Domestic Homicide Review

On Behalf of

Safer Lincolnshire Partnership

Executive Summary

in respect of:

Holly

Died Summer 2018

Marion Wright

Independent Overview Author

Date: August 2020

1. The Review Process

1.1 This summary outlines the process undertaken by the Safer Lincolnshire Partnership (SLP) Domestic Homicide Review Panel in reviewing the homicide of Holly, who was a resident in their area.

1.2 Pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members. The victim, Holly, was aged 35 years at the time of the fatal incident. She was white British and was born and brought up in Lincolnshire. Marvyn, the perpetrator was white British and was 27 years old at the time of the incident.

1.3 Criminal proceedings were completed on 18th December 2018 and the perpetrator was found guilty of murder following trial and was sentenced to life imprisonment with a tariff of 20 years before he can be considered for release.

1.4 The Domestic Homicide Review (DHR) process began with a decision panel on 28th June 2018 followed by an initial meeting of the DHR review panel on 28th January 2019. The Home Office had been informed of the likelihood of a DHR in June 2018. Marvyn pleaded not guilty to the murder but was found guilty following a trial. The DHR process was resumed immediately there was a finding of guilt. All agencies that potentially had contact with Holly and Marvyn, prior to the point of Holly's death, were contacted and asked to confirm their involvement.

1.5 Twenty one agencies were contacted and confirmed some contact with Holly or Marvyn and Holly's child. Six agencies were asked to secure their files and provide a full Individual Management Review (IMR). Fifteen agencies who had limited information provided summary reports.

2. Contribution to the DHR Process.

2.1 The agencies completing IMRs and the profile of their involvement with the individuals were as follow:-

Organisation	Author	Agency Involvement
Lincolnshire Police	Richard Naulls Regional Review Unit	Visited the victim in connection with Marvyn`s behaviour. Attended the scene of the murder, made an arrest and prosecuted the murder case.

Hampshire Constabulary	Colin Mathews Serious Case Reviewer Review Team	Investigated allegations of crimes committed by Marvyn and related incidents between 2006 & 2018. Attended MAPPA and MARAC meetings.
HM Prison and Probation Service	Sarah Reed Senior Probation Officer North East Division	Provided Court reports, assessed risk and supervised community sentences and provided offender management between 2007 & 2018 in respect of Marvyn
HM Prison and Probation Service	Rachel Crook Senior Probation Officer Seconded to HMP Lincoln	Detained and managed Marvyn through12 prison sentences at 12 different prison establishments. Last released on 26th Feb 2018.
Nottingham Community Housing Association (NCHA) Historical Domestic Abuse Service in Lincolnshire (ELDAS)	Colette O'Neill Contracts Manager NCHA	Offered outreach community based support to Holly between 27th January 2018 & 9th June 2018.
Lincolnshire Clinical Commissioning Groups (CCGs)	Claire Tozer Safeguarding Adults and Children Lead for the four Lincolnshire CCGs	Provided combined IMR including information from Hampshire, Norfolk and Lincolnshire.

2.2 A summary report was received from Lincolnshire County Council Children's Services (CS) Department who had received four notifications of Domestic Abuse Incidents from the Police between August 2017 and June 2018 where Holly was the victim and relating to her young child. There was no direct contact with the family until after the murder took place.

2.3 A summary report was prepared by the East Midlands Ambulance Service who had had various calls from Holly prior to 2018 for non-related medical issues and three attendances in relation to Marvyn for non-related health conditions in April and May 2018.

2.4 Southampton Children's Services provided a summary report concerning limited contact between 2006 and January 2008 with Marvyn.

2.5 A summary report was provided by Holly's child's Nursery School where she attended between April and June 2018.

2.6 Southampton Hospital provided information about one admission for Marvyn in April 2018.

2.7 Brief factual information concerning Marvyn was received from Southampton Housing, Southern Health and Southampton Independent Domestic Violence Advisor (IDVA) Service. A previous partner had been referred to the IDVA in 2010 as she was considered to be at risk of harm following an assault by Marvyn.

2.8 Brief factual information relating to Holly and her child was received from local district councils and a local housing group concerning tenancy arrangements. Also from Lincolnshire County Council Adult Social Care and Children's Health, Lincolnshire Community Health Service NHS Trust and United Lincolnshire Hospital Trust about limited contact regarding unrelated matters.

2.9 A specialist Alcohol and Drugs Agency was invited to join the Panel in an advisory capacity. Whilst unable to attend the panel meeting they reviewed the Overview Report to advise on relevant drugs and alcohol issues

2.10 A detailed psychiatric report concerning Marvyn was prepared for the court appearance in late 2018 and was made available to the Author.

2.11 The Department of Work and Pensions provided information about addresses for Marvyn since 2006.

2.12 As Marvyn was supervised for a period in 2006/2007 by the Youth Offending Service, the National Probation Service attempted to access records to include in their IMR but were unable to do so. Given the wealth of offending related information available from 2007, this was not considered a significant gap.

Nowadays records are transferred from the Youth Offending Service to Probation at the time of transition.

2.13 As information was received and the trail of abuse became clearer, two other areas of North Essex and Norfolk were contacted to provide any relevant information held. North Essex provided brief information and Norfolk confirmed they did not have any relevant information.

2.14 Discussion took place with a consultant nurse, safeguarding and mental capacity lead at Lincolnshire Partnership NHS Foundation Trust in relation to identifying a recommendation in connection with abusers who suffer from personality disorders.

