SOUTH NOTTINGHAMSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

Report into the death of Stacey

October 2011

16 January 2019

Eleanor Stobart

THE THOUGHTS OF STACEY'S FAMILY

Stacey meant the world to her whole family, and her loss has left an immense void.

Stacey was a kind, loving, caring, bubbly young woman. Her smile and contagious laugh would light up any room; she was the life and soul of any party. She always looked for the good in people: she had the ability to empathise with others' struggles. Stacey was vibrant and full of life; she was beautiful inside and out. She was creative and had an amazing imagination, which lives on in her daughter.

Her family have been heartbroken to learn the extent of how badly Stacey was treated by the perpetrator. He murdered something in all of us that day, but worst of all, he took her daughter's mummy from her. The thought of Stacey's daughter not having her unique, beautiful and precious mother is too painful for us all to bear. We will never let her daughter forget her, and will remind her that Stacey loved her more than anything in this world.

When we think of Stacey and look for her, we look to the brightest star in the sky. We love and miss her intensely.

CONTENTS

1 INTRODUCTION

The key purpose for undertaking domestic homicide reviews (DHR) is to enable lessons to be learned from homicides in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

This domestic homicide review was commissioned by South Nottinghamshire Community Safety Partnership following the death of a white British woman, Stacey, who died in October 2011. Her ex-partner was found guilty of her murder and in June 2012 he was sentenced to life imprisonment and ordered to serve a minimum prison term of 22 years. This report examined the contact and involvement that agencies had with the victim and the perpetrator between April 2011 and the victim's death in October 2011. In addition to the agency involvement, the report also examined the relevant past history of abuse, and incorporated the views, thoughts and questions raised by members of her family.

The review panel wishes to express their condolences to Stacey's family and friends following her death. The panel also would like to thank all those who have contributed and assisted with this review.

1.1 Timescales

South Nottinghamshire Community Safety Partnership was informed of Stacey's death in 2011 and subsequently conducted a domestic homicide review. The report was approved by the Home Office Quality Assurance Panel and published in August 2014. However, on publication both Stacey's mother and father disagreed with some details contained in the original overview report, particularly as there were discrepancies and omissions between the domestic homicide review and an earlier complaints investigation carried out by Nottinghamshire Police. The Independent Police Complaints Commission reviewed the police involvement in the case, but the family remained dissatisfied with the outcome and asked for the domestic homicide review to be re-examined.

Following negotiation between Stacey's mother, Bhatt Murphy Solicitors, South Nottinghamshire Community Safety Partnership and the Home Office, it was agreed that the domestic homicide review panel should be reconvened with a different independent Chair. The domestic homicide review panel reconvened in January 2017.

1.2 Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until after the report was approved by the Home Office Quality Assurance Panel.

To protect the identity of the family members the following pseudonyms/anonymised terms have been used throughout this review:

- Stacey – victim (deceased) 24 years
- Perpetrator – ex partner 48 years
- Stacey's daughter 5 years

} Age at the time of Stacey's death

All the family members are of white British origin.

2 THE REVIEW PROCESS AND METHODOLOGY

The review has been conducted in accordance with statutory guidance under s.9 (3) Domestic Violence, Crime and Victims Act (2004). Individual management reviews (IMRs) or information reports were sought from all agencies, organisations or departments that had any involvement with Stacey, her daughter and the perpetrator between the time the couple met in late 2008 and Stacey's death in October 2011. The panel originally decided on this timeframe as it incorporated the point that Stacey and the perpetrator met and it provided information about the perpetrator's history of violent and abusive behaviour. The agencies involved were also asked to consider any relevant information before the period under review that might have had an impact on the case.

When the panel reconvened in 2017, Stacey's family asked that the review focus on the contact that agencies had with Stacey, her daughter and the perpetrator between the assault in April 2011 and Stacey's death in October 2011. Her family felt that the period leading up to the assault on Stacey could be summarised to provide background information. Stacey's mother also asked the panel to incorporate (where possible) into the review, the issues raised on her behalf by Bhatt Murphy Solicitors (dated 30 July 2015).

2.1 Involvement of family and friends

Before reconvening the panel, the independent Chair visited Stacey's mother to ensure that her concerns were addressed and her thoughts were included in the renewed review. The Chair also liaised and agreed the new terms of reference with Stacey's mother, their support worker from AADFA (Advocacy After Fatal Domestic Abuse) and the family's representative from Bhatt Murphy Solicitors. The Chair tried to contact Stacey's father and towards the end of the process the Chair met with him and his wife and their AADFA worker. The thoughts and views of Stacey's family can be found in section 3 and throughout this review.

2.2 Contributors to the review

All agencies that had contact with any of the family members were asked to submit an initial summary of their contact. Individual management reviews and chronologies addressing the key lines of enquiry had already been completed (in 2012) by the following:

- Nottinghamshire County Council Children's Social Care
- Crown Prosecution Service
- Nottinghamshire County Council Education
- Gedling Borough Council
- Multi-agency risk assessment conference (MARAC)
- Nottingham University Hospitals NHS Trust
- Nottinghamshire Community Housing Association
- Nottinghamshire Healthcare NHS Trust
- Nottinghamshire Police
- Nottinghamshire Probation Trust
- Victim Support
- Women's Aid

The original individual management reviews contained a thorough detailed account of events between 2008 and the time of Stacey's death. These were therefore used to provide the background information for this review. Nevertheless, Nottinghamshire Police, Children's Social Care, Nottinghamshire Probation Trust[1] and the Crown Prosecution Service (CPS) were asked to provide further information in the form of an 'information report'.

2.3 Review panel

The review panel comprised:

- Eleanor Stobart, Independent Chair and Author
- David Jayne, Community Safety and Safeguarding Manager, South Nottinghamshire Community Safety Partnership
- Joe Foley, Group Manager, Safeguarding, Assurance and Improvement, Nottinghamshire County Council Children's Social Care
- Julie Burton, Senior Operational Support Manager Nottinghamshire National Probation Service
- Leigh Sanders, Detective Chief Inspector Public Protection, Nottinghamshire Police
- Lloyd Young, Review Officer, East Midlands Special Operations Unit
- Nigel Hill, Head of Nottinghamshire National Probation Service

[1] The National Probation Service was set up on 1 June 2014, along with 21 Community Rehabilitation Companies (CRCs). The Nation Probation Service and the Community Rehabilitation Companies replaced the former 35 Probation Trusts. Thus, Nottinghamshire Probation Trust divided into the National Probation Service, and Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNRCRC).

- Pam Rosseter, Group Manager, Historical Abuse, Nottinghamshire County Council Children's Social Care
- Rebecca Smith, Head of Service, Women's Aid Integrated Services

The panel met five times. All members were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved at the time.

2.4 Author of the overview report

The Chair/author of this review has been a freelance consultant for 18 years. She specialises in safeguarding children and vulnerable adults with a particular focus on domestic abuse and working with minority ethnic families. During this time, Eleanor has been appointed to undertake projects for a wide range of organisations including (amongst others) the Department of Health, Association of Chief Police Officers, Interpol, Forensic Science Service, Amnesty International, National School of Government, Home Office Immigration Enforcement, ECPAT UK and the British Medical Association.

Examples of her work include being commissioned (2000 – 2011) to research, develop and write the national statutory and multi-agency guidelines for practitioners handling cases of forced marriage for the Forced Marriage Unit (Foreign & Commonwealth Office and Home Office Unit). The NSPCC appointed Eleanor to develop a service model and accompanying manual to assist NSPCC practitioners working with South Asian children and families. Following the death of Victoria Climbié, the Department of Education commissioned Eleanor to investigate the scale and extent of child abuse linked to a belief in 'spirit possession' and 'djinns' in the United Kingdom.

Eleanor has also undertaken research on domestic abuse for Community Safety Partnerships and conducted audits and practice reviews for Local Safeguarding Children Boards. She has chaired and authored over 18 serious case reviews/domestic homicide reviews. Eleanor has a Master of Business and Administration (MBA) from Bradford University School of Management (2000) and a Master of Laws (LLM) in Child Law from Northumbria University (2011).

Prior to her work as an independent consultant, Eleanor managed services within the NHS caring for people with life limiting illnesses. She has extensive experience of working with bereaved families.

Eleanor is independent of, and has no connection with, any agency in Nottinghamshire; she has never been employed by any agency in Nottinghamshire.

2.5 Terms of reference

This overview report sought to address both the 'generic issues' set out on pages 31&32 of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- What knowledge or information did your agency have that indicated Stacey might be at risk of abuse, harm or domestic violence and how did your agency seek to protect her?
- If your agency had information that indicated that Stacey might be at risk of abuse, harm or domestic violence was this information shared? If so, with which agencies or professionals, and when?
- In what way did your agency's knowledge of Stacey's history of retracting allegations influence professionals' decision making?
- What knowledge or information did your agency have that indicated the perpetrator was violent, abusive or might cause harm to someone? How did your agency mitigate the risk he posed? And was this adequate?
- If your agency had information that indicated that the perpetrator was violent, abusive or might cause harm to someone, was this information shared? If so, with which agencies or professionals, and when?
- Identify any lessons learnt and implemented during the review process.

2.6 Specific issues for agencies

NOTTINGHAMSHIRE POLICE

To provide information that focusses on events from April 2011 and includes all interactions with the following departments/units:

- Dangerous Persons Management Unit – what was the Unit's role and how often was the perpetrator seen and reviewed? How did the Unit obtain information about the risk he posed to women and children; and how was this subsequently fed into other agencies? [This information should be reviewed from 2008 until the time of Stacey's death].
- Domestic Abuse Support Unit – set out the role of the Unit, detail each interaction with Stacey from April 2011 and explain clearly how she was supported and protected.

- The police information report should explain how the Dangerous Persons Management Unit and the Domestic Abuse Support Unit shared information about the risk that the perpetrator posed to women and children; and how this information was fed back to the professionals working to support Stacey.

- The information report should outline the role of the Violent and Sex Offender Register (ViSOR) and the Multi-Agency Public Protection Arrangements (MAPPA). It should clearly set out the links between these two processes and the Multi-Agency Risk Assessment Conference (MARAC).

CHILDREN'S SOCIAL CARE

To provide details of all meetings and interactions with Stacey, her daughter and the perpetrator from April 2011. The information report should also include any information around the period when (according to Stacey's family) the perpetrator attended parenting classes (February/March 2011) and the rationale for undertaking this work. The report should outline what information children's social care had concerning the risk the perpetrator posed to women and children (2008 onwards), and which agencies provided this information (and when).

NATIONAL PROBATION SERVICE

The information report should outline the role of the Multi-Agency Public Protection Arrangements (MAPPA). It should explore the rationale as to why the perpetrator was assessed as at MAPPA level 1, set out the frequency of any MAPPA reassessments and the information used to form the basis of those re-assessments. It should clearly set out the links between MAPPA and other processes including the Violent and Sex Offender Register (ViSOR) and the Multi-Agency Risk Assessment Conference (MARAC).

CROWN PROSECUTION SERVICE

The information report should review each interaction with Stacey or the agencies supporting her from April 2011. It should include the rationale behind any actions taken; include all information about protecting Stacey and encouraging her to engage with the court process; and how the risk that the perpetrator posed was mitigated. The report should also outline whether practice has changed since the time of Stacey's death.

2.7 Parallel reviews

At the time that the domestic homicide review was resumed, there were no other parallel reviews taking place. Both the Independent Police Complaints Commission and Nottinghamshire Police Standards Directorate had previously undertaken a review of aspects of the police involvement in this case. Any relevant information from these investigations has been included within this review as appropriate.

2.8 Equality and diversity

All the family members are of white British origin. All aspects of equality and diversity were considered throughout the review including age, race, gender, disability and religion. To ensure the review process considered issues around domestic violence and abuse there was a representative from Women's Aid on the panel.

2.9 Dissemination

In addition to the organisations contributing to this review (listed in 2.2), the following will receive copies of this report for learning within their organisations.

- South Nottinghamshire Community Safety Partnership
- Nottinghamshire Health and Wellbeing Board
- Nottinghamshire Police and Crime Commissioner
- Nottinghamshire Scrutiny Panel for Violence Against Women and Girls
- Nottinghamshire Safeguarding Adult Board
- Nottinghamshire Safeguarding Children Board
- Nottinghamshire Domestic Homicide Review Assurance and Learning Group

3 THE THOUGHTS AND VIEWS OF STACEY'S FAMILY

Stacey was born in Nottingham in 1987 and was the eldest of four siblings. She was always happy, funny, joking and playing tricks, and her mother described her as the "*out-going*" one of the family. As she was the second eldest of the children, when she was younger she viewed herself as the "*boss*" – often acting as a "*little mum*" to her younger siblings. Although Stacey was out-going, she was also vulnerable. As a child, she had delayed speech development which still affected her as an adult. It meant she struggled to articulate certain words, which made her lack confidence. She had also been diagnosed with severe dyslexia and she had a reading age of a 12-year-old throughout her adult life. Her father and stepmother explained that she needed information or letters written on coloured paper to make it easier for her to read.

Stacey was described as "*beautiful with a heart of gold*" and a "*great friend*". In 2006, when Stacey was 19 years old, her only daughter was born. She loved and doted on her – her daughter was everything to her. Then, in the summer of 2008, she met the perpetrator who "*swept her off her feet and then made her fully dependant on him*". Both Stacey's parents described how the perpetrator could come across as charming, very friendly and jokey. Her mother described how he appeared "*family-orientated*" and would put Stacey's daughter on his shoulders and play with her. When Stacey first met the perpetrator, she had lots of friends but her mother felt that over time he "*took them away from her*". Her father

described how the perpetrator introduced Stacey to his friends, who then "*kept an eye on her*" and reminded her that she was the perpetrator's "*girl*".

