DHR 2014C

Domestic Homicide Review Overview Report in respect of:

Mrs F.

Marion Wright

Independent Overview Author

Date: March 2017

1. Introduction

Preface

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Mrs F in Lincolnshire in 2014. It examines agency responses and contact with Mrs F and Mr F prior to the point of Mrs F's death. Those involved in the review would like to express their sympathy to the family and friends of the victim for their sad loss in such tragic circumstances.

1.2 The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the ways 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 upon, 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 homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter agency working.

1.3 DHRs were established on a statutory basis under Section 9 of the Domestic Violence Crimes and Victims Act 2004. The provision for undertaking the reviews came into force on the 13th April 2011. The death of the victim in this case met with the criteria for a statutory DHR in that the victim died as a result of being assaulted by her former husband at her home. The Home Office criteria for reviews includes "a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by:

a) A person to whom he or she was related or with whom he or she was or had been in an intimate relationship."

It is recognised that a domestic abuse incident which results in the death of a victim is often not a first attack and is likely to have been preceded by psychological, emotional abuse, coercive control or possibly other physical attacks.

1.4 The review is held in compliance with the legislation and follows guidance for the conduct of such reviews issued by the Home Office. I would like to thank those individuals from the different agencies for their contribution to the review and for their significant time, openness and commitment. Also the families and others for their input and their willingness to share information at such a difficult time.

1.5 Domestic Homicide Review Panel Members

DHR 2014C Panel Members	
Tony McGinty	Independent Chair of the Review Panel
Marion Wright	Independent Overview Report Author
Karen Shooter	Lincolnshire County Council Domestic Abuse Manager
Michelle Johnstone	Lincolnshire Community Health Service
Rick Hatton	Lincolnshire Police
Craig Scaife	Humberside Police
Roz Cordy	Lincolnshire County Council Children's Services
Elaine Todd	United Lincolnshire Hospital Trust
Jan Gunter	South West Lincolnshire Clinical Commissioning Group
Ian Newell	Lincolnshire County Council Safer Communities
Toni Geraghty	Legal Services, Lincolnshire. Advisor To The Panel
Ben Rush	Panel Administrator, Lincolnshire County Council
Jill Chandar-Nair	Lincolnshire County Council, Children's Services (Education)
Shu Zhen White	Chinese Community Association and Chinese Supplementary School, advised the panel on Chinese cultural issues

1.6 To reinforce the impartiality of this report it is confirmed that the independent chair of the panel whilst being employed by Lincolnshire County Council is a consultant in public health and has no direct or indirect management or oversight over the only other Lincolnshire County Council service involved in this review, namely Children's Services. The Chair does however have a wealth of knowledge and experience in relation to domestic abuse and at the time of this review was also the Chair of the Domestic Abuse Strategic Management Board, a partnership arrangement across Lincolnshire aiming to improve services for victims of domestic abuse. Neither the Chair or the independent overview report author has had any direct involvement with this case nor have they had any line management responsibility for those who have been providing services or for those managing the provision of those services. The independent overview report author has not previously been employed by any agency in Lincolnshire, other than providing a previous independent overview report. The independent overview report author is a retired assistant chief officer of Probation with 33 years experience. She had strategic lead for public protection including domestic abuse. She has experience of preparing Serious Case Reviews for MAPPA (Multi Agency

Public Protection Arrangements) and of writing previous overview reports in Domestic Homicide Reviews (DHR).

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

1.8 In line with the National Domestic Homicide Review Guidance the decision was taken to undertake the Domestic Homicide Review within a month of the homicide notification from the Police to the Chair of the Community Safety Partnership. The Home Office were notified of the decision to undertake the review on 23 July 2014. The first full review panel meeting took place on 8 October 2014. At that stage the alleged perpetrator denied the charge of murder. The review process was in part paused due to the plea of not guilty until after the conclusion of the criminal trial. The trial took place in January 2015. Mr F was found guilty of murder on 2 January 2015 and on 5 January 2015 was sentenced to life imprisonment to serve a minimum of 28 years in custody. The review process was resumed after the trial. Mr F appealed against conviction and sentence. The final appeal was dismissed in February 2016.

1.9 It was the view of the review panel that to interview the perpetrator and his family members prior to the conclusion of the legal proceedings was inappropriate in terms of potentially interfering with the court case. However, given the ongoing nature of the appeal it was decided that to delay the review any longer was inexpedient. Both Mr F and his family have since been given an opportunity to contribute to the report but have declined to do so. Any lessons to be learnt by agencies regarding practice that was identified by the process of IMR preparation and required immediate attention were to be taken forward by the agencies at once and not to be delayed until the conclusion of the review.

1.10 Parallel processes to the DHR included the criminal trial. Liaison took place throughout the criminal proceedings to ensure there was no conflict of process. There are no other reviews now that the appeal process is finalised.

<u>Circumstances that led to the review being undertaken</u>

1.11 On Tuesday 17 June 2014 police and paramedics attended the address in Lincolnshire after a 999 call was received at 12.23pm from Mrs F's then current partner Mr H.

1.12 Mrs F's dead body was found lying on the floor in the dining room of her home. She had head injuries and according to the paramedics who examined her rigor mortis had already begun. Life extinct was pronounced at 12.32pm. She was 29 years old at the time of death.

1.13 Mrs F was last seen alive near her home at approximately 9.00am that day after she had dropped her young son SF off at a local primary school.

1.14 Mr H told police officers that he had been involved in a heated argument with Mrs F the previous evening and as a result he was arrested on suspicion of her murder.

1.15 A post mortem examination was undertaken on Wednesday 18 June 2014. Mrs F was found to have sustained “multiple blunt force impacts to her head and died relatively shortly after this”. The cause of death was the brain injury.

1.16 Enquiries subsequently revealed that Mr H was not involved in the murder. Mrs F’s former husband Mr F was arrested on suspicion of her murder at 18.57 on Friday 20 June 2014 and was charged at 1.10am on Monday 23 June 2014. Mr F was 33 years old at the time of the murder.

1.17 In line with procedures the police notified the Chair of the Community Safety Partnership of the death and following liaison with representatives of key agencies it was concluded that the case met the criteria for a DHR and the Home Office were notified accordingly.

Scope of the Review

1.18 The scope of the review will include agency information available on Mrs F and Mr F and feedback from family, friends and relevant others who knew Mrs F, Mr F and their son. Records indicate the first contact with Mrs F in the UK was in early 2008. It is believed Domestic Abuse (DA) started soon after the couple’s marriage in December 2007 and there is reference to abuse taking place in 2008 when the couple lived in Essex. The primary focus of the DHR is therefore from 24 February 2008 when Mrs F came to the UK until the date that Mr F was arrested in connection with her death on 20 June 2014. It was agreed that should information be revealed at a later stage that is relevant to the review, this time period might be extended. However, this was not considered to be necessary.

1.19 The Review Panel commissioned each relevant agency involved to provide a chronology of contact including what decisions were made and action taken and an Individual Management Review (IMR) in line with Lincolnshire and National DHR procedures. Quality assurance was provided for IMRs received by the legal advisor. The review panel analysed the IMRs for themes and issues which were discussed with authors in a meeting. The process of receiving the chronologies identified that there were other agencies outside the area who may have had some contact and they were approached to see if they had any relevant information. Where there was a positive response IMRs or summary reports were requested depending on the contact. There was a delay in receiving the information which in turn delayed the review process by some months. Despite repeated requests and further delaying the completion of the review report, a private day nursery attended by the child of the family did not provide information for the review. However a brief telephone conversation whilst attempting to gather the information did establish that the nursery was not aware that DA was a factor in the family,

on this basis it was felt appropriate to finalise the report without their contribution.

1.20 The IMRs considered the Terms of Reference (TOR), whether internal policy and procedures were followed, whether on reflection the procedures were considered adequate, arrived at a conclusion and where necessary made a recommendation from the agency perspective.

Terms of Reference

1.21 Key issues identified by the panel:-

a) Identification of domestic abuse
b) Information gathering and sharing
c) Risk identification
d) Risk analysis
e) Risk management
f) Competencies, training and management accountability
g) Consideration and compliance with agency and multi-agency domestic abuse policies and procedures
h) Accessibility of services equality and diversity, cultural and religious issues
i) Mobility of the family and across border communication (i.e. any issues relating to the family moving from/to different counties where concerns/information could or should have been shared.

1.22 In order to address the key issues above, the IMR authors were charged with answering the questions set out below from the terms of reference. This required analysis of practice measured against agency standards and expectations.

1.	Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/alleged perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to MARAC?
2.	What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
3.	Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
4.	Is there evidence that historical information was analysed to provide an holistic assessment of risk.
5.	Did the agency comply with domestic violence protocols agreed with other agencies, including any information sharing protocols? Was inter and intra-

	agency communication efficient and effective?
6.	Were practitioners sensitive to the needs of the victim and the alleged perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect practitioners, given their level of training and knowledge, to fulfil these expectations?
7.	Did the practitioners seek, and were given, appropriate levels of supervision, advice and guidance during the decision making process. Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?
8.	When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies? Had the victim disclosed to anyone and if so, was the response appropriate?
9.	What was known about the alleged perpetrator? Had MAPPA been considered?
10.	Was the information recorded and shared, where appropriate?
11.	Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the alleged perpetrator and their families? Was consideration for vulnerable and disability necessary? How accessible were the services for the victim and alleged perpetrator?
12.	Have there been any other similar cases in recent years and are there any lessons that could have been learnt?
13.	To what degree could the homicide have been accurately predicted and prevented?
14.	What effective practice can be passed on to other organisations?

Methodology

1.23 The Review Panel was convened by the Lincolnshire Community Safety Partnership (CSP) and included representatives from the relevant agencies and the independent chair and overview report author. The Review Panel commissioned a chronology and IMRs from each agency and a summary report from those who had some information to share but had had limited involvement during the scoping period. Family members, friends, the perpetrator and the perpetrators employer were contacted.

