Domestic Homicide Review
Overview Report
Name of Deceased Person: "Zoe"

Independent Chair: Carolyn Carson
Independent Report Author: Allison Sandiford

Final Draft – March 2023

Contents

1. Introduction 2
2. Parallel Reviews 5
3. Involvement of Family and Wider Community 5
4. Contributors to the Review 5
5. Equality and Diversity 7
6. Background Information 8
7. Chronological Agency Interaction and Overview Prior to the Key Lines of Enquiry 9
8. Key Practice Episodes 10
Assessment and Response to Zoe feeling unwell on the 16th of August 2017 10
Assessment and Response to Patrick being found outside on the 11th of May 2018 10
Assessment and Response to Zoe having fallen on the 14th of May 2019 10
Assessment and Response to Zoe being found injured on the 16th of May 2020 11
9. Analysis by Theme 11
Agencies Understanding and Management of Domestic Abuse 11
The Role of a Private Landlord. 16
Importance of GP Registration 18
Agencies Understanding of Zoe's Lived Experience 20
10. Conclusions 25
11. Lessons Learned 26
12. Good Practice 26
13. Developments Since the Scoping Period 26
14. Recommendations 27
15. Appendix 1: Terms of Reference and Project Plan 27
16. Appendix 2: Domestic Violence Abuse Local Service Offer 31

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. The subject of this DHR is Zoe. The Review Chair, Review Author and domestic homicide review panel send their condolences to Zoe's family.

1.5. The report will examine agency involvement but will also examine the past to identify any relevant background, or trail of abuse before her death. It will also examine whether support was accessed within the community and/or if there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify if there are appropriate solutions to make the future safer.

1.6. The brief circumstances of this domestic homicide are that Zoe was found deceased at her home address by paramedics after a member of the public, having been stopped on the street by Zoe's partner (Patrick) asking for help, called the emergency services. An attending Police Officer formed the opinion that this was not a natural death. Overall Zoe had fifty-one recent bruises and abrasions over her body. The immediate cause of death was recorded as internal haemorrhage from splenic laceration.

1.7. The key purpose of undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. 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 to reduce the risk of such tragedies happening in the future. This review is seeking to examine the role of agencies who came into contact with Zoe and her partner, Patrick, to establish if there are any lessons to be learned as a result of engagement with the family or to identify missed opportunities for agency

engagement. The review also seeks to understand the family's ability to be aware of, and access, services they may have needed.

1.8. 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.

1.9. Timescales

1.9.1. This review commenced on the 11th of April 2022 and concluded on the 3rd of March 2023

1.10. Confidentiality

1.10.1. The findings of each review are confidential. Information is available only to participating professionals and their line managers. To ensure confidentiality, the victim of the homicide subject to this review is referred to as Zoe, and her partner as Patrick.

1.11. Terms of Reference

1.11.1. 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.

1.11.2. The panel identified the following key lines of enquiry for the review:

- 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?
- What was known about Zoe's lived experience, living arrangements, working arrangement and dynamics within her relationship with Patrick?
- 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.
- How accessible and responsive were support services that may have been available to Zoe and how well known were these services to the public?
- How did the Equality Act protect Zoe against direct and indirect discrimination in support services?
- What is the impact of an individual not being registered with a General Practitioner on service provision?
- How has Brexit impacted upon Zoe, and Patrick and any support offered?
- How has the Covid Pandemic impacted upon Zoe, and Patrick and any support offered?
- Identify examples of good practice, both single and multi-agency.

1.11.3. 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.

1.12. Methodology

1.12.1. 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.

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

1.12.3. 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.

1.12.4. 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.

1.12.5. 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. Parallel Reviews

2.1. The criminal investigation concluded in May 2022. Patrick denied murder but entered a plea to manslaughter. This was accepted by the prosecution. 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.

2.2. Ordinarily, a Coroner's Inquest into any homicide is opened and then adjourned, pending any criminal trial, which takes precedence. It is the Coroner's prerogative to resume an inquest following a criminal trial. On this occasion there was no Coroner Inquest as the Coroner was able to obtain the necessary information in the criminal trial.

3. Involvement of Family and Wider Community

3.1. Initial communications, which included a copy of the Home Office DHR leaflet for family members, have been made with known family members residing in the United Kingdom.

3.2. Following Bassetlaw and Sherwood Community Partnership locating and having successful contact with Zoe's niece (hereafter known as Belinda) the Review Author had first contact with her in August 2022.

3.3. The Review Chair, Review Author and the Domestic Homicide Review Panel would like to thank Belinda for contributing to this review.

3.4. Contact with Belinda was had via a virtual platform and email. Belinda was offered the support of an interpreter but declined. Belinda was extremely helpful in providing insight into the life and circumstances of Zoe and Patrick; her valued contributions are woven into the body of this report.

3.5. The author kept Belinda updated of the review throughout the process and Belinda has had sight of the overview report. Belinda has commented that she is happy with the findings.

3.6. Sadly, the review has not been able to speak to any other family members, friends, or wider community.

4. 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.

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

4.2. 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

4.3. Report Chair and Author

4.3.1. 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.

4.3.2. 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.

4.4. Dissemination

4.4.1. Once agreement for the final report has been given by the Home Office Quality Assurance Panel, this DHR report will be available on the council website. The DHR report will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 1998.

4.4.2. All organisations involved with the review will receive a copy of the DHR report as will members of the Joint Strategic Group of Bassetlaw, Newark, and Sherwood Community Safety Partnership. The action plan, recommendations and lessons learned will be shared with Equation to incorporate in County wide and domestic abuse awareness training.

5. Equality and Diversity

5.1. Whilst applying the principles of the SILP methodology, the independent chair and author have considered the nine protected characteristics under the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation).

5.2. Zoe was female, and Patrick is male. It is not possible for the review to confirm whether Zoe and Patrick were common law partners or legally married.

5.3. Whilst both Zoe and Patrick resided in the United Kingdom during the scoping period of this review, it is known that Zoe was born in Lithuania. She was born during the Soviet era meaning that her teenage years could have been lived within the backdrop of a painful period of recession and adjustment as communism was dismantled.

