Domestic Homicide Review Executive Summary Report

Subject of the report: 'Dave'
Month of death: March 2016

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Safer Leicester Partnership
Working together for a safer City

A TRIBUTE FROM DAVE'S MOTHER, ON BEHALF OF THE FAMILY

Dave was the youngest of six children.

He was a cheeky boy and grew into a cheeky chap, with a wicked sense of humour and lots of friends.

Dave loved Christmas, and as a child would be that excited, he would make himself ill. Even as an adult, Christmas was still a time of excitement for Dave, continuing up until his birthday on New Year's Eve.

Dave would be the first to help his mates if they were in trouble.

Dave's biggest achievement was his children, who he adored.

Dave was taken far too soon by the evil act of another. I have lost my son, his brothers and sisters have lost their brother, his children their daddy, and his nieces and nephews an uncle.

Our lives will never be the same.

Those we love don't go away; they walk beside us every day.

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1. INTRODUCTION

1.1 The Leicester Community Safety Partnership Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Dave's family; their loss of a much-loved son, brother and father is still keenly felt.

1.2 The progress of the review and the publication of this report have been delayed at several stages. The review process was paused to allow the original investigation and trial process to conclude. As the Home Office's quality assurance process for this review was concluding the convicted perpetrator's appeal against her conviction was heard, and the review could not be published at that time. A retrial followed, which was further delayed due to the Covid pandemic. The retrial recently concluded, and the perpetrator received the same conviction. The partnership acknowledges the impact that such delays have had on the family. Actions connected to the recommendations took place throughout the course of the review and were not subject to the wider delays associated with the legal process.

1.3 In line with the agreement of the victim's next of kin, the principal people referred to in this report are:

'Dave'	Victim (Adult male)	Aged 26
'Alice'	Perpetrator (Adult female)	Aged 24

1.4 Following a 999-call made by Alice, ambulance staff and police officers attended her home address, where they found Dave with a stab injury to his chest. Alice was also present. Dave was taken to hospital. He died from his injuries.

1.5 Alice was arrested on suspicion of murdering Dave and was taken into custody. She was interviewed and following consultation and advice from the Crown Prosecution Service, later charged with Dave's murder and remanded into custody.

1.6 Alice appeared at Leicester Crown Court six months after Dave's death, where she was found guilty following a contested trial. She was sentenced to life imprisonment with a recommendation that she must serve 17 years before parole could be considered.

1.7 In his summing up, the presiding Judge Nicholas Dean, Q.C. said: "*I cannot know what happened inside [address redacted] after about 2.15am on [date redacted], but arguing must either have continued or revived and at some point you became sufficiently angry that you seized the steak knife – this was not you in desperation seeking an object with which to defend yourself, you took a deliberate decision to*

pick up the knife and the probability is that you in fact fetched it from the kitchen." Adding that she had "*acted quite deliberately*".

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

2.1 The Chair of the Safer Leicester Partnership decided that the case met the criteria for a Domestic Homicide Review (DHR). An independent Chair/Author, Tony Blockley, was appointed. A DHR Panel was assembled which represented local agencies and included members with detailed knowledge of domestic abuse and persons with specialist knowledge relevant to the case.

2.2 Eight agencies submitted written information to the review. Interviews were held with a representative of the victim's family, as well as the perpetrator during her time in prison.

2.3 The purposes of a DHR are to:

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

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

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

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

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

f) Highlight good practice.

3. BACKGROUND

Dave

3.1 Dave was 26 when he died. He was the youngest of six children. Dave had two young children from a previous relationship, who lived with their mother. He worked full-time in a manual job.

3.2 Nine months prior to his death, Dave's relationship with the mother of his children ended. Shortly after he was admitted to hospital, due to chest pains caused by consumption of drugs and alcohol. Dave's GP referred him for a mental health assessment of his low mood.

3.3 Dave was known to have consumed alcohol excessively in a social context, and used cocaine, cannabis and steroids.

3.4 It is thought that Dave and Alice had been in a relationship for about four months prior to his murder.

3.5 Three months prior to his death, Dave attended hospital with a bruised forearm. Around this time, Police attended a domestic incident involving Alice and Dave. No offence was identified as having been committed.

3.6 Dave's family told the review that it was Dave's intention to end his relationship with Alice, on the night that he died.

Alice

3.7 Alice was 24 when she murdered Dave. She had a young child from a previous relationship.

3.8 Alice had experienced domestic violence in her childhood home.

3.9 Alice was known to the Police as a victim of domestic abuse and as a perpetrator of assaults. She had also been convicted of driving with excess alcohol and theft of a vehicle.