Stacey's mother said that she had been completely "*taken in*" by the perpetrator. It never occurred to her that he was abusive towards Stacey. She knew that he had once "*smashed the house up*" but for quite some time she did not know of his history of violence against women and children.

Stacey's father did not like the perpetrator. He knew he was abusive and refused to have him visit. Stacey's father said he always knew when the perpetrator was back in Stacey's life, as he would not see Stacey or her daughter. He thought this was because the perpetrator prevented her from visiting. Stacey's father explained that the perpetrator frequently made threats to kill him, saying he would cut the brake leads on his motorbike.

A couple of weeks before she died, Stacey, her daughter, her mother and grandfather went to the seaside for a holiday. It was clearly a very happy time and Stacey's mother had a lovely photo of Stacey building a sand castle. Stacey was happy at this time, as in her mind her relationship with the perpetrator was over and she was beginning a new life. She had a new boyfriend, a place of her own and things were looking up.

4 THE FACTS

In October 2011, an ambulance was called to attend to the perpetrator who had been stabbed in the face. Police officers arrived shortly afterwards and found the perpetrator with blood over his face, hands, arms and clothing. He was described by officers as verbally aggressive and obnoxious. He appeared to be heavily intoxicated and at first, he refused to have treatment for his injuries. After some persuasion, the perpetrator agreed to be treated by the paramedics in the ambulance. At this point, an acquaintance told police that the perpetrator's injuries were caused by his ex-partner. The acquaintance claimed he did not know her name but one of the officers knew Stacey. Officers searched the local area but could not identify where the incident took place.

The officers were then called to another incident. On returning to the police station their priority was to discover how the perpetrator had been injured and to locate Stacey. Stacey's address was not on the system; but after making several calls, they received information that she was living near to her mother's address in a suburb east of Nottingham. The officers made door-to-door enquiries and ultimately found a house where the lights were on but no one answered the door. The officers rang the mobile number they had for Stacey and heard it ring in the house.

On entering the house, the officers found Stacey's body. She had sustained multiple stab wounds. The perpetrator was arrested and subsequently charged with her murder. In June 2012, he was sentenced to a minimum of 22 years' imprisonment.

5 BACKGROUND AND SUMMARY OF EVENTS

Some of the background information in this section may not have been available to professionals at the time that the perpetrator and Stacey were accessing services.

The perpetrator was born in Scotland in 1963. By the age of 13 he had convictions for crimes such as theft, theft by house breaking and fire-raising. In 1985, he was convicted of assault and sentenced to 18 months imprisonment for knocking a man to the ground, then kicking and stamping on his body and face until he rendered him unconscious. From the age of 21 years (1984 – 1993) he lived with a partner with whom he had two children. From the beginning, the relationship was violent, he made numerous threats to kill and he would frequently carry out extremely violent unprovoked attacks on her. The violence was often spontaneous and on many occasions, he strangled her to the point where she passed out. She described to the police how he had total control over her by using fear and isolation.

In 1991, the perpetrator was charged with the rape of a 16-year-old girl. It was allegedly a particularly violent and humiliating assault involving anal and vaginal sex. He also allegedly inserted an implement into her and held a lighted cigarette to her breast. The case was dropped because the victim was too afraid to testify.

In 1993, the perpetrator (30 years) was charged with the murder of a 64-year-old woman. She had been assaulted, strangled and her house set on fire. Despite witnesses placing the perpetrator at the scene with heavily blood-stained clothing, the case was found 'not proven'. The perpetrator fled to England following the court case as there were threats made against him after the trial.

Nottinghamshire Police records from September 1994 detailed an incident when the perpetrator entered an ex-girlfriend's house in the early hours of the morning through a window. Once in the kitchen he armed himself with a carving fork. He was found in the house by the police and arrested. Whilst being arrested, he assaulted an officer.[2]

Between 1995 and 2008 the perpetrator lived in a suburb east of Nottingham with another partner with whom he had two children. Again, his partner was subjected to sustained domestic abuse. There were numerous incidents of assaults and threats until 1999. At this time, the perpetrator was convicted of the rape of a 22-year-old woman (neighbour) at knifepoint while her child was in the house. The perpetrator was sentenced to nine years' imprisonment. He was released early (having served 4 years and 8 months) in 2004 by the Parole Board against the recommendation of the probation reports which assessed him as posing a high risk to women (he was still denying the offence). His partner kept in touch with him whilst he was in prison and on release, they resumed their relationship and the domestic abuse recommenced.

As a result of his conviction for rape, the perpetrator is a Registered Sex Offender. As he was sentenced to more than 30 months in prison, he will remain a Registered Sex Offender for

[2] There were no further details about this incident and no relevant conviction appears on the Police National Computer (PNC)

the rest of his life.[3] On release, he was managed at MAPPA (multi-agency public protection arrangement) level 1[4] by the Probation Service until 2008 when Nottinghamshire Police Dangerous Persons Management Unit assumed his management.

In May 2008, his ex-partner (high risk) and their two children moved away following a period of extremely abusive behaviour. The perpetrator was issued with an harassment warning to refrain from contacting her.

On 7 June 2008, the perpetrator's Violent and Sexual Offender Register (ViSOR) records stated that he had been visited at home and talked openly about the recent domestic incident involving his previous partner. He said that the relationship had deteriorated and his previous partner had left the area with their children. He spoke about his violent past and the serious problems that can result and said that he had moved on to a "*more philosophical approach to life*". A new risk assessment was completed using the Thornton's 2000 Risk Matrix [5] and he was assessed as medium risk.

Stacey met the perpetrator in mid-2008 and they started a relationship. At the time, he was 45 years old and she was 21. On 15 August 2008, Stacey's family support worker (health) visited Stacey and her daughter (2 years) at the perpetrator's address. Stacey described the perpetrator as her new boyfriend. A register check was undertaken which revealed his violent past including the two rapes, his history of domestic abuse and the fact that he was on the Violent and Sexual Offender Register (ViSOR). Stacey's health visitor made a referral to children's social care. Children's social care checked the details with the police Dangerous Persons Management Unit and discovered that the perpetrator had raped an adult (a neighbour) with her child in the property, had an 'unproven' complaint of rape against a 16-year-old girl (who "*did not feel able to pursue the complaint*"), was "*linked*" to the murder of a 64-year-old woman and was involved in violent crime. Despite describing the perpetrator as compliant and sharing information freely, the Unit was unaware of his relationship with Stacey. There was no record on the Violent and Sexual Offender Register (ViSOR) of any visit or risk assessment being made in relation to this information.

August 2008 incident one – assault

On 23 August 2008 at about 2am, a 999 call was received from a passing motorist who had found Stacey in the street in a distressed state. She told him that her boyfriend had "*kicked*

[3] The perpetrator is required to notify the police within 3 days of any release from custody, change of address, or change of circumstance

[4] There are three levels of MAPPA management. They are mainly based upon the level of multi-agency co-operation required with higher risk cases tending to be managed at the higher levels. Offenders will be moved up and down levels as appropriate. MAPPA Level 1 is for offenders who can be managed by one or two agencies (e.g. police and/or probation). It involves sharing information about the offender with other agencies if necessary and appropriate – for further information see www.mappa.justice.gov.uk – accessed online 13 November 2017

[5] Thornton's 2000 risk matrix is a risk assessment tool for men aged 18 and over with at least one conviction for a sexual offence. It is used by prisons, the police and probation in England and Wales. It predicts the likelihood of reconviction for a sexual or violent offence – for further information see www.mappa.justice.gov.uk – accessed online 13 November 2017

the shit out of her". The caller took her home so the police could visit her there. Officers went to the house but found it in darkness and decided that she should be visited in the morning.

Just after 4am that morning, the perpetrator called the police stating that he had been punched in the face by his girlfriend. He said that Stacey had gone to stay at a nearby address. This incident was graded as 'urgent' and officers went to Stacey's home at about 5am. She explained that the perpetrator had pushed her to the floor, kicked her and then walked off. She later returned to "*make-up*" and he again pushed her to the floor and kicked her. She said that because of this attack on her, she had hit him in the face and may have broken his nose. The officers noted injuries to her hands and arrested her for assault on the perpetrator. When cautioned she said "*Yeh, I hit him to the nose and bit him on the shoulder because he was strangling me*".

On 5 September 2008, Stacey's health visitor received a letter from children's social care which stated that the earlier referral (15 August) was being closed on the grounds that the perpetrator was being supervised by the police Dangerous Persons Management Unit and the Unit had informed children's social care that the perpetrator always complied with the order. Furthermore, as his offence was against an adult, there was "*no indication that he posed a risk to children*".

On 16 September 2008, the perpetrator withdrew his complaint about Stacey. There was no record of this incident on the Violent and Sexual Offender Register (ViSOR), so it is not known if his case manager was notified. At this time, it was unclear what Stacey knew about the perpetrator's history of violence against women and girls. No agency appeared to have documented providing her with this information.

In December 2008, the perpetrator was visited at home by officers from the Dangerous Persons Management Unit. They appeared to be unaware of the domestic incident involving Stacey. The perpetrator was re-assessed (Thornton's 2000 risk matrix) as medium risk. He told officers that Stacey did not know about his sexual offence but if his relationship became serious, he would tell her.

February 2009 incident two – threats

On 14 February 2009 at 23:20pm, Stacey called the police to report an incident. She said that she had visited the perpetrator's house in a suburb east of Nottingham with the police to collect some belongings for her and her baby but he would not answer the door. So, she rang him and he made threats that he would come down to her grandfather's house where she was staying. The incident was graded as urgent and officers visited Stacey just after midnight and advised her against calling the perpetrator so late. She was told to call in the morning if she required further assistance from the police. The risk in this incident was assessed as 'high' and a referral was made to children's social care. The case was allocated to a social worker to undertake an initial assessment. However, as it was "*understood that*

Stacey and [*the* perpetrator] had *separated*", an assessment was not undertaken and the case was closed.

The Domestic Abuse Support Unit (DASU) made contact with Stacey and discussed safety issues. She told the police that she was very frightened of the perpetrator, he was very controlling and isolated her from her family. Stacey was also referred to Victim Support as a victim of harassment. Victim Support requested consent to contact Stacey but the officer never replied.[6]

On 16 February 2009, police received a 999 call because Stacey's uncle had been chased down the road by the perpetrator. He was armed with a carving knife and said words to the effect of "*You've ruined my life*". The call was graded 'immediate' and the perpetrator was arrested. He denied the offence and was released on the advice of the Crown Prosecution Service (CPS). It was clearly a domestic incident and although it was not directed at Stacey, it was as a direct result of her relationship with the perpetrator. The fact that the perpetrator was arrested for affray armed with a knife was recorded on the Violent and Sexual Offender Register (ViSOR). He was not, however, seen by his manager and no risk assessment or management plan was recorded following what was clearly a violent incident.

February 2009 incident three –third party report

On 18 February 2009, Stacey's father went to Clifton Police Station to report a series of on-going domestic incidents between Stacey and the perpetrator. He told the police that the last incident had happened on 21 December 2008 when the perpetrator had put his hands around Stacey's throat to the point that she had passed out, "*wee'd herself and once she came around her eyes showed haemorrhaging*". Stacey was seen by officers and confirmed that she had been assaulted several times but had not reported these to the police. She was uncertain whether she wanted to make a formal statement but wanted advice. She was already considered a high-risk victim of domestic abuse. She was described as "*upset and frightened*" at the prospect of being found by the perpetrator. She was also worried about her family's welfare and was "*very confused*". The perpetrator had made threats to kill her if she left him. Officers told her about the perpetrator's history and that he had been convicted of raping a neighbour. Stacey was referred to Women's Aid, given a handheld alarm and her home was also fitted with an alarm. The independent domestic violence advisor (IDVA) talked with Stacey about housing, welfare benefits, civil remedies and criminal proceedings. Stacey did not want to support the prosecution because "*it would make things worse*". She asked for time to think about what to do next but when the independent domestic violence advisor (IDVA) called her back a few days later, the phone continually went to answerphone.

[6] At this time, Victim Support was unable to offer support unless they were given explicit consent by the police officer who attended the incident. In 2010, it was agreed that if an officer did not respond, Victim Support would escalate the case to a senior officer.

The Domestic Abuse Support Unit (DASU) contacted Stacey on 20 February 2009 but she stated that she did not wish to make a statement in relation to historical domestic abuse.

March 2009 – multi-agency risk assessment conference

On 5 March 2009, a multi-agency risk assessment conference (MARAC)[7] was held and information was shared between the Dangerous Persons Management Unit, Primary Care Trust, Women's Aid, probation, children's social care and education welfare. An officer from the Dangerous Persons Management Unit was present and stated that the perpetrator said the relationship was "*only for his pleasure*" and he did not "*consider it a serious relationship*". The officer stated that there were violent offences linked to the perpetrator in Scotland but "*these were not substantiated*". It appeared to those at the meeting that Stacey was safe living with her father and so the focus was on the safety of the perpetrator's other children and "*stabilising*" the perpetrator and Stacey's separation. Little attention was given to the serious assaults that Stacey had reported. There were already allegations of criminal damage by the perpetrator against other family members and if his full criminal history had been known there might have been more concern about the safety of all those involved. The conference made a number of recommendations including (amongst other things) that the Domestic Abuse Support Unit (DASU) should liaise with the Dangerous Persons Management Unit to ensure that the perpetrator's offender manager was aware of the domestic abuse; that children's social care should arrange an initial assessment, and check the whereabouts of the perpetrator's children in order to assess whether they were at risk of harm; and that the health visitor should continue regular visits to "*reduce risk of domestic violence*". The multi-agency risk assessment conference (MARAC) records contained feedback on each action with dates. All actions were completed on time and fed back to MARAC except those of Nottingham City Children's Social Care. Furthermore, it appeared that the City Children's Social Care did not pass any information to Gedling Children's Social Care.

