NCCSP
Norfolk county community safety partnership

Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of April
in January 2017

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Preface

Norfolk County Community Safety Partnership wishes at the outset to express their deepest sympathy to the victim's family particularly to the children. This review has been undertaken in order that lessons can be learned, and we appreciate the support and challenge from the families with the process.

The Independent Chair and Report Author would like to thank the staff from statutory and voluntary sector agencies who assisted in compiling the report.

To protect anonymity, the victim will be referred to by the pseudonym, April, as chosen by the victim's family.

Glossary

Athena	Project Athena is a framework agreement for police IT systems to enable data sharing between forces
ASB	Anti-Social Behaviour
Clare's Law	Also known as the Domestic Violence Disclosure Scheme (DVDS). This allows the police to disclose information on request about a partner's previous history of domestic abuse or violent acts that could protect someone from being a victim of attack
DASH	Domestic Abuse, Stalking and Honour based violence risk assessment model introduced to all UK police forces since 2009
DHR	Domestic Homicide Review
DHR 1	Standard form used by Norfolk County Community Safety Partnership for written notification that a death has occurred which may meet the criteria for a Domestic Homicide Review
DVDS	Domestic Violence Disclosure Scheme, also known as Clare's Law (see above)
MAPPA	Multi- Agency Public Protection Arrangements - The purpose of MAPPA is to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require local agencies to work together in partnership in dealing with these offenders.
MARAC	Multi-Agency Risk Assessment Conference - The MARAC is a multi-agency meeting which considers those cases of domestic abuse that are considered (using the DASH risk assessment) to be high risk. Its aim is to provide a multi-agency respond to protect victims of domestic abuse.
NCCSP	Norfolk County Community Safety Partnership – this is a statutory partnership comprising agencies serving the county and is responsible for community safety within the county

Contents

Section One – The Review Process

1.1 Introduction and agencies participating in the Review

1.1.1 This summary outlines the process undertaken by the Norfolk County Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of one of its residents. The death occurred in January 2017.

1.1.2 The victim was April, aged 32 years, who was killed by her ex-partner at her home. He has since been found guilty of her murder and sentenced to life imprisonment with a minimum length of 24 years to be served in custody. He is a 26-year old male who had a number of convictions for assault on numerous ex-girlfriends. At the time of her murder, he was under three separate restraining orders against three separate ex-girlfriends, including April.

1.1.3 On an evening in early January 2017 April's family were concerned as she had not fulfilled the arrangements for her children to be returned to her care by their father. Because of their concerns some members of her family went to her home; a flat she shared with her two young sons. The family found April lying on the floor the flat with obvious injuries to her head and face. They called for an ambulance and just before midnight ambulance staff and police arrived. April was found to have sustained substantial facial injuries and bruising to her neck. She was pronounced dead at the scene.

1.1.4 Norfolk County Community Safety Partnership (NCCSP) was notified of the death by Norfolk Constabulary in January 2017. On 6th February 2017, the Chair of the Community Safety Partnership chaired a multi-agency Domestic Homicide Review (DHR) meeting and the decision was taken to undertake a DHR. The Home Office was notified of the decision on 7th February 2017.

1.1.5 An independent Chair and Report Author were appointed, and the Review Panel met for the first time on 2nd May 2017.

1.1.6 The final meeting of the Panel was on 21st May 2018 to finalise the report and the findings therein, and consider the actions needed to address the recommendations.

1.1.7 It was not possible to complete the review within the six-month timescale set out in the statutory guidance due to the complexity of this case, the history that had to be explored, and to ensure that the trial of the perpetrator was concluded.