1.24 A total of four meetings were held with the review panel. The first was to consider the information available, confirm that a DHR was appropriate and commission chronologies. The second meeting agreed the Terms of Reference (TOR), considered the chronologies and commissioned the IMRs. The third meeting was also attended by IMR authors and enabled agencies to present their information and allow time for others to ask questions and make comments. The fourth meeting was to consider the draft overview report and in order to ensure it accurately reflected the information provided by the agencies in a full and fair way. This last meeting identified yet more

agencies in another area that may have had a contribution to make and information was duly requested. A private day nursery was contacted but did not respond to requests to provide information.

1.25 In order for agencies to prepare their contributions they sourced and reviewed a range of information from a variety of systems and where relevant interviewed staff known to have had direct involvement with Mrs and Mr F.

1.26 The agencies completing IMRs and the profile of their involvement with the individuals were as follows:

Organisation	Author	Involvement
Lincolnshire Police	Graham White Regional Review Unit	Responded to telephone calls from the victim and her new partner and attended the scene of the murder and made arrests.
Humberside Police	Carol Ellwood Detective Inspector	Responded to telephone calls from the victim and the perpetrator between 2009 & 2011 reporting incidents of DA. Also contact with perpetrator in 2012 when he was cautioned.
United Lincolnshire Hospital NHS Trust	Lisa Blewitt Safeguarding Practitioner	Provided care for Mrs F during pregnancy and childbirth. Also provided health assessments & medical interventions. Cared for son following a school accident where he broke his arm.
South West Lincolnshire Clinical Commissioning Group	Jeanette Arnold Head of Adult Safeguarding	Provided GP services and health care between 2008 & 2014 for victim and son.
Lincolnshire Community Health	Kay Chrome Corporate	Provided health visiting & school nurse service to victim and son

Services	Safeguarding Team	between 2012 & 2014, out of hours & walk in centre services
Education Services Lincolnshire County Council	Jill Chandar-Nair Inclusion & Attendance Manager, Senior Liaison Officer for Education with children's services	Provided school services September 2013 to June 2014
North Lincolnshire Children's Services	Christine Remner, Social Worker	Provided contact/referral and an initial assessment
Northern Lincolnshire & Goole NHS Foundation Trust Community Health Visiting Service	Lisa Robinson Named Nurse Safeguarding Children	Health Visiting Services May 2009 - Feb 2012
Northern Lincolnshire & Goole NHS Foundation Trust	Michael Griffiths Named Nurse Safeguarding Adults	Health Care Services 2009 - 2011 to Mrs F.

A summary report was received from Essex Police in relation to one incident in March 2008.

A summary report was received from Lincolnshire Children's Services regarding one contact via a "stay and play" session at a Children's Centre and then contact with the child SF following the death of his mother.

Children and Families Court Advisory Support Services (CAFCASS) were contacted and a request made via The Family Court Judge to provide information about their contact with Mr and Mrs F but the request was refused by the court. However, the summary information provided by CAFCASS confirmed that the family were known to them as a result of Residence proceedings in respect of their son, from April 2013 – October 2013. CAFCASS submitted an initial safeguarding and welfare analysis in May 2013 for work towards the first hearing and a section 7 report in July 2013 for work after the first hearing. The section 7 report recommended for the already in place shared residence arrangement to continue. The slight difference was that the Family Court Advisor proposed altering it so that one parent had the child Monday-Thursday and the other Thursday – Monday. At the time the child was staying at his father's 4 nights per week and his mother's 3 nights per week, but not consecutively. During proceedings there

were concerns raised that the police had attended the family home due to violence/aggression between the parents between 2009 and 2012. The final legal output of the court was for the child to spend 4 consecutive nights with his mother, and then 3 consecutive nights with his father. As a result of not receiving a full report from CAFCASS there is a gap in fully understanding the extent of what was known by CAFCASS relating to the role that domestic abuse played in this family and the child contact arrangements and of their analysis of the issue. We are not aware what CAFCASS or the Family Court Policy is in relation to taking action to protect when they become aware of domestic abuse or indeed what action they took, if any, in this case and whether the action was considered good practice in relation to what was expected of them.

Parental separation is a known risk factor which increases risk in DA situations. It is suggested that the possible trigger for the murder in this case was a letter from Mrs F's solicitor to Mr F informing him of the intended challenge to contact arrangements to reduce his contact with his son. This increased Mrs F's vulnerability and risk. A recent report named "Women`s Aid. Nineteen Child Homicides" considers cases where there was DA and children were killed by a parent in circumstances relating to child contact. The focus is on children but in some cases women were also killed. The report makes a number of detailed recommendations for the Family Court Judiciary and CAFCASS regarding action to be taken to increase knowledge and understanding about the role of DA and to minimise the risk to women and children.

Contact was made with DA service agencies in North Lincolnshire and Lincolnshire but there was no contact with the individuals subject to the review recorded. This was also the case with the National Probation Service, Community Rehabilitation Company, Safer & Stronger Communities and Early Intervention.

A solicitor's letter from Mrs F to Mr F immediately prior to the murder concerning contact and residency of their son was shared with the Panel and included in the analysis in this report.

Immigration Compliance & Enforcement Team were contacted in relation to immigration issues.

1.27 <u>In preparing the overview report the following documents were referenced</u>:-

i. Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Review.
ii. Home Office Domestic Homicide Review Toolkit Guide for overview report writers.
iii. Call an end to violence against women and girls. HM Government published 25 November 2010.
iv. Home Office Domestic Homicide Reviews – Common Themes identified and lessons learned 2013.
v. Agency IMRs and chronologies
vi. Individual agency internal Operational Policies and Procedures.

vii. Humberside Police Domestic Abuse Information Sharing Protocol with Social Services.

viii. Information regarding DA in the Chinese culture was researched via the internet and articles were used from The Diplomat, The Asia Foundation, The All China Women's Federation and The Economist.

ix. Victims parents Witness Statements.

x. The Solicitors letter on behalf of Mrs F sent to Mr F days before the murder was shared with the panel.

xi. Women`s Aid, Nineteen Child Homicides (Bristol Women`s Aid, 2016)

1.28 Where confidential information has been detailed in relation to Mrs F and Mr F it has been gathered and shared in the public interest and in line with the expectation of the National Guidance for the conduct of DHRs.

1.29 Individuals referred to in the DHR

- Victim Mrs F aged 29, former wife of perpetrator
- Perpetrator Mr F aged 33, former husband of the victim
- Son of Mrs F and Mr F referred to as SF
- Partner of Mrs F at the time of the murder Mr H.

In order to anonymise the individuals referred to in the review, careful consideration was given to how to refer to them, taking into account cultural differences. Advice was taken from the link person who provided a reference point for Chinese cultural issues from The Chinese Cultural Association Lincoln. She confirmed the pseudonym of Mr and Mrs F is, in her view, appropriate.

1.30 Family and others involvement

The panel would like to thank the parents of Mrs F for allowing the statement they made to the Court about their daughter and her life to be shared to inform this review. Mrs F was an only child. Her parents remain living in China having visited the UK after her death to be assessed as carers for their young grandson. This visit coincided with the Criminal Trial.

1.31 The contribution of Mrs F's parents helped to achieve a greater understanding of her as an individual and mother and of the nature of the relationship between Mrs F and Mr F.

1.32 A brief discussion was held with Mr H, the partner of Mrs F at the time of her death. However, to recall events and discuss his partner was too distressing. Instead discussions took place with his mother whom we would like to thank for her contribution to enable this review to be as full as possible.

1.33 Five of Mrs F's friends were contacted and a brief discussion took place with one, another found it too distressing to discuss the loss of her friend and three others chose not to respond to the request to contribute to the review.

1.34 A letter was sent to the parents of Mr F who did not choose to contribute to the review. Contact was made with the Social Worker involved with SF. He in

turn contacted paternal sister who also declined to be involved in the review feeling she had nothing to say at this stage.

1.35 Mr F's Employers were contacted and discussion took place with The Human Resource Manager who knew Mr F personally.

1.36 The parents of Mrs F reported she was an only child and when little was happy go lucky. She was an intelligent, capable and conscientious student and her school results were above average. Her parents were very proud of her and as she was growing up they spent much of their spare time together.

1.37 Mrs F was introduced to her ex-husband by mutual friends. Her parents first met him in 2007 when in line with Chinese tradition he went to ask for their blessings so that they could marry. They only met him three times in total and did not really get to know him well or understand the kind of person he was. They had a family meal celebration in 2008 in China to celebrate their marriage but understood the main celebration would be in England.

1.38 Once married Mrs F left China and came to England to further her study and live with her husband. Mr F promised he would take good care of their daughter and they put their trust in him. Her parents were aware that after the birth of her son the marriage began to break down. She told her parents Mr F often hit her and she could not bear the pain and mental anguish and she must divorce him. Divorce in Chinese society is unacceptable and as such a taboo subject and her mother persuaded her to stay in the marriage. They were aware she had no family in England to support her and were very concerned for her but felt helpless.

1.39 Her parents recognised they were “old fashioned and traditional in their views and told her she had chosen the wrong path and sustained great pain but must stick to the marriage.”

1.40 During the break-up of the marriage “they were very worried and heart-broken as they knew she was in need of help. They hoped once she was free of the marriage she would start a new bright future.” They describe the devastation they felt at her murder.

1.41 Given the cultural intolerance and discrimination associated with divorce and domestic abuse her family have not told friends and family in China of their daughter’s death as they are too ashamed. Their view of England was that it was a safe glamorous country which adds to their shame that she died here. They are a financially secure family and have bought a piece of land in China where they intend to bury their daughter. Clearly their sense of loss and bereavement is great.

1.42 They recognise that their grandson is also a victim of these tragic events and is in need of the best possible care and help. Whilst they sought custody of their young grandson having promised their daughter they would look after him, they have not been granted custody and SF will remain in the UK with paternal relatives with whom he is familiar.

1.43 The mother of Mr H reinforced many positive aspects of Mrs F including her abilities and dedication as a mother. Mrs F planned to marry Mr H in 2015

and they had a business plan in place to buy, refurbish and let properties. Mr H's mother confirmed that Mrs F was frightened of Mr F and particularly on the weekend before she was killed Mrs F shared with family members of Mr H that she anticipated that the Solicitors letter sent re residency and contact of their son would elicit an angry and verbally aggressive response from Mr F. So much so that in the immediate days following the letter being sent the lack of response from Mr F made Mrs F think that he must not have received the letter. She told family on the Saturday before she died on the Tuesday that she would check with the Solicitor if indeed the letter had been sent to the correct address.