On 23 March 2009, Stacey's sister contacted the Domestic Abuse Support Unit (DASU) about her concerns that Stacey had "*gone back*" to the perpetrator and he was controlling her. Her sister was concerned because Stacey had "*lost*" her phone and was only able to speak to her family using the perpetrator's phone. The following day, Stacey's mother also raised concerns with the police about Stacey returning to the perpetrator. Inappropriately, her mother was advised that Stacey was "*an adult and had a right to make her own choices*" and if they had any further concerns they should contact the police via an emergency call.

[7] This is a multi-agency risk assessment conference at which local agencies meet to discuss confidentially high-risk victims of domestic abuse. The aim is to identify what safety measures and support mechanisms could be put in place for Stacey and her family. MARAC was introduced in Nottinghamshire in October 2008.

March 2009 incident four – threats to kill and assault

On 28 March 2009 police received a '999' call from Stacey reporting that the perpetrator had threatened to kill her and her daughter with a gun that he had hidden under the bed. During the incident, the perpetrator punched her three times whilst she had been holding her daughter (2 years and 8 months). This not only caused a cut to Stacey's face but meant that Stacey's head had banged against her daughter's face.

Stacey was taken to hospital by the police and treated for a large cut below her right eye. The perpetrator was arrested but made 'no comment' during interviews. He was charged with actual bodily harm (ABH), assault, criminal damage, false imprisonment and threats to kill.

The Crown Prosecution Service (CPS) files stated that Stacey made an initial statement and was "*scared that he will try to find me and threaten me with violence to retract my allegation*". It also stated that when the perpetrator was arrested he said "*Tell her it is not over I will shoot the cow*". In a further statement to the Crown Prosecution Service (CPS) she said "*I was scared, upset, terrified of him killing me*".

The perpetrator was remanded into custody. Stacey was again assessed as at high risk of serious harm and the police completed a safeguarding children form. Children's social care commenced an s.47 enquiry[8] but again the case was closed. On this occasion, because Stacey's daughter had gone to live with her birth father in a different area (although she still came back to stay with Stacey at weekends).

April 2009 – multi-agency risk assessment conference

Stacey's case was heard again at the multi-agency risk assessment conference (MARAC) on 9 April 2009. Information was shared by police, Women's Aid, probation, children's social care and the health visitor. Records showed that the police were now aware of the perpetrator's history of violence against his previous partner. However, as Stacey's daughter was living with her birth father, the focus was on how to support Stacey to give evidence in court or to assist the Crown Prosecution Service (CPS) to prosecute without Stacey's evidence.

The same day the Crown Prosecution Service (CPS) received a statement from Stacey saying she wished to retract her statement. She did not feel she could cope with going to court. The multi-agency risk assessment conference (MARAC) records stated that it was clear to partner agencies that Stacey retracted her statements "*through fear of* [*the perpetrator*]".

During this period, Stacey's daughter continued to live with her birth father but Stacey had weekend contact. In mid-April Stacey's daughter disclosed to her birth father that Stacey had hit her on her legs causing bruising. Then towards the end of May 2009, the daughter's birth father failed to collect her stating that he did not feel able to cope with her living with

[8] Under Section 47 of the Children Act 1989, if there are reasonable grounds to suspect that a child is suffering or is likely to suffer significant harm, a Section 47 Enquiry is initiated. This is to enable the local authority to decide whether they need to take any further action to safeguard and promote the child's welfare

him permanently. Thus, Stacey's daughter (2 years and 10 months) remained with Stacey at her maternal grandparents' home.

Following the perpetrator's release on 3 June 2009, the Violent and Sexual Offender Register (ViSOR) log showed that the perpetrator was visited at home. He told officers from the Dangerous Persons Management Unit that he had given up drinking "*as it seemed to be the cause of his problems*". The officers were aware that he was on bail pending a court appearance on charges of assault and criminal damage. He was assessed (Thornton's 2000 risk matrix) as medium risk.

In mid-June, Stacey accepted a property further away from her family in a former mining village and she moved in at the beginning of July.

July 2009 – trial

Stacey attended the perpetrator's trial and told counsel that she had lied in all her previous statements. She made a statement saying that the allegations had been made in revenge and through jealousy. She said she had hit herself in the face with her mobile phone breaking it. Therefore, no evidence was offered. The judge stated "*we have been outmanoeuvred by Miss* [*Stacey*]". The perpetrator was found not guilty.

On 16 July 2009, the perpetrator went to the police station to inform them of a change of address. He remained living in the suburb east of Nottingham but at a different address. During this period, there were three calls to police from the perpetrator's previous partner. First, the perpetrator had been released to a property that she was trying to sell. Second, he had removed property from that address and third, he threatened to set the house alight. On each occasion, she was informed that these were civil matters (despite their history of domestic abuse and the harassment warning).

Stacey was spoken to by police on 9 September 2009 and was "*safe and well*". She reported that she had not had recent contact with the perpetrator. She said that she had "*exaggerated the incident as she believed it would help her but her conscience got the better of her and she then gave the court a correct account*". On 15 September 2009, children's social care received a call from the police because Stacey had resumed her relationship with the perpetrator.

On 9 December 2009, the perpetrator was visited at home by the Dangerous Persons Management Unit. He told the officer that he was relieved that he was found not guilty (even though he maintained his innocence). He said that he had resumed his relationship with Stacey but was not going to move back in with her. He said he accepted that he had a drink problem and claimed that he had not had any alcohol for six months.

December 2009 incident five – assault

Just after midnight on 30 December 2009, an abandoned '999' call was received from a mobile phone (the perpetrator's). It was graded as urgent due to the fact that the sound of arguing was heard in the background. Shortly afterwards, a further '999' call was received from a different mobile (Stacey's) with the sound of a young child crying down the line. An urgent subscriber check showed that the first call came from a phone registered to the perpetrator. The control room staff made contact with the mobile and spoke to a man with a Scottish accent who refused to identify himself or say where he was. Another call came from a mobile (Stacey's) in which a person could be heard crying and then the call ended. Repeated attempts were made to contact this number and at 12:39 am control room staff spoke to Stacey. She said that she was okay and that her daughter (3 years and 5 months) had been playing with a mobile phone. She was told that officers would still visit her house in the former mining village. Officers arrived at 1:17 am to find that Stacey had been assaulted and that the perpetrator was hiding under a bed (he was not drunk). The perpetrator was arrested as he attempted to escape from the address.

Stacey made a statement about her relationship with the perpetrator. She told police that they had been reconciled for about three months following the March incident. In relation to the incident that night, Stacey said that they had been arguing. During the argument, she made reference to the fact that the perpetrator had been convicted of rape. At this point he grabbed her face and pushed her back. She ran behind the settee and the perpetrator said that he would stab himself and make it look like she had done it. The argument continued and Stacey stumbled back onto the settee, the perpetrator got on top of her and placed his hands around her throat for 20 to 30 seconds. He let her go and she ran to the bed room and made the silent call to the police.

The incident was recorded as actual bodily harm (ABH). Stacey was assessed as being at high risk of harm and referrals were made to Women's Aid and children's social care. Children's social care passed the case to a 'domestic violence worker' to undertake safety work but it was not allocated to a social worker for assessment.

During interviews, the perpetrator denied touching Stacey. Despite this, he was charged with common assault and bailed with conditions not to contact her or go within 75 metres of her property (in the former mining village). Stacey was provided with support from Women's Aid.

On 1 February 2010, the health visitor called children's social care for an update as she had been told by the social worker not to visit Stacey because of the risk of violence. She had not therefore seen Stacey or her daughter since September 2009.[9]

[9] Children's social care has no record of the health visitor being told not to visit, although the health records stated "*HV advised not to visit as* [perpetrator] *is known to be violent*". This was dated 4 September 2009. Children's social care suggested that there may have been a discussion about the potential risks when visiting and the health visitor interpreted this as being told not to visit, rather than the need for health visitors to manage the risk.

Stacey was seen by an officer from the Domestic Abuse Support Unit (DASU) on 11 March 2010. Power and control issues were discussed and the risk factors associated with her relationship with the perpetrator. Despite this, she made a statement saying she wished to withdraw her support for this prosecution. She said that she was petrified of attending court and 'special measures' in court would not help. She ceased to engage with Women's Aid. The Crown Prosecution Service (CPS) ultimately discontinued the case. The perpetrator was found not guilty of actual bodily harm (ABH) "*due to discontinuance*".

On 7 June 2010, the perpetrator went to the police station to notify the police of his change of address to Stacey's address in the former mining village.

The perpetrator was seen by officers from the Dangerous Persons Management Unit on 24 June 2010. He said he was now employed by a concrete manufacturer and was working long hours. His risk management plan remained the same as "*there was nothing to indicate that the risk presented by this individual has increased since his last review*". The perpetrator now maintained that (rather than being abstinent) he had cut down his drinking.

September 2010 incident six – assault

At around midnight on 19 September 2010, a 999 call was received from Stacey's sister stating that Stacey had been assaulted by the perpetrator. Shortly afterwards, the control room staff spoke to Stacey by phone. She told them that the perpetrator had smashed her face against the wall and that she had injuries. She was in a bedroom with her daughter (4 years and 2 months) and she thought that he may still be in the house. At quarter past midnight, officers arrived at her property in the former mining village and the perpetrator was arrested. Stacey told police that the perpetrator had been "*running around with a knife and had pushed her face into a wall*".

Later that morning officers contacted Stacey but she refused to make a statement. She told officers that she had an argument with her sister on the phone and at no time did she have a fight with the perpetrator. She had no injuries. The incident was recorded as domestic abuse, the perpetrator was interviewed but he made 'no comment' throughout. He was released without charge. Stacey was assessed as at high risk of harm.

On 16 October 2010, an officer from the Domestic Abuse Support Unit (DASU) spoke to Stacey to explain that she was at high risk of domestic abuse. Records stated that "*she refused to admit that she suffered from domestic violence and stated that she did not want any contact with police*". Police made a referral to children's social care. The case was allocated to the 'Outcomes UK Team" (agency workers) and a s.47 investigation was commenced. Stacey's daughter was considered to be at high risk of suffering harm whilst in Stacey's care. Police also made a referral to the multi-agency risk assessment conference (MARAC).

November 2010 – multi-agency risk assessment conference

The case was discussed at the multi-agency risk assessment conference (MARAC) on 4 November 2010. Information was shared between police, probation, children's social care, education welfare and the health visitor. The discussion concluded that both Stacey and the perpetrator were "*heavy drinkers and most of the domestic violence was set in this context*". They were living together with Stacey's daughter (4 years and 4 months) in Stacey's house in the former mining village. The focus of the meeting was to try to keep Stacey and her daughter "*together and safe, and supporting the actions of children's social care in this regard*".

The outcome of the meeting was that the Dangerous Persons Management Unit was asked to review any possible offences; Women's Aid tried to contact Stacey and when contact was finally made on 11 December, Stacey declined support – her case was therefore closed to the independent domestic violence advisor (IDVA) service; children's social care clarified that Stacey had signed an agreement on 28 October 2010 that stipulated that the perpetrator had to leave the family home that day and he was not to have contact with Stacey's daughter while the s.47 investigation took place. Stacey also agreed to report any future incidents of domestic abuse. The agreement clearly stated that if Stacey did not adhere to the terms, the local authority would seek legal advice with a view to removing Stacey's daughter from her care.

November 2010 – initial child protection conference

An Initial Child Protection Conference (ICPC) was held on 17 November 2010. The meeting was not attended by the police or school. Thus, apart from the Chair and minute taker, the only attendees were a team manager from children's social care, a health visitor and Stacey. A decision was taken that Stacey's daughter should be made subject to a Child Protection Plan under the categories of emotional, physical and sexual harm. Stacey and her daughter were allocated a key social worker.

The aim of the child protection plan was to ensure that Stacey's daughter was safely cared for by her mother whilst the risks posed by the perpetrator were assessed fully.

1. Social worker to see Stacey's daughter weekly. Visits to be announced and unannounced.

2. Social worker to clarify the relevant convictions in relation to the perpetrator and Stacey

3. Social worker to contact the police to establish all reports of domestic abuse between the perpetrator and Stacey

4. Social worker to compile a chronology of events and interventions to include information from health, children's social care and police

5. Health visitor to see Stacey's daughter a minimum of three monthly to check her growth and development

6. Stacey's daughter to continue to attend infant and nursery school

7. Stacey to engage with Women's Aid to address the domestic violence in her relationship

8. An assessment to be undertaken by the social worker and the specialist family support worker with the perpetrator and Stacey to include:

    - Their relationship
    - Previous and childhood history
    - Understanding of domestic violence and the impact on children
    - Support networks
    - Understanding of children's needs and ability to meet those needs
    - Resilience and protective factors with the family

A core group would consist of the social worker, specialist family support service, school, health visitor, the Dangerous Persons Management Unit and Stacey. The first core group meeting was booked to take place on 24 November 2010. Further core group meetings would be at least six-weekly.

On 10 December 2010, the perpetrator went to the police station to notify a change of address to a property in a suburb east of Nottingham. Then on 14 December, the social worker met with the perpetrator at Stacey's home because he did not "*want visits done at the home of the friends he is staying with*". He said he did not want to attend an anger management programme as he had done one before and knew his "*trigger was alcohol and he had been controlling it better over the last 12 months*".

A core group meeting was held on 16 December 2010 between the social worker, Stacey, the health visitor and the daughter's class teacher.

On 18 December 2010, Stacey was referred to Victim Support. She had been woken up by bricks being thrown at her lounge and kitchen windows. She had been too scared to look to see who it was. Stacey declined any support from Victim Support. The police did not flag it as a domestic abuse incident. Stacey "*was adamant that it was not* [*the perpetrator*]".