1.1.8 The following individuals and agencies contributed to the review:

- April's family and friends
- Perpetrator's family
- A previous partner of the perpetrator
- Circle Housing
- East of England Crown Prosecution Service
- GP surgery for victim and perpetrator
- Leeway Domestic Violence and Abuse Services
- MAPPA Co-ordinator
- National Probation Service
- NHS England Midlands and East (East)

- Norfolk and Norwich University Hospital
- Norfolk and Suffolk Community Rehabilitation Company
- Norfolk and Suffolk Foundation Trust
- Norfolk and Waveney Clinical Commissioning Groups
- Norfolk Constabulary
- Norfolk County Council, Children's Services
- Norfolk County Council, Public Health
- Norwich City Council
- Norfolk Safeguarding Adults Board

1.2 Purpose and Terms of Reference of the Review

1.2.1 According to the statutory guidance, the purpose of a Domestic Homicide Review is to:

- 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
- 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
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice.

1.2.2 The Panel agreed that the specific purpose of the Review is to:

- Establish the facts that led to the incident in January 2017 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in January 2017; suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

1.2.3 The scope of the Review, as agreed by the Panel, is to:

- Seek to establish whether the events of January 2017 could have been reasonably predicted or prevented.

- Consider the period from the perpetrator's birth (or other timescales as appropriate, to be confirmed at the first Review Panel), subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

- Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:
    - guidance from the police as to any sub-judice issues,
    - sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

Section Two – Agency contact and information learnt from the Review

2.1 April was a white British young woman with family ties in Norwich. She had two children from a previous relationship. The children lived with April but spent most weekends with their father and he remained a significant part of their lives and April's life.

2.2 The perpetrator was a white British man who had been living in Norfolk for approximately seven years. He has two young children from a previous relationship; the mother of those children was one of the victims of his severe violence. He grew up in another part of the country where his mother and the mother of his children still live.

2.3 By the age of 26, the perpetrator is known to have been violent and abusive to six girlfriends in total. He had a number of convictions for assault and had been subject to a restraining order on three separate occasions, for three different women. He was prone to heavy drinking and drug use.

2.4 The victim and the perpetrator had been in a relationship since June 2015. April had a flat in the city where she lived with her two children.

2.5 The initial stages of the relationship were intense. April seemed to have fallen in love with the perpetrator. He showered her with gifts and, early in the relationship, and brought flowers for her mother on three separate occasions. Despite having a number of previous girlfriends, April was the only girl, other than the mother of his two children, who he subsequently introduced to his own mother. After a few months the perpetrator moved in with April.

2.6 It seems it was not long before he fell into a pattern of behaviour that a number of his previous girlfriends had faced. He became controlling, overbearing and then violent. The violence was severe. He began to bombard her with calls and texts; when he did not get a response he would turn to contacting her mother.

2.7 There were two incidents reported to the authorities of arguments between the two in early 2016 but although April was spoken to by police she would not disclose the full details of the incidents between them.

2.8 It seems that April put up with a lot before she was finally able to report a serious assault by the perpetrator to police. This occurred in July 2016. The perpetrator was arrested for the assault but after she had made the report and received treatment in hospital, April would not make a formal statement or support a prosecution. However, the case proceeded to court in October 2016, resulting in the perpetrator becoming the subject of a restraining order to prevent further contact with April.

2.9 It is clear that the restraining order was not something that was adhered to; April and the perpetrator kept seeing each other. This included a trip to Rome together in November where more violence took place. When she returned she was adamant with family and friends that it was over between them.

2.10 On the evening of the fatal incident, the victim and perpetrator had been out together again in Norwich. It has never been properly established why she went out with him that night. They were at a pub in the city centre and when the evening finished they returned to her home.

2.11 It is there that he turned upon April and killed her by numerous punches to her head, effectively smashing every bone in her face. He left her dead or dying in the flat, did not raise the alarm and went to a friend's house where it is thought he took more drink and drugs.

2.12 April was found by her family the following day when they called at the house after becoming concerned that she had not made contact about the return of her children from their father's house. It is only by good fortune that her two young children did not discover April's body as they had attended the flat with other members of the family and, running ahead, found the door locked.

2.13 The perpetrator was well-known to agencies, but there had been limited involvement of agencies with April during her relationship with him.