1.44 On reflection had Mr H's mother known Mrs F's level of fear she would have encouraged Mrs F to stay with them for a while. However, this only came to light after the murder. The mother of Mr H recalled that Mrs F had a nasty scar on the back of her hand which she said had been caused by Mr F with a knife. She told the mother of Mr H that her husband would not let her go to the hospital and the incident was never reported.

2. **The facts**

Summary of the case

2.1 From information available it would appear Mrs F and Mr F began their relationship in 2007. They were introduced at a Trading Exchange Event in China by mutual friends and later married. The marriage was registered on 27 December 2007. Mr F was born and brought up in Britain and after their marriage Mrs F joined her husband in the UK where she hoped to continue her studies. Initially it would appear that the couple lived with his family in the Southend-on-Sea area. Records held by health services indicate that Mrs F first attended for a new patient screening with her General Practitioner (GP) on 16 April 2008. She was in the early stages of pregnancy, her son being born in December 2008.

2.2 There was an incident in Essex on 27 March 2008 when, following a heated argument between Mr and Mrs F, the Police were called. They attended the flat and it was recorded as a Domestic Abuse incident but as no offences had been committed the couple were given information on services available and there was no further action.

2.3 Mr and Mrs F moved to live in the north of England in mid October 2008. According to information available it would appear that the couple moved to Humberside from Essex as Mr F had gained employment in the Humberside area.

2.4 Mr F was a chemistry graduate and worked as an industrial hygienist. It is likely they moved in relation to his employment but this has not been confirmed. Mrs F did not appear to work during her 6 years living in the UK but at the time of her death was studying English.

2.5 Records indicate both Mr and Mrs F, whilst being of Chinese heritage did speak and understand written English. It can be assumed Mr F being born

and brought up in this country would have a good command of the written and spoken word. It is less likely that Mrs F was completely fluent.

2.6 On 14 November 2009 following a 999 call Mrs F reported she had been assaulted by her husband, there were counter allegations of assault made by him. Their child, who was then eleven months old, was present. No charges resulted from this disclosure and advice was provided and information about DA services locally.

2.7 There were two further reports to the Police in Humberside of DA via 999 calls, one by the victim Mrs F in November 2011 and the last in December 2011 by Mr F. No charges were made. Information was provided to Mrs F about local DA services available. There is no record of any contact with any DA agencies.

2.8 There is no suggestion that either Mr or Mrs F had been in any other abusive relationships either before or since.

2.9 The couple separated in 2012 and later divorced. Mrs F moved to live in Lincoln, she told the Health Visitor in early 2012 she had moved to flee Domestic Abuse.

2.10 The couple shared care of their son with him spending 3 nights with his father and 4 nights with his mother. A court order was made to this effect in September 2013. The DA previously reported included scratches and bruises plus evidence of coercive control. There were no further reports of DA to the Police or any other agency once the couple separated. However there was evidence of Mrs F still feeling coerced and bullied by Mr F in relation to the care of their son e.g. the Solicitors letter to Mr F days prior to the murder.

2.11 Both Mrs F & Mr F developed new relationships after the end of the marriage. Mr F lived with a new partner and her teenage children. It was Mrs F's boyfriend that found her body on the fateful day that she was killed. Attempts have been made to contact and encourage the new partners to contribute to the review and provide their important perspective on events and what lessons could be learned. Having spoken to Mrs F's partner it is clear he is still traumatised by events surrounding the murder and feels unable to contribute to the review at this stage. There has been no response to letters sent to Mr F`s partner.

2.12 There were ongoing tensions relating to contact and care of Mr & Mrs F's son. A letter dated 10 June 2014 was sent from Mrs F's Solicitor to Mr F outlining Mrs F's dissatisfactions surrounding the contact arrangements and suggesting a variation, reducing the time SF spent with his father and increasing the time spent with her. The letter indicated that if there was no response within 14 days Mrs F would apply to the Court for the variation.

2.13 On 17 June 2014 Mr H visited the home address of Mrs F as he could not get a reply from her on the telephone. He found her body on the dining room floor and rang the Police. Mrs F had died from brain trauma following multiple blows to her head with a blunt object.

2.14 Initially Mr H was arrested in connection with the murder and the little boy who was at school was placed in the care of his father Mr F. However, on 20 June 2014 due to discrepancies in the information provided by Mr F the child was placed in the care of the Local Authority and Mr F was arrested in connection with Mrs F's murder.

2.15 Mr F consistently denied the charge but was found guilty and sentenced to life imprisonment on 5 January 2015 to serve 28 years before he will be eligible for parole.

The Victim

2.16 The only daughter of her parents Mrs F was an intelligent and capable student. She was above average and she did well at school. When she was 18 she went to university to study international business. On finishing university she helped her mother with her business.

2.17 In 2007 she met and later married Mr F. They were introduced by mutual friends. By 2008 she had moved to the UK initially living with her in-laws in Essex but then moving to the Lincoln and then the Gainsborough area with her husband and baby son.

2.18 In order to consider whether her immigration status may have been a factor /barrier in Mrs F reporting and seeking help for DA, contact was made with The Immigration Compliance and Enforcement Team of the Home Office (HO). It was confirmed that Mrs F obtained a British Visa as a spouse whilst in China, this was granted from 20 February 2008 until 20 February 2010. Mrs F then applied for and was granted indefinite leave to remain as the spouse of a British Citizen as of 22 April 2010.

2.19 Her separation and divorce had not been brought to the attention of the HO, if it had have been known her status would have been revisited. However as she had a child born in the UK it is doubtful that her status would have been altered. Also if she had divorced due to DA then it is very likely that she would have been allowed to remain in any case. It is not known if her immigration status had any impact upon her decision making in relation the way she dealt with the DA she suffered.

2.20 Her parents report that one of Mrs F's hopes in coming to England was to further her studies. There is some evidence she was studying English once she moved to live independently in Lincoln. Information would suggest that whilst living with her husband she was isolated and had limited outside contact.

2.21 Mrs F reported not only physical abuse but emotional and financial abuse to the Police in 2011. She reported that Mr F had damaged her property, her bank card and mobile phone which must have left her unable to contact others or leave the area. She also referred to what amounts to psychological abuse her husband telling her that he would have custody of their son if they divorced. She informed the health visitor in 2012 that her husband had prevented her from studying English and developing friends, a form of coercive control.

2.22 The Police did provide Mrs F with details of DA services locally and Mrs F did refer to having tried to contact Women's Aid in November 2011 but was unsuccessful. Initially it would appear her English language was poor which would no doubt have hindered her ability to seek help in the early days of her marriage, but by 2011 the Police confirm they checked she could understand and read English to a reasonable level.

2.23 On a visit to China in 2011 Mrs F told her mother of the abuse she was suffering. However, given the intolerance towards DA and divorce in China and the cultural expectation that the husband is head of the household and women have to tolerate abuse her mother urged her to stay in the relationship. "She chose the wrong path and sustained great pain. I told her she must stick to the marriage". To divorce brings shame and dishonour on the family in the Chinese culture and is to be avoided at all cost. For Mrs F to go against her parent's wishes and leave her marriage would have been particularly difficult for her. It would appear she managed to do this with no help from any outside agencies or family and friends.

2.24 Following a cervical smear test that showed significant pre cancerous changes in early 2010. Mrs F became extremely anxious about her health. Treatment was provided and follow up tests showed she was clear of cancer. However, she made regular visits to the GP and insisted on being referred for investigations and tests. All proved negative. After approximately 4 years of concerns she recognised that she was suffering from panic and anxiety and needed something to help her settle. She was prescribed Beta Blockers. It is likely that her ongoing ill health was in part caused by the extreme pressure she was under as referred to above. There is research that suggests women more so than men are prone to internalising their difficulties which can manifest themselves in health problems. This may be relevant in this case.

2.25 Mrs F did have 2 new relationships after she left her husband. At the time of her death she was in a relationship with Mr H. She was welcomed into his family and visited his parent's home with her son on a regular basis and Mr H was known at her son's school as his stepdad. The couple planned to marry in 2015. Mr H is devastated by his loss.

2.26 Mrs F's son started school in 2013. She was a regular visitor to the school and was liked and valued as a helper on occasions. The school although aware Mrs F did not wish to meet up with Mr F, were not specifically aware of the history of DA.

2.27 Prior to her son starting school Mrs F did have contact with health visiting services and when she moved to Lincoln leaving her husband and living independently she did tell the Health Visitor (HV) she had moved to flee DA. Other than the Police and to NLCS, when they undertook the initial assessment, this would appear to be the only agencies she disclosed her situation to.

<u>The Perpetrator</u>

2.28 Mr F was born and brought up in the UK of Chinese heritage. He was a chemistry graduate and worked as an Industrial Hygienist. It would appear he

met his wife in China and she came back to Britain with him. Initially they lived with his parents in Southend-on-Sea. They moved north in October 2008.

2.29 Mr F had one son born in December 2008. It would appear DA was a feature from early on in their relationship. The first recorded incident was in Essex in March 2008 and then in Humberside in 2009 when Mrs F rang the Police. Mr F referred to previous incidents in Essex and that knives had been used. He intimated that he was also the victim of the abuse and told Police that he was having counselling via his work. Whilst Mrs F was considered by the Police to be the victim of all three recorded incidents Mr F was never charged with any offences but was interviewed on two occasions, both interviews were under caution one of which was whilst in Police custody.

2.30 In order to clarify the situation regarding Mr F receiving counselling via his work, his Employer was contacted. The Human Resource Manager confirmed that there is a confidential counselling service provided for staff at work. However as it is confidential, details of those accessing the service are not known, therefore we cannot confirm whether Mr F used this service or indeed if he did whether his domestic situation was a focus of the contact. There is a clause in the contract between the employer and counselling service however, that makes it clear, that if an employee discloses information that would be a cause for concern or amounts to the commission of an offence the counsellors will notify the relevant agencies, so that appropriate action can be taken. This did not arise in this case. Friends and Colleagues at work were shocked by the death of Mrs F and of Mr F`s culpability and find it very hard to believe he could have perpetrated such a terrible crime.