5.4. In 2007 Zoe and a friend moved to the United Kingdom. This was physically easy to do at the time because both the United Kingdom and Lithuania were part of the European Union which enabled free movement. However, on the 31st of January 2020, the United Kingdom withdrew from the European Union. Zoe, having been a legal resident in the United Kingdom since 2007 was eligible to apply for settled status; without settled status Zoe would be unable to legally work, use the NHS, or rent a home.

5.5. Less is known about Patrick, but he had been born in the Union of Soviet Socialist Republics before subsequently moving with his parents to Lithuania. It is not known when he moved to the United Kingdom.

5.6. Whilst the review understands that domestic abuse can affect anyone, regardless of age, disability, gender identity, gender reassignment, race, religion or belief, sex, or sexual orientation, it is recognised that in the year ending March 2020, an estimated 1.6 million females aged 16 to 74 years experienced domestic abuse[1]. This is in comparison to an estimated 757,000 males. More women are killed as a result of domestic abuse than men.

5.7. Women's Aid assisted the panel to be better informed on issues relating to women experiencing domestic abuse and the support available.

5.8. As mentioned, a Lithuanian Specialist was contacted to assist the panel to be better informed on issues relating to the Lithuanian Culture but did not attend.

6. Background Information

6.1. 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[2]. 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.

6.2. 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 to live in 2015, 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.

6.3. 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.

6.4. 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.

6.5. 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.

6.6. In 2018 Zoe's mother died in Lithuania. Zoe did not travel to Lithuania despite Belinda helping her to obtain a ticket. Around this time, Belinda became aware of Zoe losing another job due to alcohol.

---

[1] Domestic abuse in England and Wales: November 2020 - GOV.UK (www.gov.uk)

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

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

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

6.9. 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.

6.10. 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.

6.11. 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.

6.12. On the day of the murder, Patrick told a resident on the street that his wife[3] was dead in the house and he needed help. The resident called emergency services using 999.

6.13. 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[4] metal pole and meat tenderiser was recovered from the address.

6.14. 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.

6.15. 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.

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

6.17. 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.

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

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

[3] It has not been possible for this review to establish whether Zoe and Patrick were legally married or not.

[4] 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.

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

8. Key Practice Episodes

The review highlighted the following as key episodes in the case:

8.1. Assessment and Response to Zoe feeling unwell on a day in August 2017

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

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

8.1.3. Zoe was diagnosed with hypertension[5]. 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.'

8.2. Assessment and Response to Patrick being found outside on a day in of May 2018

8.2.1. 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.

8.2.2. 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.

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

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

8.3. Assessment and Response to Zoe having fallen on a day in May 2019

8.3.1. Zoe was found by a passer-by in the street having fallen. Paramedics were called and upon attendance they used language line[6] 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.

8.3.2. 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.

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

8.3.4. 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] High Blood Pressure – can be dangerous if untreated.

[6] Interpretation and Translation Services

8.3.5. No further information is documented regarding discharge.

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

8.4.1. 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.

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

8.4.3. 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.

8.4.4. 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.

8.4.5. 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.

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

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

9. Analysis by Theme

Following multi-agency discussions of the Key Episodes and Terms of Reference[7], the following themes have been identified for practice and organisational learning:

9.1. Agencies Understanding and Management of Domestic Abuse

9.1.1. Domestic violence is the most common type of violence in the United Kingdom. In the year ending March 2020, there was an estimated 1.6 million women aged 16-74, who had experienced domestic abuse in the last 12 months[8].

[7] See Appendix 1; Section 6
[8] Microsoft Word - Annual Audit - Early Release - Final version (womensaid.org.uk)

9.1.2. Local data from 2019 shows that 20,464 people in Nottinghamshire had experienced domestic violence in the previous 12 months[9]. The area has the highest rate of reported and recorded domestic abuse in the East Midlands[10]. Consequently, it is crucial that agencies in Nottingham and Nottinghamshire improve their understanding and management of domestic abuse.

9.1.3. Zoe did not ever report or disclose that she was victim of domestic abuse, but domestic abuse is a largely hidden crime[11]. Whilst domestic abuse accounted for 18% of all offences[12], recorded by the police in England and Wales in the year ending March 2021, it is still the crime least likely to be reported to the police. This makes the aforementioned figures even more worrying.

9.1.4. Non-disclosure highlights the importance of professional curiosity[13] which helps practitioners to gain a general view and understanding of what life is like for an individual and use the information to assess potential risks.

9.1.5. Reflection of Zoe's case notes evidence that Zoe was seen by local professionals with facial injuries and an old bruise above her eye in May 2020, and by professionals in London with bruises on her legs in September 2020.

9.1.6. In addition, the letting agent had seen Zoe with a black eye and was aware of drunken behaviour from both Zoe and Patrick, poor home conditions and financial problems. (This is discussed in more detail later in the report.)

9.1.7. This review has also been informed that it has been established during the criminal investigation that members of the community had, at times, heard Zoe and Patrick arguing, and a work colleague had seen Zoe with a black eye also.

9.1.8. However, in the absence of any community disclosure and any of the information known by professionals being shared multi-agency, no professional meetings convened, and no referrals were made to support services - for either substance use or domestic abuse. Had the pattern of bruising and black eyes been recognised, a referral may have been made to an Independent Domestic Violence Adviser or Women's Aid. Such specialist professionals could have attempted to work with Zoe and support her.

9.1.9. Professionals' opportunities to exercise curiosity and gain any understanding of Zoe were limited as interaction was only had on five occasions[14] within the scoping period. It was, therefore, very important to fully utilise all of the contacts, which on some occasions were with the police and on all occasions, were with emergency health care services.

9.1.10. Police during their contacts with Zoe took Zoe's explanations of her injuries at face value. It is recognised that in the absence of Zoe disclosing any assault and in the presence of her accounting for her injuries by way of falls, a Domestic Abuse, Stalking and Honour Based Violence risk assessment[15] would have proved ineffective as Zoe could have potentially not disclosed anything. However, Officers could have demonstrated better professional curiosity into Zoe's circumstances and completed intelligence checks post the incidents. In addition, Officers could have added intelligence to their systems which may have helped identify potential abuse over time when a pattern of repeated incidents/injuries became visible.

