Domestic Homicide Review
Executive Summary Report

Name of Deceased Person: "Zoe"

Independent Chair: Carolyn Carson
Independent Report Author: Allison Sandiford

Final Draft – March 2023

Contents

1. Introduction

1.1. Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

1.2. DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process.

1.3. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions with an aim to avoid future incidents of domestic homicide and violence. The review also assesses whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff.

1.4. To protect their identities and those of their family members, pseudonyms have been used in this review; the victim of the homicide is referred to as Zoe, and her perpetrator as Patrick. The Review Chair, Review Author and domestic homicide review panel send their condolences to Zoe's family.

1.5. At the time of the fatal incident, Zoe, aged 43 years of age and Patrick aged 50 years of age, resided in the United Kingdom. Zoe had been born in Lithuania; Patrick had been born in the Union of Soviet Socialist Republics but had subsequently moved with his parents to Lithuania.

1.6. The criminal investigation concluded in May 2022. Patrick denied murder but entered a plea to manslaughter. This was accepted by the prosecution. On the 26th of May 2022, Patrick was sentenced to a period of imprisonment of nine years and four months. Patrick must serve a minimum of two thirds, less the 10 months spent on remand.

1.6.1. On the 29th of November 2021, the Review sub-group of the Bassetlaw and Sherwood Community Partnership recommended the circumstances of this case as fulfilling the criteria for a statutory domestic homicide review and this was approved by their Chair. (A domestic abuse specialist from Nottinghamshire Women's Aid was on the panel to advise.) The Home Office were informed of the decision on the 2nd of December 2021.

1.7. The Serious Incident Learning Process (SILP) model of review was commissioned to be used within the domestic homicide review process.

1.8. SILP is a learning model, tried and tested in safeguarding reviews for both children's and adult's cases, including domestic homicide reviews, and takes account of principles enshrined in government guidance. The process seeks to engage front line staff and their managers in reviewing cases to focus on why those involved acted in a certain way at the time.

1.9. An initial scoping meeting and first panel meeting was held on the 11th of April 2022, where agency representation, terms of reference, the scoping period and the project plan were agreed. This was followed by a 'report authors' briefing on the 6th of May 2022, and a full days learning event on the 5th of September 2022. A recall event convened on the 9th of December 2022.

1.10. Whilst applying the principles of the SILP methodology, the independent chair and author have followed the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, as amended in December 2016. Importantly, the model has incorporated four review panel meetings, a sufficient number of meetings in this case for the panel to effectively support the review and to discharge their duties.

2. Contributors to the Review

Agency	Contribution
NOTTINGHAMSHIRE POLICE	• Individual Management Review, Provided by an Independent Review Officer. • Attended Learning and Recall Event
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	• Individual Management Review provided from Named Nurse, Safeguarding Adults. • Attended Learning and Recall Event
NOTTINGHAM COUNTY COUNCIL – ADULT SOCIAL CARE	• Attended Learning Event
BASSETLAW INTEGRATED CARE PARTNERSHIP	• Attended Learning and Recall Event
NOTTINGHAMSHIRE WOMEN'S AID	• Attended Learning Event.
CHANGE GROW LIVE	• Attended Learning Event
EAST MIDLANDS AMBULANCE SERVICE	• Individual Management Review provided from an Independent Safeguarding Lead.

2.1. Bassetlaw Newark and Sherwood Community Partnership sought to include a Lithuanian Specialist within the review process but was unsuccessful.

2.2. The Review Panel members

Carolyn Carson
Independent Chair, Review Consulting.
Allison Sandiford
Independent Author, Review Consulting.
Nicolette Richards

Domestic Abuse Coordinator, Bassetlaw, Newark and Sherwood Community Partnership.
David Swift-Rollinson/Mark Dickson
Regional Review Officer/Detective Chief Inspector, Nottinghamshire Police
Mandy Green
Head of Services, Nottinghamshire Women's Aid Ltd
Dave Hinds
Change, Grow, Live
Elizabeth Proctor
Safeguarding Specialist Nurse for Adults, Nottingham, and Nottinghamshire Integrated Care Board
Amanda Marsden
Team Manager, Nottinghamshire County Council, Adult Social Care.
Richard Idle
Safeguarding Lead, Sherwood Forest Hospitals
Alan Batty
Public Protection Business Manager, Newark and Sherwood District Council.
Emma Wilson
Safeguarding Lead, East Midlands Ambulance Service