Section Three – Key issues arising from the Review

3.1 **The perpetrator's history of abuse**

3.1.1 This review has not sought to make contact with all of the perpetrator's previous partners, but from information from April's friends and family and one of his ex-partners we can see similarities and begin to paint a picture of the perpetrator and his approach to relationships. He is articulate and socially aware and on first meeting presents as charming and caring. He has a tendency to move very quickly in his relationships and make great shows of affection for example, buying flowers every week, meals out and holidays. He was described as being fun and caring and he loved to spend his money on pleasing others.

3.1.2 He is known to use alcohol, drugs and steroids to excess and, on a number of occasions, it has been suggested that his violence has been fuelled by this substance misuse.

3.1.3 His physical violence was always interpersonal, with punches to the face and head; it was not the use of weapons.

3.1.4 We are very clear in this review that coercion and control over partners, as well as physical violence, was prevalent within his relationships. He attempted to continue the control and fear even when a relationship ended, using texts, emails and turning up in the street in his van. His level of charm and manipulation cannot be overstated.

3.1.5 The perpetrator had become an extreme bully of vulnerable women. He was selfish, manipulating, controlling, and extremely violent. He was a very dangerous young man to any woman who fell for his charms.

3.1.6 The issue for society, and authorities in particular, is how we identify those who are dangerous and how we protect those who are thus vulnerable. This Review welcomes the changes to sentencing policy announced on 22nd February 2018. The policy change recognises that assaults that occur in domestic circumstances are often more serious than those that do not because of their effect upon victims. This is a step-forward in terms of protecting the public.

3.1.7 This Review, however, would go further and suggest that the type of serial, repeat, violent offending as displayed by this perpetrator should automatically be considered an aggravating factor. Longer prison sentences should follow for repeat offenders with mandatory rehabilitation courses whilst in prison, with continuation in the community upon release. There has to be a deterrent.

3.2 **Why did the victim not feel able to access support?**

3.2.1 The full report explores in detail the reasons why April may have continued in her relationship with the perpetrator, but it is absolutely clear that we must do more to make domestic violence and abuse socially unacceptable. The Government's Green Paper 'Transforming the Response to Domestic Abuse' published on 8th March 2018, appears to be a huge step forward in this respect. It seeks to address domestic abuse at every stage from prevention through to rehabilitation.

Section Four – Conclusions

4.1 When the perpetrator was sentenced for April's murder the Judge passed comment that this was one of the worst cases of domestic violence to come before the Courts. Whilst all cases of domestic abuse can have serious impact upon their victims, the serial nature of the perpetrator's offending, the multiplicity of victims and his relatively young age mark this case out as different.

4.2 Staff from a range of agencies did act. The perpetrator was visible to multi-agency safeguarding processes and panels of MAPPA and MARAC. He was on statutory supervision by probation services. Children's social care were aware of him and involved to protect April's children. Specialist domestic abuse services were aware of him and were working with April to protect her. None of this protected April and the level of threat that he truly posed was not recognised by the processes set up to protect her and deter him.

4.3 The true risk may not have been recognised partly because of the level of some of his convictions. Common assault is understandably at the lower end of the violence spectrum, but final offences convicted or accepted at court often bear little resemblance to what a victim faced.

4.4 In 2008, the probation services recorded in their risk assessment of the perpetrator that 'he has the capacity to cause fatal harm'; he then consistently remained as high risk. This might have been an opinion, it might have been challenged by him, but it was a professional opinion by a professional body. The information sharing legislation specifically permits this type of information sharing and agencies charged with protecting the vulnerable must be fully aware of risk assessments such as these and not all were in this case.

4.5 The perpetrator's criminal convictions prior to April's murder do not adequately represent the risk he posed to his victims and the fear he instilled within them. The evidence of the volume and nature of texts alone indicate his need for control and his childlike tantrums, which are far more dangerous as a violent grown man; when he does not receive a response the level of aggression in his texts is quite astonishing.