---

[9] Domestic Abuse (2019) - Nottinghamshire Insight
[10] https://www.nottinghamshire.gov.uk/media/4064609/policeandcrimepanelannualreport-202122.pdf
11 How common is domestic abuse? - Women's Aid (womensaid.org.uk)
12 Domestic abuse prevalence and trends, England, and Wales - Office for National Statistics (ons.gov.uk)
13 Professional curiosity is the capacity and communication skill to explore and understand what is happening for an individual rather than making assumptions or accepting things at face value.
14 Four were local - 16.7.17, 11.5.18, 14.5.19, 16.5.20 and one was out of area - 1.9.20.
[15] The purpose of the Domestic Abuse, Stalking and Harassment and Honour-based violence (DASH) risk assessment is to ensure professionals employ a proactive response to a domestic situation by asking direct questions to assess risk.

9.1.11. In the hospital environment a written prompt is given to professionals in documentation to be professionally curious and to enquire with a patient about any potential issues regarding safeguarding and/or domestic violence. This prompt clearly works - the safeguarding boxes were checked by staff at the Urgent Care Centre and Emergency Hospital Departments when Zoe attended.

9.1.12. However, this prompt does not trigger any enhanced level of professional's curiosity and whilst the case notes indicate that Zoe denied any abuse, there is no evidence of any exploration being had with Zoe as to whether she understood or would recognise domestic abuse. Yet this is often the case, as perpetrators often reduce a woman's contact with the outside world which prevents her from recognising that his behaviour is abusive and wrong[16].

9.1.13. Domestic abuse is complicated and even some people who have been, or are victim, are unclear as to what constitutes abusive behaviour. A possible Lithuanian viewpoint of domestic abuse is discussed later in this report, but putting cultural considerations aside, was enough explained to Zoe and were enough questions asked in routine enquiry?

9.1.14. This question is particularly pertinent to Zoe's presentation in May 2020 when, whilst Zoe did not disclose abuse, professionals could see an aged injury above her eye and she was presenting with fresh facial injuries that the member of the public who found her in the street, suggested looked like Zoe had been punched in the face.

9.1.15. Upon receiving the report from the member of the public, Police Officers informed the ambulance service of this suggestion during their initial call. Police were then first on the scene and asked Zoe how she had come about the injury. Zoe informed them that she had fallen and had not been a victim of assault. This was taken at face value.

9.1.16. The ambulance service, having already been told of the initial comment made by the member of the public, also asked Zoe how she had sustained her injuries. Again, Zoe informed that she had fallen.

9.1.17. The possibility that Zoe may have been victim to any kind of assault was not shared further with staff at the hospital, and no other professionals asked Zoe how the injuries had been conceived. The receiving professionals believed what they had been told by the ambulance crew without doubt and concluded that the injuries were the result of a fall.

9.1.18. On this occasion domestic abuse enquiries were still undertaken but potentially completed as a tick box exercise rather than with any real curiosity - even though it was noted that Zoe also presented with a bruise above her eye. This was a missed opportunity for deeper routine enquiry and to demonstrate professional curiosity.

9.1.19. Being professionally curious is not always easy, particularly when practitioners are working in a busy environment such as that in a hospital emergency setting, but practitioners must check themselves to ensure that they have not assumed how an injury has been acquired.

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

9.1.21. This review has been assured that this lesson is currently being addressed as the Trust now has a Service Level Agreement with Nottinghamshire Women's Aid to provide a full time Hospital Independent Domestic Violence Advocate, based within the Safeguarding Team. This is a significant development which means there is now a fully trained and experienced practitioner, with specific skills and experience, on hand to support staff members in the recognition and management of potential domestic abuse, and also, directly support survivors of domestic abuse.

[16] Why don't women leave? - Women's Aid (womensaid.org.uk)

As part of this Service Level Agreement, the Trust are provided with cover from Women's Aid for any period when the Hospital Independent Domestic Violence Advocate is not available during the normal working week.

9.1.22. Within this role the Hospital Independent Domestic Violence Advocate delivers domestic abuse training to health professionals and reviews the Domestic Abuse, Stalking and Honour Based Violence Risk checklists whereby domestic abuse may have been identified.

9.1.23. Also, all staff newly employed by the Trust must now attend an induction programme which includes a safeguarding session. Within this the Hospital Independent Domestic Violence Advocate delivers a session on issues around people presenting to the hospital who may have experienced domestic abuse, and how the staff can recognise, support, record and respond.

9.1.24. All clinically facing staff have a mandatory annual face to face update relating to safeguarding, which may reference domestic abuse. This is variable as the Trust has to cover a breadth of issues, but it has been agreed that the focus of this mandatory update for 2023/24 will be upon domestic abuse, with specific reference to enhancing the ways in which routine enquiry can be developed, with further focus on enhancing the degree of further professional curiosity.

9.1.25. It is reassuring that much of the initial indication of domestic abuse will now be noted as a patient attends the Emergency Department. All the nursing staff, both qualified and unqualified, from this team now attend an additional mandatory days training which covers a variety of subjects: one of which is domestic abuse with the focus being on routine enquiry, supporting effective completion of a Domestic Abuse, Stalking and Honour Based Violence assessment, and how to engage with patients who may be reluctant or have difficulty in expressing their potential experience of abuse.

9.1.26. Finally, the Trust now adds alerts to a patient record system (reviewed by staff in the Emergency Department) to those patients who have previously been identified as having experienced domestic abuse, and those heard at a Multi-Agency Risk Assessment Conference[17]. This will now alert staff to any historical reference to domestic abuse and will identify at an early stage the requirement to consider whether domestic abuse may be a factor in the current presentation.

9.1.27. The Trust reports having seen signs of improvement already. There is a considerable rise in the number of Multi-Agency Risk Assessment Conference referrals in the last 12-18 months, which whilst in part may be due to increased community incidence, is also considered to be reflective of greater recognition within the clinical areas. The Hospital Independent Domestic Violence Advocate's view is that staff confidence in the use of professional judgement is growing.