3.10 In a previous relationship Alice had reported two assaults on her, by her then-partner, Bruce. At the time, he made a counterclaim that she was violent and had stabbed him in the past. Bruce later pleaded guilty to charges of criminal damage. A restraining order was made for Bruce not to contact Alice directly or indirectly for a period of two years, and he was ordered to pay compensation.

3.11 In 2014, when Alice moved out of her mother's address, she was allocated a place in supported housing accommodation, as she was pregnant. Alice

disclosed to staff at the housing project, her use of M-CAT (also known as Mephedrone, which is a powerful stimulant and is part of a group of drugs that are closely related to amphetamines).

3.12 Alice was known to drink excessively, and Probation Services concluded that alcohol use was the main factor in her offending behaviour, causing her to be unable to recall events.

3.13 On one occasion, Alice attended hospital outpatients for treatment to an injury which she said happened during "play-fighting" with her then boyfriend.

3.14 After leaving her supported housing accommodation, Alice reported receiving intimidating calls and texts from the father of her child.

4. ANALYSIS

4.1 The incident in which Dave died, according to agencies' records, was an isolated one, although Dave's family and friends identified previous incidents of abuse that had not been reported to any official agency.

4.2 Neither Dave nor Alice disclosed any concerns about each other to agencies outside of what were reported to police as isolated incidents, which were not identified as crimes.

4.3 Alice reported a history of being abused within previous relationships. She also had a history of violence to members of the public that on reflection could be potentially identified as an indicator of abuse within her relationships.

4.4 Alice does appear to have been signposted to specialist domestic abuse services when her case (relating to a previous partner) was scheduled in the specialist domestic violence court, but the records showed that despite the support agency attempting to contact her, they were unable to do so.

Professional Curiosity

4.5 There were occasions when agencies (Leicestershire Partnership Trust (LPT), Medical Practice 'A' and Medical Practice 'B') could have taken the opportunity to explore Alice and Dave's individual history of relationships.

4.6 LPT, Medical Practice 'A' and Medical Practice 'B' had opportunities to routinely enquire with Alice about her relationships and consider the impact of abuse in these, however these opportunities were not taken.

4.7 There were several opportunities for a proper assessment of the safeguarding risk to Alice (Health and Housing) and her child (Gaining a Place project (GAP), Probation and Health) that did not take place.

4.8 The Leicester Urgent Care Centre (LUCC) could have taken the opportunity to enquire further when Alice first presented with an injury to her ear caused by 'play fighting'. Subsequently her GP could have made further enquiry following notification from the LUCC.

4.9 There were opportunities for GAP, her GP and George Eliot NHS Trust to share information. Each agency was aware of information but did not consider it in the wider context and consequently the information was not known between agencies and her treatment was delivered in isolation.

4.10 This case demonstrates the failure to link specific incidents to a pattern of behaviours by Alice. Her actions could be seen as escalating - both in terms of frequency and severity.

4.11 With Dave, it seems there were limited opportunities for agencies to identify or enquire about domestic abuse. The police had an opportunity to engage with Dave following a domestic incident reported by Alice two months prior to his death. At this time Alice had called the police, but on attendance she was alone at her address and would not engage further. The callout was recorded as a domestic incident as it could not be ascertained that a crime had occurred. Dave was outside the property when Police attended. Leicestershire Police had an opportunity to discuss domestic abuse with Dave and complete a DASH risk assessment, but this did not happen.

4.12 Leicester City Council Children's Social Care (CSC) missed the opportunity to support Alice as a child, having known there was domestic abuse in the home. As she approached adulthood, CSC had another opportunity to enquire about the level and impact of violence both in and outside the family home.

Potential barriers

4.13 Engaging in the review process, Dave's family was not aware that any domestic violence support services were available to men; there was an assumption that the services were all for women. Dave's mother also said that she did not think that her son would have approached such services for fear of being perceived as weak.

4.14 Gender constructs and the negative association of what a 'victim' looks like, appears to have been barriers that might have been present in this case.

4.15 Alice and Dave's substance use may have disguised the impact of abuse in the relationship and this could have obstructed agencies considerations.

4.16 Dave's family felt that Dave was in fear of retaliation from Alice's family and friends if he left the relationship, as he knew them to be capable of violence.

4.17 Dave moved in with Alice the day after they met. Dave had been living in the house he shared with his ex-partner whilst she moved to her sisters. The impact of the potential homelessness could have been a factor that restrained Dave from separating and/or ending the relationship.

4.18 Within this review it has been unclear whether those affected by abuse, directly or indirectly, knew about the full range of services available, but it does seem

clear for Dave and Alice there would have been barriers to accessing them. These seem to have included:

- Thinking they would be only for women
- Thinking they would be ineffectual
- Fear of family reprisal
- Fear of being seen as weak
- Fear of losing a relationship

4.19 It is often a challenge to understand that a victim one day may be the perpetrator next. A challenge for agencies and staff is to have an appreciation of this possibility and engage with individuals accordingly.