4.6 Had he been convicted of the July 2016 assault upon April he may have received another prison sentence, this may have prevented the murder of April. Had he been under the scrutiny of MAPPA at the time it may have meant more cross agency resources were alive to his potential and this may have had a deterrent effect. None of these things are certain and it would be wrong to blame any individual for failings in this case that led directly to the tragic events that resulted in April's death. There is only one person to blame for April's death; that is the perpetrator.

4.7 All agencies have contributed positively to this review and have been frustrated that the collective efforts to protect April failed and all have looked to find ways to make changes to the 'system' to better protect others in the future. The fact is that all of the publicity, all of the actions by staff from agencies and specialist support organisations, in addition to what she was being told about the perpetrator's behaviour by her friends, could not make April safe and afford her an exit. This shows how much more needs to be done to protect those vulnerable to attack. The recommendations within this Review, the changes to sentencing policy and the proposals set out by government for strengthening our approach to domestic violence and abuse will make a difference.

Section Five – Recommendations

5.1 In line with Norfolk's thematic learning framework, which has been drawn from a number of reviews – Domestic Homicide Reviews, Safeguarding Adults Reviews and Serious Case Reviews – the recommendations will be grouped under the following headings:

- Professional Curiosity
- Information Sharing and Fora for Discussion
- Collaborative Working, Decision Making and Planning
- Ownership, Accountability and Management Grip

An additional section has been added for the purpose of this review – National Recommendations

5.2 Professional curiosity

5.2.1 That the existing programme of awareness raising across all GP practices in Norfolk is stepped up for adult safeguarding, to raise professional curiosity and knowledge of referral routes, signposting to specialist support agencies and triggers for and signs of abuse (Recommendation 11)

5.2.2 That A&E staff are trained in domestic abuse, including how to ask the abuse question and how to complete the DASH form (Recommendation 14)

5.2.3 That consideration is given to a process that will allow A&E staff to check previous attendances for those attending with assault injuries. This will assist in a more holistic view of the patient presenting at A&E (Recommendation 15)

5.3 Information sharing and Fora for Discussion

5.3.1 That, alongside the awareness raising campaigns undertaken in Norfolk, there are two specific campaigns recommended. The first targeted at young people to stress the message about healthy relationships and the second at hairdressers, beauticians etc. as potentially confidants of victims (Recommendation 1)

5.3.2 That the publicity within Norfolk surrounding the Domestic Violence Disclosure Scheme (DVDS) is reviewed, with a view to ongoing and targeting awareness raising campaigns. Consideration should be given to adopting and publishing, on the police website, the explanatory leaflet used in a number of forces (Recommendation 2)

5.4 Collaborative Working, Decision Making and Planning

5.4.1 That when a Clare's Law disclosure is pending, the police system Athena, should be updated so that any officer who goes into the record will see that there is an outstanding disclosure and can contact the specialist officers in the case (Recommendation 3)

5.4.2 That the impact of the Leeway post to support the police in DVDS disclosures is evaluated in order that its value can be clearly seen (Recommendation 4)

5.4.3 That consideration is given to how the needs of the whole family can be managed effectively across the multi-agency processes – MAPPA, MARAC and safeguarding children (also a national recommendation below) (Recommendation 30)

5.5 Ownership, Accountability and Management Grip

5.5.1 That, where a person is reluctant to hear a disclosure, it is referred back to the DVDS panel for consideration to be given to making the disclosure to a family member who may be in a position to offer some protection to the victim (Recommendation 6)

5.5.2 That Norfolk Police reviews the way in which intelligence and information about the relationships of known repeat perpetrators is analysed and acted upon. It is further recommended, as a matter of course, when intelligence of information is received about a known perpetrator being in another relationship an application under the DVDS is always automatically made (Recommendation 7)

5.5.3 That the East of England Crown Prosecution Service review their practices for achieving evidence led prosecution without victim complainant (victimless prosecutions) (Recommendation 8)