9.1.28. The table below also shows an increasing number of professional judgement Domestic Abuse, Stalking and Honour-based violence risk assessments being received each quarter which highlights the improved curiosity and thinking of the professionals:

	Q1 (April - June)	**Q2 (July – September)**	**Q3 (October – December)**	**Q4 (January – March)**
2021	1	9	7	7
Developments	Hospital Independent Domestic Violence		Monthly training sessions on professional	

[17] A Multi-Agency Risk Assessment Conference is a process that brings together statutory and voluntary agencies to jointly support victims/survivors of domestic abuse who are at a high risk of serious harm or homicide and to address the behaviour of the perpetrator.

	Advocate employed		curiosity and judgement started	
2022	12	14	10 (As of 09/12/2022)	Data not yet available *(January-March 2023)*

9.1.29. However, it must be remembered that whilst increased training may have resulted in better professional curiosity and staff considering assessment and referral, if Zoe had continued to not want support, the discussions would have just remained a note on her file.

9.1.30. Zoe presented with bruises on another occasion but professionals in Newark never knew of this: Zoe presented at a hospital out of the local area in September 2020, having fallen whilst disembarking a train. On this occasion the staff noticed that Zoe had aged bruising to her legs and asked her about it. Belinda was present with Zoe and heard Zoe tell staff that she had got the bruises during a fall. Neither staff or Belinda questioned Zoe any further, and the information was not shared with professionals in Newark as Zoe did not have a GP to whom the hospital could send their discharge record. This is discussed later in the report but evidences how Zoe's lack of GP contributed to professionals not being able to gain a full understanding of Zoe.

9.1.31. Belinda has informed this review that she did not ever suspect any domestic violence abuse within Zoe's relationship with Patrick. It made sense to Belinda that Zoe might fall and suffer bruising because Belinda knew that Zoe would sometimes drink too much with Patrick. However other members of the community have now informed police that when Zoe and Patrick were in drink they could both be nasty and aggressive. And neighbours told police conducting house to house enquiries of loud arguments on the days leading up to Zoe being found deceased.

9.1.32. In addition, as previously mentioned, a colleague at the car wash where Zoe had worked for 2-3 years had seen that Zoe had a black eye. Zoe had told her that she had fallen on the stairs at home.

9.1.33. All the people who had witnessed Zoe's arguments and/or bruises were foreign-born individuals living in the United Kingdom. The fact that none of them ever telephoned the police to report any concerns or possible domestic incident, indicates either a reluctance to engage with services and/or a poor understanding of domestic abuse and safeguarding concerns.

9.1.34. 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.

9.1.35. A reluctance to report incidents for whatever reason is further evidenced when one considers that while domestic violence is not unique to any one community in Britain, research by the charity Safe Lives found that *Black, Asian or minority victims of domestic abuse, particularly migrant women, are trapped in abusive relationships one and a half times longer than white-British women*[18].

9.1.36. A main administrative issue that could be affecting the reluctance of a member of a migrant community to report a potential victim of abuse to the authorities, could be related to residency concerns. Whilst pre-Brexit this review is not aware of any residency issues for Zoe, other members of the community would not know whether drawing her to the attention of United Kingdom authorities could put her status in jeopardy.

[18] Supporting B&ME victims – what the data shows | Safelives

9.1.37. Post-Brexit, Zoe and Patrick's migrant community may have become even more reluctant to report potential crimes for fear of drawing either Zoe or Patrick to the attention of authorities - in case they did not have the correct documents to prove their continuous residency.

9.1.38. It is reality that the British police refer migrant witnesses and victims to the immigration authorities. In 2018, Human rights groups Liberty and Southall Black Sisters complained about such police activity, for the very reason that it deters the reporting of domestic abuse incidents. Their 'super-complaint' prompted the Home Office Review: Review of data sharing: migrant victims and witnesses of crime[19], published in 2021. The review undertook a series of workshops with representatives from the domestic abuse sector and representatives from the modern slavery sector. During these engagements, representatives from both sectors reportedly endeavoured to make clear that Immigration Enforcement does not have a safeguarding role given the clear conflict of interest in upholding our immigration laws. As a result, the Home Office said they will be introducing an Immigration Enforcement Migrant Victims Protocol which they believe will allow migrants to feel safe in the knowledge they can report to the police.

9.1.39. It is also important to acknowledge that people's perceptions and reporting of abusive behaviour is inherently subjective. People who have lived in countries with effective domestic abuse policies may be more aware of abusive behaviours.

9.1.40. Whilst there are many charities and organisations in the United Kingdom who generate social awareness of what constitutes domestic abuse, and who continually and successfully campaign to influence government policy on domestic abuse, such campaigns are not always available in Lithuanian.

9.1.41. However, this review has been informed that Kings Mill Hospital has access to Domestic Abuse information cards in a variety of languages and formats – including Lithuanian and in terms of Specialist domestic abuse services for Lithuanian people in Nottinghamshire, the National and Nottinghamshire Domestic Abuse Helplines access Language Line to support any victim that is not English speaking. Nationally, there are Lithuanian specific services in London (Aanchal Women's Aid and Refuge), Peterborough (Peterborough Women's Aid), West Sussex, Suffolk, and Norfolk.

9.1.42. 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.

9.1.43. Even in the absence of any recognition of potential domestic abuse and/or substance misuse, information known to professionals potentially suggested that Zoe may have had needs for care and support - Professionals established during Zoe's presentation at Kings Mill Hospital in May 2020 that Zoe was smelling of alcohol, had sustained injuries, had an aged bruise, had no money, no means of getting home, and was not registered with a GP Practice.

9.1.44. Consideration could have given to whether Adult Social Care welfare checks should have been requested. As a consequence, at the very least, Adult Social Care could have attempted to contact Zoe to give advice, signpost to Citizen's Advice and Welfare Rights, and given her lack of finances, provided information regarding food parcels.