The panel met on the following dates:

- Scoping Meeting — 11th of April 2022
- Author's Briefing — 6th of May 2022
- Learning Event — 5th of September 2022
- Recall Event — 9th of December 2022

2.3. Report Chair and Author

2.3.1. The review commissioned Carolyn Carson, to act as Independent Chair. Carolyn is an independent safeguarding reviewer. She is a retired Police Superintendent who specialised in Safeguarding, retiring whilst holding the post of Safeguarding Lead at Her Majesty's Inspectorate of Constabulary, in 2011. Post retirement from 2012, Carolyn has conducted adult safeguarding reviews, domestic homicide reviews and SILP, independently. Carolyn has no links to Bassetlaw, Newark, and Sherwood Community Partnership or any of its partner agencies.

2.3.2. The report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with no links to Bassetlaw, Newark, and Sherwood Community Partnership or any of its partner agencies. Allison gained experience in domestic abuse and safeguarding both adults and children whilst working for a police service. Allison was part of a team responsible for the force's contribution to delivering Early Help, preventive support and problem-solving interventions for adults and children, in partnership with other key local and regional agencies. She represented the force at strategy meetings and protection conferences to assess risk and negotiate actions with other agencies to instate interventions to safeguard individuals' lives. She also gained experience in chairing meetings, conferences, and partnership initiatives such as daily management risk meetings and Multi-Agency Risk Assessment Conferences. Since 2019 Allison has conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews, both independently and with SILP. In 2019 Allison completed the SILP Lead Reviewer Course and has since completed the Home Office online learning with regard to conducting Domestic Homicide Reviews. Allison has a positive attitude to continuing professional development and regularly attends training and seminars.

2.3.3. The Review Chair, Review Author and the Domestic Homicide Review Panel would like to thank Zoe's niece, hereafter known as Belinda, for contributing to this review.

2.4. Terms of Reference

2.4.1. The terms of reference and Project Plan appear at Appendix 1 and detail the purpose, framework, agency reports to be commissioned and the areas for consideration for this review.

2.4.2. For effective learning, it was agreed that the scoping period for this review will be from the 16th of August 2017, when Zoe presented at the emergency department of a hospital, until the 22nd of July 2021, the date Zoe was found deceased.

3. Background Information

3.1. Zoe moved from Lithuania to Hull in the United Kingdom around 2007 with a friend. Within a few years, Zoe had started a relationship with Patrick[1]. Around 2012, Zoe and Patrick moved to Newark. Zoe's friend also moved to Newark with her new partner, and they all rented a flat together.

3.2. Zoe visited her family in Lithuania in 2013. This is the last time she saw family apart from her niece (Belinda) who, following a visit in 2014, returned to the United Kingdom in 2015 - to live, initially staying with Zoe. Patrick was visiting Lithuania at the time, but Belinda recalls that Patrick was known to be drinking heavily and was no longer working. His health was problematic, but he did not attempt to claim any benefits in the United Kingdom - effecting Zoe the sole earner.

3.3. Prior to Patrick returning, Zoe asked Belinda to move out of the property. Belinda rented a room nearby until she moved to Kent in September 2016 to study. During this time Belinda noticed that Zoe was drinking more, and she became aware of Zoe being dismissed from two jobs after attending under the influence of alcohol.

3.4. In 2017, Zoe's friend (whom she had moved from Lithuania with) asked that Zoe and Patrick move out of the address. Zoe's friend has since explained to Belinda that this was because of Zoe's and Patrick's excessive alcohol intake, and them not paying enough for the rent and bills. (Zoe and Patrick owed the friend a lot of money by this time.) As a result, the relationship between Zoe and her friend broke down. Belinda recalls that it also became harder for her to maintain a relationship with Zoe as Zoe would often not answer her calls or return messages.

3.5. In August 2017 Zoe suffered a period of feeling unwell and she attended the Emergency Department at the hospital - where she was diagnosed with hypertension.

3.6. In 2018 Zoe's mother died in Lithuania. Despite Belinda helping her to obtain a ticket, Zoe did not travel to Lithuania. It was around this time that Belinda became aware of Zoe losing another job due to alcohol.