2.31 It would appear Mr F stayed in contact with his parents and there is reference to them being at the family home when one of the DA incidents occurred in 2011. Mr F was in a new relationship at the time of the murder and lived with his new partner and her teenage children. Following the separation there was a County Court hearing on 27 August 2013 where a contact and residence order was issued. His son was to stay with his father three nights at weekends and half his school holidays.

2.32 Mr F picked his son up from school on three Fridays out of four and dropped him off at school on Monday mornings. He regularly contacted school and was involved in his son's education. It was these contact arrangements and the impact it was having on her son that was subject of the Solicitors letter that was sent to Mr F by Mrs F's Solicitor just days before the murder and may have been a trigger for Mr F planning and executing his former wife's murder.

2.33 It is alleged and accepted by the Court that Mr F planned the murder, he organised an alibi, drove from his home to the outskirts of Lincoln then cycled to Mrs F's home and killed her. Cycled back to his car and then went Mountain biking. He collected parking tickets and cafe receipts to authenticate his story.

2.34 Initially Mr H was arrested in connection with the murder. The Police placed the couple's son with his father. It was three days later that Mr F's story was found to have discrepancies and he was arrested and later convicted of the murder. He has never accepted responsibility for the murder and an appeal against both conviction and sentence has been refused.

3. Chronology

3.1 The chronology of agency contact with Mrs F and Mr F is attached at Appendix A.

Synopsis of critical events

3.2 Mr and Mrs F married and she came to the UK from China in 2008. Their son was born later that year.

3.4 The first DA incident on 27 March 2008 was investigated by Essex Police. The second DA incident reported to the Police took place in November 2009. Mrs F made a 999 call and alleged physical abuse by Mr F, he made counter allegations. No arrests were made, but both Mrs F and Mr F were interviewed under caution by the Police and during the Police contact they were advised to seek counselling to resolve their differences. Their son who was 11 months old was present in the house.

3.5 On 19 November 2011 Mrs F made a 999 call to Humberside Police alleging she had been the victim of DA. Mr F had damaged her property, her bank card and mobile phone and she was calling from a phone box. No charges were made and Mr F was not interviewed by Police. She had attempted unsuccessfully to contact women's aid.

3.6 On 6 December 2011 Mr F made a 999 call to say there had been a domestic incident. Mr F was arrested at the scene by Humberside Police but released without charge the following day. Their son aged 3 years was present and said to Police "Daddy did it". A referral was made by Police to North Lincolnshire Children's Services.

3.7 December 2011 North Lincolnshire Children`s Services undertake a Section 17 Initial Assessment and conclude SF is not a Child In Need.

3.8 2 April 2012 - Mrs F and her son are now living in Lincoln. She discloses to the health visitor that she had moved to flee DA.

3.9 17 December 2012 – Mrs F takes son to out of hours medical services. Nurse notes appeared agitated that son's father was waiting outside.

3.10 23 May 2013 – Couple Divorce.

3.11 27 August 2013 – County Court hearing contact and residence order issued. Mr F to have son three weekends out of four and half his school holidays.

3.12 30 September 2013 - Son breaks his arm in a fall at school and is admitted to hospital for short period.

3.13 24 October 2013 - Son calls the Police to say he was on his own and his mummy was dead. Mrs F was present when Police visited the home and confirmed all was well. Mrs F said that SF occasionally behaves in such a way making up stories.

3.14 22 February 2014 – 999 call from Mrs F to say her boyfriend Mr H was at the home refusing to leave. Police visited and boyfriend had gone. No offences were committed.

3.15 28 March 2014 – Joint meeting with both Mr and Mrs F at son's school to discuss behaviour. Mrs F requests that she doesn't attend as she considers her ex husband will not allow her to speak and will blame her son's difficult behaviour upon her. Head Mistress insists both parents attend. Mrs F was quiet, Mr F far more eloquent.

3.16 17 June 2014 – Mrs F was tragically found having been killed.

3.17 20 June 2014 – Mr F arrested for the murder of his ex-wife.

4. **Analysis of Involvement**

Individual Management Reviews (IMRs)

4.1 In this section practice is analysed and evaluated against agency policy and procedure via the IMRs. Further analysis takes place in the next section directly answering the TOR questions.

4.2 Essex Police

On 27 March 2008, within a matter of weeks of Mrs F coming to the UK from China a passing Police Officer reported hearing a domestic incident at a flat in Essex. As a result two officers attended the address and ascertained that Mrs F and Mr F had had a heated verbal argument regarding personal issues that were not disclosed. There were no injuries to either party and no offences were disclosed.

4.3 In line with policy and practice a DASH risk assessment was completed and was approved by the supervising Police Officer. The incident was risk assessed as standard. The grading of the initial response and subsequent assessment complied with the policy at the time.

This information was not available to subsequent police services to inform their risk assessments, as it would be now, with the use of PND. PND only came into being in 2011. There was the scope when PND was introduced to convert older records and DA information details should have been included automatically in this process, however for some unknown reason the March 2008 incident was not converted to the Essex PND records. The process of this review has highlighted the gap in this technical process. As a result

Essex Police have informed their PND Coordinator with a view to try and identify the gap and close it.

4.4 A form containing advice and details of what support agencies could provide would have been left with both parties and there was no further contact. Although Mrs F had only just come to the UK there was no reference to language or ethnicity being an issue or that Language Line (Essex Police translation service) was necessary.

4.5 Humberside Police

The Police IMR was conducted using a range of records, several policy documents and discussion with staff where appropriate.

4.6 The first incident of DA that was reported to the Police in Humberside took place on 14 November 2009. Mrs F rang 999 stating she had been assaulted by her husband. The Police attended and both Mrs and Mr F were present as was their 11 month old son. Both parties claimed they had been assaulted by the other and showed scratches and abrasions as evidence. Given the counter allegations and that neither wished to press charges the Police Constable contacted his supervisor at Sergeant level to seek advice. The Essex Police information was not available to Humberside Police, as discussed above.

4.7 A decision was made to interview them on a voluntary basis at the home address, this was a question and answer interview under caution. Information was provided during the course of the interviews that there had been previous incidents of DA between the couple but none of these had been reported to the Police. Mrs F informed Police that the couple had been having problems for some time and consented for details to be provided to other agencies if necessary. Mr F said he had previously been attacked by his wife with knives and showed the officers some scars to his arms. Mr F said he had attended counselling which was arranged through work, he attended this alone. There were no close relatives living in the area, parents were living in China and Essex.

4.8 At the time the Police in Humberside had a Force Practice Direction on dealing with Domestic Abuse which prior to the incident was last updated in December 2007. The Practice Direction has since been reviewed. The policy document at the time was based on national guidance issued by the Association of Chief Police Officers. The Police had a Domestic Violence Form known as the F913 to record incidents of DA. The F913 had been updated in March 2009. The risk assessment tool in use during this time period was The Separation, Pregnancy, Escalation, Community Isolation, Stalking and Harassment and Sexual Abuse (SPECSS). The officers dealing with the incident graded it as standard on the F913. Standard Risk means no significant current indicator of risk of harm and no action was taken against either party.

4.9 In line with procedure the incident was reviewed by the Domestic Violence Co-ordinator and the risk level raised to medium. A decision was made to send Mrs F a letter providing her with helpline numbers for local support

groups. Medium Risk – means there are identifiable indicators of Risk of Harm. The offender has the potential to cause harm but it is unlikely to do so unless there is a change of circumstances e.g. loss of accommodation, failure to take medication.

4.10 The interviews were recorded in English. The appropriateness of this was discussed with the officers by the IMR author. The officers stated throughout their investigation both Mrs F and Mr F conversed with them in English and it was clear both parties understood the proceedings. The couple were asked to read their record of interview and only sign it if they agreed it was a true and accurate record. The signatures at the end of both interviews were in English.

4.11 The incident log from 14 November 2009 stated that the supervising Police Sergeant utilised "The Humberside Police investigation of Crime Discretion Protocol" to take no further action on the case. This was discussed by the IMR author as the policy clearly states that it cannot be used for Domestic Related Crime. The Sergeant said he was aware of this and that he did not use the Policy and the entry on the incident log must have been entered in error. His reasoning for no further action was that there was no formal complaint of assault from either party, injuries were minor and the couple were seeking counselling. This response was considered appropriate action by the IMR author at that time as there was no positive action policy in place. There is no evidence that the couple did pursue counselling as advised.

4.12 It was noted that although a helpline card was sent to Mrs F one was not sent to Mr F and whilst they both were interviewed as victim and perpetrator the Domestic Violence Form only recorded Mrs F as Victim and Mr F as perpetrator. However the DV form has since been amended to identify where counter allegations are made which can provide important intelligence when considering future risk assessments. Professional judgement is used when at the scene to gather all evidence to identify who is the victim, taking into consideration new legislation around coercive control which has recently been the subject of training for all relevant staff.

4.13 Although there was a child present the details of the incident was not shared with children's services. This was in line with the protocol that was in place at the time. The protocol detailed when a referral was to be made to NL Children's Services and at that time the incident of 14 November 2009 did not meet the criteria. This policy has since been updated and had this incident occurred whilst this new policy was in place the matter would have been referred to NLCS

4.14 The second recorded incident of DA took place on 19 November 2011. The family were living at the same address. Contact by Police followed a 999 call from Mrs F reporting that she had been arguing with Mr F and that she had left the property leaving her husband and 3 year old son in the property. She was ringing from a call box and was interviewed away from the family home. Mrs F informed the Police that due to the problems she had been having with her husband she had returned to China for a 10 day break leaving her son

with her husband. Her husband had arranged for relatives from Essex to stay at the address to help with child care.

4.15 During the argument it is alleged that her husband damaged some of her property including bank cards and her mobile phone when he became aware she had tried to contact Women's Aid. The attending officers completed a F913 and SPECSS Risk Assessment in line with policy; they noted she was isolated and had no friends in the area, factors which increase risk. Officers also recorded that Mrs F was suffering from "mental abuse" by her husband who was telling her that he would obtain custody of their son. There was no physical violence during this incident.

