LEICESTERSHIRE SAFER COMMUNITY STRATEGY BOARD

DOMESTIC HOMICIDE REVIEW [Final]

OVERVIEW REPORT

INTO THE DEATH OF

AB

Chair	Heather Pick
Author	Cherryl Henry-Leach
Date of Report	27th October 2017

Contents

1. INTRODUCTION

1.1. The main people referred to in this review are:

AB	the Victim	60 years	UK British
NF	the Offender	72 years	Barbadian/UK resident
JF	Son of AB and NF	29 years	UK British
MM	Partner of JF	30 years	UK British

1.2. On 17th April 2015 JF, the adult son of AB and NF, was unable to contact his parents. JF became concerned that his parents had not attended a pre-arranged family celebration, and asked a neighbour to check on their well-being. The neighbour found the body of AB in the kitchen and on hearing noises upstairs located NF in a bedroom and immediately alerted the police. NF was arrested at the scene. A post mortem showed that AB died of stab wounds. NF was charged with her murder and remanded into custody by the Court on 20th April 2015.

1.3. On 31st March 2016, during a Finding of Fact hearing, NF entered a guilty plea to manslaughter, on the grounds of diminished responsibility. He was then made subject to a Hospital Order under the Mental Health Act 1983.

1.4. The Panel would like to formally express its sincere condolences to the family of AB for their loss, and thank JF and MM for their contribution to this report. In line with JF's expressed wishes, the parties referred to in the report are referred to by their initials.

1.5. The Domestic Homicide Review Chair and Overview Report Author would like to thank the Leicestershire and Rutland Safeguarding Board Business Office, Panel members and professionals who contributed to, and supported, the completion of this review.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

2.1. Decision Making

2.1.1. The statutory requirement to complete a domestic homicide review rests with the Community Safety Partnership (CSP) for the area in which a homicide takes place. In Leicestershire and Rutland, local procedures are in place for the CSPs to commission a review through the Joint Safeguarding Adults Board and Local Safeguarding Children's Board Serious Case Review Subgroup. In this case, the CSP was notified of the incident on 18th April 2015 by Leicestershire Police. A request for information was sent to agencies on 21st April 2015, with a ten day deadline for responses. All agencies complied with the request and most submitted nil returns, having had no contact with AB, NF or their son, JF.

2.1.2. The information obtained was compiled into a summary report and presented to the Leicestershire and Rutland Safeguarding Adults Board Serious Case Review Subgroup on 7th May 2015. That group decided the criteria for a domestic homicide review had been met in this case and made a recommendation to the Leicestershire Community Safety Strategy Board to undertake a review. On 19th May 2015 the Chair of the Board considered that recommendation and decided to commission a domestic homicide review. The Home Office was informed of this decision on 27th May 2015.

2.1.3. The first Panel meeting was held on 28th August 2015 and the second on 6th November 2015. Reviews should be finished within six months of notification of domestic homicide reviews being made to the Home Office, and the Panel was aware that the completion date was 27th November 2015 [Paragraph 42 of the DHR Guidance]. At the second Panel meeting, the Chair, with the unanimous support of the Panel, decided to hold the review in abeyance until the outcome of the criminal justice process. On the 23rd November 2015, the Home Office was advised that the review would not be completed within the prescribed timescales and the Home Office has not made any representation to the Panel or the Community Safety Partnership in relation to this decision.

2.2. The Domestic Homicide Review Panel

2.2.1. In line with the Leicestershire and Rutland domestic homicide review protocol, the Panel was chaired by Mrs Heather Pick, Assistant Director, Personal Care and Support, Adults and Communities Department, Leicestershire County Council. Mrs Pick is also the Vice Chair of the Leicestershire and Rutland Safeguarding Adults Board and the Chair of the Leicestershire and Rutland Adults Serious Case Review Subgroup.

2.2.2. The overview report author, Mrs Cherryl Henry-Leach, was appointed on behalf of the Panel as an independent practitioner. Mrs Henry-Leach is currently employed as the Operational Manager of a project funded by the Department for Education (DfE) which seeks to transform social care responses to domestic abuse, led by a Children's Services Trust in another part of the country. Prior to this, she was employed as a Local Authority Domestic Abuse Coordinator in South Yorkshire. Mrs Henry-Leach is also an Associate for a national agency that holds the lead for Multi Agency Risk Assessment Conference (MARAC) development on behalf of the Home Office and an External Associate and Subject Matter Expert to the College of Policing. She has not been employed by any of the agencies involved in this review. Mrs Henry-Leach has completed the Home Office domestic homicide review training packages, including the additional on-line modules on chairing reviews and producing overview reports. The Panel agreed that Mrs Henry-Leach, who is also of Caribbean descent, fulfils the criteria set out in the statutory guidance for the conduct of domestic homicide reviews due to her expertise on domestic abuse and the specific issues linked to this case as identified in the terms of reference.

2.2.3. The Chair and Overview Report Author were supported by the Panel, whose membership was as follows:

Performance and Consultation Manager, Hinckley and Bosworth Borough Council

Head of Professional Practice and Education, Leicestershire Partnership NHS Trust

Designated Nurse, Safeguarding Adults and Children Leicester, Leicestershire and Rutland Safeguarding Team, hosted by Leicester City Clinical Commissioning Group (CCG)

Community Safety Team Manager, Children and Family Services, Leicestershire County Council

Detective Chief Inspector, Adult Safeguarding Lead, Leicestershire Police

Deputy Director for People, Rutland County Council

Board Manager, Safeguarding Boards Business Office, Leicestershire County Council

Administration, Safeguarding Boards Business Office, Leicestershire County Council

In addition to the above agencies, a local domestic abuse specialist service was invited to be part of the panel but was unable to do so, but offered to give consultancy advice where required. The Panel agreed this and that the specialist representation was provided by Mrs Henry-Leach.