3.7. In May 2018 Patrick was found unresponsive outside his accommodation. A neighbour rang 999. Paramedics attended and took him to hospital.

3.8. In May 2019 Zoe fell in the street. A passer-by found her and rang 999. Zoe was taken to hospital.

3.9. Following Brexit, Zoe contacted Belinda for help with attending the Embassy in London and renewing her passport. Belinda arranged to meet Zoe in London but on the day, Zoe fell whilst disembarking the train. Zoe was taken to University College Hospital where it was established that she was suffering a Pelvic Inflammatory Disease and was under the influence of alcohol. Belinda attended the hospital with Zoe and recalls a nurse asking Zoe about bruises on her legs. Zoe said she had fallen. Belinda also recalls that it was during this hospital attendance that she learned Zoe had not ever registered with a GP in England.

[1] This review has been unable to confirm when Patrick moved to the United Kingdom.

3.10. Whilst at the hospital, Belinda telephoned family in Lithuania, but when it became apparent that the family had learned of Zoe's excessive drinking, Zoe argued with Belinda and discharged herself.

3.11. Zoe and Belinda did not speak again until June 2021 when Zoe asked Belinda for a second time for help with her passport to secure residency in the United Kingdom. This was their last contact.

3.12. On the day of the murder, Patrick told a resident on the street that his wife[2] was dead in the house and he needed help. The resident called emergency services using 999.

3.13. Upon entering the property, a Police Officer found Zoe lying on the bed covered in multiple bruises across her back, shoulders, and arms. The Officer formed the opinion that this was an unnatural death and that Zoe had been assaulted numerous times. A bloodied[3] metal pole and meat tenderiser was recovered from the address.

3.14. Whilst police were conducting enquiries with neighbours (who recalled arguing and aggressive raised voices over the previous few days) Patrick shouted, *"I kill my wife"*, and was arrested on suspicion of murder.

3.15. A post-mortem toxicology showed Zoe to have a blood alcohol concentration of 350 mg/dl. A forensic scientist estimated Patrick's blood alcohol concentration at the midpoint of the stated time of the incident, to have been 280 mg/dL. For the purposes of comparison, this is almost 4 ½ times the legal limit for driving a motor vehicle in England and Wales of 80 mg / dl.

3.16. After being shown photographs of Zoe's injuries, Patrick admitted assaulting Zoe, but not so seriously as to cause her death. In May 2022 Patrick entered a guilty plea to manslaughter for which he was subsequently sentenced to a period of imprisonment of nine years and four months.

3.17. Belinda is clear that whilst she was concerned for Zoe regarding her alcohol intake and Patrick not working, she never suspected, or saw any violence within Zoe's and Patrick's relationship.

4. Chronological Agency Interaction and Overview Prior to the Key Lines of Enquiry
(pre-16.08.2017)

4.1. In 2006 Patrick was arrested by Humberside Police for a positive breath test following a road traffic collision.

4.2. In 2007, Patrick was assaulted by four youths whilst he was walking down a street with Zoe. Patrick did not support a police investigation.

5. Key Practice Episodes
The review highlighted the following as key episodes in the case:

5.1. Assessment and Response to Zoe feeling unwell in August 2017

5.1.1. Zoe attended the hospital accident and emergency department by ambulance at 08:44 hours.

5.1.2. Zoe reported to have been feeling unwell for three days. She said that she felt faint and had fallen on her way to work. Case notes record that Zoe *smelt of alcohol* and Zoe acknowledged that

[2] It has not been possible for this review to establish whether Zoe and Patrick were legally married or not.
[3] A forensic report explained that there was extremely strong support that blood which was tested from the pole and the meat tenderiser had originated from Zoe.

she had been drinking alcohol the previous evening. There is no documentation of any further exploration of Zoe's alcohol use.

5.1.3. Zoe was diagnosed with hypertension[4]. It was recorded that she was not registered with a GP, but she was discharged and asked to attend one. The safeguarding questions were answered 'no' in relation to domestic violence and past medical history was recorded as 'none.'

5.2. Assessment and Response to Patrick being found outside in May 2018

5.2.1. Emergency services received a report of a cold, confused male, who had been found by a neighbour in the garden. It was established to be Patrick.

5.2.2. Paramedics woke Patrick and took him inside to be assessed. Patrick was unable to remember the events leading up to him being in the garden and was assessed to be lacking capacity. The review cannot establish any further details regarding this assessment.