4.16 The police had a positive action policy in place by this time to ensure that attending officers dealt with incidents of DA in a positive manner to reduce the likelihood of a repeat and to protect the victim.

4.17 It is force policy that when dealing with DA incidents during which children are present or in the household that they are seen and checked. On this occasion this did not happen nor did they interview Mr F. There was no explanation for this on either the F913 or the incident log. This may have provided an opportunity to refer to Children's Services and to get other agencies involved and also to at least inform Mr F his behaviour was unacceptable and of the possible consequences. His parents were at the house and it would have also presented the chance to alert them to the concerns.

4.18 The officers informed Mrs F they would arrange for some help for her from the Domestic Violence Unit (DVU) and external agencies. The incident occurred on a Saturday and at that time the DVU did not work weekends. From April 2015 staff do work weekends. Contact was to be on the home landline whilst Mr F was at work. Mrs F rang on the Sunday to say her husband was at work and she was at the property with his parents. She was not sure the phone was working so officers may need to attend the address.

4.19 Contact was made from the DVU on the Monday and contact numbers for seeking legal advice provided. The risk level was considered to be medium.

4.20 The next incident took place on 6 December 2011 and was reported via a 999 call by Mr F, he reported that his wife had been violent towards him whilst they were discussing how the assets would be divided as part of their divorce. Officers attended the home address and spoke to both parties after which Mr F was arrested on suspicion of assault. Mrs F informed officers that she had been assaulted whilst trying to video her husband during a verbal argument over assets. The video footage had been destroyed prior to Police arrival. Mr F was detained in custody on suspicion of assault whilst the matter was investigated.

4.21 The officers on this occasion whilst having sufficient information to complete the Form F913 decided that an interpreter was required to obtain a full statement from Mrs F. This was good practice to ensure all relevant information was shared and understood. It brings into question whether an

interpreter was necessary and could have added quality to previous contacts by Police.

4.22 The Form F913 was completed with a risk assessment of medium. The following note was recorded, “Graded medium at this time as the offender is in custody and therefore no current risk to Mrs F. However, depending on the outcome of the custody case against Mr F consideration needs giving by the officer in charge to regrading this as a High risk case if warranted”.

4.23 Mrs F showed officers a 'Divorce child custody and asset agreement form' that she and her husband had signed. It had been created by her husband saying that "she will surrender all assets to him and that he will give up his right of custody and she will receive £10,000 on the sale of assets.” It is clear from this that Mrs F required independent advice to ensure matters were settled fairly and that her interests were fully considered. At this visit, whilst the police obtained photographs of injuries which involved scratches and bruising to arms, the 3 year old son commented “Daddy did it”.

4.24 The case was reviewed by a Detective Inspector who made a decision that no further action would be taken. Mr F was then released from custody. The rationale for this was that the injuries were not serious; the offence is denied by Mr F, the only witness was a three year old child and further work would be undertaken by the DV Co-ordinator and NLCS.

4.25 A referral was made to NLCS in line with the agreed process to be progressed in accordance with a Section 17 Initial Assessment of the Children’s Act 1989. The situation arose where Mr F was being released, Children’s Services had not visited and Mrs F was unaware he was being released. The Child Protection record stated there was no Social Worker available nor was there a Social Worker available that evening from the emergency duty team so a Social Worker would visit the following day.

4.26 No further action was taken by the police in relation to this matter. NLCS records show a letter was sent to Police informing them that they would be taking no further action. The Police consider their Positive Action Policy was followed and resulted in Mr F`s arrest and information being shared with Children`s Services via the referral process. When the risk assessment was reviewed by The DV Unit it was maintained as medium risk.

4.27 On reflection and with hindsight as part of this review the IMR author and the officer involved consider criminal charges should have been brought in relation to this incident.

Lincolnshire Police

4.28 This IMR was undertaken by the East Midlands Special Operations Unit, Regional Review Unit on behalf of Lincolnshire Police. Research was undertaken within various police systems. Officers involved with providing a service in the case were spoken to. The chronology and IMR indicated that there were two incidents that are relevant to this review and that fell within the scoping period.

4.29 On Saturday 22 February 2014 Mrs F made a 999 emergency telephone call to Lincolnshire Police to report that her boyfriend Mr H was at her home and refused to leave. The incident log stated that she had let Mr H into her house and they had argued, she had asked him to leave but he was refusing to do so. The log stated Mr H had not been violent towards her but they were shouting at each other. The Force Control Operator updated the log to the effect that Mr H could be heard in the background crying and pleading with Mrs F and it was her that was shouting.

4.30 The incident was graded urgent and officers were on the scene within 6 minutes. Mr H had left the home by the time Police Officers arrived. A DASH risk assessment was completed and graded the initial risk categorisation as standard. On the risk assessment form the officer stated “this is an argument over the male being insecure and believing that the caller has cheated on him”. No offences had been committed and therefore Mr H was not arrested.

4.31 There was one minor error on the DASH risk assessment questionnaire. In response to the question “Are there any children, step children that aren’t the abusers in the household, the officer answered no but included SF, Mrs F’s son's details. It was clarified with the officer that this was a typing error and the answer should have been yes. The police officer recorded that they did not see the child and he was not present during the interview or the incident and he recalled that he was staying with a relative.

4.32 The incident was reviewed by the Public Protection Unit the following day in line with procedure and intelligence checks were undertaken to establish if there had been any previous DA incidents involving Mrs F and Mr H and the child. No relevant information was found and the DASH remained as standard, therefore no further action was taken by the police. Information about the incident was appropriately shared with Children’s Services.

4.33 The Police National Database (PND) was not checked. Had it been, the history of DA in Humberside would have been identified and taken into account to enable a holistic assessment. It is a requirement of the force that officers and staff check PND in all DA cases. This policy was not adhered to on this occasion and the lack of crucial historical information potentially undermined the quality of the DASH risk assessment and the decision making that followed.

4.34 There were two instances of burglary at the home of Mrs F; one on 17 May 2014 and one on 1 June 2014. The Police investigated both at the time and have confirmed as part of the DHR process that they do not consider they were in any way related to the relationships and DA issues.

4.35 On 17 June 2014 at 12:23 Mr H made a 999 call to Lincolnshire Police to report he had found Mrs F on the floor at her home in Lincoln. He also told the Force Control Room (FCR) operator that Mrs F had a 5 year old son whom he was sure was at school, this was confirmed by Police. At 12:52 on 17 June 2014 Mr H was arrested on suspicion of murdering the victim. He told staff in the FCR that he had had a disagreement with Mrs F the previous evening and told officers at the scene that they had been involved in a heated argument.

4.36 SF remained in the care of the school until his father was visited by police colleagues in Humberside and asked to attend school to collect SF. Mr F arrived with his partner and following a vulnerable witness interview they took SF and left for his father's home. Again had the police checked the PND they would have been aware of Mr F having been considered the perpetrator in at least 3 DA incidents in Humberside and this may have prompted liaison with Lincoln Children's Services before placing the child with his father.

4.37 On 18 June 2014 Mr F was interviewed at Grimsby Police Station to provide a witness statement. SF was seen by police when they collected Mr F and again the following day when they visited.

4.38 On 19 June 2014 Mr H was released from custody on bail. He remained at that time the only suspect in the murder.

4.39 At 14:15 on Friday 20 June 2014 as a result of enquiries concerning the movements of Mr F on 17 June and discrepancies identified in the witness statement he provided on 18 June the Senior Investigating Officer (SIO) decided that Mr F was a suspect in the murder of his former wife and instructed that arrangements were made for him to be arrested as soon as possible. A Police Protection Order was made in respect of SF and he was taken into the care of Children's Services after his father had been arrested.

4.40 It would have been better if the liaison with police and Children's Services had occurred much earlier in the investigation i.e. on day one rather than four days later on 20 June 2014. The SIO or one of his nominated officers should have approached the Detective Sergeant in the Public Protection Unit (PPU) for advice and appointed that officer to determine the most appropriate way to deal with the case of the child. That almost certainly would have instigated a referral to Children's Services and enabled a joint agency strategy discussion and an assessment based upon shared information and experience to have taken place.

<u>Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)</u>

4.41 The IMR was written following the IMR author obtaining and reviewing information held in the relevant medical records.

4.42 Mrs F was seen at hospital for obstetric and gynaecological procedures between 31.07.09 and 20.07.11. This involved outpatient appointments and two periods of short inpatient activity during which time her then husband was in attendance. Although not specified it does appear that Mr F took a lead role in negotiating arrangements for Mrs F, possibly due to issues of command of language. It is the view, that four years on, a greater focus would be placed on gathering the needs and views of Mrs F. in her preferred language via "The Big Word" translation system which is now available.

4.43 Now, all frontline staff in the Women's and Children's Department are encouraged through safeguarding supervision to ask patients about domestic violence and take action if the response is positive. At the time of contact with Mrs F. there was no concerns recorded about DA and no indication that this was a feature this family.

United Lincolnshire Hospital Trust (ULHT)

4.44 In preparing the IMR medical notes for Mrs F and SF were sourced and analysed. There was no current or historical record of contact with Mr F. Staff were not interviewed as they work rotationally and have since moved on. However, not being able to interview staff was not felt to impinge on the effectiveness of the IMR.

4.45 Mrs F's obstetric care and treatment was transferred to ULHT on 6 November 2008. Southend Hospital transfer documentation was included in the IMR.

4.46 Despite parents requesting an elective lower segment caesarean section Mrs F had a normal delivery of a son on 12 December 2008. It was noted during her pre natal examination that she had a blood disorder . This did not have an impact on her pregnancy or birth of her son. She had moved to Lincolnshire on 14 October 2008 and was discharged from the hospital to the care of the Community Midwife. Routine visits were made and there were no concerns.

4.47 Between April 2013 and February 2014 Mrs F was seen at the hospital by various specialists in relation to breast lumps, gynaecological concerns and ear, nose and throat concerns. She was worried she had cancer. To reassure her, a whole body CT scan was undertaken. It revealed no significant underlying pathologies and as such she was discharged to her GP. It was noted she remained somewhat anxious despite reassurances and the specialist felt it was likely she would pursue matters again. Indeed a gynaecology clinic appointment was booked for 31 July 2014 following GP referral. Sadly Mrs F's death preceded this appointment.