2.15 Both the agency review panel members and the Individual Management Review (IMR) report authors, who have provided agency evidence considered by the review, are independent from any direct involvement in the case or direct line management of those involved in providing the service.

3. The Review Panel Members

3.1 DHR 2018 P Review Panel Members

Marion Wright		Independent Overview Report Author / Chair
Jon McAdam	Head of Protecting Vulnerable People	Lincolnshire Police
Richard Naulls	Regional Review Unit	Leicestershire Police
Sarah Norburn	Domestic Abuse Coordinator	Lincolnshire Police
Colin Matthews	Serious Case Reviewer	Hampshire Police
Yvonne Shearwood	Children's Services	Lincolnshire County Council
Sara Reed	Senior Probation officer (Offender Management)	Her Majesty`s Prison and Probation Services
Rachel Crook	Senior Probation Officer	Lincoln Prison
Claire Tozer	Safeguarding Adults and Children Lead	NHS Lincolnshire Clinical Commissioning Group
Rachel Parkin	Home Choices Team	West Lindsey District

	Manager	Council
Michelle Hillard	Safeguarding Assistant	East Lindsey District Council
Pippa Foster	Head of Care and support	Nottingham Community Housing Association
Karen Ratcliff	Service Manager	We Are With You
Mandy Gilmour	Manager	ELDAS (now EDAN Lincs)

Panel Support Members.

Toni Geraghty	Legal Advisor to the Panel	Legal Services Lincolnshire
Teresa Tennant	DHR Administrator	Lincolnshire County Council
Jade Sullivan	Domestic Abuse Lead	Lincolnshire County Council

3.2 A total of five meetings were held. The Review Panel met to consider information available, to consider Terms of Reference (TOR), and to commission IMRs. A second meeting involved the Chair/Author and the Safer Lincolnshire Partnership support staff to consider cross boundary agency involvement and what action was necessary to capture information from other areas. The third meeting was to consider information contained in IMRs, any apparent learning, to identify gaps and to seek further information and clarification as appropriate. The third meeting was also attended by key report authors, enabled agencies to present their information, to give time for others to ask questions and make comment. A fourth meeting involved the Chair/Author visiting Lincolnshire Police to watch body worn camera footage. A fifth meeting involved the Panel to consider the draft overview report and ensure that it fully and accurately represented the information of those agencies that contributed.

4. Chair and Author of the Overview Report

4.1 To reinforce the impartiality of this report, it is confirmed that the Independent Chair/Independent Overview Author, referred to as The Author, is not employed by any Lincolnshire agency in any other capacity and has not previously had any direct involvement in this case. Neither has she had any line management responsibility for those who have been providing services or for those managing the provision of those services. The Independent Chair/Author is a retired Assistant Chief Officer of Probation with forty three years relevant experience. She had strategic lead for Public Protection including domestic abuse and had been involved in working with offenders who commit crimes of domestic abuse. both through individual and group work. The Author was responsible for the management of the introduction of MARAC, in 2009, into the area in which she worked. The Author has undertaken many training courses in relation to domestic abuse and the pattern of behaviour this involves. The most recent event attended was the Domestic Homicide Review Workshop developed by AAFDA (Advocacy After Fatal Domestic Abuse) and Standing Together in November 2019. She has experience of providing Serious Case Reviews for MAPPA (Multi Agency Public Protection Arrangements) and writing numerous Domestic Homicide Reviews. The Author has had a special interest in domestic abuse throughout her career having first undertaken a placement with Erin Pizzey at Chiswick Women's Aid in 1975.

5. Terms of Reference for the Review.

5.1 In order to address the key issues, agencies were charged with answering the questions set out below and providing analysis for their answers.

Issues to be addressed: -

a) To examine whether there were any previous concerns, incidents, significant life events or indications that might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions. Had the perpetrator previously been a MAPPA offender and if so, how had his risk been managed?

b) When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse including coercive control and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

c) When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices, including details about Clare`s Law, to make informed decisions? Were they signposted to other agencies

and how accessible were these services to the subjects? Was the victim's perception of danger canvassed?

d) Were issues of mental health, alcohol or drug use a factor in this case and if so, what action had been taken to engage the individual in treatment?

e) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

f) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information or patterns of behaviour and whether action was taken?

g) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

h) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

i) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

j) Were any issues of disability, diversity, culture or identity relevant?

k) Consider the barriers to accessing support and safety in this case.

l) Consider the management oversight and supervision provided to workers involved

m) Consider whether there are training needs arising from this case.

n) Was information shared across area borders in a timely way, in line with agency procedures, leading to effective communication and case management?

6. Background Information.

6.1 Holly and Marvyn met in Lincolnshire in April 2018. Holly had moved to the town in which she lived about six months previously to make a fresh start. Her youngest child lived with her and she had wanted a bigger three bedroomed house so that her teenage child could have her own room when she came to stay at weekends. Her older child lived with her paternal grandparents and father in a nearby village.

6.2 Holly had been in a long term relationship for eighteen years with the father of her two children. They had separated in 2015 but had shared financial commitments and saw each other regularly regarding contact with their children. The youngest child went to visit her father and paternal grandparents, with whom he was living, regularly for weekends. Holly visited her ex-partner's family and home in connection with the girls and had been there the week or so before she was killed.