On 22 December 2010, the perpetrator was assessed by the Dangerous Persons Management Unit using the Thornton's 2000 risk matrix; he remained medium risk. He told officers that he was not able to see Stacey when her daughter was present. He also confirmed that he was still drinking but "*had cut down and that incidents between him and Stacey were drink related*".

Dangerous Persons Management Unit informed children's social care (13 January 2011) that the perpetrator could be violent with alcohol, but they did not consider him to be a direct risk to children (this information overlooked the previous assault involving Stacey's

daughter; the perpetrator's past offence of raping a neighbour at knifepoint whilst her child was present in the property, and the (alleged) rape of a 16-year-old child).

On 14 January 2011, children's social care arranged a home visit to ascertain further information for the parenting assessment. Thus, when Stacey's daughter came home from school, the social worker stayed to supervise the contact between her and the perpetrator for a short period.

January 2011 – review child protection conference

The review conference on 17 January 2011 was attended by the social worker, two officers from the Dangerous Persons Management Unit and a teacher.

The social worker explained that she had undertaken two sessions with the family and it had become apparent that the perpetrator was staying with Stacey's relatives. The perpetrator was not "*keen*" to attend sessions on anger management or domestic violence as he had done these and recognised the "*triggers*" – also he worked long hours and weekends and it would not be easy for him to attend. They were described as both wishing to "*resume their relationship*" and had been out a couple of times while Stacey's daughter was being looked after by family members.

The officer from the Dangerous Persons Management Unit asked Stacey whether she knew about the perpetrator's offending history. Stacey said that the perpetrator had told her that it was not rape but consensual sexual intercourse and that the woman had made it up. The social worker noted that the perpetrator was capable of violence but that there was no evidence of domestic violence in his previous relationships (there was not wider discussion about the perpetrator's history of domestic abuse or the fact that he was estranged from his own children from previous relationships).

The outcome was that although Stacey was doing a good job of parenting her daughter, there were still concerns about domestic abuse and concerns that she had not "*shared the child protection concerns with her immediate family*". It was decided that her daughter should remain on the plan for emotional and physical abuse. There would be no further involvement from the police, but Stacey would contact the Domestic Abuse Support Unit (DASU) if she needed further advice. Stacey was again asked to make contact with Women's Aid by the end of the week for further support. The social worker would continue to see Stacey's daughter at least every two weeks. If the perpetrator returned to live with Stacey before the assessment was complete or if there were any further incidents of domestic abuse, children's social care would consider whether legal advice should be sought i.e. it may not be safe for her daughter to remain in her care.

On 1 February 2011, children's social care commenced the parenting assessment. Both the perpetrator and Stacey were present. The process and dates of the assessments were explained to them. Each session was to run from 10am to 3pm. In all Stacey had four sessions planned with the social worker and the senior family worker; the perpetrator had three planned sessions. All the sessions were to take place at the "*family home*".

PLAN FOR STACEY		
DATE	SESSION	PLAN FOR DISCUSSION
1 February 2011	Introductory session	Both Stacey and the perpetrator present
21 March 2011	Session One Social worker cancelled due to other work commitments – session continued with the family worker	This session was to outline the support available to Stacey which could have prevented the violence within the home To explore domestic abuse and Stacey's relationship with the perpetrator
29 March 2011	Session Two	Ensuring safety for Stacey around domestic abuse and for her daughter concerning all facets of child abuse. The session included stability i.e. school, relationships and home for her daughter
7 April 2011	Session Three	Emotional warmth, guidance and boundaries
11 April 2011	This session was cancelled because of a domestic incident	

PLAN FOR THE PERPETRATOR		
1 February 2011	Introductory session	Both the perpetrator and Stacey were present
21 February 2011	Session One	Support available to the perpetrator which may stop the violence within the home Historical information and childhood history Criminal history
8 March 2011	Session Two	Relationships including historical information about domestic abuse (between the perpetrator and Stacey) Ensuring safety of Stacey and her daughter
15 March 2011	Session Three	Stability – the perpetrator's role within the household Guidance, boundaries and emotional warmth

Although the sessions reviewed the couple's relationship and included domestic abuse, the main focus was on skills based parenting. On 17 February, during a home visit by the social worker Stacey asked whether she could continue to see the perpetrator, if her daughter was elsewhere. This was agreed on the ground that the concerns were around the perpetrator and Stacey.

On 1 March 2011, a core group meeting was held. Present were Stacey, the social worker and head teacher. Stacey asked if the perpetrator could attend the parents' evening and this

was agreed. Stacey also said that she had told her mother about children's social care involvement.

On 7 April 2011, the social worker visited Stacey at home to go through the parenting assessment. Her daughter was seen and described as "fine", she was very chatty and relaxed. Stacey's daughter told the social worker that Stacey had put a television on her bedroom wall and how she was looking forward to seeing her birth father at the weekend. Stacey said she would be spending time with the perpetrator at the weekend as her daughter was away.

6 OVERVIEW OF INTERVENTION APRIL – OCTOBER 2011

April 2011 incident seven – assault

In the early hours of the morning on 9 April 2011, police received a 999 call from Stacey at her home in the former mining village. She said that the perpetrator had beaten her up, smashed the house up, pulled a television off the wall and hurt her dog. She also said that he tried to strangle her and her teeth were loose.

The call was graded as 'immediate' and officers arrived 30 minutes later. A neighbour informed the police that the perpetrator had run away from the house and a police dog found him hiding in a nearby garden. On being confronted, he became extremely violent and was forcibly detained. During this he received a cut to his mouth and spat blood at the officers and on arrest he said of Stacey "*I'll fucking kill you*".

The incident was recorded as domestic abuse and an assault on a police officer. Stacey provided a detailed witness statement. She stated they had been out and had a considerable amount to drink and the perpetrator was also taking drugs. When they returned home, they argued about his drug taking and the perpetrator punched and kicked her. He then "*strangled her by putting both of his hand around her throat***"**. He was interviewed but denied the assault stating that Stacey had fought with another girl. He was charged with assault and remanded in custody.

A Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment was completed. Although Stacey refused to answer any questions, she was assessed as being at high risk of harm. A referral was sent by the police to Victim Support. Victim Support staff emailed (11 and 21 April) the officer in the case to seek consent to contact Stacey but there was no response. The case was closed shortly after the email had been sent to the officer in the case on 21 April 2011.

On 11 April 2011, Stacey contacted the social worker and explained what had happened. The social worker liaised with the senior family worker and the planned assessment was cancelled. Stacey stated that she did not want to be in a relationship with the perpetrator as he was too unpredictable.

On 11 April 2011, the perpetrator appeared at court and was granted bail with conditions not to contact Stacey or go near the area where she lived. On 13 April 2011, Stacey informed the Witness Care Unit that she would attend court; although, as she had dyslexia, she wanted someone to read the oath for her. She explained that she would be able to read any letters sent to her. The following day, Stacey went to the emergency department at Nottingham University Hospital NHS Trust for an x-ray of her teeth. As staff were concerned about her, they contacted children's social care, but were reassured that children's social care were already involved in the case.

Stacey was seen by her social worker on 12 April. She was concerned that the perpetrator may have been released and was told to speak with Women's Aid for support. Following a referral from the Domestic Abuse Support Unit (DASU), Women's Aid contacted Stacey on 15 April, but she "declined support". The Domestic Abuse Support Unit (DASU) placed a person of interest (POI) marker on Stacey's address in the former mining village.

On 17 April, Stacey made a statement in which she said that she had exaggerated her account and the perpetrator had not kicked her. She said that she had been drunk when she made the statement. Despite this, the Crown Prosecution Service (CPS) decided to continue with the prosecution. A police log on 26 April 2011, stated that Stacey would not be referred to the multi-agency risk assessment conference (MARAC). No reason was given.

Due to school holidays and bank holidays during April and May 2011, the core group meeting due to take place around 20 April 2011 was cancelled. The social worker visited Stacey and her daughter on 27 April 2011 at Stacey's sister's home. Stacey was "*struggling to cope*" without the support of her family but there was no record of any support options being explored. Then on 10 May 2011, the social worker informed the Family Support Service that Stacey and her daughter had not been seen since the end of April. The social worker phoned Stacey on 13 May. Stacey was described as tearful; she wanted to be nearer her family because she was not coping.

The social worker telephoned Women's Aid on 16 May 2011 to discuss housing options for Stacey. Women's Aid confirmed that housing would not consider rehousing Stacey in the same area that the perpetrator was living. The social worker agreed to discuss this with Stacey and to take the multi-agency risk assessment conference (MARAC) forms with her. There was no record to confirm that this was done.

Withdrawal of complaint

On 23 May 2011, Stacey withdrew her complaint against the perpetrator. She said that she was drunk at the time and could not be sure what she had said. She agreed that the final decision as to whether she would have to go to court was with the Crown Prosecution Service (CPS) but she said she would be reluctant to attend if she was ordered to do so.

The following day (24 May 2011), the social worker visited Stacey who was "*very tearful and low*". She was taking anti-depressants and said she was struggling and needed her family

around her. Again, housing options were discussed but Stacey did not want to go to a refuge; she wanted to live near her family. The same day, Women's Aid closed her case.

On 26 May 2011, the Crown Prosecution Service (CPS) records noted that Stacey was a "high-risk" victim and therefore they must try to prosecute the perpetrator. They reviewed other sources of evidence that were available such as the '999' tape. The perpetrator appeared at the Magistrates' Court on 6 June and was committed to the Crown Court. The following day (7 June) he attended the police station to notify the police of his change of address to a property in the suburb east of Nottingham (close to Stacey's mother).

The Witness Care Unit sent Stacey a letter on 9 June 2011, outlining the perpetrator's bail conditions i.e. not to contact directly or indirectly Stacey, not to enter the former mining village where Stacey lived and to reside at an address known to the police. This letter was found by Stacey's mother following her death. On the back the perpetrator had written in capital letters "I FUCKING LOVE YOU LADY THEY WILL NEVER STOP US BEING TOGETHER [THE PERPETRATOR] AND STACEY FOREVER".

On 13 June 2011, Stacey contacted the police officer in the case to explain that the reason she withdrew her complaint was that the perpetrator been secretly seeing her. The perpetrator had begged her to retract the allegation and threatened her saying that if she gave evidence he would get his "*mates to sit in court and stare at her*". She told the officer that the perpetrator had stayed with her over the previous weekend and at one point she thought he might assault her again. She was also concerned because the perpetrator should not have stayed with her as children's social care was undertaking an investigation and she was afraid that they might remove her daughter. The same day, Stacey also contacted the social worker. Stacey explained that she was visiting an aunt in Sheffield.[10] She told the social worker that she had contact with the perpetrator almost immediately after the domestic incident. He had visited her (when her daughter was not present) and that he had put pressure on her to retract her allegation. He was threatening, abusive but sometimes tearful and pleaded with her, as he did not want to return to prison. She explained that he had been aggressive towards her when she had seen him the previous weekend and she was scared. The social worker called the police officer in the case to confirm the information that Stacey had provided.

The same day (13 June), Stacey also called the Women's Aid helpline as she had been advised to by her social worker. She talked about housing options but did not want to go to a refuge. They also discussed safety planning and Stacey asked the worker to let her social worker know that she had contacted the service. The following day Stacey phoned the helpline again requesting information on support services in Sheffield.

Also on 13 June 2011, the perpetrator was visited at home (friend's house) by the Dangerous Persons Management Unit. The officer discussed the assault on Stacey and the assault on the police officer. He denied both charges. He said that Stacey had dropped the

[10] There was some confusion between agencies as to whether Stacey and her daughter had moved to Sheffield. However, it appeared that they were only there for a few weeks

charges and this was the fifth time – their relationship had finished because she had "*put things on Facebook about his offending*".

Review child protection conference

On 14 June 2011, a review child protection conference was held. Present were the social worker, school nurse and a senior family worker. Stacey was not present as she was still in Sheffield. Her daughter remained subject to a child protection plan. The records noted that the social worker was leaving the department on 30 June 2011 and "*this is a matter that requires urgent reallocation to undertake the immediate work that is now required to ensure this family's future safety*". It was also documented that the perpetrator was to have no contact with Stacey's daughter.

Perpetrator remanded into custody

The perpetrator was arrested on 16 June 2011 for witness intimidation. He denied the offence and was bailed pending further investigation. He was however remanded into custody for breaching his bail conditions.

On 27 June 2011, Stacey telephoned children's social care to inform them that she had returned from Sheffield and was now staying with her sister. Her grandfather had secured a property for her opposite her sister's house in a suburb east of Nottingham and she was due to move at the beginning of August. Stacey appeared to be more positive. She talked about plans for her future employment, she described feeling "*much better*", feeling "*supported and safe*" and she was "*over the perpetrator*". She was told that she would be allocated a new social worker as her previous one was leaving.

The Dangerous Persons Management Unit undertook a MAPPA (multi-agency public protection arrangement) review on the perpetrator on 30 June 2011. The Thornton's 2000 Risk Matrix (sexual) remained medium whilst the perpetrator's Thornton's 2000 Risk Matrix (violence) was graded as 'high'. Despite this, records stated that it was unnecessary to raise the perpetrator's level of risk management to level 2 or 3 as there were no apparent triggers for re-offending. The plan was to:

- Monitor any intelligence and/or calls from the public
- Visit at least every 6 months in accordance with ACPO[11] guidelines
- Respond to any partner agency tasks
- Monitor relationship with Stacey – even though stated that they have separated
- Monitor children's social care involvement with regards to Stacey's daughter

[11] Association of Chief Police Officers

On 11 July 2011, the investigating officer contacted Stacey to discuss the outcome of the analysis on Stacey's phone. Stacey explained that she had been seeing the perpetrator (in breach of his bail conditions). Stacey said the relationship was now over. She made a statement admitting that she had contacted the perpetrator explaining that she did this because she loved him. It detailed the pressure that the perpetrator put on her in relation to going to court. The police provided the Crown Prosecution Service (CPS) with information that showed that Stacey had been in contact with the perpetrator while he was in custody and after his release. The Crown Prosecution Service (CPS) reviewed the case and decided that there was "*no realistic prospect of a conviction for witness intimidation*". The case was closed with no further action.