5.2.3. Paramedics conveyed Patrick, and Zoe, to Lincoln Hospital. Upon arrival, Patrick's confusion had resolved, and no treatment was required.

5.2.4. There is no record of any exploration of Patrick's alcohol use.

5.3. Assessment and Response to Zoe having fallen in May 2019

5.3.1. Zoe was found by a passer-by in the street having fallen. Paramedics were called and upon attendance they used language line[5] to communicate with Zoe. It was established that Zoe had pain to her head and back. Zoe was conveyed to the Urgent Care Centre for assessment at 09.59 hours.

5.3.2. Language line was not used with Zoe at the Urgent Care Centre, but Zoe told healthcare professionals that she had experienced 'dizziness and pain across her whole chest for a while.' It was noted that Zoe appeared intoxicated, but she said that her last alcoholic drink had been the previous night. There is no documentation of any further exploration of Zoe's alcohol use.

5.3.3. Zoe was also noted to be presenting as anxious – but there is no further description.

5.3.4. The prompted questions in the Emergency Department documentation regarding safeguarding and domestic violence were both answered to state that there were no concerns. Zoe was noted by the attending nurse to be considered a 'falls risk' due to a previous fall. No GP details were noted.

5.3.5. No further information is documented regarding discharge.

5.4. Assessment and Response to Zoe being found injured on a day in May 2020

5.4.1. Zoe was found in the street at 8:06 hours with facial injuries by a member of the public - who then telephoned emergency services. The member of the public reported that it looked like Zoe had been punched in the face and that she was bleeding.

5.4.2. Zoe told Police Officers who attended the scene that she had been drinking overnight and was on her way to work when she had fallen onto her face. Zoe said that she had not been assaulted. Consequently, all further information sharing between services, reported that Zoe had

[4] High Blood Pressure – can be dangerous if untreated.

[5] Interpretation and Translation Services

fallen - no other professionals were informed of the person who found Zoe reporting that it looked like she had been punched.

5.4.3. Officers called for an ambulance and advised the ambulance service that they would take Zoe to the police station to administer first aid. Upon attendance at the police station paramedics conveyed Zoe to Newark Urgent Care Centre for further assessment, where they were advised that she needed to be reviewed at Kings Mill Hospital. This is because Newark Urgent Care Centre is not an emergency department. The centre only deals with minor injuries, and it was felt Zoe's injuries required assessment at an acute hospital. This happens often and was not something that Covid had impacted on. Zoe needed reassurance from the crew to cooperate with being conveyed to Kings Mill Hospital for further assessment of her injuries.

5.4.4. Zoe arrived by ambulance to Kings Mill hospital Emergency Department at 10:56 hours. At the hospital Zoe was noted to have a 1.5cm bruise above her eyebrow and was recorded as appearing intoxicated. There is no documentation of any further exploration of Zoe's bruise or alcohol use.

5.4.5. Following assessment, Zoe was discharged. Zoe told healthcare professionals that she had no money or means of getting home (the hospital is twenty-two miles from Zoe's home address). The nurse advised the duty nurse manager, who did not authorise transport at that time as it seemed that Zoe may still be able to source her own transport. It is documented that Zoe was happy to wait and frequently left the department to go for a cigarette. She was later informed that the hospital was unable to provide transport but there is no other recorded information in regard to this.

5.4.6. No GP details were noted, and Zoe's past medical history was recorded as nil. Safeguarding concerns were ticked as 'no.'

5.4.7. The next time any professional interacted with either Zoe or Patrick was on the day when Zoe was found deceased.

6. Key Issues Arising from the Review

6.1. The key issues arising from the review were:

Agencies Understanding and Management of Domestic Abuse
The Role of a Private Landlord.
Importance of GP Registration
Agencies Understanding of Zoe's Lived Experience

7. Conclusions

7.1. Zoe met Patrick after she had moved from Lithuania to the United Kingdom around 2007.

7.2. There were no reports of domestic abuse within their relationship, but neighbours and colleagues recall arguments and on one occasion, a bruise to Zoe's eye.

7.3. Both Zoe and Patrick consumed alcohol.

7.4. Zoe presented to emergency healthcare on three occasions and Patrick, on one occasion; on all occasions either a smell of alcohol, or the influence of alcohol was noted.