6.3 Records indicate there were on-going tensions regarding money with her ex-partner. Also, her ex-partner did not want the relationship to end. The Police had been called on three occasions by Holly in connection with this and they had referred her to a domestic abuse agency for support in January 2018. She had had three sessions with the agency which will be referred to later in the report. The domestic abuse agency was unaware Holly was in a new relationship. The last contact they had being 17th April 2018.

6.4 Whilst physically frail due to on-going health problems in connection with her lungs, Holly was strong in her determination to start afresh following the break- up of her long term relationship.

6.5 The house move meant she lived further away from her parents and family. She did not know anyone in the new town. In the police interview she referred to not knowing people locally and feeling lonely. It was taking her child to nursery locally that she became acquainted with Marvyn's sister who also had young children and lived nearby. It was by chance that Holly met Marvyn and his sister when visiting a local supermarket, during her interview with the police the week before her death she said "Me and Marvyn got chatting, we just wanted to stay in the friends zone for a little while."

6.6 Marvyn had only been released from a two year four month prison sentence weeks before they met. Due to his lack of cooperation and challenging behaviour whilst under the supervision of Her Majesty`s Prison and Probation Service (HMPPS), he had been recalled to prison and was released on his Sentence Expiry Date (SED). This meant he was not under any supervision or post release licence conditions to the probation service. He had initially, stayed with his sister for a couple of weeks, but then returned to Southampton, which was his home town, for a friend's grandmother's funeral. Whilst there, he had abused drugs with his friend, with whom he was staying, and had suffered a drug induced psychosis. He had been

hospitalised for a short time, but had discharged himself against medical advice and had come to stay with his mother who lived close to Holly and his sister.

6.7 Marvyn and Holly had only known each other for seven weeks when she was murdered. The relationship had become intense very quickly and the threats and aggression had escalated equally as quickly. Holly told police during interview, which was captured on body worn camera that after just a few weeks together Marvyn had thrown paint all over her door and windows. Holly had said to him “Well we’re not even together and it already feels like you’re controlling”. This outburst followed the fact that he was unhappy she was going to a holistic health event with friends. This incident was not reported to the police at the time. He tried to clean the paint off and the relationship continued.

6.8 Holly also told Lincolnshire Police on the one occasion they attended; she had been frightened by Marvyn’s threats. The police captured the full interview on a body worn camera. The recording has been shared with the report author and in order to capture Holly’s voice in the review, elements are quoted in the following paragraphs “It just all spiralled from nothing really, just 'cos I wasn’t doing something his way. I could feel the tension. He started shaking and said do you want me to fucking knock you out, I was like I’m not having this and I called the police”. Marvyn was aware she had called the police and said “Oh I can’t believe you, you bitch! You’ll pay for this. You’ll pay for this” and he left.

6.9 Holly admitted to being petrified by his aggression. When asked by Lincolnshire Police, she confirmed she had details of local Domestic Abuse Support Services and showed the Police a letter she had recently received. Police provided information about The Domestic Violence Disclosure Scheme (DVDS) and gave her directions to the local Police Station, only a short walk from her home, in order for her to make an application for disclosure of relevant information under “Right to Ask".

6.10 In the same interview with Lincolnshire Police, Holly reported that Marvyn told her he had just been released from prison for dishonesty “to get revenge on some old friends”. Marvyn had not shared that he had been abusive in previous relationships, but did say he could not see his child because of his aggression. There had not been any physical violence towards Holly but she recognised “I just don’t want to put myself in a situation where I’m going to get hurt in front of my child. I can defend myself a little bit but she can’t.” He had accused her of sleeping with other men. He had threatened to damage her property and talked about being good with knives. She said “When it’s good it’s brilliant. When it’s not so good, I am petrified of him.” She answered yes to the Domestic Abuse, Stalking and Honour Based Violence (DASH) question about Marvyn loitering around her property and shared with the police officer some intimidating, unpleasant text messages she had received from him. She referred to him suffering from mental health difficulties and the recent use of the drug Crystal Meth.

6.11 When as part of the DASH assessment Holly was asked if he had ever threatened to kill her and did she believe that he was going to do it? She answered “No, but I do believe if I told anyone about the issues and everything, he would do something

to me, my car or my home. I don't think this is the backlog of it all yet. I've just got it all to come".

6.12 The Police Officer graded the DASH risk assessment as standard and advised Holly to contact the police via 999 should there be any further difficulties. She was also advised to keep her door locked and only let Marvyn in if she felt it was safe to do so.

6.13 The next known contact with any agency was when Holly dialled 999 eight days later, on the day of her murder. The call handler could hear the sound of screaming and the thudding of the beating that led to her death. The police went to her home and on forcing entry, found her dead. Marvyn was arrested soon afterwards leaving his mother's home.

7. Summary Chronology.

June 2006 – December 2007

7.1 Hampshire Police were called to several incidents at the family home in Southampton during 2006 and 2007, where Marvyn's mum made allegations of him causing damage. On three occasions she made complaints of him assaulting her by kicking and punching her in the face. These events were interspersed with offences of theft, burglary and robbery. Often Marvyn was under the influence of alcohol and was very drunk when the Police arrested him.

7.2 Southampton Children's Services had been involved with the family however the case was closed in March 2006 due to lack of response. There were several occasions when Children's Services were asked to provide an appropriate adult to attend interviews and Court, as his mother refused to attend.