On 15 July 2011, the school nurse contacted children's social care and was informed that there was no social worker allocated to Stacey and her daughter. The school nurse raised concerns that "*no one was attending the meeting*". [In a 'transfer' document in the children's social care records it stated that "*Assessments have been completed and the perpetrator is considered too high a risk to ever be allowed to live within the family unit*". This document also stated that the next core group meeting would take place on 18 July 2011; while the next review child protection conference (RCPC) would take place on 28 November 2011]. There appeared to be some confusion as to which team was responsible for the case. It was clarified that the case was now the responsibility of Gedling Children's Services Team.[12]

On 19 July 2011, counsel instructed that there was no realistic prospect of convicting the perpetrator, as they "*could not show that the injuries caused to Stacey were made by* [*the perpetrator*]". Concerns were raised in relation to Stacey's previous statements that cast doubt on the veracity of her account. A further statement on 11 July only "*amplified the doubts*". On 25 July 2011, the perpetrator appeared at court and pleaded guilty to two counts of common assault. The case was adjourned while a pre-sentence report (PSR) was prepared for the two offences. The perpetrator was remanded in custody.

On 25 July 2011, Stacey and her sister went to the local police station. Stacey was concerned that the perpetrator would be released from prison. She was scared and requested a panic alarm.

Stacey telephoned children's social care on 26 July 2011. She wanted to know who her new social worker was and the outcome from court. She was informed that a social worker had not yet been allocated. The same day, children's social care contacted the Domestic Abuse Support Unit (DASU) about the outcome of the perpetrator's court appearance. The officer said that Stacey had been in the day before to enquire whether the perpetrator had been released. The officer who was handling Stacey's case would contact children's social care on her return (27 July 2011). The duty social worker telephoned Stacey to update her.

[12] The case had been held by a central agency team which had been in place to increase capacity. That team ceased in July 2011 and all the cases were reallocated

On 1 August 2011, the police informed children's social care that the perpetrator was due to be released on 16 August. It was on 9 August that Stacey moved into her own property close to her mother and sister in a suburb east of Nottingham.

On 2 August 2011, the perpetrator was interviewed via video link by the offender manager who had been allocated to prepare the pre-sentence report (PSR). The same day it was noted by children's social care that Stacey's daughter had not been seen since June (although records showed that it was in fact 24 May 2011 and furthermore, it was not clear from records whether Stacey's daughter was actually present that day). The following day (3 August), Stacey "*reluctantly*" agreed that her daughter could be seen by children's social care at her maternal grandfather's house. It appeared that (contrary to Stacey's previous information) her family only knew a little about what was happening and were not aware that children's social care was involved. Ultimately, Stacey's daughter was seen on 4 August 2011 with her maternal grandfather, who by now had a good understanding of why Stacey's daughter was on a child protection plan.

On 8 August 2011, the offender manager preparing the pre-sentence report (PSR) discussed the case with the programme tutor from the Nottinghamshire Probation Trust. The offender manager wanted to establish if the perpetrator was suitable to undertake the integrated domestic abuse programme (IDAP). It was noted that although the perpetrator denied domestic abuse, it was not "*total denial*". The concerns included "*his level of engagement/what he will take away, level of responsibility and also his employment. Offender manager to note these in her PSR".* Therefore, he met the criteria for the integrated domestic abuse programme (IDAP).

The offender manager also contacted Safeguarding Children Information Management Team to check whether the perpetrator, Stacey or her daughter were known; she was informed that Stacey's daughter had been subject to a child protection plan since 17 November 2010. The name of "*current social worker was unknown*" but the name and telephone number of the office was provided. A check was made with the Domestic Abuse Support Unit (DASU). This provided the offender manager with information about all the police call outs to incidents of domestic abuse between the perpetrator and Stacey.

Perpetrator released from prison

On 15 August 2011, the perpetrator received a two-year community order. He was required to participate in the Integrated Domestic Abuse Programme (IDAP) and was given a restraining order that prohibited him from contacting or communicating with (or attempting to contact or communicate with) Stacey or her daughter, either directly or indirectly.

At this time, the perpetrator's case was allocated to another offender manager for on-going supervision. On 19 August 2011, he had an initial case appointment with his offender manager. At his next meeting on 26 August 2011, he stated that he had been working away all week (although his offender manager did not seek any evidence). He said he was not in a relationship and had had no contact with Stacey.

Children's social care allocated a new social worker to the case on 24 August 2011. However, the social worker was due to be away on annual leave, so a home visit to Stacey and her daughter on 1 September 2011 was done by a duty social worker. Stacey described being well supported by her family who lived close by; her daughter was starting at a new school; and there was no evidence of contact between the perpetrator and Stacey. There was no evidence that the duty social worker contacted the police to confirm the perpetrator's whereabouts.

During the perpetrator's meeting with his offender manager on 1 September 2011, he said he might be going to Jersey for work. During his meeting with his offender manager on 9 September 2011, the perpetrator again discussed going away for work. He also told his offender manager that Stacey had tried to contact him under a fictitious name on Facebook. He said he blocked it because he was worried that she would try to get him "*into trouble*".

On 15 September 2011, the new social worker contacted the school and school nurse to confirm details of the core group meeting on 20 September 2011 at the daughter's school. The school nurse raised concerns about Stacey moving back to the suburb east of Nottingham as the perpetrator was also living in the area. The social worker also left a message for an officer at the Domestic Abuse Support Unit (DASU). The same day, the perpetrator reported to his offender manager that he was now homeless and unemployed. He said he was staying with various friends and living off loans. There was no documented liaison with other agencies following this significant change of circumstance.

The new social worker visited Stacey and her daughter at home on 19 September 2011. Stacey said that she had not seen or had any contact with the perpetrator. Although she did mention that her daughter was missing him (her daughter did not raise this with the social worker during direct work).

On 20 September 2011, the core group meeting was held. Stacey, the social worker, a teacher and school nurse were present. The group was informed that the perpetrator was sometimes seen in the school playground, as he had friends that lived in the area (this information was not shared with the police or probation). It was agreed that the school would let Stacey know, and inform the police and children's social care if the perpetrator was seen again.

On 21 September 2011, when the perpetrator visited his offender manager, he provided a new address. He also said that he was not in a relationship but Stacey had approached him in a nightclub and he had told her to stay away from him. This information was not shared with the Domestic Abuse Support Unit (DASU) or children's social care and no referral was made to the Women's Safety Worker to ascertain the veracity of this allegation with Stacey. The perpetrator's offender manager completed a referral on the case recording and management system (CRAMS) to the integrated domestic abuse programme (IDAP) on 23 September 2011. The form was completed late and was of a poor standard.

On 28 September 2011, the perpetrator visited his offender manager at the office. The same day the Violent and Sexual Offender Register (ViSOR) log noted that there was a MAPPA (multi-agency public protection arrangement) review on the perpetrator. All databases were

checked and nothing of concern was raised. Thus, his risk of recidivism for sexual offending remained 'medium'; the plan was considered "*fit for purpose*"; and nothing within the risk assessment gave reason for raising his MAPPA level or the need to share information. The date for his next review was set for 13 December 2011.

On 29 September 2011, the start of sentence OASYs assessment [13] was completed by the perpetrator's offender manager. The assessment was late and was largely copied from the pre-sentence report (PSR) OASys assessment. The perpetrator was assessed as posing a medium risk of serious harm to Stacey, future partners and children. On 4 October 2011, the perpetrator visited his offender manager at the office. The same day, the social worker telephoned Stacey to cancel a planned home visit.

On 11 October 2011, children's social care undertook a home visit. Stacey's daughter was seen alone. Stacey stated that she was not in a relationship with the perpetrator and had not been for about seven months – although she had once bumped into him in the street. She told the social worker that she had a new partner and gave his name to the social worker to check.

The perpetrator met with his offender manager and a member of the programmes team on 12 October 2011. Records stated that the perpetrator would be attending an "*evening group, will be working in Newcastle for the next three weeks so instruction for orientation after this please*". Directly after this meeting, the perpetrator met with his offender manager to discuss the previous three-way meeting. The perpetrator reported "*not to be in a relationship currently as wanted to focus on work and finding independent living when can afford it*.'[14]

A few days later, the perpetrator murdered Stacey.

7 ANALYSIS OF INTERVENTION

7.1 Children's Social Care

In November 2010, Stacey's daughter became subject to a child protection plan. At the initial child protection conference, it was decided as the perpetrator and Stacey wished to be in a relationship, a parenting assessment should be undertaken by the social worker and

[13] The Offender Assessment System (OASys) is the assessment tool used by the Prison Service and Probation Trust to assess and record the likelihood of reoffending and risk of serious harm. It plays a pivotal role in assessment, case management, targeting of treatment programmes, referrals to partnerships, resource allocation and risk management for offenders aged 18 and over. OASys is the tool that allows the National Offender Management Service (NOMS) practitioners to assess an offender's likelihood of reoffending by systematically examining a number of offending-related factors, including offending history; education, training and employability; relationships; drug misuse; alcohol misuse; emotional well-being; thinking and behaviour; and accommodation, lifestyle, and associated thinking, behaviour and attitudes – for further information see www.mappa.justice.gov.uk – accessed online 13 November 2017.

[14] This record was not completed contemporaneously but on 19 October 2011 – after Stacey's murder

a specialist family support worker. The perpetrator was asked not to reside at Stacey's address while the assessment took place. The purpose of the assessment was to gain a comprehensive account of their relationship and to fully understand the risk he posed in relation to Stacey and her daughter. During the assessment, the perpetrator and Stacey were seen separately. In addition to the initial introductory session, Stacey had four sessions and the perpetrator attended three. There did not appear to be any interrogation of the emotional harm caused to Stacey's daughter by the domestic abuse; nor any discussion about the potential future impact or indeed the actual previous physical harm that had already been caused to Stacey's daughter during past incidents.

Following the assault in April 2011, the level of risk from the perpetrator was too high to consider any further work with him and therefore the parenting assessment was not completed. From then all plans were based on his permanent exclusion from the household.

Nonetheless, given the perpetrator's history of violence against women and girls, and his enduring history of domestic abuse, children's social care should have undertaken a focussed risk assessment of the perpetrator rather than seemingly trying to do this as part of a wider parenting assessment. Clearly if the risk assessment had then confirmed that it was inappropriate for him to be part of the family, it would not have been necessary to undertake the wider elements of the parenting assessment. Indeed, such a focussed risk assessment of the perpetrator should in fact have taken place in August 2008 when professionals first identified that Stacey and the perpetrator were in a relationship. Since Stacey's death, a specific safeguarding assessment and analysis framework (SAAF) has been introduced to assist staff to focus more clearly their analysis, particularly looking at the adults' capacity to change.

Following the parenting assessment, during the summer of 2011, there was a period of time when Stacey's daughter's case was not allocated to a social worker. Her social worker left the department on 30 June 2011. This social worker was part of a central agency team that had been brought into Nottinghamshire to increase the capacity within children's social care. This team was coordinated by Outcomes UK. When the Outcomes UK contract ended, all cases requiring further intervention were re-allocated within District Children's Services Teams. When her social worker left, the case became the responsibility of the permanent Gedling Children's Services Team. However, there appeared to be some confusion about this; and it was not clarified until 15 July 2011.

Although her case was then managed by the Gedling duty service, there was very little contact. Stacey phoned children's social care on 27 June to inform them she had returned from Sheffield; Stacey phoned again on 26 July 2011 to ask who her new social worker was; and the duty social worker telephoned Stacey back that day to say that the police did not have an update about the court case and whether the perpetrator had been released. It was not until 2 August 2011 that the manager noted that Stacey's daughter had not been seen since June (although records showed that the last meeting with Stacey was on 24 May and it was unclear as to whether her daughter was actually seen that day). It was then that the manager asked the duty social worker to undertake a home visit. This finally took place on 4 August 2011. Thus, neither Stacey nor her daughter were seen between 24 May and 4 August 2011.

Clearly, as Stacey's daughter was subject to a child protection plan, the level of scrutiny and intervention should have been far greater and her case should have been reallocated more quickly. Particularly as the transfer records stated that "*this is a matter that requires urgent reallocation to undertake the immediate work that is now required to ensure this family's future safety*". Records clearly showed that the perpetrator was deliberately making contact with Stacey and her daughter during June 2011, and following his release from prison (September and October 2011), even though the child protection plan prohibited such contact. Children's social care did not explore this information thoroughly enough, share the information with the police or consider whether Stacey's daughter should be removed from her care.

Stacey's father and stepmother described their difficulties acquiring information about what was happening. On one occasion, they visited Stacey at home and found the perpetrator there. They tried to phone children's social care to understand what was happening but were told that it was confidential. At first, Stacey's father did not believe Stacey when she said that children's social care was undertaking a parenting assessment with the perpetrator. Her father and stepmother felt that this gave the perpetrator some kind of legitimacy in Stacey's eyes, as Stacey told them that it showed that children's social care believed he could be a good parent.

Children's social care now has a greater focus on domestic abuse and the risks and impact that it has on children and families. As part of this focus, a team manager always attends multi-agency risk assessment conferences (MARAC) and any actions are recorded in case records; and there is now an early alert system to inform schools of children living in households where there is domestic abuse. Senior managers give greater attention to case management and children's social care has introduced a quality management framework (QMF) to ensure that there are quarterly audits to establish the quality of a sample of 'open' cases. There are also supervision audits to ensure that staff receive monthly supervision.