7.5. Within Zoe's communications with professionals, there is only one occasion when proper consideration was had as to whether Zoe required the services of an interpreter to ensure effective communication. There is no evidence of cultural consideration.

7.6. Similarly, there is no evidence during any of Zoe's presentations to professionals of professional curiosity being applied regarding Zoe's falls and injuries, or alcohol consumption and as such, agencies did not establish substance misuse as an issue, or consider that Zoe's injuries may have been as a result of domestic violence.

7.7. Zoe had not registered with a GP Practice. This prevented health discharge notices from being held in a central location by one organisation and prevented any follow up care being administered.

7.8. In the absence of GP and Zoe seeking support from any organisations or agencies, only the private letting company had any insight into Zoe's and Patrick's lived experiences.

7.9. Had the letting company had procedures through which to share the information with support services, an opportunity would have been created for support services to attempt to engage Zoe. In the absence of these procedures, Zoe was not made aware of what support was available to her.

7.10. Zoe's culture and language was a potential barrier to her seeking support from services, and likely increased her isolation within society. This combined with a lack of disclosures and professional curiosity, left Zoe unidentified as a potential vulnerable adult, and victim of domestic abuse. This rendered her situation as invisible to professionals.

7.11. In consequence, at the time of her death, having been violently assaulted by Patrick, Zoe was found to have sustained a number of cruel injuries with evidence that the homicide was not an isolated, violent event. On-going violence had remained hidden with agencies not being aware of Zoe's lived experience and suffering. Sadly, the review cannot ascertain what Zoe understood about her situation and if she knew that help and support is available to victims of domestic abuse in Newark.

7.12. Unless the recommendations of this review are implemented, the same outcome will be apparent for future victims of domestic abuse in Zoe's situation.

8. Lessons to be Learned.

8.1. **Lesson 1:** Presenting injuries on Zoe were not sufficiently explored and domestic abuse not considered due to a lack of professional curiosity by professionals.

8.2. **Lesson 2:** Zoe's domestic abuse remained hidden due to presenting injuries not able to be centrally collated and community members not reporting witnessed injuries.

8.3. **Lesson 3:** The private letting company had valuable insight into Zoe and Patrick lived experiences that wasn't shared with agencies.

8.4. **Lesson 4:** The consequence of Zoe not being registered with a GP Practice was that no one was able to collate her medical situation, substance issues and out of area presentations for medical care.

8.5. **Lesson 5:** Proactive use of Social Prescribing may assist vulnerable persons in Zoe's position, especially where there is no registered GP.

8.6. **Lesson 6:** Zoe's cultural experiences may have impacted on how Zoe recognised and managed domestic abuse. Professionals need to be curiously alert to cultural differences and incorporate this vital information into risk identification and management to prevent future harm.

8.7. Lesson 7: Professionals are not always sensitive to the limitation's language capabilities can bring to communication and an interpreter should always be considered carefully, even when first impressions suggest that a presenting person is able to converse in English.

9. Recommendations from the Review

9.1. The following multi-agency recommendations are made to Bassetlaw, Newark, and Sherwood Community Safer Partnership:

9.1.1. Recommendation 1:
Bassetlaw, Newark, and Sherwood Community Partnership should ensure that work is undertaken which seeks to educate the local community about what constitutes domestic violence abuse, the support services available and what to do if they suspect that a neighbour or friend is victim. The education must be in both English and other prominent local languages, such as Lithuanian and Polish.

9.1.2. Recommendation 2:
Bassetlaw, Newark, and Sherwood Community Partnership should consider developing links to private landlords to help them foster safeguarding processes.

9.1.3. Recommendation 3:
Bassetlaw, Newark, and Sherwood Community Partnership should satisfy themselves that migrant members of their community are being encouraged and supported to register with a GP, in order to help any victims of domestic abuse be supported in the community by a GP.

9.1.4. Recommendation 4:
Bassetlaw, Newark, and Sherwood Community Partnership should share this report with a Lithuanian Specialist and request feedback which will help them be better informed on issues relating to Lithuanian culture.

9.1.5. Recommendation 5:
Bassetlaw, Newark, and Sherwood Community Partnership should reassure themselves that consideration of culturally specific elements is encompassed within Safeguarding training.