4.48 The only other contact with the hospital was following SF having a witnessed fall at school on 30 September 2013. He had a broken arm and was admitted for treatment including manipulation under general anaesthetic and the application of a plaster-of-paris cast. This had to be repeated some 11 days later. There were follow up appointments to check all was well and the injury was healing. During attendances no information was disclosed to cause concern or warrant further exploration of any safeguarding issues.

4.49 One thing of note was in connection with SF documentation that it stated, "both parents in residence on ward", however, there is no clarification as to whether this was mother and biological father or mother and her current partner.

South West Lincolnshire Clinical Commissioning Group

4.50 In preparing this IMR there was a review of written information, primarily from GP records of Mrs F, Mr F and SF. Additional information and evidence has been obtained from policies and protocols. An interview took place with the GP with whom Mrs F had her last four surgery appointments between 12 November 2013 and 29 April 2014. The information provides a summary of provision of primary health care by the GP practices where Mrs F was registered from 24 February 2008 to 20 June 2014.

4.51 Mrs F attended for a new patient screening with her Registered General Practice in Essex advising she had performed a positive home pregnancy test.

4.52 Between May 2008 and September 2008 she attended on three further occasions. She was referred to a consultant surgeon complaining of a lump in the breast. The changes were consistent with pregnancy changes.

4.53 Between October 2008 and April 2009 Mrs F was registered with a village surgery near Gainsborough, Lincolnshire. She attended three times. Following the birth of her son she attended for a routine six week post natal check. It was noted her English language was poor and the majority of the consultation was conducted through her husband as translator. Mrs F was recorded as suffering baby blues. She was seeing the health visitor regularly. To use a relative to translate would now not be considered good practice and an interpreter would be used whenever necessary. In April 2009 Mrs F was registered at a surgery in Gainsborough, Lincolnshire. Records indicate she was a house wife and teetotaller who had never smoked. Her main spoken language was Cantonese.

4.54 After diagnosis and treatment for pre-cancerous cervical changes in January and March 2010, it would appear Mrs F became, perhaps not surprisingly, anxious about her health fearing she had cancer. She was a regular visitor to her GP complaining of breast, neck, axilla and nasal lumps and gynaecological concerns.

4.55 Mrs F's final consultation with her GP took place on 29 April 2014 during the consultation Mrs F stated she felt panic and anxiety and requested medication to settle her. She continued to complain of a breast lump. Cream and Beta Blockers were prescribed by the GP and a note made "suspect hypochondrial personality". A further appointment was made with the practice nurse who did locate a possible lump in her breast and referred her to the Breast Clinic. The appointment was scheduled following Mrs F's death.

4.56 The GP that was interviewed remembered Mrs F well and recalled the focus during consultation by Mrs F was a number of concerns relating to her physical well being. He stated Mrs F spoke English fluently and was able to describe her anxieties well, at no time did she raise any safeguarding concerns or issues with regards to Domestic Abuse.

4.57 Whilst Mrs F referred to feelings of anxiety and panic it would not appear the reason for this was considered or explored with her beyond the physical issues. To have used greater professional curiosity and explorative questions

may have prompted Mrs F to share more information about her circumstances.

4.58 SF attendances at the practice were for routine screening and infections.

4.59 Mr F's contact with General Practices was predominantly related to asthma management. In September 2011 Mr F attended for suture removal further to a repair of a laceration to his right hand.

Northern Lincolnshire and Goole NHS Foundation Trust Community Health Visiting Service(NLAG HV)

4.60 For the purpose of this review the IMR author obtained and reviewed Health Visiting records, including paper and electronic records, held by the NHS Foundation Trust.

4.61 One Health Visitor (HV) and the Nursery Nurse involved with the family were interviewed; the other two HVs involved have now retired. However following analysis of the case by the IMR author it was felt to be unnecessary to approach them as it was extremely unlikely they could have added anything further to the IMR.

4.62 The North Lincolnshire Health Visiting Service did not directly identify any domestic abuse within the case. However, they became aware of DA after NLCS assessment following Police referral in December 2011. Health Visiting were informed by NCLS in a letter in December 2011 that there had been three incidents of DA and that NCLS had done an initial assessment and were satisfied the child SF was not at risk. NCLS wrote to HV to explain this and that they would not be taking further action, however, if HV had concerns in the future to contact them.

4.63 Mrs F. moved to Lincoln within weeks of this assessment. Despite the information about DA, there was no North Lincolnshire Health Visiting contact with the family after the NLCS assessment or any evidence of decision making or risk analysis with regard to future HV interventions. Although procedurally the HV service was not required to follow up this family, it would have been considered good practice for this to have occurred. HV 3 accepted NLCS assessment without challenge or further discussion; this was considered to be a question of professional judgement. As there were no additional health needs for the child it would be acceptable for there to be no contact. However on reflection good practice would have been to have further discussion with NLCS, to explore decision making and to record that the communication had taken place. Also to record the decision of the HV and the plans for future intervention. The use of SBAR (Situation, Background, Assessment and Recommendation) in HV practice promotes comprehensive recording of assessment and decision making. HVs are now required to record which service is to be provided.

4.64 The HV had visited the family at the home address on three separate occasions, twice in 2009 and once in 2011 for routine contacts. The HV recalled Mrs F. had limited English at the initial visit in 2009. Mr F was present at each visit and spoke fluent English. The use of interpreters was not considered nor was there documented consideration regarding supporting Mrs F. to extend her English language. There was no organisational policy at that time that directed practitioners to use an interpreting service if the client's first language was not English. Now there is an Interpreting and Translation Service Policy which is clear that if a client's first language is not English an interpreting service should be offered and use of family members or friends is considered inappropriate. This principle is reiterated in the organisations current DA Policy. Both policies were introduced in mid 2014.

4.65 The current NLAG NHS Foundation Trust Domestic Abuse Pathway operational since February 2014 specifies that screening for DA should take place during Universal health contacts within the first year of a child's life. The screening tool is also used at the ante natal stage. Further screening is recommended at 24-30 month developmental assessment. If the DA screening tool had been in practice, this may have provided an opportunity for Mrs F. to disclose her situation. Current practice provides this opportunity.

4.66 Records indicate that SF was meeting his developmental milestones and no concerns were raised by parents who were both present at all visits. Records do not identify any additional needs for SF or any parental relationship difficulties. The family were assessed to receive standard input via Universal Services.

4.67 NLAG HV at the time of contact did not formally utilise the Assessment Framework (DOH 2000) which supports holistic assessment of children and families. Therefore, routine assessments within Universal contacts, did not formally promote routine exploration of parenting capacity, family and environmental factors. Where children were identified as having additional needs the HV service would use the Assessment Framework within reports. Practice documentation has developed since July 2013 to incorporate SBAR model (Situation Background, Assessment and Recommendation) supporting holistic assessment of all children and families. If used at the time, it may have led to identification of additional needs including parental relationship difficulties and maternal isolation in the community.

4.68 Practice has also developed in regard to information provided to all families in the Parents Held Record (Red Book). Information regarding DA services available is now provided to all families and gives further opportunities for victims to seek support and promote changes in their lives.

4.69 Whilst the Police had clearly identified risk issues and referred to NLCS, the HV documentation does not evidence any single or multi agency risk analysis or management plan or whether it was appropriate for the family to remain in Universal provision or whether Universal Plus would have become more appropriate. Universal Plus provides support for children and families with additional needs utilising the early help offer and would involve assessment

and meetings with lead professionals. There was a lack of professional curiosity in terms of the safety plan the family may have had in place to protect SF and no separate information gathering by HV to inform their intervention.

4.70 There were two episodes of the family moving across county borders, once in May 2009 when they moved into North Lincolnshire and then movement out of the area in early 2012. There is no recorded telephone or written handover to the Lincolnshire Health Visiting team in 2012. Guidance during this period advises telephone handover and completion of written correspondence to the receiving HV for families with additional needs moving out of the area. As there was no analysis or reassessment of need following the information about DA the family remained in Universal provision and this important process of a verbal or written handover did not happen.

4.71 This omission in terms of handover also suggests the records may not have been reviewed by the HV responsible for transferring them. These records were requested by Lincoln and returned for movement out in April 2012. This was after the initial visit had taken place in Lincoln and therefore the Lincoln HV had approached and attended this contact with no prior information or knowledge of the historical DA in North Lincolnshire.

Lincolnshire Community Health Service (LCHS)

4.72 The IMR was conducted by referring to all relevant child health and adult health records via the System One electronic health recording. This included out of hours and walk in centre information. The IMR author read what was recorded by the Health Visitor (HV) in the previous community trust where Mrs F and SF lived until 2012. Mr F was not known to LCHS. A range of relevant policies and procedures were considered and staff interviewed as appropriate. LCHS includes the School Nursing Service.

4.73 On 23 March 2012 the LCHS Health Visiting Team received notification from the GP alerting them to the transfer in of SF and a home visit appointment by the HV was made for 2 April 2012. This all took place within recommended timescales.

4.74 The health records were received by the child health department on 19 June 2012. They were recorded as reviewed by the HV on 2 July 2012. There was no record that the ethnicity or language spoken was considered at the time of the appointment or that an interpreter was required or that the letter sent was translated.

4.75 Good HV practice denotes that for vulnerable children/families a verbal handover is given by the previous HV to the receiving HV or that the receiving HV makes contact with the previous area. This is to ensure early transfer of knowledge and also to support practitioners to take into account any known risks to ensure safety whilst visiting. There was no evidence that either the previous or the receiving HV followed this good practice. Had this taken place the history of DA with the family would have been known to inform risk assessments. The family and healthy lifestyles business unit has already developed and ratified a new policy in 2015. LCHS Policy for the transfer in and out of unborn babies and pre-school age children to a new HV caseload to ensure what was considered good practice previously becomes a clear requirement by practitioners to share and gather information to inform assessment and safe visits. A monthly audit trail to ensure compliance with policy has been developed to be carried out by The Family and Healthy Lifestyles locality leads.