2.3. Parallel Processes

2.3.1. On the 7th September 2015, NF was assessed by a consultant forensic psychiatrist as being unfit to stand trial for the charge of murder. At the Crown Court sitting in Leicester a Finding of Fact hearing took place on the 31st March, 2016. In NF's absence, a guilty plea to manslaughter on the grounds of diminished responsibility was accepted by the Court. The sentencing judge recognised that NF was suffering from dementia and psychotic depression at the time of AB's death and sentenced him to a hospital order under the Mental Health Act 1983.

2.3.2. HM Coroner's inquest was opened and adjourned following confirmation of the criminal justice process and will not be re-opened. The Panel also confirmed that a mental health investigation would not be undertaken in relation to this case due to NF not being a current patient or having received service support within the last 12 months. As such, the case did not meet the criteria for a mental health investigation and the Panel was satisfied that this was in line with protocols that existed at the time of this report.

2.3.3. NF had received treatment from the Leicestershire Partnership NHS Trust in 2007 and a serious incident investigation was considered. However, the circumstances did not meet the criteria for such an investigation.

2.4. Individual Management Reviews (IMRs)

2.4.1. Two agencies submitted individual management reviews:

- Leicestershire Partnership NHS Trust – Mental Health Services
- West Leicestershire Clinical Commissioning Group (CCG) – GP records

2.4.2. The following agencies reported no relevant contact with AB and NF:

- Leicestershire County Council – Children and Family Services
- Walsgrave Hospital

- George Eliot Hospital
- Multi Agency Public Protection Arrangements
- Derbyshire, Leicestershire, Northamptonshire and Rutland Probation
- University Hospitals of Leicester NHS Trust
- Coventry, Warwickshire Partnership NHS Trust
- Hinckley and Bosworth Borough Council

2.4.3. Leicestershire Police also confirmed that there had been no recorded incidents of domestic abuse between AB and NF, and that the only calls they had received from AB were linked to her employment as a manager of a children's home. On 28th August 2015, the Panel agreed these were not relevant to this review.

2.5. Liaison with Friends and Family

2.5.1. NF has not given an account of his actions which resulted in the death of AB to the Police or the Court. Due to the parallel criminal process it was agreed by the Panel that there would not be any contact with NF until the conclusion of the criminal justice proceedings against him. Once these were concluded, NF was invited to contribute to the domestic homicide review, but declined to do so. The Panel ensured that the invitation to NF was facilitated by NF's consultant psychiatrist.

2.5.2. AB is survived by her son, JF. The Panel agreed in the terms of reference that family and significant others would be invited to contribute to the review. The Police Senior Investigating Officer restricted contact with JF and other potential witnesses until the criminal proceedings had been concluded. Information shared by the Police Investigation Team did not identify a need for contact to be made with NF's children from his previous relationship, or his ex-wife. JF did not advise on any other acquaintances who could have shared information about NF with the Panel. Background information relating to AB and NF's relationship was made available to the Panel through a statement shared by the Police Investigation Team. At the conclusion of the criminal justice process, JF was contacted and agreed to meet, with his partner, MM, with Cherryl Henry-Leach and the Board Office Manager on behalf of the Panel. Information provided at this meeting is included where appropriate throughout the report.

2.5.3. The Panel considered if AB's work colleagues and employer would be invited to contribute to the report. The Police Senior Investigating Officer advised the Panel that in the course of the extensive enquiries undertaken by the Police after the homicide, their discussions with AB's colleagues and employer did not indicate that domestic abuse or violence was a feature for AB. As this

aligned with JF's account of his recollections of AB's working life, and also his discussions with AB's colleagues after her death, the Panel agreed not invite AB's work colleagues and employer to contribute to the report.

2.6. Confidentiality

2.6.1. The findings of each serious case or domestic homicide review commissioned by the Leicestershire and Rutland Safeguarding Board are 'official sensitive' and information is available only to participating officers, professionals and their line managers with the approval of the review's Chair. Once the review has been quality assured and accepted by the Home Office the official sensitive designation is lifted.

2.7. Dissemination

2.7.1. The following agencies have received copies of this report:

- Hinckley and Bosworth Borough Council
- Leicestershire Partnership NHS Trust
- Leicester City Clinical Commissioning Group (CCG)
- Children and Family Services, Leicestershire County Council
- Leicestershire Police
- Rutland County Council
- Safeguarding Boards Business Office, Leicestershire County Council.

3. TERMS OF REFERENCE

3.1. The overall purpose of a domestic homicide review[1] 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, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

3.2. Timescales for the Review

3.2.1. The period for this review is between the 17th October 2007 and the 17th April 2015. This spans the time between NF's first incident of mental illness and the date of the homicide.

3.3. Case Specific Terms

1. To review if practitioners involved with AB and NF were knowledgeable about potential indicators of violence/domestic violence and aware of how to act on concerns about a victim or perpetrator.

2. To establish if there were any opportunities for professionals to "routinely enquire" as to any domestic abuse to the victim that were missed.