9.1.6. Recommendation 6:
Bassetlaw, Newark, and Sherwood Community Partnership should reassure themselves that interpreters are available for safeguarding practitioners and that practitioners are confident in their use.

10. Appendix 1: Terms of Reference and Project Plan

DOMESTIC HOMICIDE REVIEW
TERMS OF REFERENCE & PROJECT PLAN

SUBJECT: Operation Highlight

Victim: Zoe

1. Introduction:

1.1 This Domestic Homicide Review was commissioned by Bassetlaw, Newark & Sherwood Community Safety Partnership in response to the death of Zoe who was found by paramedics deceased in the bedroom of her property covered in bruises.

1.2 Zoe's long term partner Patrick was present at the scene and appeared to be in drink. It was he who had alerted a member of the public to the fact that his partner was inside the property and stated that he had killed Zoe. The member of the public had then contacted the police.

1.3 The DHR referral from the Police was received by the CSP on the 11th of October 2021once the cause of death had been established.

1.4 The case details were considered by the CSP on the 29th of November 2021. The CSP agreed a recommendation to the Chair that the case details met the criteria for a DHR to be commenced.

1.5 The scoping period was agreed to be from the 16.8.17 to the 22.7.21.

2. Legal Framework:

2.1 A Domestic Homicide Review (DHR) must be undertaken when the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse, or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

2.2 The purpose of the DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a

coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)

3. Methodology:

3.1 This Domestic Homicide Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focussing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

3.2 This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3 The SILP model of review adheres to the principles of.

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

4. Scope of Case Review:

4.1 Subject **Zoe**

4.2 Scoping period: **16.8.17** to the **22.7.21.**

4.3 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period, including an account of what is known about behavioural, social or emotional difficulties of family members where relevant. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

5. Agency Reports:

5.1 Agency Reports will be requested from:

- Police
- Sherwood Forest Hospital

- East Midlands Ambulance Service

5.2 Agencies will be requested to use a SILP Report Template.

5.3 Summary information is requested from- if relevant:

- GP

6. Specific Areas for Consideration:

a. What is known about the Lithuanian Culture, in particular whether it recognises an equal status between female and male and the context in which violence against women may be perceived?
b. What was known about Zoe's lived experience, living arrangements, working arrangement and dynamics within her relationship with Patrick?
c. Explore whether there were any language barriers and whether any such barriers had any effect on Zoe's ability to access support. How accessible are domestic abuse services where English is not a survivor's first language.
d. How accessible and responsive were support services that may have been available to Zoe and how well known were these services to the public?
e. How did the Equality Act protect Zoe against direct and indirect discrimination in support services?
f. What is the impact of an individual not being registered with a General Practitioner on service provision?
g. How has Brexit impacted upon Zoe, and Patrick and any support offered?
h. How has the Covid Pandemic impacted upon Zoe, and Patrick and any support offered?
i. Identify examples of good practice, both single and multi-agency.

7. Engagement with the family

7.1 A key element of SILP is engagement with family members, to ensure their views are sought and integrated into the Review and the learning. The family will be notified of the DHR by a letter from the Chair. The review author will follow up by contacting the family, and ensure they are consulted on the terms of reference for the review.

7.2 Further contact will be made to invite participation in the review by a personal interview, correspondence, or telephone conversation prior to the Learning Event. Contributions will be woven into the text of the Overview Report and the family will be given feedback at the end of the process.

8. Timetable for Domestic Homicide Review:

Timetable for Case Review:

Scoping Meeting and panel 1	11.4.22
Letters to Agencies	21.4.22
Engagement with family	Begin once authorised
Author's Briefing	6.5.22
Agency IMR's completed, quality assured and submitted to Chair	1.7.22

Agency Reports quality assured by Chair and Author	18.7.22
Agency Reports distributed	20.7.22
Learning Event inc Panel 2	5.9.22
First draft of Overview Report to	5.10.22
Recall Event inc Panel 3	25.10.22
Second draft of Overview Report to	TBA
Presentation and sign off	TBA