7.3 In 2007 Marvyn had been made subject to an Intensive Supervision and Surveillance Programme (ISSP) which was the most rigorous non- custodial intervention available for young offenders. He was supervised by The Youth Offending Service. As Marvyn was working positively with the ISSP, Children's Services closed the case. The National Probation Service have attempted to gain the Youth Offending Team records from that time but have not been successful.

2008 – 2009

7.4 Offending behaviour continued throughout 2008 and 2009 with offences of dishonesty. Marvyn, having reached eighteen years old in June 2008, was then sentenced as an adult. The Youth Offending Team ceased involvement and the Probation Service became the relevant criminal justice agency. Marvyn was

sentenced to two months Youth Custody for failure to comply with a community sentence. He was supervised post release and sessions focussed on his use of alcohol and temper control. He disclosed he had, as a child, witnessed violence between his mother and stepfather.

7.5 In 2009 there was a further D. A. offence which involved assaulting his mother by hitting her in the face when drunk. There was an additional charge of assaulting a police officer. He was sentenced to twenty-one weeks at a Youth Offending Institute (YOI). He was released from custody in July 2009 on three months` Notice of Supervision.

7.6 He was seen by his GP in August 2009 who referred him to the Community Drug and Alcohol Service. He was put on a waiting list and was given information about self-help groups until he could be seen. In October 2009 the Community Drug and Alcohol Service discharged him due to his lack of response.

2010 – 2012

7.7. In January 2010 Marvyn was made subject to a Community Supervision Order for assaulting his sister in December 2009. He had been throwing things at her, threatening her and ripping curtains from the windows. He had been drinking at the time. Marvyn's life was recorded as being chaotic. His mother had left the family home, moving to another area and he faced imminent homelessness. 2010 saw further offences of assaulting a stranger, damage and burglary. Sentence was deferred and between April 2010 and September 2010 there followed a period of positive engagement with The National Probation Service. Sessions focussed on anger management, use of alcohol and attitudes to women. During a three month period Marvyn disclosed four different partners but did not disclose the nature or extent of any of the relationships.

7.8 In August 2010 Marvyn's behaviour deteriorated again. Police were called as Marvyn was sitting on top of a bridge and passers-by thought he intended to jump. He was upset and distressed and was detained by the police under Section 136 of the Mental Health Act for his own safety. He was assessed in police custody. No mental illness was detected and he was referred to his GP. In September 2010 he assaulted his partner and also her friend when she intervened. They had been in a relationship for only two months. As a result of this latest domestic abuse incident and Marvyn's failure to meet the requirements of the deferment, he was sentenced to sixteen months in a Youth Offender Institution. Whilst in custody at various establishments during this period, Marvyn's behaviour was often disruptive and subject to adjudications. He did not complete any meaningful work to address his risk and as a result, it was felt his risk remained high. In November 2011, he was referred to the Mental Health Team within the prison due to concerns about his presentation and behaviour.

7.9 In October 2010, the victim of the assault was referred to a Multi-Agency Risk Assessment Conference (MARAC) for a safety plan to be developed she was supported by Women's Aid. Due to the risk assessment of High Risk of Serious Harm to partners made by probation, Marvyn was referred to the Multi-Agency

Public Protection Arrangements (MAPPA) by probation and was registered as a Category Three Level Two offender **(see footnote at end of report after glossary) in January 2011.

7.10 Due to his failure to cooperate with probation on his release in May 2011 Marvyn was recalled to prison and was released on his sentence expiry date in February 2012.Given he was under twenty-one years old, in line with legislation at the time he was released on a three month Notice of Supervision. He failed to comply and was returned to custody on three occasions. The releases from custody involved a comprehensive range of licence conditions to manage his risk .He was eventually released in April 2012. He again failed to comply but Notice of Supervision had terminated before his arrest.

7.11 In March 2012, Hampshire Police identified that Marvyn had a new partner. An application was made to disclose to her Marvyn's propensity for violence to partners. This was before Domestic Violence Disclosure Schemes were implemented and was considered to be good practice This information was disclosed but she wished to continue the relationship. The case was deregistered from the final MAPPA level 2 meeting in May 2012 as probation supervision was about to end.

2013 -2015

7.12 There was a fifth domestic abuse conviction in August 2013 in North Essex where it is recorded that after a further relationship had ended, Marvyn visited his ex-partner`s address where he pulled her hair, fought with her and damaged her glasses. He then damaged her car and stole a purse from within it. He was sentenced to two months custody concurrent to a sentence for other matters. There are a few months when it is not clear what was happening in Marvyn`s life due to him moving areas and limited agency contact. Lincolnshire Police were able to identify two periods of custody for offending. One involved battery but there are no details. It would appear Marvyn had addresses in Watford, Norfolk and Morecambe around this time.

7.13 Marvyn attended Norfolk Community Healthcare City Reach Services in April 2013 requesting help with his mental health. He said he had been up and down for years and that his brother had bi-polar. He can be happy for a day or two and then be upset by small comments. He reported recent arguments with his girlfriend and had self-harmed. He said he had some suicidal ideation but was not brave enough to take action. He was reviewed for anger reactions and agitation and they documented that "he really needs psychotherapy not medication." He was prescribed an anti-psychotic drug.

7.14 In April 2013 he was seen again. He said he didn't want to take his medication but his girlfriend thought he should. He said he had bi-polar but clinicians did not think he had. They documented that couple counselling would be a good idea and encouraged him to contact MAP (a counselling and mental health service for young people).There was no evidence he pursued the counselling suggested.