It was evident from children's social care records that many of the prescribed meetings e.g. core group meetings and regular meetings with Stacey and her daughter did not take place. Furthermore, child protection meetings e.g. core group meetings were poorly attended by partner agencies. This inevitably contributed to the paucity of information shared between the agencies and equally it may have led to Stacey to minimise the risk she faced or assume that agencies were not interested in protecting her. Practice now has changed. The Nottinghamshire Safeguarding Children Board now receives regular quarterly performance information, which includes data regarding agency attendance at child protection conferences. The independent chairs of conferences are expected to escalate any concerns regarding an agency's contribution and this includes sending 'alerts' to the relevant agency. Children's social care managers undertake quarterly case audits as part of their Quality Management Framework; this involves scrutiny of the effectiveness of multiagency working including core groups in child protection cases.

7.2 Nottinghamshire Police

Police records showed that in November 2010, a 'place of interest marker' was attached to Stacey's address in the former mining village. It stated "*Please treat all emergency calls by Stacey as immediate and take positive action on arrival. Please update the Domestic Abuse Support Unit of any incidents reported by Stacey, even if they are not domestic violence related*". At the time, the 'officer in the case' would be sent emails every two months to establish whether the place of interest marker should remain in place. The officer had 28 days to respond; if there was no response, the marker would be removed.

In June 2011, the Domestic Abuse Support Unit confirmed that the place of interest marker was to remain in place until early August. At the time the perpetrator was in custody and was due to appear at court in late-July. It was decided that the place of interest marker would be reviewed following the outcome of his court appearance. Then in August 2011 the place of interest marker was removed from Stacey's address in the former mining village on the grounds that "*there had been no incidents reported in the past few months* (although he had been in custody during this period) *and* [*the perpetrator*] *was subject of an unlimited restraining order with conditions not to contact either Stacey or her daughter*".

Stacey's new address was not entered on the system. The Nottinghamshire Police Professional Standards Directorate reviewed the family's complaint against the police in November 2014 and concluded the officer in the case should have informed the Domestic Abuse Support Unit of Stacey's new address; who in turn should have updated CATS (Child Abuse Tracking System). In addition, an Independent Police Complaints Commission (IPCC) report identified that there was learning to be gained about the way restraining orders were recorded on police information systems.

On the night of Stacey's death, officers could find no record of her address, despite the perpetrator having a restraining order not to contact her. This issue is of great concern to her mother, who has never understood why it took the police around 3½ hours to find Stacey. That night, police were called to a stabbing incident and found the perpetrator being treated by paramedics. The perpetrator was uncooperative and would not speak to the police. A friend of the perpetrator's, who was present, told officers that the perpetrator was concerned he would be arrested for breaching a restraining order. The friend also indicated that Stacey was responsible for the perpetrator's injuries.

The officers were then called to another incident. On returning to the police station their priority was to discover how the perpetrator had been injured and to locate Stacey. Stacey's address was not on the system; but after making several calls, they received information that she was living near to her mother's address in a suburb east of Nottingham. The officers made door-to-door enquiries and ultimately found a house where the lights were on but no one answered the door. The officers rang the mobile number they had for Stacey and heard it ring in the house. With hindsight, the Police National Computer (PNC) would have provided details of the perpetrator's Protection from Harassment Order. This specified that the perpetrator was not to contact Stacey or go near her address on **** Street – although it did not state the house number. Nevertheless, the police officers were not provided with

this information on the night and their focus was on finding Stacey and nothing in the records indicated her change of address.

7.2.1 Domestic Abuse Support Unit (DASU)

The Unit was formed in 2005 to manage high risk victims of domestic abuse.[15] High risk victims were allocated a specific officer and were referred to Women's Aid. Part of the Unit's role was to share information with other agencies and to attend meetings such as the multi-agency risk assessment conference (MARAC).

Between April 2011 and Stacey's death in October 2011, there was limited communication between Stacey and the Domestic Abuse Support Unit (DASU). After the assault on 9 April 2011, a detailed statement was taken. On 13 April, an officer contacted her to explain the perpetrator's bail conditions and a referral was made to children's social care. Then on 23 May 2011, Stacey withdrew her complaint of assault and on 13 June 2011, Stacey contacted the investigating officer to explain that she had withdrawn her statement because the perpetrator had intimidated her. At this point she admitted that he had stayed at her house for the weekend. In July 2011, Stacey made another statement "*admitting she had made numerous attempts to contact the perpetrator when he was in custody and following his release*".

Between the date of the perpetrator's conviction (15 August 2011) and Stacey's murder, there were no police records relating to any on-going risk and intervention plan. However, there was an entry relating to the restraining order that had been issued at court and an entry concerning the removal of a place of interest marker from Stacey's address in the former mining village. During this period, there was little evidence of multi-agency working e.g. no regular contact between the Unit and children's social care, the Dangerous Persons Management Unit (DPMU) or probation, and Stacey was not referred to the multi-agency risk assessment conference.

Stacey's family and the terms of reference for this review asked Nottinghamshire Police to "*explain clearly how Stacey was supported and protected*" between April 2011 and her death in October 2011. Stacey's mother made a specific complaint concerning a meeting that Stacey had with a police officer on 25 July 2011. Stacey's sister was present during this meeting and stated that Stacey asked for a panic alarm. This complaint was covered in depth in the Independent Police Complaints Commission review and the Nottinghamshire Police Professional Standards Directorate investigation. The Independent Police Complaints Commission concluded that it was "*more likely than not*" that Stacey requested a panic alarm. As there was no record of this meeting within Nottinghamshire Police records, there was no additional information to include within this domestic homicide review.

The Domestic Abuse Support Unit has provided all the available information and there was no further detail to include in this review.

[15] The procedures and systems that were in operation in 2011 have subsequently been replaced and updated

7.2.2 Dangerous Persons Management Unit (DPMU)

Following the perpetrator's conviction for rape in 1999, he was required to sign on the Sexual Offenders Register for life. Information about him was recorded on the Violent and Sex Offender Register (ViSOR).[16] His supervision by probation ended in 2008, after which Nottinghamshire Police Dangerous Persons Management Unit was responsible for his MAPPA (multi-agency public protection arrangements) management.

MAPPA – Multi-agency public protection arrangements

Multi-agency public protection arrangements (MAPPA) is the process through which the police, probation and prison service work together with other agencies to manage the risk posed by violent and sexual offenders living in the community in order to protect the public. There are three categories of violent and sexual offenders who are managed through MAPPA.

Category 1	*Registered sexual offenders are required to notify the police of their name, address and other personal details, under the terms of the Sexual Offences Act 2003.*
Category 2	*Violent offenders who have been sentenced to 12 months or more in custody or to detention in hospital and are now living in the community subject to Probation supervision.*
Category 3	*Other dangerous offenders who have committed an offence in the past and are considered to pose a risk of serious harm to the public.*

There are three levels of MAPPA management. They are based upon the level of multi-agency co-operation required with higher risk cases tending to be managed at the higher levels. Offenders will be moved up and down levels as appropriate.

Level 1	*Ordinary agency management is for offenders who can be managed by one or two agencies (e.g. Police and/or Probation). It will involve sharing information about the offender with other agencies if necessary and appropriate.*
Level 2	*Active multi-agency management is for offenders where the ongoing involvement of several agencies is needed to manage the offender. Once at level 2, there will be regular multi-agency public protection meetings about the offender.*
Level 3	*Same arrangements as level 2 but cases qualifying for level 3 tend to be more demanding on resources and require the involvement of senior people from the agencies, who can authorise the use of extra resources. For example, surveillance on an offender or emergency accommodation.*

[16] The violent and sex offender register (ViSOR) is a secure national database that was developed to support multi-agency public protection arrangements (MAPPA) by assisting cooperative working between the 'Responsible Authority' agencies (police, probation and prisons). It is used in the joint management of individuals posing a risk of serious harm. ViSOR provides officers fulfilling public protection roles with a confidential communication tool through which they are able to exchange information with others involved in multi-agency offender management.

Throughout the period under review, the perpetrator was managed by MAPPA[17] under category 1 (sex offender) at level 1 (single agency – police/probation).

Between February 2008 and Stacey's death in October 2011, the perpetrator was visited by the Dangerous Persons Management Unit on eight occasions. The Unit only became aware of Stacey's relationship with the perpetrator in August 2008 when the health visitor made enquiries about the perpetrator.

Subsequent risk management plans appeared to disregard the perpetrator's threats to kill and the assaults on Stacey (August 2008, March 2009, December 2009, September 2010, April 2011), the incident when the perpetrator chased her uncle with a knife (February 2009), the third party reports of domestic abuse (February 2009), the fact that Stacey was considered a 'high risk' victim of domestic abuse and had been referred to the multi-agency risk assessment conference (March 2009, April 2009 & November 2010), that Stacey's daughter was on a child protection plan (November 2010) and that the perpetrator used alcohol and drugs.

The primary focus of the Unit appeared to be on the perpetrator as a sex offender and therefore his history of violence (particularly against women and girls) was lost. This is concerning as his original conviction was for rape – which by its very nature, is a violent act. Furthermore, men who are perpetrators of domestic violence and abuse are likely to use sexual violence towards their partners.

The focus on the perpetrator as a sex offender meant that he remained medium risk and was always managed at MAPPA level 1. Had his other offences and behaviour (e.g. denial) been taken into account, officers might have considered a request to manage him at level 2. There was an occasion in July 2011, when the perpetrator's Thornton's 2000 Risk Matrix (violence) was graded as 'high' but he continued to be managed at MAPPA level 1. This was a lost opportunity to involve other agencies such as children's social care, the Domestic Abuse Support Unit and health services. A multi-agency meeting at this stage may have highlighted some of the information held by separate agencies. For example, probation was aware that there had been contact between the perpetrator and Stacey over Facebook and at a nightclub, children's social care was aware that the two had "*bumped*" into each other in the street – it may have helped identify some of the discrepancies in the information that each agency was being given.

There appeared to be a culture where perpetrators were managed by the Dangerous Persons Management Unit (DPMU) under MAPPA and their victims by the Domestic Abuse Support Unit and multi-agency risk assessment conference (MARAC) – yet there was no regular, consistent or meaningful exchange of information between these Units and systems. Practice has now improved. The Dangerous Persons Management Unit (now Management of Sexual and Violent Offenders, MOSOVO) and the Domestic Abuse Support Unit are both under the command of Public Protection. Staff routinely transfer between these departments and this has led to a greater understanding of the work of each

[17] For further information see www.mappa.justice.gov.uk – accessed online 13 November 2017.

department. Furthermore, the departments are now located next to each other, which has improved the exchange of information and the timeliness of communication.

When information was shared by the Dangerous Persons Management Unit, it was erroneous. For example, the Dangerous Persons Management Unit informed children's social care that the perpetrator was not a danger to children; despite his alleged rape of a 16-year-old child (who was "*too afraid*" to take action), a child being present in the property when he raped his 22-year-old neighbour at knifepoint, and Stacey's daughter being in her arms when the perpetrator punched Stacey in the face.

The Dangerous Persons Management Unit was a member the children's social care core group whilst Stacey's daughter was on a child protection plan. Despite this, no officer attended any of the core group meetings (December 2010, March 2011 or September 2011) – although two officers attended the review child protection conference in January 2011.

7.3 Multi-agency risk assessment conference (MARAC)

It was not clear why Stacey's case was not heard at the multi-agency risk assessment conference (MARAC) following the assault in April 2011. Stacey had been assessed as high risk and therefore her case should have been heard. On 13 April 2011, a Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment was completed by the police and sent to Women's Aid. On 26 April 2011, the multi-agency risk assessment conference (MARAC) County Coordinator at Women's Aid recorded on the police system (CATS) that Stacey's case would not be going to the multi-agency risk assessment conference (MARAC). No rationale was provided. Both police and Women's Aid stated that at this time there was not the capacity to refer all high-risk cases to the conference. Therefore, cases were triaged before the meeting and only those considered the highest risk were heard. A detailed review of the police records[18] in January 2013 concluded that there was no recorded reason as to why Stacey was not referred to the multi-agency risk assessment conference (MARAC). This was because although anecdotally there was a triage system in place, nothing was documented. Thus, there was no record of why individuals were not considered eligible for the multi-agency risk assessment conference (MARAC) nor was there an identified system to re-refer individuals who were triaged out but remained high risk.

At the time, the police compiled the list of cases to be heard at the conference without consulting the independent domestic violence advisors (IDVA). Practice has now changed and police consult with independent domestic violence advisors (IDVA) before compiling the list and the reason a high-risk case is excluded from the meeting is recorded.

On 16 May 2011, the social worker had a telephone conversation with Women's Aid and agreed to take the multi-agency risk assessment conference (MARAC) forms to Stacey, but

[18] The original domestic homicide review panel asked Nottinghamshire Police to review the reason why Stacey's case had not been referred to the multi-agency risk assessment conference (MARAC).

again there was no referral recorded. In the six months leading up to Stacey's death, there were many occasions, reasons and opportunities for her case to be discussed at the multi-agency risk assessment conference (MARAC) but this was never done. In addition to the police referral following the assault in April 2011, there were opportunities for health, police, the social worker and school to re-refer e.g. following the child protection conference in June or the core group meeting in September 2011. Agencies should have considered a referral before the perpetrator was released in August 2011. Any of the agencies involved could have made a referral – indeed, all the agencies involved should have made a referral.

There have been a number of improvements to the system since 2011. In September 2011, the Protocol for Nottinghamshire's multi-agency risk assessment conferences (MARAC) was revised. The conference still meets every two weeks. Any agency can make a referral through the multi-agency risk assessment conference (MARAC) administrator by completing a domestic abuse stalking and harassment (DASH) form and a multi-agency risk assessment conference (MARAC) referral form. The case should be heard within four weeks of the referral being submitted.