Substance use

4.20 Alcohol was a significant factor for both Dave and Alice. Both used alcohol frequently and in high amounts and took part in offending behaviour during those periods. This could have impacted on their perception of their relationship and any behaviour within it.

4.21 There is evidence of disclosure that Alice could not control her alcohol consumption and that she was unable to recall events following the consumption of alcohol. Alice's violent offending was in an environment where alcohol was consumed.

4.22 Dave consumed illicit drugs in the form of steroids, cocaine and cannabis. The local specialist service providing support for substance misuse, informed the review that using steroids and other substances puts extra stress on the body and can be dangerous. The usual effects and risks of using a substance can be amplified when using steroids.

4.23 Probation case records indicate that Alice disclosed high alcohol use socially and that she had no problems with this. She did state that prior to her pregnancy there were occasions that she went out with the "girls" maybe once a month and she would drink to excess; once she started drinking she would lose the ability to cease drinking and would continue until she was unable to recollect events. When questioned about drug use by Probation and Health Visitor, records indicate that she denied any use. However, she disclosed her use of M-CAT whilst she was pregnant; this was reported by GAP, although the review is unable to ascertain how frequent her use was.

4.24 Probation have identified that the service could have made further checks on this issue.

4.25 Even though it seems her drinking either moderated or stopped for a period when she had her baby, four months later it was enough of a concern to be a factor in the written warning from the GAP Project. Alice was involved in seven known incidents involving violence, mainly in/around bars, but also drink-driving.

4.26 The review raises the issue of whether agencies did enough to facilitate a specialist assessment of Alice's substance misuse issues. A specialist assessment could have identified a need for support/treatment, although of course that does not mean that she would have engaged or that it would have been successful in addressing issues. The probation worker and the GP are identified within the report as addressing alcohol issues; the review is unable to determine if the midwife or GAP staff looked it at. Screening tools are available for health professionals-such as Audit C which could have identified whether a specialist assessment was needed. It may be though her drinking was not identified as an issue with health staff, so alcohol screening was not thought necessary.

Information Management

4.27 During the review it was identified that IT systems were changed (Police and Housing Options) and therefore information was lost and/or referrals may not have been made. A key lesson for agencies from review is to consider the impact of system changes and the methods and process for ensuring that data is not lost and that any referrals made during this period are followed up to ensure they have been appropriately made and received.

5. KEY FINDINGS AND RECOMMENDATIONS

Finding 1 – Possible barriers to reporting harm

Although Dave's family and work colleagues knew of Alice's violent behaviour towards him, the support of local domestic abuse services was not sought.

Recommendation 1

Develop a local campaign which:

- is targeted at family and community members who would rather keep knowledge of domestic violence to themselves
- challenges beliefs and assumptions that not sharing such knowledge of abuse protects the victim
- supports people to engage with support services.

Recommendation 2

GAP and Police should assure themselves and partners that their staff routinely signpost and actively encourage victims and perpetrators to engage with support services.

Recommendation 3

Deliver a robust and sensitive marketing campaign to raise the awareness of the abuse of males, containing details of points of access to support services.

Finding 2 – Supporting the practice and learning of Practitioners

The review identified several occasions where professionals could have enquired more about presenting circumstances and accounts given by the perpetrator. These instances were missed opportunities for support and/or intervention.

Recommendation 4

GAP and Probation should assure themselves and partners that their staff are able to recognize increasing vulnerability associated with patterns of behaviour in the context of domestic abuse.

Recommendation 5

Review the content and impact of the male victims training course to ensure it reflects the learning from the Review.

Finding 3 – Services to meet the needs of victims/survivors

The review was unable to ascertain if Dave was aware of domestic violence and abuse support services available locally, but his family and others believe that he would not have sought help in any event.

Recommendation 6

Review the current services for male victims to reassure the partnership that they offer appropriate support to victims within Leicester, recognising the barriers to reporting.

6. CONCLUSIONS

6.1 Domestic abuse was present in Alice's earlier relationships and in the relationship with Dave.

6.2 It is important that agencies assess all factors when managing incidents surrounding domestic abuse and consider the wider impacts. This would include risk assessments for both parties; recognising increasing violent behaviour and any subsequent impact on a relationship; barriers for male reporting, the impact of perceptions of masculinity and the general lack of understanding of domestic abuse within a male population.

6.3 The review has identified that there was information known to other third parties that shows Dave had been the victim of significant assaults; yet did not discuss this with any official agency. It is not clear why that was the case, although it is suggested that Dave was intimidated and also that he cared about Alice.