2015 - 2018

7.15 There was an assault conviction against his ex- partner in January 2015, which had involved threatening her, wishing their unborn child dead and grabbing her arm causing bruising. In March 2015 he was sentenced to six weeks in custody suspended for twenty-four months with a requirement to attend the Building Better Relationships Programme. The couple had been in a relationship approximately six weeks when it ended in December 2014. The victim later found she was pregnant with Marvyn's baby. He then started sending her abusive text and telephone messages.

7.16 Marvyn gave a Lincolnshire address when he appeared in Court in Southampton in 2015. When contacted by Lincolnshire Probation, he said he would not come to Lincolnshire because people wanted to kill him. He was subsequently breached and the suspended sentence was activated and he was sentenced to three months custody. He never completed the Building Better Relationships Programme. He was released in June 2015. Whilst in custody he damaged his cells and furniture. An action was identified in the Risk Management Plan at this time and for subsequent releases for a referral to MAPPA should Marvyn enter into a new relationship or resume contact with his previous partners.

7.17 In August 2015 Marvyn was sentenced to two years four months for three offences of burglary of dwellings, allegedly homes of his friends against whom he referred to as seeking revenge.

7.18 During the first year of sentence, Marvyn moved prison on three occasions and was subject to a number of adjudications for behaviour such as smashing his cell. There is no evidence Marvyn engaged in any interventions during this period. He was released in November 2016 but failed to arrive at the probation approved premises and a recall was initiated immediately. He was returned into custody in December 2016. He had spent some time staying with his sister in Lincolnshire before travelling to Southampton to make an unsuccessful attempt to see his daughter. He was subject to a restraining order not to have contact with his ex-partner, mother of his child.

7.19 During the last year in prison prior to his release in February 2018, his engagement with his offender manager improved slightly. He made some partial admissions to acts of domestic abuse. However, he minimised this behaviour and there was a level of victim blaming. He also failed to comply with the prison regime, again being subject to multiple adjudications. Latterly, he began to self-harm by cutting his arms.

7.20 The Parole Board conducted a single member panel review in early February 2018 and identified risk factors including grievance-thinking, poor temper control, relationship instability, alcohol misuse, aimless lifestyle and poor thinking and decision making skills. The panel was not satisfied that he was motivated to engage and that it was necessary for the protection of the public that he remained confined to closed conditions without early release. He was, subsequently, released on his

sentence expiry date in late February without any supervision restrictions or licence requirements, in line with legislation.

March to June 2018

7.21 Southampton Hospital reported to Hampshire Police that Marvyn, who was being held under Deprivation of Liberty Safeguarding Under the Mental Capacity Act, had absconded. The Police located him and returned him to hospital. He was suffering from psychosis, in part, induced by the use of drugs. He was hallucinating and was very agitated. Marvyn`s mental health had improved by the following day and he was assessed as having capacity. He discharged himself later that day, against medical advice. At that point, he went to stay with his mother in Lincolnshire.

7.22 Three days later, Marvyn attended an out of hours (OOH) surgery in Lincolnshire with chest pains. Several tests were taken and he was advised to register with a GP. He returned five days later to OOH, again with chest pains. He was advised to attend A&E immediately but refused. The results of the tests were sent to his GP in Southampton. A week later, he again went to the OOH asking for medication. They encouraged registration with a GP and with the Alcohol and Drugs Service. Two weeks later, he registered with a GP near his mother's home but was never seen there, missing one appointment and walking out of two others before being seen.

7.23 In January 2018, Lincolnshire Police had referred Holly to a local domestic abuse agency for support following three incidents involving her previous partner and father of her children. No violence had been disclosed and no offences had been committed. The referral suggested that Holly was reliant on her previous partner for financial support and highlighted her support needs, as budgeting, emotional support and building a social support network. It was recognised she was socially isolated.

7.24 The local domestic abuse agency began supporting Holly in late March, a couple of weeks before she met Marvyn. There were three contact sessions. One was just about the time she met Marvyn in mid-April. She did not disclose to the Domestic Abuse worker that she was in a new relationship at that time. We do not have the exact date the relationship began so this non-disclosure may have been due to the fact it was so new.

7.25 The sessions had covered issues relating to where to go for finances, emotional well-being, and safety planning and establishing a safe word. Holly advised she had obtained a spare mobile phone and had the domestic abuse agencies office and out of hours telephone numbers logged.

7.26 A DASH risk assessment was completed relating to her previous relationship and concluded as standard risk. The following support session was cancelled by Holly. Over the next two weeks, numerous calls and messages were left for Holly to which there was no reply. As a result, a no contact letter was sent advising that if there was no contact in the next month, the domestic abuse agency would close the support offer. Holly never responded to the letter but referred to having received it during her interview with the police.

7.27 Lincolnshire Children's Services (LCS) had received the three D.A notifications from the Police relating to her previous relationship. These incidents identified verbal abuse. As there had been three incidents within a twelve month period, consideration was given to whether any action might be taken. LCS assessed there was no indication of the need for an assessment by a Social Worker at the time and no evidence of the younger child being at risk of harm. A decision was made that if there were any further incidents, consideration would be given to the undertaking of an assessment.

7.28 In April and May 2018, the East Midlands Ambulance Service was called in relation to Marvyn having chest pains. Both calls were from Holly's home and he was seen there. The Ambulance crews advised Marvyn to go to hospital but he refused on both occasions to go. In May, the police were called to Marvyn's sister's home due to a domestic disturbance where Marvyn was smashing garden pots. There was no complaint and no action was taken.