Currently, any high-risk cases that are not discussed at the multi-agency risk assessment conference (MARAC) will still be given priority by the police and the independent domestic violence advisor (IDVA) services. The reasons for a high-risk referral not being discussed at the multi-agency risk assessment conference (MARAC) are now documented on police intelligence databases (e.g. Niche and CRMS). These reasons could include for example there being sufficient interventions already in place or a change of circumstances (i.e. death of a perpetrator).

In addition, regular audits are now undertaken to establish which agencies regularly attend and make referrals to the multi-agency risk assessment conference (MARAC). This performance data is presented to the multi-agency risk assessment conference (MARAC) steering group and the Nottinghamshire Domestic and Sexual Abuse Executive Board by the Crime and Drug Partnership (CDP). Figures showed that in 2017 (quarter two), 57% of all referrals to the multi-agency risk assessment conference (MARAC) in Nottingham were made by agencies other than the police. This is above the 25% target recommended by SafeLives.

From September 2017, there will be four multi-agency risk assessment conferences (MARAC) across Nottinghamshire. This will ensure there is a conference both in the City and County every week. Now all high-risk cases are heard at the multi-agency risk assessment conference (MARAC).

7.4 Crown Prosecution Service (CPS)

The Crown Prosecution Service was invited to provide additional information concerning the contact that the service had with Stacey following the assault in April 2011. The Crown Prosecution Service declined stating that they had no further information to add and would not therefore participate in a further review. The service considered that a "*detailed review*

has already taken place" and "there were no failings in the actual decision-making in this case noted in the earlier review".

This was disappointing as Stacey's family was keen to understand how Stacey was supported through the court process considering she had a speech impediment, the reading age of a 12-year-old and required any information to be provided on coloured paper.

It was evident that although policies may have been complied with, there appeared to be a lack of understanding concerning domestic abuse and the use of intimidation and control. The perpetrator manipulated Stacey and used intimidation and threats to ensure she retracted or withdrew any allegations. It was unclear from the original individual management review, the extent of the knowledge professionals had of domestic abuse within the Crown Prosecution Service.

Nevertheless in 2017, the Clerk of Nottingham Magistrates Court (in conjunction with guidelines from the Judicial College[19]) introduced training, awareness and refresher events for magistrates (JPs), District Judges and legal advisors to consider the specific features that come with cases of domestic abuse such as coercive control. There is online training available from the Prosecution College[20] and directly from the Crown Prosecution Service (CPS) Headquarters. East Midlands Crown Prosecution Service (CPS) organises its own internal training when there are updates in the legislation. The Senior Crown Prosecutor for East Midlands trains Independent Domestic Abuse Advisors across the UK on how to prosecute perpetrators of domestic abuse. For those with an interest in domestic abuse, there are specific courses that prosecutors can go on using their individual learning account (ILA). This provides all prosecutors with an allowance to undertake training of their choice, providing it is relevant to their work.

7.5 Nottinghamshire Probation Trust

Following the assault in April 2011, an offender manager completed the perpetrator's pre-sentence report (PSR). The OASys risk assessment noted the perpetrator's history of domestic abuse and children's social care involvement with Stacey's daughter; there was however, no mention of his offending history and no reference to humiliation, control and power over women, or his use of weapons and drug misuse. Ultimately, the offender manager assessed the perpetrator as medium risk of serious harm to known adults (namely his partner and future partners) and children. The general risk to the public was assessed as low.

There was considerable information available to the offender manager including:

- Witness statements

[19] The Lord Chief Justice is responsible for arrangements for training the courts' judiciary in England and Wales under the Constitutional Reform Act 2005. The Senior President of Tribunals has an equivalent responsibility in relation to judges and members of the tribunals within the scope of the Tribunals, Courts and Enforcement Act 2007. These responsibilities are exercised through the Judicial College.

[20] The Prosecution College is a website is the e-learning hub for Crown Prosecution Service (CPS) employees

- Photographic evidence of damage caused to the house
- The injuries sustained by Stacey
- The frequency of the known domestic abuse incidents
- The indication that the perpetrator had binged on alcohol and amphetamines/cocaine prior to the assault
- The nature and context of the rape in 1998
- The nature of his previous offences (including the not proven murder)
- The level of denial expressed by the perpetrator
- The extent to which he blamed Stacey in his police interview
- The concerns over use of weapons
- The fact that Stacey's daughter was on a child protection plan

Given this information, the original individual management review author concluded that the perpetrator should have been assessed as posing a "*high risk of serious harm physical/emotional to Stacey and future partners, medium risk of serious harm to public (including sexual harm to women) and high risk or physical/emotional harm to children (with her daughter specifically being named as at risk)*".

Thus, both the pre-sentence report (PSR) and OASys risk assessment underestimated the level of risk of serious harm he posed. A Thornton's 2000 Risk Matrix should have been undertaken. In addition, the individual management review author also deemed that as the case was complex, MAPPA (multi-agency public protection arrangements) level 2 management should have been considered.

In August 2011, the perpetrator was sentenced to a 24-month community order with a supervision requirement of 24-months and a requirement to attend the accredited integrated domestic abuse programme (IDAP) lasting 24 sessions. The court imposed a restraining order for an indefinite period. At this time, another offender manager took over the perpetrator's supervision. In the pre-sentence report (PSR), the perpetrator had been assessed as posing a risk to children, however, this risk to children was not registered on the probation case recording and management system (CRAMS). Also, his offender manager omitted to undertake other actions. First, a home visit should have been arranged within 10 working days of the start of the perpetrator's order; and second, a referral should have been made to a Women's Safety Worker[21] within five days of the start of the perpetrator's order.

The perpetrator's offender manager maintained weekly contact with him, but there was no liaison with the relevant external agencies. When the perpetrator told his offender manager

[21] As part of the integrated domestic abuse programme (IDAP) Women's Safety Workers provided support for the partners of men sentenced to, or required to complete the programme. Women were contacted at the beginning of their partner's order and subsequent contacts were made at times when they may have faced additional risk e.g. the commencement, midpoint or end of the programme. In this case, a Women's Safety Worker may have helped understand Stacey's perspective of the risk she faced.

that Stacey had contacted him via Facebook and later that she had approached him at a nightclub, both these incidents were a breach of his restraining order. These significant events should have been shared with the Domestic Abuse Support Unit (DASU), the Dangerous Persons Management Unit, and children's social care. A referral should have been made to Women's Safety Worker to ascertain the veracity of these allegations about Stacey contacting the perpetrator. There was no consideration of the possible breach of either the restraining order or non-compliance with the child protection plan.

During the perpetrator's period of supervision, the offender manager did not seek any evidence to confirm that he was working, nor did the offender manager undertake any one-to-one work with him concerning his offending behaviour.

Stacey's murder led to a Serious Further Offence (SFO) investigation by Nottinghamshire Probation Trust. This was completed in 2012.

7.7 Victim Support

Stacey was referred three times to Victim Support. Practice at the time meant that when domestic abuse was indicated, the Victim Support staff would seek consent from the police to contact the victim unless the victim was identified as 'high risk'. In which case, Victim Support would refer the case to the multi-agency risk assessment conference (MARAC) unless it was clear on the information system that the victim had already been referred by the police. Victim Support would then close the high-risk case as these victims were supported by the independent domestic violence advisors (IDVA).

Stacey was first referred to Victim Support in February 2009 as a victim of harassment when the perpetrator would not let her collect her daughter's belongings from his property and he was verbally abusive. On this occasion, the worker contacted the police officer in the case to ask whether Stacey had consented to be contacted. The officer did not reply and therefore Stacey's case was closed to Victim Support. The Victim Support records do not explain why the worker did not "*chase the police officer three times*" which would have been normal practice. Furthermore, at the time Victim Support was based at police stations and the police officer could have been approached directly to clarify whether Stacey had given her consent to being contacted. In 2010, it was agreed with Nottinghamshire Police that when a police officer did not respond, Victim Support could escalate the case to a senior officer.

Stacey was referred a second time to Victim Support in December 2010 following an incident when she had bricks thrown through her window. The incident was not flagged as domestic abuse on the police referral because although Stacey had not seen who did it, she assured police that it was not the perpetrator. Had Victim Support, however, undertaken a system check, it would have highlighted the history of domestic abuse and this could have been discussed with Stacey. Instead Victim Support made contact with Stacey and undertook a 'basic needs assessment'. Stacey was described as "*a bit jumpy but she said she has good support from her family and friends*". She declined further support and the case was closed.

The third referral occurred on 9 April 2011 following the assault on Stacey by the perpetrator. Two emails were sent to the police officer in the case and, as there was no response, the case was closed on 21 April 2011. Victim Support records showed that the case was flagged as high risk and thus should automatically have been referred to the multi-agency risk assessment conference (MARAC) for consideration; however, this did not happen.

It was clear that the police did not respond to Victim Support's requests to contact Stacey. Nevertheless, Victim Support did not pursue the police for a response and thus Victim Support missed opportunities to support Stacey and be more enquiring about her circumstances. Victim Support no longer works with victims of domestic abuse. This work has all been transferred to Women's Aid.

7.8 Women's Aid

During the period under review, Women's Aid provided a free, holistic, confidential and independent service for women and children who were experiencing or who had experienced domestic abuse. The role of the independent domestic violence advisor was to support those women going through the domestic violence court or the multi-agency risk assessment conference (MARAC) process and to work in close partnership with the Domestic Abuse Support Unit (DASU) and the Crown Prosecution Service (CPS).

Stacey was supported by Women's Aid at various times through the multi-agency risk assessment conference (MARAC) process and court processes from February 2009 until April 2011. The final referral was made to Women's Aid in April 2011 following the perpetrator's assault on Stacey. Stacey told the independent domestic violence advisor (IDVA) (over the phone) that she had ended the relationship with the perpetrator and they discussed his bail conditions (not to go to her property). Stacey explained that she was not scared of the perpetrator and she thought he would leave her alone as long as she did not contact him. Although, later in the conversation she stated that he might try to contact her or go to her address if he had a drink. The independent domestic violence advisor (IDVA) conducted a "*full assessment of risk and needs*" over the phone, which resulted in an 'individual safety and support plan'. As part of this plan, the advisor arranged for a 'place of interest' marker to be attached to Stacey's address and Stacey also asked for a 'crime prevention' visit. There was no documentation to confirm whether a crime prevention visit was arranged or whether one took place.

Stacey told the independent domestic violence advisor (IDVA) that she did not want any special measures at court or a pre-trial visit. Ultimately, Stacey's case was closed on 24 April 2011. The practice at the time was to close a case after two weeks, if a victim had not made contact. Stacey's case would have been re-opened if she had made contact again. Women's Aid emailed the police to inform them that Stacey had declined support. The email contained a request for a crime prevention visit.

The closure of Stacey's case is concerning as Stacey was clearly vulnerable at this time. She was a high-risk victim, going through the court process, she was living alone with her

daughter in an area distant from the support of her family. The independent domestic violence advisor (IDVA) should have had a greater understanding, awareness and given greater consideration to the risk that Stacey faced i.e. the risk around separation, the history of domestic abuse and the perpetrator's history of breaching his bail conditions. Instead the case was closed when Stacey was at her most vulnerable without a referral to the multi-agency risk assessment conference (MARAC).

Had Women's Aid continued to support Stacey, her worker could have not only supported her through the court process but also would have noted her change of address and ensured that a place of interest marker was attached to her new address.

8 EMERGING THEMES AND RECOMMENDATIONS

8.1 Power, control and manipulation

The perpetrator was skilled at using power, control and manipulation to ensure that Stacey withdrew any allegations against him. He controlled her phone, he controlled her friendships and he used threats to force her to retract or withdraw allegations. It appeared that agencies and professionals had little understanding of his ability to control and coerce Stacey. Indeed, professionals failed to recognise that the perpetrator was controlling and manipulating them. For example, he consistently told police officers from the Dangerous Persons Management Unit that he had either given up drinking or had cut down on his use of alcohol and thus his use of drugs and alcohol did not inform risk assessments. He manipulated these officers into thinking that his relationship with Stacey was not serious. He denied previous allegations which led officers to incorrectly conclude that he was not a risk to children.

The perpetrator informed the social worker that he did not want to attend either an anger management course or a domestic abuse course because he was aware of "*his triggers*". He was offered a parenting assessment but refused to be seen at the address where he was living and thus it took place at Stacey's address (despite him not being permitted to go there as part of the child protection plan). This could have been seen as giving the perpetrator some credibility, especially as he was then given permission to go to parents' evening at Stacey's daughter's school and was allowed to see Stacey at weekends when her daughter was with her birth father. These must have appeared as mixed messages to Stacey.

The perpetrator was very good at presenting himself. The school described how "*he seemed articulate and appeared interested*" and had "*a calm manner*". He was even seen in the school playground when he had a restraining order prohibiting him from contacting or communicating with Stacey or her daughter. Yet (although this was discussed at a core group meeting) the police were not informed.

The perpetrator appeared to avoid attending the perpetrator programme (IDAP) by telling his probation officer that he was working away. His probation officer however never sought

any evidence to confirm his whereabouts. The perpetrator also said that Stacey had tried to contact him or they had seen each other. The probation officer accepted this information without considering that the perpetrator may have orchestrated these contacts with Stacey.

When the perpetrator wrote on the back of his bail conditions that he and Stacey would be together forever, it may have appeared to her that no one could prevent him from doing whatever he wanted. Stacey did however manage to separate from him. She met someone new and appeared to move on with her life. This of course took away the perpetrator's power and control over her which in turn increased her vulnerability.

8.2 Information sharing and working in silos

The lack of information sharing in this case made it easier for the perpetrator to manipulate the system. When he was seen in the playground at Stacey's daughter's school, the information was not shared with the police or probation. This meant that no consideration was given to the possibility that he might have been stalking Stacey and that it may have been a breach of the restraining order.

