lying to say she had and that she was receiving counselling (although this might have been the talking therapies she had four years previously.) No one who knew of the violence towards Ryan mentioned considering, or discussing with him, reporting the matter to the police or anyone else.

5.61 Ryan maintains that he was the main domestic abuse victim in this relationship, but never reported anything to the police despite his father urging him to. He says that Nicole could be the 'sweetest person in the world' or could 'flip and be violent,' especially when drunk. He said that she would attack him and endanger the children too. His reasons for not reporting were that he was frightened of the children being taken in to care, or him not being able to see them. Nicole is clearly not in a position to provide her perspective or to rebut these assertions.

5.62 It is apparent that their previous experiences weighed heavily on Nicole and Ryan, but the level of violence they are alleged to have inflicted on each other was such that their children might have been a lot safer elsewhere, if even for a short period to allow them to consider and establish a safer future. Their fixation about keeping the family together, come what may, might have exacerbated their toxicity together and, as several friends and family have suggested, led to the events that occurred.

9. **Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.**

5.63 Nicole herself was well aware of services available given her past experiences of domestic abuse, the DV-MARAC process prior to this review period and previous experience of Refuge accommodation in another area. Therefore, in this case, a lack of awareness of local services is not believed to be a factor but her experience of them and their consequence may be.

5.64 There was little awareness expressed by Nicole's family, friends or Ryan as to who else could support them should they be concerned about domestic abuse, other that the police and CSD. Ryan said he would never have sought support at the time as he was living his own normality. It was not until he left Nicole that he 'truly realised he was subject to coercive control and abuse.' He said he did not know of any services for men and if there were any they would have to work very hard to persuade him to access them.

10. Whether any previous services provided to Nicole relating to domestic abuse or safeguarding during the period under review, and her experience of them impacted on the likelihood of seeking further support or interventions.

5.65 Nicole had experience of being subject of child protection interventions previously and it may be this experience and the fear of losing her children created a barrier to her formally reporting any abuse perpetrated against her. She did voice this concern

to some of her friends and, whilst her children were not removed statutorily, the experience seem to have stuck with her and provided a disincentive to report. That is not in any way a suggestion that it was not right that, at the time, Lily and Ethan needed to live elsewhere.

5.66 However, domestic abuse related services were not provided in the period, but there was a safeguarding assessment. Despite the outcome this review has questioned, this appears to have been a positive and helpful experience for the family, during which both adults and all the children were spoken to and co-operated fully.

5.67 Nicole subsequently had what was perceived to be a positive and open conversation with a social worker in MASH. All of this lead to a view that Nicole would feel able to approach CSD if she felt vulnerable or at risk, even though she would minimise any concerns due to her fear of losing her children or retribution from Ryan.

5.68 However, what is now known is that she was in fear of losing her remaining children and told friends that she would not report matters to the police (and therefore probably not be completely open with CSD) for fear of the consequences for her family. Following the assault that led to her conviction, Lily and Ethan lived with their father (despite that breaking down) but there remains a question about how agencies can re-engender trust and assure previous service users that their interventions do not necessarily lead to children being removed and families broken up. The status quo risks a complete disengagement from support due to myths, misconceptions and extra-ordinary previous experiences.

5.69 Many friends, family, even Nicole and Ryan themselves expressed that their relationship was toxic. The full truth of who was the primary perpetrator is disputed by those who knew them, but the level of violence inflicted by Ryan on Nicole resulting in her death, the bruising to her body and neck and the fear she expressed to friends as to what might happen is compelling. However, both knew that the violence in the relationship was damaging to the children as well as themselves. Both, however, were strongly influenced in any decision to seek help by the consequences of Nicole's conviction for assaulting one of her children.

5.70 This review, in no way infers that the action taken following that conviction was wrong or ill-judged. However, what these tragic circumstances teach us is that the impact of such action remains with those affected by it for years and risks leading them to make unwise decisions about their and their children's future and safety. All agencies, particularly those with coercive powers, should reflect how they can re-engage people who have had negative previous experiences and help them to understand that they are there to support and only, in extremis, are they forced into removing children from parental care.

Recommendation 7

The Test Valley CSP develops a wide-reaching communication strategy that publicises the full nature of domestic abuse services with particular emphasis on the supportive nature of those services, aimed especially towards those who may have had negative experiences of statutory services in the past. The purpose should be to improve confidence in all survivors, perpetrators and third parties, of any gender, to seek help and to reduce fear of negative consequences in raising concerns.

5.71 This review has highlighted that where people have had previous negative – albeit highly appropriate – interventions from statutory services and where children remain in the family, they can be disinclined to access support for fear of repeating the experience. In this case, this was complicated by a fractious, often violent, dynamic with both parties reporting being the victim and being subjected to coercive control.

5.72 There was nothing within the review that indicated any agency or service did not take into consideration any protected characteristics – such as they were. However, the recognition, assessment and sharing of concerns and referrals was, on occasions, substandard. This meant that when the relationship significantly deteriorated in the last six months of Nicole's life no one agency or partnership held the full picture so none were in a position to intervene and support so as to safeguard the parties involved.

5.73 There is no guarantee that had those opportunities been taken the outcome would have been different but perhaps the risks might have been better appreciated and options presented to mitigate them.