7.29 Holly`s young child attended pre-school near to their new home. Holly always collected her. Marvyn went to pick her up with Holly on two occasions. Staff recognised him from an incident that had happened in the schools main office when he had collected his nephew. The incident involved Marvyn being rude and truculent with staff when his authority to pick up his nephew was challenged. The mother of the child, Marvyn`s sister, was contacted and gave permission and the issue was resolved. Staff asked Holly`s child the following day who Marvyn was, she said he was "Mummy`s friend". There was no further involvement with school.

7.30 In June 2018, Holly called Lincolnshire Police to report she had been involved in an argument with her partner, Marvyn. He had left the property before the police had arrived. During the argument he had verbally threatened to "knock her out". She had been in the relationship six weeks.

7.31 Marvyn's mood swings made Holly believe he had mental health issues. She disclosed a previously unreported incident whereby he had been angry about her going out with friends to a holistic health event and also his belief she was sleeping with other men. Whilst she was out, he had thrown paint over her doors and windows and had been sending her abusive texts.

7.32 Marvyn had told Holly he had recently been released from prison, he was known for having a temper and was not allowed to see his child due to his aggression. She disclosed when the relationship was not good she was petrified of Marvyn and had no doubt that he was capable of hitting a woman. Holly intimated she could protect herself a bit, but her child could not. She was asked and confirmed she had information about Domestic Abuse. services; she also had details of the Samaritans. She was advised of the Domestic Violence Disclosure Scheme. She stated she was not aware if there had been previous domestic abuse in Marvyn`s relationships but there had been an incident at his sister's recently where there had been damage and the police had been called. Advice was given about staying safe and to call the police if there was any reoccurrence. A DASH risk assessment was completed which indicated standard risk and Children's Services were notified.

7.33 Children's Services received notification about the incident three days later. It was communicated that the incident was a verbal altercation and no violence was reported, although threats had been made. On being notified, Children's Services did not take any further action as "there was no significant risks" indicated in the notification received from the police.

7.34 Eight days after the first reported incident to Lincolnshire Police, Holly was beaten to death by Marvyn.

8. Key Issues Arising from the Review / Lessons Learned

8.1 It is important that the pattern of escalating risk is identified and considered by those making the Domestic Abuse Assessment. Holly had only been in the relationship seven weeks when Marvyn brutally killed her. In that time, there had been one incident of damage to Holly's property that had gone unreported and one reported incident, a week before her death.

8.2 Some perpetrators can progress through the stages of abuse to homicide very quickly. For others, it can take many years. It was a matter of record in Marvyn's case, that previous abuse with another partner had taken place at approximately six weeks into the relationship. There is new academic research and a supporting model to help understand the different stages leading to domestic homicide known as the Homicide Timeline and developed by Dr Jane Monckton Smith. Consideration should be given to this learning, being translated into practice for use by frontline workers and their supervisors, to assist in recognising the critical steps when making assessments.

8.3 In the DASH risk assessment, undertaken the week before the killing, the level of coercive control was not recognised. The focus of the concern was on whether there had been physical violence, of which there was none reported. The coercive controlling behaviour involving threats, damage, abusive texts and calls and an element of stalking was not given sufficient weighting, in risk terms, as an indicator of seriousness. To our knowledge, the first physical assault was the brutal attack that killed her.

8.4 In managing risk, past behaviour is a key factor in understanding future risk. Whilst there had been a history of familial and intimate partner domestic abuse by Marvyn, this was not known to the police officer and others involved with the case involving Holly. The limited information on the local police Niche System was due to the fact that his offending was, predominately, in different force areas, away from the region. Because of this Marvyn's history of being considered high risk of serious harm to partners and a previously registered MAPPA offender was not accessed and investigated. A check of the PND and the PNC systems would have shown his offending history. The VISOR flag on his PNC record had gone unnoticed. This is recognised as an omission.

8.5 Whilst advice was given to Holly on support and staying safe, there were no attempts made to focus upon, manage and divert Marvyn`s abusive behaviour. All options to prevent further abuse by the perpetrator should be considered, including interview, warnings, restraining orders, arrest and charge. A psychological assessment may have assisted in identifying the risk of serious harm and possible risk management interventions.

8.6 There was a lack of information sharing at various stages of involvement in this case. As Marvyn did not meet the criteria to be subject to public protection processes whilst in prison, the prison was not required to share information at the time of his release in 2018. Similarly as Marvyn was released at his SED, there was no requirement for the probation service to share information. This is subject to a recommendation. Hampshire Police did not update their local intelligence system in April 2018, with information about Marvyn being detained under Deprivation of Liberty Safeguards of the Mental Capacity Act. As the level of coercive control and previous domestic abuse history had not been identified by Lincolnshire Police, it was not included in the information shared with Lincolnshire Children`s Services. Each piece of information provides a crucial part of the whole picture and helps to identify the pattern of emerging risk.

8.7 The quality of the risk of harm assessment underpins the effectiveness of the risk of harm management plan. The OASys risk assessment undertaken at regular intervals during custody had not been completed as required at the termination of contact, as Marvyn was being released from prison. This meant a cloned version of a previous assessment had been pulled through; it was out of date and therefore lacked the rigour expected. The risk management plan linked to the outdated assessment did however refer to informing any new partner of the risk presented by Marvyn and the need to inform Children's Services if there were children involved. Whilst remaining relevant the lack of any statutory supervision meant this plan was not shared nor activated.