There were other occasions when information was not shared. In July 2011, police provided the Crown Prosecution Service (CPS) with information that showed that Stacey had been in contact with the perpetrator while he was in custody and after his release, but this was not shared with children's social care. Again, this was a breach of his bail conditions and may have had an impact on the child protection plan.

Apart from a number of specific occasions when information was not shared, there was also evidence that agencies worked in isolation. Information was not shared between the Dangerous Persons Management Unit, the Domestic Abuse Support Unit and the multi-agency risk assessment conference (MARAC). Therefore, professionals did not view Stacey's vulnerability in tandem with the perpetrator's offending behaviour. In particular, the Dangerous Persons Management Unit did not include the perpetrators assaults on Stacey to inform their risk assessments. In addition to this, when there were opportunities to view the perpetrator's behaviour in the context of his relationship with Stacey and her daughter (child protection meetings), very few agencies attended the meetings. Often these meetings comprised of two agencies.

This working in silos and lack of information sharing contributed towards the perpetrator's history of violence and his history of domestic abuse being lost. Which in turn increased Stacey and her daughter's vulnerability and risk of harm. Ultimately, the lack of information sharing meant that Stacey's new address in the suburb east of Nottingham was not documented under her name within the police recording systems. At the time children's social care would have been aware of this information. An Independent Police Complaints Commission (IPCC) report identified that there was learning to be gained about the way restraining orders were recorded on police information systems.

Since 2011 there have been improvements in joint working. During the latter part of 2014, a pilot project was set up to explore ways in which joint working and co-location of staff might

improve the outcomes for both victims and perpetrators of domestic violence. The focus was on serial/repeat perpetrators who were still in a relationship with their partners.

The project was based in Nottingham City and included staff from probation, a police officer and a women's safety worker. The project only ran for six months and it was not possible to fully evaluate the outcomes because of a limited number of cases where all three agencies were engaged. Nevertheless, there were examples of good practice which showed that timely intervention with both a perpetrator and their partner provided effective and timely protection.

The commitment to working towards these improved outcomes has persisted. Over the last year (2017), the Integrated Offender Management (IOM) [22] across Nottinghamshire has been re-organised to include a cohort of 40 perpetrators of domestic abuse. Nottinghamshire Police, Community Rehabilitation Company (CRC) and National Probation Service and substance misuse providers, all work together to manage these cases. The Nottinghamshire Police and Crime Commissioner has agreed to fund independent domestic abuse advisors (IDVAs) to work alongside the statutory partners, supporting and providing interventions to partners. There will be a formal evaluation of this project.

8.3 Understanding domestic abuse and risk

The perpetrator had a 25-year history of violent offences. Despite this, the Dangerous Persons Management Unit viewed the perpetrator's risk solely through the lens of a sex offender (as his most recent custodial sentence had been for rape and he was being managed as a sex offender under MAPPA). This focus on him as a sex-offender meant that his escalating violence during the period under review was not considered during his risk assessments. Indeed, overtime the police lost sight of his previous offences and came to the conclusion that he was not a risk to children. The perpetrator had in the past been charged with the rape of a 16-year-old but the case did not progress because she was too "*afraid*" to testify. The officers from the Dangerous Persons Management Unit described this offence (and the non-proven murder charge) as "*unsubstantiated*" and thus did not consider it as an offence against a child. As a result, children's social care also concluded that the perpetrator was not a risk to children (despite her daughter being hurt during one of the perpetrator's assaults on Stacey).

The perpetrator's probation officer also underestimated the risk he posed to woman and children. This resulted in the information the perpetrator provided about his contact with Stacey not being shared with other agencies such as the police and children's social care. Thus, the potential breach of his restraining order did not lead to any sanctions.

At the time of Stacey's death, the Dangerous Persons Monitoring Unit used a risk assessment called the Thornton's 2000 risk matrix which largely relied on historical and actuarial information. In recognition of this limitation, in January 2017, the National

[22] Integrated Offender Management (IOM) is a nationwide initiative where criminal justice partners are co-located and share common caseloads to focus on locally defined offending priorities

Probation Service (Nottinghamshire) and the Dangerous Persons Monitoring Unit (DPMU)[23] implemented a new risk assessment and plan. The new assessment tool is known as ARMS (Active Risk Management System). It provides a greater emphasis on behaviour as a whole, rather than focusing on sexual offending. As a consequence, assessments take into account the offender's relationships, the nature of those relationships and the impact they have on an offender's sexual offending. Thus, although the ARMS assessment would not directly assess and address domestic abuse, the nature of an intimate relationship would be factored into the overall assessment and therefore the worker would consider domestic abuse when working with the perpetrator.

This review showed that professionals find it difficult to understand why victims return to their abuser. Instead of blaming them, professionals need to support them to leave. There are many reasons women do not leave an abusive relationship. According to Women's Aid these include:

- Danger and fear
- Isolation
- Shame, embarrassment or denial
- Trauma and low confidence
- Practical reasons.

In mid-June 2011, the perpetrator was remanded in custody for breaching his bail conditions. This was an ideal opportunity for professionals to provide adequate support to Stacey and encourage her not only to assist a prosecution but also to help her to leave him. Stacey appeared ready to move forward and testify against him. She had already asked for someone to read the oath in court for her. Both police and children's social care knew that he was putting pressure on her to retract her allegation. Despite this, after July there was no input from the Domestic Abuse Support Unit (DASU), neither Stacey nor her daughter were seen by a social worker between 24 May and 4 August 2011, no referral was made to the multi-agency risk assessment conference (MARAC), there was no input from the independent domestic abuse advisor (IDVA) and no triangulation of information by the probation officer. Between April 2011 and her death in October 2011, there was a window of opportunity that was missed. Stacey had managed to overcome some of the barriers to leaving. She had moved, she had the support of her family around her and she was feeling more confident. Her family felt that she had started to move on with her life.

Just before her death, she told her social worker that she had a new boyfriend. Many victims, their families and indeed professionals continue to believe that once a victim has separated from their abusive partner, the abuse will stop. However, post-separation violence and abuse is an issue for a significant number of victims of domestic abuse (and their children). One research study[24] showed that 76% of women who had separated suffered further abuse and harassment from their former partner. In fact, research shows

[23] This is now called Managing Sexual Offenders and Violent Offenders (MOSOVO)

[24] Humphreys, C and Thiara R, Neither justice nor protection: women's experiences of post-separation violence, Journal of Social Welfare and Family Law, Volume25, Issue 3, 2003 – accessed online 4 August 2017

that women are at greater risk of violence and being killed after separating from abusive partners.[25] It is not clear whether the perpetrator knew that Stacey had met someone else, but if he had, this would have made her more at risk of harm.

8.4 Victim vulnerability

Throughout her adult life, Stacey had a reading age of a 12-year-old.[26] She also had a speech impediment and therefore she found it hard to articulate certain words. Her mother described how Stacey was sometimes embarrassed by her speech. Clearly the perpetrator used this to control her as he told her he would get his friends to go to court and stare at her. It appeared that professionals were not always alert to Stacey's particular vulnerabilities.

There was nothing recorded about how professionals might support Stacey with her reading difficulties – particularly in the light of her father's comment about how she required written information on coloured paper to make it easier for her to read. We know the letter sent to her explaining the perpetrator's bail conditions was on white paper. Records showed that she asked for someone to read the oath for her in court. Her difficulties reading and articulating herself may have had an adverse effect on her confidence and her ability to engage not only with the court process but with professionals generally.

The perpetrator was 24 years older than Stacey. Research[27] suggests that women who have relationships with older men can be more vulnerable to a range of abuse including sexual and financial abuse. Abuse is about power and control and therefore both power and control can be features of relationships where one partner is significantly older than the other.[28] Professionals also did not appear to appreciate the potential risks related to the perpetrator and Stacey's age difference. Stacey's vulnerability as a young single mother living away from her family should have informed risk assessments.

Although it was the correct decision for Stacey's daughter to be on a child protection plan, the unintended consequence may have led Stacey to be more secretive about the perpetrator's behaviour. She may have felt she had to hide any contact that he had with her from professionals. Of course, he would have known this and may well have used this to control Stacey further, which in turn would have increased her vulnerability.

From records, it was evident that Stacey's name had been spelt differently on numerous occasions. In fact, children's social care never spelt her name correctly. In the police

[25] See for example www.womensaid.org.uk – accessed online 13 November 2017

[26] Around 15% (5.1 million) adults in England, can be described as 'functionally illiterate'. They would not pass an English GCSE and have literacy levels at or below those expected of an 11-year-old. They can understand short straightforward texts on familiar topics accurately and independently, and obtain information from everyday sources, but reading information from unfamiliar sources, or on unfamiliar topics, could cause problems – see for example www.literacytrust.org.uk – accessed online 1 October 2017

[27] See for example, Ellen Volpe *et al*. What's age got to do with it? Partner age difference, power, intimate partner violence and sexual risk in urban adolescents, January 2013 – Journal of Interpersonal Violence www.journals.sagepub.com – accessed online 4 August 2017

[28] www.loveisrespect.org/content/aint-nothing-number/

systems, her name had been recorded in ten different ways. This inevitably meant that information about her or incidents would not be available to officers depending on how they entered her details. This again may have increased her vulnerability.

8.5 Professional curiosity and professional challenge

Throughout this review, there was an impression that professionals did not really consider the circumstances in which Stacey and her daughter found themselves. It was apparent that professionals focused their attention on Stacey rather than the perpetrator. It was clear from the perpetrator's history that he was violent; his previous relationships had been violent; he was a misogynist with a predilection for harming women whether he was in a relationship with them or not. His history of sexual offending was known to professionals – as well as the level of violence, control and humiliation he used as part of that offending. He used knives and implements (cigarette, carving fork, bottle) during the alleged assaults. This too was known. Yet it did not appear that professionals were knowledgeable about domestic abuse[29] nor were they curious about Stacey's relationship with the perpetrator. This was compounded as professionals did not challenge the perpetrator. He told professionals what they wanted to hear. For example, he told police officers that he had cut down on his drinking. He told his probation officer that he was working away. He used excuses not to attend courses on domestic abuse or anger management telling professionals he knew what his "triggers" were. Again, no one challenged him. Similarly, when both Stacey and the perpetrator told professionals that they had bumped into each other, this was not challenged. Even when professionals at the core meeting heard that the perpetrator was seen at Stacey's daughter's school, this information was not explored – was he there to threaten Stacey, was he stalking her, or was he there to see her daughter?

9 CONCLUSION

This has been a distressing, protracted domestic homicide review process, particularly for Stacey's family. Both her mother and father disagreed with some of the details contained within the original domestic homicide review. Stacey's mother has worked tirelessly to have the case re-reviewed so the family could understand what happened to Stacey and why. The panel hopes that this report goes some way to answering some of the family's many questions. Needless to say, we have not been able to provide clarity to every issue that was raised, but the panel has tried.

It is clear from this review that Stacey was a wonderful daughter and mother, who was preyed upon by a violent, controlling manipulative man. He isolated, threatened and physically harmed her. There is no doubt that she was afraid of him.

[29] For example, neither probation nor children's social care recognised the danger to Stacey when she disclosed contact with the perpetrator after his release from prison. No agency considered a further referral to the multi-agency risk assessment conference when he was released. Professionals did not appreciate the lengths the perpetrator went to in order to make Stacey retract her allegations. Professionals did not recognise they too were being manipulated by the perpetrator.

He had a history of violence against women and girls. He had a conviction for rape and a not proven murder charge. Despite his history, professionals focused their attention on Stacey rather than him. Professionals did not comprehend the danger he posed, they did not recognise they were being manipulated by him and they failed to see how few choices Stacey had available to her. The result was that when he was released from prison and Stacey tried to separate from him, many agencies either ceased their engagement with her or did not recognise the risk she faced. This left Stacey vulnerable at the very point that the perpetrator was likely to be at his most angry, because he had lost his power and control over her.

10 RECOMMENDATIONS

There were 39 single agency recommendations arising from the original domestic homicide review that was completed in November 2013. These single agency recommendations aimed to make improvements to a wide range of issues including (amongst other things):

- The multi-agency risk assessment conference process
- The police response to disclosures of domestic abuse e.g. building an evidence based prosecution that does not rely on the victim's evidence
- Record keeping across all agencies
- Developing training on domestic abuse
- Reflective supervision in complex cases
- Information sharing between professionals and agencies

Work has already been completed on all of these recommendations following the initial domestic homicide review. Some of the detail about improvements to services has been included within the body of this report and the full list of recommendations and subsequent activities can be seen in the attached action plan. Nevertheless, in the course of evaluating this domestic homicide again, a number of issues arose that the panel felt necessitated further consideration.

1. Nottinghamshire Police should undertake an audit to establish whether restraining orders are appropriately recorded on police information systems e.g. on both the perpetrator's and the victim's records

2. In order to reassure South Nottinghamshire Community Safety Partnership (SNCSP), Nottinghamshire Safeguarding Children Board should present a report regarding its scrutiny of multi-agency attendance at child protection meetings to the Partnership and the Safer Nottinghamshire Board (SNB)

3. South Nottinghamshire Community Safety Partnership should review how effectively the multi-agency public protection (MAPPA) and the multi-agency risk assessment conference (MARAC) processes now link and share information

4. In order to reassure the Safer Nottinghamshire Board that agencies are attending and making referrals to the multi-agency risk assessment conference (MARAC), the SNB DSA Executive should present/report the outcome of the regular audits to the Safer Nottinghamshire Board

5. South Nottinghamshire Community Safety Partnership should request further detailed information about the training on domestic abuse that is currently provided to staff working in the Crown Prosecution Service and how many staff have accessed the training

6. The Home Office statutory guidance for the conduct of domestic homicide reviews should clearly set out the conditions under which completed and quality assured domestic homicide reviews are reconvened and re-reviewed.