4.76 On 2 April 2012 the HV conducted a home visit, SF was 3 years and 4 months of age. Records indicate “mother (Mrs F) moved two months previously to escape domestic violence to herself, she had not been able to work, develop her English or have friends.” It is recorded that the parents shared contact with their son and that Mr F collected SF. Mrs F told the HV that Mrs F’s Solicitor had organised all contact arrangements and she had signed all documents and she thought negotiations were now closed. It is recorded that Mrs F thinks SF is safe from not being hit by his father but not sure if this will continue. The HV enquired further and was told that SF had witnessed DA but Mr F’s Solicitor said there was no evidence despite Police having been called out on at least one occasion. The HV advised Mrs F that legal issues are not closed and advised her to access women’s aid and seek legal representation. The HV advised of local Chinese families and the Chinese church and informed of groups for Mrs F herself.

4.77 There was no evidence of discussion ,enquiry or professional curiosity regarding current domestic violence or that the HV considered it good practice to complete a DASH risk assessment to ascertain risks as Mrs F was still in regular contact with Mr F especially at hand over times for their son. Routinely asking the question about DA at every contact with clients, if safe to do so, was introduced as part of the training programme for the period April 2014 to March 2015 for all staff in LCHS. However, it has been part of training previously delivered. The Department of Health (DOH 2005) `Responding to Domestic Abuse` promotes direct questions and enquiry about DA of all women seen.

4.78 Professional curiosity, the IMR author felt, should have led to the practitioner asking Mrs F whether she had ever been referred to a Multi Agency Risk Assessment Conference (MARAC) and if the answer was yes to take the necessary to transfer to the local area MARAC team.

4.79 An enquiry about involvement with Children’s Services was not made nor was it ascertained whether Mrs F had a safety plan in place with regard to contact handover times. No risk assessment was recorded or evidence of referral to Children’s Services. There were missed opportunities for further

assessment. Poor quality information gathering and then risk assessment led to flawed decision making and missed opportunities to consider options to protect mother and child although the HV did signpost to Services available.

4.80 The HV identified that SF was due a developmental assessment when three and a half years old. This was recorded as a targeted assessment which suggests the HV wanted to be able to undertake further assessment of the situation and to complete the developmental assessment herself. This normally occurs when the HV wishes to follow up concerns. However, the assessment was carried out by the nursery nurse and not the HV without any reasons being recorded. There is ongoing work in relation to roles and responsibilities with the HV teams. The HV would have had to delegate this work to the Nursery Nurse (NN) at a joint monthly meeting. Apparently any cases at the time not identified as child protection would be delegated to the NN to undertake. There was a missed opportunity at this developmental assessment or when records were reviewed for the HV to have seen Mrs F and reassessed the risks of DA to herself and the child.

4.81 There is no evidence that the NN considered DA or asked questions of Mrs F. She was aware that the couple were sorting contact arrangements out. Whilst the NN confirmed it was her usual practice to ask the question about DA. There was no reference to this or a response in the records. NN stated if there had been a positive reference she would have further assessed risk. The need for clear record keeping around asking the question of DA and recording responses continues to be underpinned in all training packages delivered.

4.82 On 2 July 2012 previous HV records were received and reviewed by the current HV. It was recorded that NLCS had received a referral from Police regarding three incidents of DA. HV records that the HV team are aware of previous history of DA but parents are no longer living together. There is significant research evidence that the risk of DA is still there even if cohabiting has ceased and especially where there is conflict over child contact. It was a missed opportunity to contact Mrs F to check all was well.

4.83 There was no record that an interpreter was required and there were no concerns with regard to language barriers. LCHS have access to the language line for interpreting services. The Walk in Centre (WIC) nurse recorded SF's ethnic category and first language spoken as English.

4.84 On 17 December 2012 following an attendance at Out of Hours (OOH) for a minor illness. The OOH nurse recorded Mr F was waiting outside and that Mrs F was anxious about this, but went out with him willingly. The OOH nurse would not have been alerted to the previous DA as the HV team had not identified DA as a risk. Had they done so the risk alert flag would have been placed on both Mrs F's and her son’s records. All staff are aware to be alert to risk flags on records and the OOH nurse may then have asked the question about DA and made a further assessment when Mrs F appeared anxious at seeing Mr F. This was clearly a missed opportunity perpetuated by poor quality of previous risk assessment leading to others not being alerted to the risk of DA.

4.85 The LCHS discharge guidance pathway in place since 2010 means that all OOH contacts for children are tasked for the HV to review. The HV would have seen the comment about Mrs F's anxiousness at seeing Mr F and with her knowledge of the family and history of DA there was a further missed opportunity to follow this up with a targeted contact to reassess and ask the questions about DA.

4.86 In September 2013 SF started school. There was the one school record entry where he fell and fractured his arm and was admitted to hospital.

Unless a child is identified as vulnerable by the HV and discussed directly with the School Nurse (SN) on school entry then a child's record is closed to the HV team and opened to the SN team at the first contact with the service. SF had not been identified as a vulnerable child and this led to a further missed opportunity for the SN service to be alert to the concerns and to target contact with child and parent.

4.87 A review of the records by the SN when alerted to admission to the hospital ward should have identified previous history of DA. This could have prompted a targeted contact. However, because the SN had not been alerted by the HV to previous DA or about the contact with his father and the potential for a troublesome handover the SN would not have had any reason to suspect this was anything other than a routine case and would not have suspected DA.

Education

4.88 The IMR was competed using information provided by the Interim Head Teacher via records and interview. School records included correspondence with parents and a discussion with the parent support worker.

4.89 SF started school on 12 September 2013 in the reception class having previously attended a pre-school nursery. SF was typically dropped off by his mother Mrs F and collected by her or her new partner Mr H. Three weekends a month SF was collected by his father at the end of school on Fridays and brought back to school on Monday mornings. School were informed of the shared residency order by Mr F. Although school had open channels of communication with Mr F from the point of his sons admission in September the family in the main was seen to comprise of mother Mrs F, her partner Mr H and SF.

4.90 On 30 September 2013 SF fractured his arm by falling from the lower section of the climbing frame. Mrs F came into school to go with him to hospital. Mum informed Dad of the injury whilst she was waiting for the ambulance.

4.91 On 31 January 2014 Mr F met with the Parent Support Advisor (PSA) to clarify his position in regard to his involvement with his son. Mr F indicated he would "prefer private education." The relationship with Mrs F was not felt to be great as dad feels mum to be inconsistent. He would like the school to note any concerns they have regarding SF and home. Mr F was concerned Mrs F may not prioritise reading etc. Mr F says "there is a Court Order in place and Mrs F is not able to take their son to China."

4.92 On 21 March 2014 Mr F requested the next available appointment with the Parent Support Advisor. An appointment was made for 28 March 2014. The purpose of the meeting was to find out more about the child and get to know the parents and to build professional relationship in order to better support SF.

4.93 A letter was sent to both parents inviting them to attend a meeting on Friday 28 March to discuss the class teachers concerns about SF's behaviour. The Class Teacher and PSA were uncomfortable to meet with parents together as they were divorced. The Head Teacher's view was that parents needed to meet together and put aside their differences on this occasion. There was no historical information available to the school regarding previous DA or awareness of the indicators of increasing risk e.g. conflict over child care.

4.94 On 27 March 2014 when Mrs F dropped off her son she asked the class teacher if she could speak with her at the end of the day. This was because she said Mr F would not let her speak in the meeting and would blame the change in her son's behaviour on her. In the brief conversation after school Mrs F said she felt the change in behaviour and bad language was due to time spent at his father's home because he had a new partner with two teenage children. There appears to be a lack of any exploratory questions about reasons behind Mr F's alleged controlling behaviour.

4.95 The meeting took place with both parents present. Mr F gave details of what SF behaviour was like at home. He did not blame Mrs F but was struggling to manage the behaviour. Neither parent made eye contact with the other. Staff felt "it was like conducting a parallel conversation." Mrs F was very quiet and Mr F was far more eloquent and "tried to make an impression." Continuing support was provided for Mr F through weekly contact with the class teacher on a Friday after school.

<u>Lincolnshire Children's Services</u>

4.96 Lincolnshire Children's Services had little knowledge of the family until the death of Mrs F. SF and his mother had attended one "stay and play" session on 29 July 2013 but there was no further contact with the family.

4.97 There was one notification prior to the homicide this was on 26 February 2014 and involved Mr H and Mrs F. This had been assessed as standard risk DA using the DASH by police and no concerns had been identified about SF therefore as per procedure this was logged as a notification only and no action was taken.

4.98 When the Police began investigating the murder on 17 June 2014 the Police did not involve Children's Services despite the child living with his mother at the time of her death.

4.99 A Police Officer from Lincolnshire CID rang the Lincoln Family Assessment and Support Team (FAST) directly for information but would not provide any details. This was incorrect procedure. The Police Officer should have requested information from the safeguarding unit or out of hours via the

customer service centre. A strategy discussion should have been held and joint decisions made around the care of SF. None of this occurred.

4.100 On 19 June 2014 a police officer from the Serious Crime Unit requested information from the safeguarding unit about the family, however, a referral was not made to Children's Services. Children's Services became involved on 20 June 2014 when they were informed by Police that SF was in the care of his father who was about to be arrested. A worker went with the Police to Grimsby and SF was taken into the care of the Local Authority and a foster placement was found. SF was made subject to Public Law Proceedings and was placed on an Interim Care Order.

4.101 There is a recommendation by Lincolnshire Police relating to information sharing and communication with Children's Services where there are children involved in Homicide enquiries.

North Lincolnshire Children's Services

4.102 The IMR was completed using information from records held by North Lincolnshire Council's Care First System.

4.103 The agency received a contact referral on 8 December 2011 following three incidents of DA within a 2 year period being reported by Police. A referral was processed and recommended an initial assessment. The initial assessment was undertaken by a Social Worker.

4.104 Following a home visit and observation of the child SF, it was concluded that there was no significant impact or impairment of the health and development of the child to suggest that he was a child in need in line with section 17 of the Children's Act.

4.105 Both Mrs F and Mr F were interviewed independently. Recommendation was made for Mrs F to be supported by universal services such as Carr Gomm and Women's Aid and she was sign posted to these services.