8.8 During Marvyn`s time in custody the management of his difficult, disruptive behaviour became the focus of contact. This obscured the aims of sentence planning and risk of harm management. The frequent changes in prison establishment and the changes of offender manager created a further distraction.

8.9 The process surrounding the implementation of the Domestic Violence Disclosure Scheme has a government support timeframe of thirty six working days, regardless of right to know or right to ask, unless it is considered urgent. In this case if there had been a non-urgent request to share information, the communication would not have taken place before Holly was killed. The "Right to Ask" element of the DVDS was explained to the victim. Speed of action can be fundamental, a review of the Domestic Violence Disclosure Scheme process has been undertaken in Lincolnshire in 2020 and also there has been national case law pushing for quicker timeframes on such applications.

8.10 It was recognised that whilst Marvyn had previous convictions for domestic abuse offences against his mother, sister and intimate partners, there was never a record of a weapon being used. The convictions were for common assaults which did not

always reflect the frightening nature of the attacks or the victim's experience. The details of what actually took place in previous domestic abuse incidents should be investigated and understood by those undertaking any new risk assessment.

8.11 When Marvyn was deregistered from being a MAPPA offender in May 2012, it was not due to a reduction of risk but due to the fact that his supervision by the National Probation Service had come to an end. The Hampshire Police did not consider it appropriate as a single agency, to take on the risk management through the MAPPA process, which fundamentally requires a multi -agency approach. Whilst this decision related to multi-agency involvement there was a lack of Hampshire Police considering any other capability to manage the risk that Marvyn posed. The Hampshire Police reviewer has provided details of different approaches that have been developed within the force since 2012 which are designed to provide just that kind of risk management, through Integrated Offender Management and through High Harm Capabilities within local policing.

8.12 Accurate recording underpins quality information. The discharge summaries from UHSFT following Marvyn being detained under the Deprivation of Liberty Safeguards of the Mental Capacity Act were inaccurate and did not provide the full information of events to the GP. The need for improved recording was also identified by Her Majesty`s Prison and Hampshire Constabulary in relation to the completion of the PPNI.

8.13 The Domestic Abuse Support Service identified a lack of professional curiosity relating to case closure. They were about to move to case closure without adequate consideration of the reasons behind the lack of contact and without following the agreed plan of contacting Holly`s Mother followed by a safe and well check by the police if necessary.

9. Conclusions.

9.1 The speed with which Marvyn moved from meeting Holly to coercively controlling, threatening and murdering her has shocked all those close to Holly and those undertaking this review. He had a history of domestic abuse against his family and intimate partners. It is recorded that his controlling, abusive behaviour escalated to violence very quickly in previous relationships where abuse had been reported.

9.2 The risk Marvyn presented was known by some criminal justice agencies. He had been registered as a MAPPA offender and MARAC had been involved with one of the victims in Southampton. He had moved around the country and spent periods in twelve different prisons. He had never engaged or complied with the vast range of interventions planned to manage his risk. He had been subject to adjudications in prison and recalled to custody for failure to comply on Licence and with community supervision. On the last occasion he was released from custody, due to his lack of co-operation, it was at his SED and there were no Licence conditions or monitoring.

9.3 Marvyn decided to move to Lincolnshire where his mother and sister lived. He was not on any local agency’s radar due to his recent move and spending the last two

years in custody. There was a lack of local knowledge. He was often convicted of common assault which is the lower level of the violent offences which did not reflect the frightening and abusive nature of his behaviour. There was no record of Marvyn previously using a weapon

9.4 Holly was lonely and isolated having recently moved home to make a fresh start with her young child. She was forthright and determined and called the Police immediately she felt at risk from Marvyn. Her friend indicated she gave Marvyn another chance believing she could make a difference and change his behaviour.

9.5 Holly was not prepared to tolerate his controlling behaviour and on the Saturday asked him to go to his mother's house for a couple hours as she was feeling suffocated by him. This appears to be the trigger that led to his anger at her resistance to his control and he killed her.

9.6 Whilst agencies had information of Marvyn' risk and patterns of behaviour, this was not easily accessible to those making the most recent assessments and decisions. Had the risk Marvyn presented and his domestic abuse history been shared with Holly, it is not known what her response would have been. We do know that she wished to protect her child from such risks.

9.7 It is hoped the lessons learned from this review will influence improvements in practice. However, it is clear it was not the action or lack of action by any of the agencies that resulted in the killing of Holly. It was, solely, Marvyn's decision to take her life and he, alone, is responsible.

10. Recommendations.

10.1 **National Probation Service – Lincolnshire.**

10.1.1 Ensure the OASys termination plan is completed incorporating the assessment of risk and need at the time.

10.2 HM Prison Service.

10.2.1 Recording of contacts should be improved to consistently document contact and actions and to ensure information related to identified and presenting risks is included in each case.

10.2.2 Ensure the overarching aims of sentence planning and emerging patterns of behaviour are not lost in the day to day practical issues of managing those prisoners who display challenging and disruptive behaviour.

10.2.3 A primary aim of service delivery should be consistency of offender manager wherever possible. Where this cannot be achieved, a process should be developed to ensure effective handover of the case between offender managers and prison establishments to ensure the aims of sentence planning and risk management are prioritised.

10.3 Nottingham Community Housing Association (NCHA)

10.3.1 Project managers to review all contact plans and associated case notes to ensure staff are following the plan. Caseload supervision will include checks on contact plans.