3. To establish how professionals carried out risk assessments, including whether:

    a) the risk management plans were reasonable response to those assessments;

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7

b) the risk assessments and management plans of NF took account of his history where relevant;

c) there were any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals, including the use of markers/warnings indicators within agency systems;

4. To establish if any agency or professionals considered any concerns were not taken seriously or acted upon by others;

5. To review whether the frequency of agency contact with NF was appropriate and in line with agreed protocols or assessment of need;

6. To review the appropriate use of Mental Health Legislation;

7. To consider how issues of diversity and equality were considered in assessing and providing services to AB's and NF's protected characteristics under the Equality Act 2010 – age, disability, race, religion or belief, sex, gender reassignment, pregnancy and maternity, marriage or civil;

8. To establish whether local safeguarding procedures were being followed properly; to include consideration of the victim or perpetrator as being in need of services as a vulnerable adult;

9. To establish how effectively local agencies and professionals worked together;

10. To establish any issues affecting public confidence in the protection of people in vulnerable situations, locally;

11. To establish whether relevant policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, were applied and whether current policies are fit for purpose;

12. To identify any good practice and changes that may have already taken place;

13. Establish for consideration what may need to change locally and / or nationally to prevent serious harm to victims in these circumstances;

14. The review should make recommendations to be considered when revising the Leicestershire Multi Agency Domestic Abuse Strategy.

3.4. Other Considerations

3.4.1. In undertaking this review the Panel was mindful that extensive involvement of agencies does not appear to be a feature of this case with only one Mental Health Service and GP involvement with NF, and GP with AB. It was agreed that if another agency's involvement was identified through this process this would be brought to the attention of the Safeguarding Board Business office who would then arrange for additional IMRs to be obtained. During the course of the review, no such involvement was identified. The Panel is to be commended for the conduct of the review which was in line with emerging best practice in relation to domestic homicide reviews; with effective analysis and conclusions of the information related to this case. In addition, the Panel also sought to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including their dependent children where relevant;

- Identify clearly what those lessons are, both with and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result;

- Apply those lessons to service responses, including changes to policies and procedures as appropriate;

- Reduce domestic violence homicide and improve service responses for all domestic violence victims and where relevant their children, through improved intra and inter-agency working.

The Panel also agreed that:

- Whilst it is not the purpose of this review to consider the handling of child protection concerns, if there are any such issues that arise from this review that relate to the safeguarding of children, these will be specifically shared with the Safeguarding Children's Board;

- Learning from this case will also be shared with the Leicestershire and Rutland Safeguarding Adults Board.

4. AB AND NF

4.1. BACKGROUND

4.1.1. From the witness statement JF provided to the Police Investigation Team, and the meeting with JF and MM, the Panel was able to piece together information about the couple's background. JF and MM confirmed the content of the statement as reflective of their lives with AB and NF.

4.1.2. JF says that AB and NF met after NF was divorced, and advised that NF maintained contact with his four children from his first marriage. It is JF's understanding, based on the view of other family members who knew the couple when they met, including NF's ex-wife, that although AB was initially reluctant to enter a relationship with NF (JF believes AB had formed the impression that NF had a reputation as a womaniser), she did eventually agree to meet with him and, from this initial meeting, their relationship was "right" and they "loved each other very much". JF had no recollection of his parents arguing, saying his mother and father had a "strong relationship" that appeared, to JF, to be mutually supportive. JF recalls a very settled childhood with his parents and extended family, and described both of his parents as being "calm and laid back". The description of NF given by JF is that NF was a "very private person…" who didn't share his personal views or feelings with very many people, if at all. The only time JF could recall difficulties between the couple was when JF was a child. JF recalled NF lost money gambling, something that JF says NF "got really in to" at the time. JF recalls AB asking NF not to continue gambling and supporting NF to resolve his financial difficulties. JF believes that NF complied with AB's request for some time, although in his later life NF would place bets on horses during the horse racing season, JF did not think gambling became an issue between his parents after this period until 2007, and this is discussed further in this report.

4.2. AB

4.2.1. AB came to Leicester as a child with her family, when her father relocated from another part of the country, to undertake employment in the area. The police confirmed to the Panel that domestic abuse did not appear to be a feature in her parents' relationship.

4.2.2. JF describes AB as a very hardworking individual who was committed to her role as a manager of a children's home in the Leicester area. AB loved to travel and JF believed she worked to fund family holidays which he recalled with fond affection. AB, in her later years, took on a caring role for her father and was looking forward to her retirement. JF described his mother as "a

lady… she liked nice things but was not materialistic so long as she was comfortable". JF advised that the only time he could recall his mother shouting was because of her being tired after working long shifts, but this did not happen very often.

4.2.3. JF and MM shared their view that, prior to her death, AB was looking forward to her forthcoming marriage and the family holiday.

4.2.4. MM also stated that AB was very loving toward her grandson, and recalled with deep affection, how AB welcomed her into the family. Both JF and MM have expressed their view that they will ensure their son, AB's grandson, is aware of how AB's life ended.

4.3. NF

4.3.1. NF came to the UK as a migrant from Barbados when he was 19 (in 1959) and settled in the UK. The Police confirmed with NF's ex-wife that domestic abuse was not a feature in NF's relationship with her. NF met AB in a public house around 36 years ago [1979]. In both his statement and his interview with the Report Author and Board Manager, JF shared the concern that NF spoke infrequently of his parents, and JF's belief that NF's mother suffered with poor mental health.

4.3.2. JF recalls that NF was also hard-working and was employed as a lorry driver until 2007, following a road traffic accident whilst working, which resulted in penalties on his licence. JF believes this incident unnerved his father, who was subsequently more cautious on the road. Shortly after this accident, JF recalled his father assaulting a colleague who, according to NF, had been racially provocative toward him. NF was suspended from work and JF described how his family was shocked at NF's reaction which JF described as completely out of character for his father. Soon after his suspension, NF attempted suicide and this resulted in a hospital admission, which was followed by a longer term admission to a mental health ward. The Panel understand that NF did not return to work after this episode and JF states that, on the advice of AB, he retired after his discharge from hospital.