9.2. The Role of a Private Landlord.

[19] Review of data sharing: migrant victims and witnesses of crime (accessible version) - GOV.UK (www.gov.uk)

9.2.1. Whilst Zoe and Patrick had little contact with statutory agencies, they had regular contact with a private letting company. The company was approached and invited to be involved with this review but has sadly declined.

9.2.2. But staff had informed police post Zoe's death that:

- both Zoe and Patrick would regularly smell of alcohol,
- Patrick presented as being unwashed and appearing very unkempt,
- in May 2019, due to other tenants complaining that Patrick was always drunk and being verbally aggressive towards them, the company moved Zoe and Patrick to different accommodation,
- the property was continually dirty and unkempt, and
- on one occasion a tenant manager had seen Zoe with a black eye but had not asked her about it due to the language barrier.

The company was also aware of Zoe and Patrick's financial difficulty as the rent was not being paid.

9.2.3. Undoubtedly the private letting company was the only service to have a picture of Zoe's and Patrick's life and circumstances.

9.2.4. The private rented sector is an important part of the housing market, accounting for 4.5 million homes and representing around 19% of all housing in England[20]. As a private landlord the letting company has a legal responsibility to ensure that the property is safe for the tenants but there is also an important role to be played in safeguarding. Particularly because, as is evidenced in the case of Zoe, private landlords can be the first to see any signs of a problem arising - neglect of a property, unexplained damage, reports of anti-social behaviour and rent arrears, are all indicators.

9.2.5. Whilst this review cannot conclude for certain that Zoe was a victim of economic abuse, the fact that Patrick was not working, not claiming benefits and yet able to drink to excess, suggests that there was a potential element of control on how Zoe spent her money. Had the letting company shared their information, a link may have been made between rent arrears, alcohol, and abuse – including coercive control.

9.2.6. Women's Aid describe coercive control as behaviour designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour. Since meeting Patrick, Zoe had fallen out with her friend, had stopped contacting her family in Lithuania and was becoming increasingly estranged from Belinda. One could conclude that Zoe was being exploited because she had to work to pay for the rent, bills, and provisions that both she and Patrick necessitated. Zoe became trapped in a world of debt, alcohol and physical abuse that eventually led to her death.

9.2.7. Landlords are not expected to become specialists in safeguarding and domestic abuse behaviours but sharing concerning information could significantly improve the lives of their tenants. Staff working for private letting companies need to be professionally curious when they enter a property or work with a tenant and staff training should be given which teaches staff what indicators to look out for and what to do with the information. Equally, where known about, agencies should consider approaching private landlords for safeguarding information going forwards.

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

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

[20] Landlord and tenant rights and responsibilities in the private rented sector - GOV.UK (www.gov.uk)

9.3. Importance of GP Registration

9.3.1. For reasons that this review is unable to confirm, Zoe was not registered with a GP Practice in the Newark area. This had potentially serious health consequences as in addition to responding to bouts of ill-health, GPs are involved in preventative activities such as immunisations, early detection procedures, and imparting general health advice.

9.3.2. Importantly a GP is a professional who can get to know a person and potentially develop a trusting relationship. And, a GP Practice, with its posters on the walls, leaflets, and knowledgeable staff, is a source of local information.

9.3.3. Documentation suggests that Zoe self reportedly[21] lived with epilepsy. There is no evidence of Zoe ever disclosing this to healthcare professionals, but this is a condition that would require continuing and co-ordinated care. Upon this being discussed, a GP would have referred Zoe to a medical specialist who would then have communicated details of any consultations back to the GP to ensure a team-based approach. Zoe's suggested epilepsy went undiagnosed in Newark and untreated.

9.3.4. Not being registered with a GP also caused Zoe to be unable to access follow up treatment following presentations at emergency healthcare provisions. It is standard policy that details of out of hours consultations are sent directly to a patient's GP and had Zoe had a GP, such correspondence would have been included in her GP record.

9.3.5. Consequently, registration with a GP Practice would have provided oversight of all Zoe's hospital presentations as follows:

16.08.2017	Fallen	Smelt of alcohol.	
14.05.2019	Fallen	Smelt of alcohol.	
16.05.2020	Fallen	Appearing intoxicated	Facial injuries and old bruise.
01.09.2020	Fallen	Intoxicated	Bruises to the legs.

9.3.6. As a result, Primary Care could have proactively contacted Zoe to discuss the recurrent theme of falling and alcohol. Potentially, such contact could have led to a broader professional understanding of Zoe's lifestyle and vulnerabilities, and during subsequent conversations, Zoe may have disclosed substance misuse and/or domestic abuse. Such a disclosure could have resulted in the GP referring directly to a Multi-Agency Risk Assessment Conference and other local domestic abuse and/or substance support services.

9.3.7. **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.**

9.3.8. Anyone in England can register with a GP Practice. It is free to register, and you do not need proof of address or immigration status, identification, or an NHS number.

9.3.9. Whilst there is no research available locally, some research has been conducted nationally when it came to the attention of Healthwatch in 2016 that many people were experiencing significant problems when trying to register with GP.

9.3.10. As a result, Healthwatch in Haringey explored the issue further and during an on-street survey found that 17% of the people they spoke with, did not have a GP. The main reason for people not having registered with a GP was because they did not feel that they needed to, or because they

[21] This review has been unable to establish whether Zoe did live with epilepsy or where the information has come from.

faced problems doing so. The most communal problem that prevented people from registering was difficulties with providing proof of address.

9.3.11. Whilst this review is unable to establish whether Zoe ever attempted to register with a GP or not, and whilst it is recognised that Zoe had an address, the survey highlights the common problems that Zoe may have faced or had she have heard about - been deterred by.

9.3.12. 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.

9.3.13. In the absence of a GP, Zoe needed a different holistic approach to connect her medical presentations with socioeconomic care. Such an approach could have seen health professionals, upon recognising that Zoe was presenting smelling of alcohol, and/or had financial problems, referring Zoe to community-based services - which would offer to support her.

9.3.14. Social Prescribing offers this approach. - Social Prescribing Link Workers[22], are based in Newark's local GP Practices. Their aim is to connect people to practical and emotional community support. Link Workers have time to build a trusting relationship and could have explored with Zoe; what mattered to her, created a shared plan with her, and introduced her to community support.