11. Appendix 2: Domestic Violence Abuse Local Service Offer

Name	Contact Detail
Juno Women's Aid	W: https://junowomensaid.org.uk/ T: 0808 800 0340
National Domestic Violence Helpline (Female)	T: 0808 200 0247
Men's Advice Line (Males)	T: 0808 801 0325
National LGBT Domestic Violence Helpline (Same-sex relationships)	T: 0800 999 5428
Newark Women's Aid	T: 01636 79687
Nottinghamshire Women's Aid	W: www.nottswa.org T: 01909 533 610
Nottinghamshire Police	Emergencies: 999 Non-emergencies: 101
Nottinghamshire County Council	W: www.nottinghamshire.gov.uk T: 0300 500 80 80
Citizens Advice Bureau	Website T: 0300 456 83 69
Newark and Sherwood District Council	W: https://www.newark-sherwooddc.gov.uk/ T: 01636650000
Universal Credit Helpline	T: 0800 328 56 44
Turn2Us	W: www.turn2us.org.uk
Centreplace	W: www.centreplace.org.uk T: 01909 479 191
HOPE	W: www.hopeservices.org.uk
Refuge	W: https://www.refuge.org.uk/
National Women's Aid	W: https://www.womensaid.org.uk/
Nottinghamshire Rape Crisis	W: https://nottssvss.org.uk/
Equation - support available for men and women	W: https://www.equation.org.uk/
Notts Help Yourself	W: www.nottshelpyourself.org.uk
Safe Spaces	W: https://uksaysnomore.org/safespaces/

Housing

Seeking help for domestic abuse does NOT automatically mean you will have to leave your home, all situations are different, we can help & advise:

Staying in your home:

If you are subjected to domestic abuse but want to stay in your home, there are a number of options that may be available to you:

- Apply for a court order (known as an injunction) against the person who is abusing you. The injunction can protect you or your child from being harmed or threatened by the person who has abused you (a 'non-molestation order') or decide who can live in the family home or enter the surrounding area (an 'occupation order'). Even if you do not own or rent the property you are living in, you can still apply for an injunction. (see website gov.uk for more details). If your income is low, you may be entitled to 'legal aid' to help with the costs of this.
- Apply for a Domestic Violence Protection Notice/Order against the person who is abusing you; this can prevent them from returning to the home and grants the police and magistrates' courts time to put protective measures in place. This can be done in the immediate aftermath of a domestic violence incident, where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.
- Request a referral to the Council's Sanctuary Scheme. If your referral is accepted, you could get measures installed at your address such as additional lighting and locks, fire proof letterbox or external door, secure gates/fencing etc. to make your home safer internally and externally.
- Contact domestic abuse charities who can provide someone to talk to, support and access to legal advice such as Nottinghamshire Women's Aid (nottswa.org) National Domestic Violence Helpline or Men's Advice Line
- Visit the Council's website https://www.newark-sherwooddc.gov.uk/
- **Moving Out Of Your Home - Staying Safe**

If you are subjected to domestic abuse and need to move out of your home to a safer place, there are a number of options that may be available to you:

- Contact local support organisation's such as Nottinghamshire Women's Aid or the National Domestic Violence Helpline who can help you plan your move safely. They can advise of your rights and options and find a space in a specialist refuge in another part of the country where you can live safely and be supported to settle.
- Contact your landlord to see if they can offer a move to an alternative property (Council's and Registered Providers will have a policy in place to deal with this type of situation).
- Apply as a homeless person to any Council in England. If it is not reasonable for you to remain in your present home and you have nowhere else to go, if you are in priority need, the Council can provide you with emergency accommodation in a safe area whilst they try to work with you to find more settled accommodation elsewhere. You will be in priority need if you have children or are pregnant, the Council may also consider you to be in priority need if you are vulnerable because of your circumstances and needs.
- If the Council accepts you are homeless, you will be owed what is called "a relief duty" and you will be given a 'Personalised Housing Plan' which will outline the steps that both you and the Council are required to take to relieve your homeless situation. The Council will work with you for a period of 56 days, or until you secure a new home. If it is not possible to find a new home during this 'relief period', you may be accepted as homeless and owed a full housing duty.

- If you need to leave your home quickly, try to make sure you have essentials with you such as a change of clothes, toiletries, medication and important items such as your passport, bank and credit cards and mobile phone. You do not have to make any decisions about giving up your home permanently until you have obtained advice about your rights from a Solicitor, the Council or specialist advice agency such as Nottinghamshire Women's Aid.

Last Updated on Tuesday, March 8, 2022

https://www.bassetlaw.gov.uk/community-and-living/domestic-violence-and-abuse/