4.3.3. The Panel is aware that NF had financial difficulties in 2007, and these came to light at the time of his self-harming and subsequent hospital admission. JF understands that NF informed AB that he had accrued substantial debt, of approximately £18,000. It is understood by the Panel that this was solely the result of gambling debt. JF states that AB was supportive of NF, and chose to clear his debt by way of re-mortgage and encouraged him to retire. JF was clear that AB offered to do this as it was, to her, a practical solution to a difficulty that had arisen in her relationship with NF. MM shared her view that

AB would always support those she loved in any way she could and this act was a reflection of her nature. The relationship appeared to return to normal despite a variation in the couple's routine – NF spent time at home while AB went to work.

4.3.4. JF advised that the marriage was the suggestion of NF who was clear that he wanted their wedding to be a small affair attended by close family. JF was of the view that both parents wanted the marriage to proceed, although NF did initially voice concerns to JF about how the marriage would impact on any inheritance he would leave for his children from his previous relationship. In this conversation (that occurred between NF and JF), JF states that he assured his father that this would not be an issue and encouraged NF to discuss his concerns with AB. JF believed his parents then discussed NF's concerns and drafted wills to ensure their wishes for the disposal of their property following their deaths were recorded in addition to confirming their wedding plans.

5. FACTS BY AGENCY

5.1. Leicestershire Partnership NHS Trust (LPT)

5.1.1. LPT provides integrated mental health, learning disability and community health services for patients living in Leicester, Leicestershire and Rutland.

5.1.2. The Panel was aided by a very helpful IMR which discussed the significant mental health episode that NF experienced in 2007. This appears to correlate with JF's account of what occurred in that it explains that NF was voluntarily admitted to hospital with self-inflicted wounds following his suspension from his employment for assaulting a fellow employee. Once treated for these injuries NF was then admitted to a local mental health unit for treatment as an inpatient, again on a voluntary basis. NF admitted his financial difficulties to attending physicians, advising them of a gambling debt that totalled £18,000 and described feeling anxious that as he was nearing retirement he did not know how to pay off his mortgage. During his inpatient period, NF was diagnosed with non-psychotic depression and presented with low mood, a sense of hopelessness and pre-occupation with his financial issues. NF appeared to respond to treatment well, and following successful periods of home leave, was discharged after 12 weeks and referred to his GP for on-going treatment. The Panel confirmed that the assessments NF was subjected to during this period would have assessed his level of risk to himself and also others, and he was considered to pose a minimal risk to others. The IMR confirms that NF did not come to the notice of their services after his discharge back to the care of his GP.

5.2. West Leicestershire CCG – GP Surgery

5.2.1. Both AB and NF were patients of this surgery and the Panel received reports for both in relation to the care they received. Both were diagnosed with diabetes and attended for routine checks and follow up appointments for conditions related to this illness. AB was last seen by the surgery in February 2015 and the surgery has confirmed that she exhibited no symptoms or signs of mental distress or depression, nor was there any records of domestic abuse on her records or injuries that could be associated with domestic violence. NF was also treated for depression by the surgery following his inpatient period of treatment at a local mental health unit until 2011. The treatment he received was the routine prescribing of anti-depressants which was reduced as appropriate toward the end of his treatment for depression in 2011. The surgery advises that NF was last seen by the surgery on December 2014. His annual review included the completion of a depression screening tool, which revealed no signs or symptoms of depression, nor did

he express any concerns about depression. At the request of the Panel, the GP surgery confirmed that medics linked to the GP surgery, who treated both AB and NF for their diabetes, did not identify either as suffering from any signs of mental distress or depression, nor did they note any indicators that domestic abuse was an issue for either AB or NF.

6. ANALYSIS AGAINST THE TERMS OF REFERENCE

6.1. Introduction

6.1.1. Despite diligently and thoroughly looking for evidence of domestic abuse and factors which could be associated with it, only difficulties with mental health featured in relation to NF. It is known that victims can be very adept at hiding signs of domestic abuse from professionals. Whether that applied in this case is not known for a fact but the Panel agreed that, after its extensive consideration of the information shared during the review, this did not appear to be the case for AB or NF.

6.2. Term 1

To review if practitioners involved with AB and NF were knowledgeable about potential indicators of violence / domestic violence and aware of how to act on concerns about a victim or perpetrator

6.2.1. The Panel was satisfied from the IMRs and the Panel discussions that practitioners involved in this case were knowledgeable about potential indicators of domestic abuse. It was clear that the agencies involved had received locally available training about domestic abuse and also safeguarding vulnerable adults. From the IMRs it was clear to the Panel that staff within those agencies were able to articulate how they would act on any concerns about either a victim or a perpetrator. However, the Panel could not find any evidence to support any hypothesis that AB or NF were either a victim or perpetrator of domestic abuse or that professionals involved with them missed opportunities to offer support.

6.2.2. The Panel also confirmed that all agencies, including the voluntary sector have attended domestic abuse training, and so would be equipped to recognise the signs and indicators of domestic abuse, in addition to responding appropriately to it.