9.3.15. However, this review has been informed that whilst the NHS website says anyone should be able to refer a person for Social Prescribing, members of the community in Newark are only given an appointment with a Social Prescribing Link Worker via health professionals or the GP within the Primary Care setting. This review has been informed that this is due to the number of patients needing support in Mid Nottinghamshire and there already being waiting lists for patients of the GP practices. But as already mentioned, Zoe was not registered with a GP practice.

9.3.16. Other organisations can work with residents in the area and support them similar to how a Social Prescribing Link Worker would (for example, Age UK Connect), but unfortunately Zoe did not access community groups, or any agencies who could have signposted her to such services. The only organisations with the opportunity to signpost Zoe, were the hospitals but they don't give local information.

9.3.17. According to the NHS England website, when Social Prescribing works well, people can be easily referred to link workers from a wide range of local agencies, including General Practice, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise organisations.

9.3.18. This could have greatly benefitted Zoe and Patrick. It could have helped both Zoe and Patrick address alcohol issues, disclose the domestic abuse and could have resulted in Patrick claiming the correct benefits and contributing to the household financially.

9.3.19. This review has been informed that Sherwood Forest Hospitals NHS Foundation Trust is supporting the appointment of Social Prescribers within the hospital setting, as part of a long-term plan in support of Primary Care networks.

9.3.20. The role will work primarily with colleagues in the Hospital Emergency Department who may be able to identify individuals who could benefit from the type of support that could be offered through this initiative. The Social Prescribing Link Worker will aim to support people to take control of their health and wellbeing, which can be difficult for vulnerable individuals, particularly in the midst

[22] NHS England » Social prescribing

of presentation to an acute hospital service. The Trust would hope that the Social Prescriber would be able to encourage individuals who have not registered with a GP, that it is in their best interest to do so with a benefit being that a consistent approach to their healthcare can be promoted.

9.3.21. The post within the Trust has been agreed but is awaiting appointment at the time of writing this report.

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

9.4. Agencies Understanding of Zoe's Lived Experience

9.4.1. Zoe was born in Lithuania during the Soviet era. Whilst it remains unknown how this affected Zoe, her teenage years could have been lived within the backdrop of a painful period of recession and adjustment as communism was dismantled.

9.4.2. As a young adult, Zoe suffered a significant bereavement in Lithuania, and it was a few years after this that she and a friend moved to the United Kingdom. This was physically easy to do at the time because both the United Kingdom and Lithuania were part of the European Union which enabled free movement.

9.4.3. In 2017, at the beginning of the scoping period of this review, Zoe had been living in the United Kingdom for about ten years. Zoe had started a relationship with Patrick with whom she was residing, but they were struggling for money. Patrick was experiencing poor health and was neither working nor claiming any benefits. Consequently, the onus to earn money was on Zoe. Zoe had to earn enough to pay the rent, the bills, buy food, and alcohol.

9.4.4. Zoe and Patrick lived in shared accommodation with Zoe's friend and her partner, but Zoe's relationship with her friend was becoming strained. This was because Zoe and Patrick owed the friend a lot of money for rent and bills and Zoe's friend did not like how much alcohol Zoe, and Patrick were drinking.

9.4.5. By 2017 Zoe had not visited her family in Lithuania for four years. She was in regular contact with her niece (Belinda) who had also moved to the United Kingdom - but following Zoe's friend asking Zoe and Patrick to move out of the address they shared, Zoe, for unconfirmed reasons, stopped answering Belinda's messages as much and often would not pick up the phone when Belinda called her.

9.4.6. For a reason that cannot be verified but may have been linked to either a medical condition or alcohol use, Zoe started to experience dizziness and self-reported having suffered a few falls which resulted in hospital attendance in August 2018, May 2019, May 2020, and September 2020. Zoe may have suffered other falls that have not been brought to the attention of professionals, either due to not having been reported by Zoe or due to the lack of GP collation.

9.4.7. Zoe not being registered with a GP Practice, did not seek any routine medical advice regarding dizziness. She only saw medical professionals when she was found on the floor (sometimes with injuries), and someone called an ambulance for her.

9.4.8. Both Zoe and Patrick were drinking a lot of alcohol. Zoe had to work to pay for the alcohol but would often not be sober when she attended work. Consequently, Zoe was dismissed from multiple jobs and had to quickly find new employment.

9.4.9. Zoe now found herself living alone with Patrick, often feeling unwell, estranged from her friend, out of touch with her family and in a cycle of drinking a lot of alcohol with Patrick (which she had to find the money for). Zoe was responsible for maintaining a tenancy, yet she was unable to pay rent or bills and the debts were increasing.

9.4.10. Whilst it cannot be confirmed as true, it is also very probable, given that she was seen by colleagues and housing staff with a black eye, and the number and cruel nature of bruises Zoe was found to have on her body when deceased, that Zoe was being physically abused by Patrick.

9.4.11. Research[23] shows that women who come to the United Kingdom as migrants are often at a higher risk of domestic abuse in the first place. And as an immigrant, Zoe faced unique challenges in seeking support; in addition to the fact that Zoe was thousands of miles away from most of her family, it is likely that Zoe was not aware of the range of support available to her in the United Kingdom and/or how to access it. For example, Zoe may not have understood that she could access a refuge space or that the police would take any allegation she made of domestic abuse seriously.

9.4.12. On the 31st of January 2020, the United Kingdom withdrew from the European Union. Zoe, having been a legal resident in the United Kingdom since 2007 was eligible to apply for settled status. The deadline for applications was the 30th of June 2021[24] but Zoe needed a valid passport to apply and hers had expired. Without settled status, Zoe would have, amongst other things, been unable to legally work, use the NHS, or rent a home.

9.4.13. Within the documentation provided, this review has not seen any reference to any professional who met Zoe, striving to understand her culture.

9.4.14. Cultural curiosity is an interest in understanding and learning more about a person's cultural background, experiences, and viewpoints. It involves learning about someone's cultural heritage and appreciating how that person thinks or conducts themselves taking into consideration their cultural background. Understanding someone's culture can help you better empathise with them and provide appropriate services.