5.5.4 The National Probation Service have identified a number of service specific recommendations which this review recommends are undertaken (Recommendation 10):

- To plan and implement effective measures to reduce caseloads and workload pressure on staff working at the relevant office
- To widen and improve the recruitment campaign/package to encourage new applicants and experienced probation staff to relocate to the relevant office
- To clarify the boundaries of all local measures introduced to reduce offender manager workloads with high risk offenders in the community

5.5.5 That the pack provided to locum GPs by a practice includes information on how they can make sure patients 'of concern' are followed up. For example, where to direct a 'patient task' to make sure a follow up in the case of a DNA (Did Not Attend) (Recommendation 12)

5.5.6 That DNA (Did Not Attend) processes in GP surgeries are reviewed to ensure their effectiveness for safeguarding purposes (Recommendation 13)

5.5.7 That a 'safeguarding' box is added to Symphony as a mandatory reporting field in the hospital. This should include if there are any safeguarding concerns and identify whether the concerns relate to a child, adult or domestic abuse (Recommendation 16)

5.5.8 That A&E staff are identified to train as Domestic Abuse Champions (Recommendation 17)

5.5.9 That domestic abuse information is displayed in public areas in the hospital, specifically toilets which should have contact details for charities and support services (Recommendation 18)

5.5.10 That, as suggested by a consultant in the Maxillo-Facial surgery department, a specific session on domestic abuse is included in the induction programme for all junior doctors joining the department (Recommendation 19)

5.5.11 That the Hospital Trust considers Domestic Abuse Awareness becoming a mandatory training requirement for patient facing staff, acknowledging the pressures that exist for different mandatory training (Recommendation 20)

5.5.12 That children's social care ensure non-abusive, absent parents are informed of any concerns and involved in any assessments that are undertaken (Recommendation 21)

5.5.13 That children's services review their process for sending out letters such as those sent to April, to ensure that they are all case specific and written in light of the information available (Recommendation 22)

5.5.14 That children's social care holds a series of workshops and communications is implemented to share the learning identified (Recommendation 23)

5.5.15 That procedures in the children's social care department are reviewed to ensure the learning is captured in future practice (Recommendation 24)

5.5.16 That a specific learning event is held for those in the children's social care who were directly involved in the case (Recommendation 25)

5.5.17 That customer services and repairs staff/contractors are reminded of Circle 33's Safeguarding and Domestic Abuse policies and ensure that requests for repair or concerns raised by third parties, linked to actual or potential domestic abuse, are also recorded as a Safeguarding Alert and/or ASB case and passed to the Neighbourhood Team for further action (Recommendation 26)

5.5.18 That Neighbourhood Officers at Circle 33 are reminded of the Domestic Abuse and ASB policies and their relevance to this case (Recommendation 27)

5.5.19 That each Neighbourhood Team in the Circle Group acquires equipment to provide additional security and reassurance to victims of domestic abuse e.g. door braces and alarms (Recommendation 28)

5.5.20 That the Clarion Group (Circle 33) considers a Community Safety Strategy which prioritises domestic abuse and identifies improvements to the current offer to its customers (Recommendation 29)

5.6 National Recommendations

5.6.1 That a national evaluation of Clare's Law is commissioned to assess its use and effectiveness in protecting victims (Recommendation 5)

5.6.2 It is recommended that the Ministry of Justice review the adequacy of staffing in the National Probation Service to ensure realistic caseloads, so that there is effective monitoring of high risk offenders and public protection is not compromised (Recommendation 9)

5.6.3 That consideration is given to how the needs of the whole family can be managed effectively across the processes of MARAC (focusing on the victim), MAPPA (focusing on the offender) and safeguarding (focusing on the children involved) (Recommendation 30)

5.6.4 That for serial and/or repeat perpetrators, where there is evidence regarding violent or serious harmful offending, this should automatically be considered as an aggravating factor and longer-term prison sentences should follow with mandatory rehabilitation courses whilst in prison (Recommendation 31).