6.3. Term 2

To establish if there were any opportunities for professionals to "routinely enquire" as to the any domestic abuse to the victim that were missed

6.3.1. From the IMRs submitted, the Panel noted that the GP surgery had the most recent involvement with NF and AB. It was unclear to the Panel, from the IMR

if routine questioning had been undertaken in the absence of any indication that domestic violence abuse was a feature for either AB or NF. Clarification from the IMR author identified that routine questions would occur when a patient presented with mental distress, depression or visible indicators of domestic violence. The Panel discussed this term at length and agreed that routine questioning about domestic abuse when all patients are seen by GPs, in line with guidance[2] published by the National Institute for Clinical Excellence (NICE), was something to which the Partnership should aspire but consideration would need to be given to time constraints for patient appointments. It agreed that where there are indicators of domestic abuse, GPs should enquire about domestic abuse being an issue for the patient. The Panel confirmed that the CCGs were undertaking significant activity to ensure that GPs are fully informed of the help and support available to them should they receive a positive disclosure from victims of domestic abuse. JF was clear that domestic abuse was not a feature in his parents' relationship. The Panel concluded that this was not a missed opportunity for either AB or NF. No recommendation is made in the review.

6.3.2. The Panel was also aware that, at the time of the review commencing, coercive control was not an offence, but considered how coercive control can be difficult to identify if domestic violence is not a feature of the pattern of abuse experienced by the victim. It was agreed that equipping the work-force to recognise and respond appropriately to coercive control would be something for the Partnership to consider, but was not something that, based on the information shared during this review, was a feature in the couple's relationship. JF and MM advised that they had not observed coercive control to be a feature in the relationship between AB and NF and that if they had they would have supported AB or NF to seek support. The Panel concluded that professionals involved with either AB or NF had not missed any opportunity to support AB or NF either as a victim or perpetrator of coercive control as part of a pattern of domestic abuse.

6.3.3. The Panel also considered if NF's gambling should be considered abusive in the context of his relationship, given the link between financial issues and risk escalation in cases of domestic abuse[3]. This was explored at length alongside the description of the couple's relationship provided by JF in his statement. The Panel concluded that in the absence of any other indicator of domestic abuse, it could not establish if NF's gambling in 2007 and the subsequent financial difficulties the couple experienced were indicative of NF

[2] NICE Guidance PH 50 – Domestic Violence and Abuse: Multi Agency Working (2014) at www.nice.org.uk

[3] Adams, A. et al (2008). "Development of the Scale of Economic Abuse", Violence Against Women: Sage

perpetrating abusive behaviour toward AB. It concluded that AB, upon learning of NF's financial difficulties and the cause of them, supported NF in a practical and supportive manner, and that this was of her own volition. This was supported by JF's recollection of those events and the solution AB used to address this issue was pragmatic in that AB protected herself from further financial issues in the future. In the absence of any indications to the contrary, the Panel agreed with JF and found no evidence to indicate a need for any professional involved with AB or NF, at the time NF's financial difficulties came to light, to explore this further with either AB or NF.

6.4. Term 3

To establish how professionals carried out risk assessments, including whether:

i) The risk management plans were a reasonable response to those assessments.

ii) The risk assessments and management plans of NF took account of his history where relevant.

iii) There were any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals, including the use of markers/warnings indicators within agency systems.

6.4.1. The Panel evaluated the support provided to NF in 2007 and agreed that Mental Health Legislation was considered appropriately at this time. It also noted that prior to his discharge, consideration was given to the risk NF posed to the community, which included risk he posed to AB. Based on the information available to professionals supporting NF at that time, which included him accessing medical care in the community, *and* from the assessments undertaken at that time, along with JF's observations of his parents' behaviour, the Panel found no indication that he would pose a significant risk to AB after his discharge.

6.4.2. The Panel also agreed with JF and MM that there were no identifiable warning signs available to any professional that would have identified NF posing a risk to AB preceding AB's homicide. Both JF and NF were clear that had they had any concerns in relation to AB or NF they would have supported them to seek appropriate support. Therefore it follows that there was no opportunity to develop risk assessments or management plans that would have afforded AB protection from NF.

6.4.3. On consideration of all the evidence available to them, the Panel agreed that NF's mental health may have declined rapidly prior to the incident and this resulted in a very sudden and fatal incident. This also correlated with information about the couple's life in the weeks preceding the homicide provided by JF. JF accepted this conclusion. The Panel also agreed that the rapidity of this decline and escalation of risk posed by NF to AB did not afford any opportunity for any professional to intervene and reduce any risk posed by NF to AB at the time of the fatal incident. Nor did it afford any opportunity for any family member to observe or express any concern that would have afforded opportunity for professional intervention and / or risk reduction.

6.4.4. The Panel wished to explore with NF if he was aware of him requiring support since his discharge from mental health provision in 2011, and if he was aware, how he could access this. Unfortunately, NF's mental health declined to such an extent and the Report Author understands that at the time of authoring this report, medical assessments are on-going to determine the nature of his mental illness and if this is psychological or neurological. The Panel is aware that the outcome of these assessments will require a significant period of time before they can be finalised. Throughout this review, the Panel liaised with NF's psychologist until such time that NF could be, and was, invited to contribute to this review, but NF declined to do so. In line with JF's wishes, the Panel agreed not to progress this line of enquiry with NF.

6.5. Term 4

To establish if any agency or professionals considered any concerns were not taken seriously or acted upon by others

6.5.1. The Panel agreed that no agency or professional involved with AB or NF prior to the fatal incident were in a position to identify any concerns. From the information shared during this review, the Panel was satisfied that, had any concerns arisen, these would have been taken seriously and acted on appropriately and responsively.