9.4.15. For example, although Lithuania now has an excellent modern state healthcare system, funded by the government through a national health insurance scheme, consideration could have been had by professionals learning that Zoe did not have a GP, as to whether anything in Zoe's background was a potential barrier to her registering with a GP. Understanding any such barrier could have helped a professional to help Zoe to overcome it.

9.4.16. In 2019 domestic violence was the second most reported crime in Lithuania after burglary. The then police Deputy Commissioner said[25] that from January to October in 2019, Lithuanian police was alerted to 35,000 cases of domestic violence, and 80 percent of the victims were women. He reported that domestic violence was a result of deep social problems and victims often had widely unequal access to relief services. Material and psychological help being more readily available in towns than in rural areas.

9.4.17. The Women's Information Centre has said that statistics show that every third woman in Lithuania has experienced domestic violence but has highlighted that non-physical abuse was not being acknowledged. Consequently, the figures will not be accurate as many cases of domestic abuse remain unreported – according to the programme manager, abuse in Lithuania is often treated as violence only if it leaves physical marks.

9.4.18. Upon learning of this, one wonders what understanding Zoe may have had of domestic abuse. Also, even had Zoe recognised the full extent at which she was potentially experiencing domestic abuse, further research of Lithuania shows that the response to domestic violence can sometimes be inadequate. At a press conference[26] in Lithuania on the International Day for the

[23] Intersections of Immigration and Domestic Violence: Voices of Battered Immigrant Women Edna Erez, Madelaine Adelman, and Carol Gregory
[24] Eligible individuals could still apply after this date.
[25] Domestic violence second most common crime in Lithuania - LRT
[26] Domestic violence second most common crime in Lithuania - LRT

Elimination of Violence against Women, the Women's Information Centre spoke of victims being forced to change their residence and jobs so that their abusers could not find them as unless the abuser actively threatened them with death or a serious health disruption – nothing could be done.

9.4.19. Consequently, whilst it cannot be confirmed due to no professional enquiring into her cultural background, it is possible that Zoe needed additional reassurance of how the United Kingdom would respond to allegations of domestic abuse and what support would be offered to her.

9.4.20. This demonstrates how there are aspects of culture which can affect misunderstandings of what a person can expect when seeking support in a new community. Professionals working with individuals from different cultural backgrounds must recognise that misaligned cultural filters could overthrow the confidence of foreign-born service users as to whether they need any support and/or are accessing the correct support.

9.4.21. 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.

9.4.22. Professionals may worry that acknowledging cultural differences could be perceived as negative stereo typing and be considered discrimination. And this review recognises that no individual necessarily represents what may be true of their cultural background. But research demonstrates that there are cultural differences. If professionals do not acknowledge this, they will be unable to consider whether any accommodation is needed to ensure that a service user is not put a disadvantage.

9.4.23. This review understands that it is not possible for every professional to learn of every culture, but there are generic skills to competence, such as open-minded awareness of the differences that cultural background can produce. This should be regardless of how long a foreign-born person has lived in the United Kingdom and has sought to integrate with the United Kingdom.

9.4.24. 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.

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

9.4.26. In response to English language limitations, translation services are available to help professionals navigate the complexities of professional systems and workings with a service user.

9.4.27. This review has been informed that Zoe spoke English well enough to converse in day-to-day conversation. For this reason, the only instance of an interpreter being used by professionals conversing with Zoe, is in May 2019 when a passer-by found Zoe in the street having fallen. Paramedics upon attendance used language line.

9.4.28. This was good practice as whilst, when people do not speak each other's language, it is obvious that an interpreter is required, when a foreign-born speaker uses the English language fluently, as Zoe did, professionals assume that the person will be able to understand the whole conversation. However, this could be untrue and in verbal exchanges across a cultural divide it is unsafe to presume that a full mutual understanding is being achieved even when both parties are using English fluently.

9.4.29. Whilst Zoe could speak and understand English, it must be acknowledged that most of her time was spent with other people who spoke Lithuanian, Patrick, her friend, and her niece. Zoe also

resided within a community which was made up of many people who had come to the United Kingdom from Lithuania. Consequently, Zoe may not have practiced the English language very much at all.

9.4.30. There are benefits to interpreters having been used during all Zoe's presentations at health departments. Interpreters would have offered reassurance that Zoe was understanding professional's questions correctly, and that Zoe was not withholding disclosure or information because she was unsure how to verbalise her exchange in English.

9.4.31. The reality of this happening is evidenced by case records dating from September 2020. When Zoe having fallen whilst disembarking a train, attended a hospital in London, Zoe was recorded to be in a confused state and it is noted that because of this, Zoe was struggling to converse in English. A translator was still not sought – instead, Belinda, who was present with Zoe, translated.

9.4.32. Whilst it is understandable that in the case of an emergency, where patient care is an immediate priority, a family member translating might be appropriate, for patients who do not share a professional's first language, the gold standard is to use a professional interpreter.

9.4.33. Using a family member risks skewing a consultation as their own version of events or opinions can creep into the conversation. Similarly, a family member may distort a professional's question or response if they think it is something that could upset their loved one.

9.4.34. Using a family member also raises concerns around the confidentiality of the patient who may not want their family member privy to the whole consultation conversation.

9.4.35. A professional interpreter is always preferable as they provide some assurance around quality, accuracy, and confidentiality. And professionals should not accept a person's decline of an interpreter without first explaining the full benefits to them. A foreign-born person may overestimate the level of English they have and/or underestimate the level of English that can be required in a medical setting and turn down an interpreter.

9.4.36. Also, it is reasonable to expect that a person presenting at an Emergency Department having fallen or suffered a health-related episode, may find their fluency in a second language reduced. It is also reasonable for a person with the slightest linguistic weaknesses to struggle to describe, for example, health concerns, symptoms, or discuss personal information such as domestic abuse or substance misuse.

9.4.37. Whilst this review recognises that it is sadly not possible to ask Zoe whether she ever considered disclosing any abuse or discussing any concerns she may have had regarding either her own, or Patrick's excessive alcohol use – is it possible that Zoe would have struggled to find the words unless communicating in her first language?