10.3.2 Contact Policy to be amended to include the standard practice of contacting agencies involved if contact is not established, including safe and well checks. This practice will be shared with service users at sign-up to the contract.

10.3.3 Case Closure Policy will be reviewed to include recorded discussion and approval from the project manager.

10.3.4 Staff and managers must satisfy themselves that contact has been established either through NCHA staff, agencies or the police before closing support. NCHA staff will complete a DASH risk assessment with service users at final support session.

10.3.5 NCHA staff will provide contact details for national domestic abuse helplines and other services relevant to the service user before a case is finally closed.

10.3.6 Staff will offer support to obtain a critical marker on the address at the point of the needs and risk assessment for new service users and at point of move-on for refuge service users.

10.3.7 Project Managers to review all initial support plans to ensure staff are reviewing them within 30 days. Caseload supervision will include checks on review periods.

10.4 Lincolnshire Police.

10.4.1 Remind staff not to rely on an act of physical violence to take action against the perpetrator. Coercive control is an offence and can be a predictor of high risk of harm and requires consideration for charges to be brought.

10.4.2 Ensure police officers responding to allegations of domestic abuse are able to identify and fully investigate coercive controlling behaviour.

10.5 University of Southampton NHS Foundation Trust.

10.5.1 To discuss this case at the Acute Medical Unit Governance Forum in order to share learning.

10.6 Hampshire Constabulary.

10.6.1 Hampshire Constabulary's Response and Patrol Command should review the guidance given to frontline response officers with regard to their responsibilities for completion of a detailed and informed PPNI form when dealing with vulnerable people.

10.7 Lincolnshire Partnership NHS foundation Trust.

10.7.1 Lincolnshire Partnership NHS Foundation Trust to lead a piece of multi-agency work to consider the prevalence of personality disorder in perpetrators involved in Domestic Homicide Reviews and Child Serious Case Reviews in Lincolnshire over the past five years. The purpose would be to consider a process for identifying potentially dangerous abusers in order to undertake a full forensic assessment with a view to mitigating harm and identifying risk management interventions to provide public protection. The findings to be shared with The National Domestic Homicide Review Panel to inform national developments.

10.8 Safer Lincolnshire Partnership.

10.8.1 Continue to raise awareness of the role of coercive control in domestic abuse cases.

10.8.2 Consider expanding current multi-agency training to include information on the Eight Stage Timeline leading to Domestic Homicide developed by Dr Jane Monckton Smith.

10.8.3 Write to The National College of Policing to request consideration be given to The DASH risk assessment review including questions relating to Dr Jane Monckton Smith`s Eight Stage Domestic Homicide Timeline.

10.8.4 Ensure multi-agency domestic abuse training includes information on the importance of having all details of the perpetrators previous domestic abuse charges, convictions and behaviours. This information is key to understanding the level of the risk posed when making a thorough risk assessment.

10.8.5 Consider developing a “Managing Perpetrators Strategy” which captures all existing structures in Lincolnshire for managing domestic abuse perpetrators.

10.8.6 Consider requesting that the National Domestic Abuse Perpetrators Strategy addresses the issues of improving processes when working across area boundaries.

10.8.7 Write to Her Majesty`s Prison and Probation Service nationally to share the learning from this review relating to the need to share information regarding an offenders risk of harm at the pre-release stage. The sharing of information refers to those offenders that do not meet the MAPPA threshold or the other current public protection categories e.g. sexual offences against children. This review suggests consideration be given to extending the practice of pre-release multi-agency meetings on all relevant prisoners as conducted at HMP Lincoln.

10.9 The Home Office.

10.9.1 Consider developing a published list of contacts in every community safety partnership area to facilitate the timely gathering of relevant information across area boundaries to inform the preparation of DHRs and to avoid unnecessary delays.

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11. Glossary of Terms.

AA	Alcoholics Anonymous
AAFDA	Advocacy After Fatal Domestic Abuse
AMU	Acute Medical Unit
BBR	Building Better Relationships
CCGs	Clinical Commissioning Groups
CRU	Central Referral Unit (Police)
CS	Children's Services
D.A.	Domestic Abuse
DASH	Domestic Abuse, Stalking and Honour Based Violence
DHR	Domestic Homicide Review
DV	Domestic Violence
DVDS	Domestic Violence Disclosure Scheme
ELDAS	Historical Domestic Abuse Service in Lincolnshire until 2018
FCR	Force Control Room
GENIE	Police Intelligence Search Engine
GP	General Practitioner
HMIC	Her Majesty's Inspectorate of Constabulary
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services
HMP	Her Majesty's Prison
HMPPS	Her Majesty`s Prison and Probation Service
HRDA	High Risk Domestic Abuse Assessment Process
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisor

IMR	Individual Management Review
ISSP	Intensive Supervision and Surveillance Programme
LCS	Lincolnshire Children's Services
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hubs
NCHA	Nottingham Community Housing Association
NHS	National Health Service
NICHE	Police Recording and Intelligence Management Systems
OASys	Offender Assessment System
OOH	Out Of Hours
PNC	Police National Computer
PPU	Police Public Protection Unit
PND	Police National Database
PPN	Public Protection Notice
SED	Sentence Expiry Date
TOR	Terms of Reference
UHSFT	University of Southampton NHS Foundation Trust
VISOR	Violent and Sex Offenders Register