6.6. Term 5

To review whether the frequency of agency contact with NF was appropriate in line with agreed protocols or assessment of need

6.6.1. It was clear to the Panel that NF was proactive in ensuring that his medical checks were routinely undertaken and agency contact with him was, therefore, appropriate. During those checks, the Panel found no evidence to indicate that NF required a mental health assessment.

6.7. Term 6

To review the appropriate use of Mental Health Legislation

6.7.1. The Panel agreed this was appropriately considered and implemented in 2007, when NF was voluntarily treated as an inpatient. There was no evidence to indicate to the Panel that NF should have been detained under the Mental Health Act for his own safety or the safety of others in the years, months weeks or days prior to the homicide of AB.

6.8. Term 7

To consider how issues of diversity and equality were considered in assessing and providing services to AB and NF (protected characteristics under the Equality Act 2010 – age, disability, race, religion or belief, sex, gender reassignment, pregnancy and maternity, marriage or civil partnership)

6.8.1. The Panel considered at length NF's background as a migrant West Indian living in the UK for a number of years, and the influence this would have had on his relationship with AB as this developed. The Panel noted that anthropological research of West Indian culture tends to facilitate the development of strong female characters that take a leading matriarchal role in relation to finances, lifestyle and within family dynamics[4]. This research suggests, that, as West Indians migrated out of the West Indies in the 1950s / 1960s, and settled in other countries, they developed intimate relationships with partners of non-Afro Caribbean descent. It noted this research explores the relationships between Caribbean males and White British or European females, in which the females in those relationships undertook a matriarchal lead within the family unit. As a result, similar dynamics in those relationships were established and these mirrored the dynamics in traditional West Indian family units[5]. The Panel noted that the relationship between AB and NF followed this pattern and so it also considered research that suggests this can be a form of societal gender abuse[6]. Based on JF's description of his mother and the dynamics he observed within his parents' relationships, the Panel found no evidence to suggest that the dynamics and roles formed in their

[4] Marriott, M. (1993). "A Review of Women and Change in the Caribbean". Indiana University Press: London

[5] Bush, B. (2006). "A Classic Study of the History of Caribbean Women". Kingston: University of the West Indies Press

[6] Bereton, B. (2013) "Women and Gender in Caribbean Historiography". At www.sta.uwi.edu; Newton, M. (2005) "Philanthropy, Gender and the Production of Public Life in Barbados". Durham and London: Duke University Press

relationship were the result of any abuse perpetrated by NF, coercively or otherwise. As a result of this conclusion, the Panel agreed that professionals involved with AB and NF would not have necessarily considered these factors as a basis to inform service delivery to AB or NF, but found no evidence to suggest this should have been the case.

6.8.2. The Panel also considered research undertaken on behalf of the Race Equality Foundation, in relation to Afro Caribbean males and their experience of accessing mental health provision in the UK. This suggests that access to mental health support is rarely undertaken voluntarily due to the patient perception of providers being institutionally racist or patients' fear of being labelled and / or stigmatised within their community following diagnosis. This is compounded by the resultant high figures of inpatient treatment following crisis intervention which frequently require medication and a level of risk management in the community. It is interesting to note that this research states that physical health issues would not be met with the same degree of suspicion by West Indian males, who, generally, will access support for physical issues voluntarily and routinely where required to do so. The Panel noted that NF's medical history mirrored this research - NF's mental health issues were reflective of NF receiving support following periods of significant crisis, and may have been compounded by NF's observation of his mother's decline in mental health, but he was diligent in seeking support for issues linked to his physical health. The research also endorses the role of mental health advocates that encourage and support patients to continue to engage with mental health providers. Based on JF's description of his parents' relationship following NF's mental health issues in 2007, the Panel formed the view that AB fulfilled this role and supported NF very much akin to how a mental health advocate would in terms of supporting him to access follow up treatment in the community. JF's and MM's description of AB indicated that this role was undertaken freely by AB, and this was something AB would automatically do for people she cared for. The Panel could find no evidence that would suggest her undertaking this role was not of her free will or choice.

6.8.3. Following the Panel noting that NF, when experiencing significant difficulties which adversely impacted on his mental well-being in 2007, followed the pattern suggested in the above referenced research, the Panel also considered this research alongside the psychiatric report prepared by NF's defence team during his remand for murder. The psychiatric report author indicated that NF, with hindsight, may have been able to recognise a possible need for mental health support in the days preceding the murder of AB. However, NF did not disclose to the author of his psychiatric report that he had advised AB of the possibility of him needing mental health support. NF did not give any indication to the psychiatric report author if his ethnicity would

have prevented him accessing this support had he or AB identified the need for him to do so. The Panel was not able to explore this further with NF, due to the continued decline of his mental health during his remand. The panel was also mindful that it was apparent from JF's recollection that NF had not disclosed to JF any issues that were causing NF concern prior to the death of AB. JF also advised the Panel that had NF disclosed any such issues JF would have supported his father to discuss these with AB.

6.8.4. The Panel fully discussed and considered whether the above referenced research should result in a recommendation in this review. The West Indian population in the area where AB and NF lived is comparatively small when the local demographic is considered[7], and the Panel balanced this against research in relation to emerging themes in relation to men accessing mental health support. Whilst the Panel accepted the research findings in relation to NF's ethnicity, it also noted similar trends in terms of males' delayed access to care in relation to their mental health leads and the resultant higher level of management required[8]. The Panel agreed that service providers need to mindful as to how they can ensure their service provision can be made accessible to males in line with research findings, including those from local black, minority, ethnic and refugee (BMER) communities, prior to the need for crisis intervention to ensure earlier support. As a result of the research it considered, the Panel agreed that they could not identify if this was an issue in this particular case, and so have recommended that this is scoped out following this review.