9.4.38. Finally, whilst both the United Kingdom and Lithuania are Northern European countries and consequently professionals may presume a common communication style; research[27] suggests that Lithuanians are usually conservative in their communication, hence Zoe may not have offered detail in her responses to the questions she was being asked by professionals. Using a native communicator may have made it easier to establish more detail and encourage a greater response.

9.4.39. 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.

[27] Business communication - Business Culture

9.4.40. 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.

9.4.41. This review must also consider how the Covid Pandemic could have affected Zoe. Within the scoping period of this review, Zoe was supported by professionals in the local area in August 2018, May 2019, May 2020.

9.4.42. None of these dates coincide with the national lockdown but the latter professional contact, in May 2020, comes just six days after the restrictions had been lifted. Consequently, professionals attending Zoe on that occasion were rapidly adapting to new working conditions. In fact, the second phase of a UK wide study[28] exploring the impact of the Covid-19 pandemic on health and social care has highlighted that social work and nursing were the most impacted occupational groups.

9.4.43. One of the main problems arising from the Covid pandemic both during lockdowns and as restrictions were eased was that it frequently left services with reduced staffing levels as:

- Staff were redeployed to other teams/units,
- Staff who had been exposed to the virus, had to self-isolate, and
- Staff who had been unfortunate enough to contract Covid-19 were off work.

9.4.44. The Emergency Department at the hospitals, whilst utilising agency staff to manage these staff absences, also saw an increase in the amount of people attending. Likely because people were struggling to visit their GP Practice.

9.4.45. All of this had a significant impact on the whole NHS service, and it is praiseworthy that Zoe was always attended to by paramedics and the Emergency Department in a timely manner.

9.4.46. In December 2020, seven months before Zoe was found deceased, a new variant of Covid-19 spread across the United Kingdom which resulted in the Prime Minster implementing local restrictions and a further lockdown on the 6th of January 2021. It was only on the 19th of July 2021, three days before Zoe was found deceased, that most legal limits on social contact were removed.

9.4.47. Consequently, the last sixteen months of Zoe's life were affected by the Covid Pandemic. Possibly the most significant issue was the pandemic's personal effects upon Zoe (a person experiencing alcohol misuse and domestic violence abuse).

9.4.48. The car wash where she worked would have been directed to temporarily close. This lack of employment would have potentially caused Zoe additional stress and difficulties financially and would have left her living the lockdown with Patrick every day, all day, without any respite from alcohol or abuse.

9.4.49. The lockdowns saw an overall increase in people's alcohol consumption during Covid 19. In July 2021 Public Health England released a paper called 'Alcohol consumption and harm during the Covid 19 pandemic'[29]. The findings show an increase in the heightened risk level of alcohol consumption from 2020 to 2021. However, post 2021 the levels returned to normal - suggesting that it was lockdown which saw this rise in alcohol consumption. From March 2020 to March 2021, there was an increase of 59% in people who reported to drink over fifty units a week for a man, and over thirty-five units per seek for a woman.

9.4.50. The increase in alcohol consumption during Covid 19 saw a rise in alcohol-related deaths. Fatalities relating to alcohol rose by 20% in 2020, going from 5819 in 2019 to 6983 in 2020.

[28] HSC Workforce Study

9.4.51. In addition, to how Covid affected people's alcohol consumption, the environment created by Covid, increased Zoe's risk of domestic violence. When the first 'lockdown' was announced in March 2020, charities, such as Women's Aid, highlighted the increased risk of harm and isolation for those affected by domestic abuse. Because, as mentioned, domestic violence is often a hidden crime that is not reported, data can only provide a partial picture of the actual level of domestic abuse experienced. But the Office for National Statistics report that in mid-May 2020, there was a 12% increase in the number of domestic abuse cases referred to victim support. Between April and June 2020, there was a 65% increase in calls to the National Domestic Abuse Helpline, when compared to the first three months of that year.

9.4.52. At the time of writing this review, no more up-to-date figures were available, but the data so far evidences the increased risk Zoe was at during the latter half of the scoping period of this review.

10. Conclusions

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

10.2. 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.

10.3. Both Zoe and Patrick consumed alcohol.

10.4. 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.

10.5. 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.

10.6. 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.

10.7. 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.

10.8. 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.

10.9. 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.

10.10. 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.

10.11. 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.

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

11. Lessons Learned

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

11.2. **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.

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

11.4. **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.

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

11.6. **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.

11.7. **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.

12. Good Practice

12.8. During discussion and within records, there is evidence of good practice within agencies who supported Zoe, and Patrick and it is equally important to develop learning from this good practice as it is from any shortcomings. Good practice has been included within the body of this report, but the reviewer would highlight the good practice exampled by paramedics when they were called to Zoe in May 2019 and used language line to communicate.

13. Developments Since the Scoping Period

13.1. Agencies have already made some important amendments to practice since the scoping period of this review. These developments have been included in the body of this report.

13.2. In addition, Nottinghamshire Police have informed this review that:

13.1.1. Nottinghamshire Police are aware of the restrictions that language can place when managing incidents and communicating with potential victims and witnesses of crimes. The force has a central data base of staff with second language ability to allow for deployment of such officers when and where appropriate, this of course is dependent on those Officers being on duty at that time and readily deployable. All Officers have issued to them a mobile phones in order to allow them to access translation services whilst dealing with the public to aid communications.

13.1.2. Nottinghamshire Police are actively seeking to better understand and engage the communities they serve. Each Neighbourhood Policing area produces an annual community engagement plan that is specific to their area and demographic of population residing there. The force uses a range of media to communicate with all members of the public and targets communities with literature and digital content in a variety of language. The Newark and Sherwood Neighbourhood Policing Team are aware of the increased Eastern European population within their area and are seeking to build better links to that section of the community. This includes drop in policing surgery's, working with local employers to host open days, and identifying key individuals within the community to develop further relationships.

14. Recommendations

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

14.1.1. 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.

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

14.1.3. 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.

14.1.4. 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.

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

14.1.6. 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.

15. 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

16. 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/