6.9. Term 8

To establish whether local safeguarding procedures were properly being followed; to include consideration of the victim or perpetrator as being in need of services as a vulnerable adult.

6.9.1. The Panel agreed that, prior to the homicide, and in line with the descriptions provided by JF and MM, neither AB nor NF fit within the definition of a vulnerable adult and so there was no requirement for local safeguarding procedures to be followed. The Panel was satisfied that if either of them had been identified as vulnerable adults, practitioners involved with them were clear on how the local pathways could be followed to ensure their needs were assessed and would have undertaken the appropriate steps to ensure this happened. After the homicide, NF became identified, by definition, as a

[7] Leicestershire Community Profile 2005 at www.leics.gov.uk
[8] Wilkins, D. et al (2008) "The Gender and Access to Health Services Study". University of Bristol at www.menshealthforum.org.uk

vulnerable adult and the Panel, and JF, were satisfied that his care and support is of the appropriate standard.

6.10. Term 9

To establish how effectively local agencies and professionals worked together.

6.10.1. The Panel was in agreement that in relation to AB and NF, professionals worked together effectively to address their medical needs appropriately and in line with their age and abilities. JF and MM agreed that had it been apparent to AB that if medical issues needed further exploration in relation to AB, she would have undertaken steps to address this. In relation to NF, AB and / or JF would have encouraged him to seek support and / or treatment. JF did not identify any concerns in relation to the mental or physical well-being of either his parents. The Panel found no evidence to suggest that either AB or NF required additional support prior to the homicide, and agreed that no opportunity presented during the course of this review for the Panel to analyse if this was effectively undertaken.

6.11. Term 10

To establish any issues affecting public confidence in the protection of people in vulnerable situations, locally.

6.11.1. The Panel did not identify any issues in this review that would identify the need to locally increase public confidence in the protection of people in vulnerable situations. The Panel considered at length, JF's view that this was an unexpected incident without any precursor that could have afforded professionals the opportunity to offer support to either AB of NF. NF's mental health has declined to such an extent that the Panel is unable to discuss his perception of events that resulted in the homicide of AB. The Panel also considered NF's commentary, made to his psychiatrist since his arrest, and the resultant diagnosis, and reached the conclusion that this event was unexpected and could not have been predicted.

6.12. Term 11

To establish whether relevant policies, protocols and procedures (included risk assessment tools) that were in place during the period of review, were applied and whether current policies are fit for purpose.

6.12.1. All domestic abuse policies considered during this review were found to be contemporaneous and in line with current good practice in relation to

domestic abuse and adult safeguarding. The Panel noted from the IMR that GP Surgery A did not have a domestic abuse policy. Further clarification on this point identified that GP Surgery A followed the CCG's safeguarding policy which includes how to respond to domestic abuse and the Panel were satisfied that GP Surgery A would therefore, be aware on how to respond appropriately to concerns about domestic abuse and any safeguarding issues that could have presented during their contact with AB and NF. The Panel discussed if there was a need for a recommendation in relation to this but was advised by the CCG that this activity was underway at the time of the review and would be concluded in September 2017. In light of this assurance, the Panel agreed a recommendation was unnecessary.

6.12.2. The Panel also considered NF's gambling and whether this had any bearing on the death of AB. It is widely accepted that gambling can adversely impact on family stress. Financial issues in the context of a relationship where domestic abuse is a feature can be a lethal risk indicator[9]. It should be noted that the Panel did not find any evidence of domestic abuse linked to NF's gambling (or any other issue between the couple). JF, in his witness statement, noted that AB and NF kept their incomes very much separate, with NF making contributions to the family resources when requested to do so by AB and, on occasions, voluntarily. The Panel noted that at the time NF disclosed his gambling debts, there was no evidence of domestic abuse in his relationship with AB prior to NF's disclosure. The Panel did not find any evidence that his gambling was a risk indicator of domestic abuse prior to the homicide, and this was confirmed by the investigation of AB's homicide by Leicestershire Police (which did not identify any financial problems for AB or NF). JF was also clear that to his knowledge, financial issues were not a pressure for his parents prior to the homicide. JF also shared with the Panel that he had undertaken his own enquiries to confirm this was the case after the death of AB, and this had given him further reassurance that neither of his parents had any financial pressures prior to the homicide. The Panel did consider if AB's response to NF's debt in 2007 was an indication of domestic abuse, but noted the couple's finances were kept separate from that point, and recognised, from JF's account, that this was an agreement mutually reached by his parents. The Panel also agreed that, in line with JF's recollection, on AB becoming aware of NF's debts, AB undertook a supportive measure on the agreement that NF ceased gambling to the extent that surfaced in 2007. The Panel was assured, and JF also agreed, that NF appeared to adhere to this agreement. The Panel agreed

[9] Richards, L. et al (2008) "Policing Domestic Violence". Blackstone's Practical Policing Guide. Oxford University Press; Adams, A. et al (2008) "Development of the Scale of Economic Abuse". Violence Against Women: Sage

the couple, led by AB, found a sensible resolution to a potentially serious issue within their relationship. The Panel found no evidence to suggest NF's gambling was a contributory factor to AB's death.

6.13. Term 12

To identify any good practice and changes that may have already taken place.

6.13.1. The Panel worked very well together and fostered a collegiate atmosphere that promoted learning from these tragic circumstances to identify any lessons that could lead to the prevention of domestic homicides in the future. It responded to gaps in information expediently and ensured that all opportunities to establish whether any agency had contact with this family were pursued.

6.14. Term 13

Establish for consideration what may need to change locally and / or nationally to prevent serious harm to victims in these circumstances.

6.14.1. The Panel agreed there was a need for the Partnership to ensure that all policies and procedures required refreshing to ensure that coercive control and the response to it were included. However, having found no evidence of coercive control being a feature for any of the subjects of this review, it agreed it would not be appropriate for the Panel to make any formal recommendation in relation to this finding.

6.15. Term 14

The review should make recommendations to be considered when revising the Leicestershire Multi Agency Domestic Abuse Strategy.

6.15.1. The Panel considered contact with AB's colleagues and employer as well as NF's friends and family, but noted that the extensive police investigation, and discussions with JF and MM, did not identify any additional family and friends who the Panel could approach to ascertain if they had noticed deterioration in NF's mental wellbeing. The Panel also considered, at length, the 2007 incident which included NF assaulting a work colleague after NF stating (after the event) that he experienced racially insulting behaviour from this individual. The Panel reflected on JF advising that NF's violent response was uncharacteristic for NF. It agreed with JF that situational factors that impacted on NF at that time led to this response, and his

response was the result of the significant amount of stress NF was experiencing as a result of his financial situation at that time. This resulted in a very rapid decline in NF's mental wellbeing which required medical crisis intervention and the findings to this conclusion are covered in Term of Reference 7. The Panel did question if the level of violence was something NF would resort to when facing crisis during a decline in his mental health, but were in agreement that this was unlikely to be a recurring response for NF on the basis of JF advising that the 2007 incident was completely out of character for his father. Noting NF's repeated interest in gambling (which is prominent in West Indian communities[10]), the Panel requested the police share information pertaining to NF's finances in addition to disclosing NF's antecedent history. This enquiry revealed nothing of concern in terms of how NF reacted to crisis and no re-established gambling patterns in relation to NF prior to the death of AB. JF's views, and his own enquiries that were undertaken after AB's homicide, supported this conclusion. The Panel, therefore, agreed that NF experienced a sudden onset of mental health symptoms which were not identified by any professional because he had no contact with them between the time of the onset and the death of AB.

6.15.2. The Panel, from the information shared in this review, could not identify any causal factor for this decline in NF's mental wellbeing and, due to his declining to contribute to this review, are unable to explore this further with him.

[10] Garfield-Smith, M. (1974). "The Plural Society in the British West Indies". University of California Press, referenced in Odell Korgen, O. (2017) "Cambridge Handbook for Sociology: Specialty and Interdisciplinary Studies volume 1", University of Cambridge Press; see also Mona JM (2009) Jamaican Casino Initiative: Policy Options https://www.mona.uwi.edu/alumni/sites/default/files/alumni/jamaicas-casino-initiative.pdf University of the West Indies

7. CONCLUSIONS

7.1. The Panel agreed that no indicators of domestic violence or abuse went unnoticed by professionals who had contact with either AB or NF prior to the fatal incident in April 2015. The Panel also found no evidence to suggest that AB or NF had disclosed to friends or family that they were experiencing domestic violence or abuse from their partner, or were perpetrating domestic abuse. As a result, the Panel found no indication that AB required specialist support from a Domestic Abuse service or through the Multi Agency Risk Assessment Conference. The Panel also agreed, on the basis of the information considered during this review, it is likely that NF experienced a sudden onset of mental health symptoms that did not afford professionals the opportunity to assess his needs. As a result, there was no opportunity for NF to receive support for mental health issues or to undergo an assessment in relation to the risk he posed to AB.

7.2. The Panel was satisfied and in agreement, from this review, that the death of AB could not have been predicted or prevented.

7.3. Through the process of undertaking this review the Panel had opportunity to consider research which has increased insight into Afro Caribbean culture. This was considered alongside its consideration of the individual management review reports, additional reports that clarified information contained within IMRs and JF's account of his family life.

7.4. The Panel identified that there were two specific actions or learning points to progress, namely:

- the Panel recognised that on-going activity in relation to raising awareness of support available to men who are impacted by difficulties in relation to mental ill health needs to be cognisant of research that identifies specific barriers for BMER males, to ensure, where possible, accessibility of service provision, treatment and support prior to crisis intervention.

- GPs would be supported by the development of a practice safeguarding specific safeguarding policy that includes identification of, and responses to, domestic abuse in line with contemporary national best practice and guidance. The Panel is aware this is under progression and will be concluded by 30th September 2017.

7.5. JF advised that the death of AB has impacted on not only himself and his immediate family but also everyone who knew AB. JF described the loss of AB to all who knew her as "devastating and wide reaching". The Panel, being

mindful of the impact AB's tragic but sudden death has had on AB's family and friends, thank JF and MM for their contribution to this report.

8. Predictability / Preventability

8.1. The Panel agreed that, due to the apparent rapid decline in NF's mental wellbeing, which gave no opportunity for professionals to assess or identify a need for mental health support to be offered, AB's death could not have been predicted or prevented.

Appendix A – Definitions

Domestic Abuse: Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour: A range of acts designed to make a person subordinate and / or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour: Is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Mental Health: A person's condition with regard to their psychological and / or emotional wellbeing.

Mental illness: Mental illness refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities e.g. depression, anxiety, schizophrenia.

Mental wellbeing: There are many different definitions of mental wellbeing but they generally include areas such as: life satisfaction, optimism, self-esteem, feeling in control, having a purpose in life, and a sense of belonging and support.

A vulnerable adult: An adult who has needs for care and support, is experiencing, or is at risk of, abuse or neglect, and, as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.