4.106 Investigations for the purposes of preparing this review report did not identify that Mrs F had any contact with the universal services referred to above. On reflection NLCS consider it may have been beneficial, given the risk factors surrounding the break- up of a relationship, to have followed up with Mrs F whether she had a support network or a relationship with a trusted adult outside of the home situation.

5. Analysis of involvement relating to the specific Terms of Reference

5.1 Did the agency have policies and procedures for DASH risk assessments and risk management for domestic violence victims and perpetrators ad were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

5.1.0 Back in 2008 Essex Police were using the DASH risk assessment process in line with their then current policy and procedure. The summary report indicated practice at the time was in line with the expectation of the agency.

5.1.1 Humberside Police have a Force Practice Direction on dealing with DA last updated in 2007 prior to the incidents in 2009. The Policy document is based on national guidance issued by the Association of Chief Police Officers (ACPO). There is a dedicated Force lead for DA and there is a specialist DV Unit within the Protecting Vulnerable People Unit. The DV Co-ordinators review all incidents of DA and refer cases and share information as necessary. Humberside Police were using the risk assessment SPECSS a recognised DA assessment tool during their time of contact with the family and a specific form the F913 to record the assessment and other DA information. Following all three DA incidents the correct process was followed and the F913 completed. They were all reviewed by the DV Co-ordinator who increased the risk from standard to medium on the first categorisation in 2009. The other two assessments were agreed as medium. It was appropriate to increase the risk given the history and unreported incidents of DA within the family.

5.1.2 At the incident in November 2009 both Mrs F and Mr F considered they were both victims and agreed they were both perpetrators and the crime reports and files reflect this. However, in terms of the final analysis by Police the Domestic Violence record only records Mrs F as the victim and Mr F as the perpetrator. With hindsight it would have been better practice for both to be recorded as victim and perpetrator. For future intelligence and risk assessments it is important to capture that both parties were subject to and agreed the counter allegations. In line with policy as it was then there was no referral to Children's Services even though a child was present. This policy has since changed and a referral would now be required.

5.1.3 At the second incident of abuse in November 2011 the Officers did not attend the home address and therefore did not gather all the relevant information in order to make a full risk assessment. Officers attending interviewed Mrs F away from the home and did not visit the home address to see either Mr F, the alleged perpetrator, or the three year old son. The fact that the alleged perpetrator was not seen was not identified during the secondary risk assessment. Policy makes it clear all parties should be interviewed.

5.1.4 At the last recorded incident in December 2011, Mr F was arrested and detained but released without charge on the basis of involvement of the DV Unit and involvement of NLCS and due to the advice given to have counselling. It was recorded that the risk may be increased to high, however, there was no further follow up to confirm counselling or the implications of NLCS assessment of no further action and the risk was not reassessed. Had the risk been high this would have triggered a referral to MARAC, this did not occur .As the incident was referred to Children's Services to undertake an initial assessment of the family this would have involved liaison with partner agencies. The Humberside Police consider the circumstances of this case would have been unlikely to have reached the threshold for a referral to

MARAC – the mention of high risk was made by the attending officers and not by the DVC staff who undertook the secondary risk assessment.

5.1.5 NLCS Social Workers (SW)do not routinely complete separate DASH risk assessments however SWs have been trained regarding the use of DASH and elements of these are considered within the risk analysis framework which is used in all cases within NLCS.

5.1.6 NLAG HV had a Domestic Violence policy at the time of their contact. On review of the policy it was recognised that there are limitations in respect of DASH and MARAC training. This has now been addressed within the updated DA Policy which provides specific practitioner responsibilities with regard to the use of the DA Screening Tool, DASH, assessment and MARAC processes. The new policy also gives specific direction in relation to safeguarding children for front line practice.

5.1.7 Lincolnshire Police current Domestic Violence and Abuse Policy has been in place since September 2013. It is a comprehensive policy which contains detailed procedures for dealing with concerns about DA including procedures for DASH risk assessments.

5.1.8 The DASH risk assessment completed in respect of 22 February 2014 was completed fully with the exception of one error. The assessment of standard risk would appear accurate. However, a further intelligence check via the Police National Database (PND) was not undertaken. Had it been done it would have shown the history of DA in the Gainsborough area when Mrs F lived with her husband. Whilst this information would not have altered the standard risk assessment it is Force Policy in completing the DASH risk assessment to check the PND. It would have alerted officers to the fact that SF had lived with DA previously and potentially was experiencing it again (although he was not present at the incident on 22 February 2014 and was staying with relatives). It would have allowed officers to consider whether SF was at risk of significant harm and to report those concerns if necessary via the Force's "Stop Abuse" process which involves further research and possible referral to Children's Services.

5.1.9 NHS providers and commissioners within Lincolnshire work in partnership with other agencies to ensure a consistent approach to identifying and acting in support of victims of DA. Primary Care and GP Surgeries have access to relevant policies and procedures with regards to safeguarding adults and children which are accessible through Clinical Commissioning Group websites with clear links to the safeguarding and DA partnership boards and further information.

5.1.10 As there was never a disclosure of DA, nor were concerns raised by the primary care team that DA may have been an issue, neither suspected DA and therefore were not involved in making any assessments. The GP became concerned that Mrs F was suffering from psychological difficulties in relation to her health and well being because of her continued anxiety about a range of health issues. However, Mrs F was killed before any action in relation to this could be taken. Mrs F did disclose to the GP she was suffering

anxiety and panic and was prescribed Beta Blocker. The reasons for her feelings did not appear to be explored.

5.1.11 It is acknowledged that there is a variant level of skill and competence in primary care regarding some issues within safeguarding e.g. Domestic Abuse. Currently, together with the DA partnership, there is a project underway to strengthen the primary care response specifically working with GP practices to provide specialist training and support in completion of the Coordinated Action Against Domestic Abuse (CAADA) – DASH risk assessment (Now Safer Lives).

5.1.12 Through training and supervision LCHS practitioners are made aware of and encouraged to access the LCHS website and the LSCB (Local Safeguarding Children's Board) web pages where there are links to national documents and guidance in relation to Domestic Violence including the MARAC operating protocol. The ACPO/CAADA/DASH risk assessment and referral forms, the MARAC toolkit for health visitors, school nurses and midwives are also available.

5.1.13 There is a Domestic Violence/Abuse section within the safeguarding part of the LCHS intranet site which all practitioners can access. LCHS have a lead nurse in post for domestic abuse and a team of deputy named nurses. Domestic Violence has been the focus of the mandatory safeguarding training programme that continues to be rolled out to all staff. The aim was to increase practitioners' awareness and confidence in recognising DA and to routinely ask the question about domestic violence.

5.1.14 Despite policies and processes being in place the DASH risk assessment was not used when Mrs F disclosed she had moved to flee DA. There is no evidence of any questions being asked regarding DA or any follow up or information sharing taking place with other relevant agencies. The HV did signpost Mrs F to local services for support but these were not accessed.

5.1.15 The designated safeguarding lead in the school had completed two days training and refresher training in 2013 and the school had received whole school safeguarding awareness in 2012 and again in 2014.The Parent Support Advisor had attended Domestic Abuse training as part of her previous role in another school. Via the training provided schools are reminded to seek appropriate training through the Lincolnshire Safeguarding Children's Board.

5.1.16 There was a member of staff in the school who had been trained in DA and MARAC procedures (in a different role) and was working closely with the family, however, that member of staff did not have any evidence to indicate there was or had been DA.

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

5.2.1 Essex Police undertook a DASH risk assessment in March 2008 following a heated verbal argument between Mr and Mrs F. The risk assessment was

standard, no offences having been committed. In line with policy, information was provided and no further action taken.

5.2.2 For Humberside Police the three reported DA incidents provided key points for assessment and decision making in the case. The incident of 19 November 2011 did provide an opportunity for a full assessment and the opportunity to gather further information, share the information and make informed decisions. This did not occur as Police only interviewed Mrs F away from the home address and did not follow up the contact by interviewing Mr F the alleged perpetrator or to see the son who was three years old and vulnerable given his age and dependency. This was not picked up and challenged by the officer from the Domestic Violence Unit who reviewed the case subsequently.

5.2.3 Despite Mr F being arrested and held in custody for a short time in December 2011 he was released without charge and there was no further action. Children's Services were informed in order to make an assessment. The rationale to take no further action against Mr F has been reviewed as part of this report and discussed in detail with the officer involved who, with hindsight, considers a prosecution should have been pursued. This would have reinforced the message to Mr F that his behaviour was unacceptable . It would have also supported Mrs F and given her advice and assistance. Even so it was soon after this that Mrs F left her husband taking her young son and moved to independent living in a different city

5.2.4 There were three opportunities for NLAG HV service to make assessments. There was no DA Screening Tool used at the time and it was only when they were informed by NLCS of the DA did they become aware. Current policy would support screening for DA at regular intervals .However even when they did become aware of DA they did not take the necessary steps to discuss the situation and make a reassessment in relation to their intervention, which was not a procedural expectation but would have been considered good practice.

5.2.5 North Lincolnshire Children's Services undertook a Section 17 assessment in December 2011. They did not consider SF was a child in need at that time in line with policy and instead sign posted Mrs F to services that could support her.

5.2.6 For Lincolnshire Police the opportunities for assessment and decision making followed the incident of 22 February 2014 when Mrs F dialled 999 as her then partner would not leave her home. Also the early stages of the murder investigation following the discovery of Mrs F body on 17 June 2014 when they placed SF with Mr F.

5.2.7 The assessment made and decision taken by the officer who attended on 22 February 2014 and the officer who reviewed the incident and risk assessment the following day were not as informed as they might have been. The PND had not been checked and therefore information was missing and

the assessment was not made based upon a full history and lacked the rigour expected.

5.2.8 The assessment and decisions made in relation to placing SF with his father and considering Mr F as a suspect would have been enhanced had this full information been available and if the Police had made an early referral to Children's Services to discuss the best options for the child.

5.2.9 The service delivered to Mrs F by the GPs she consulted was based upon her presenting/reporting concerns and information she herself provided. This is not uncommon within General Practice. Allocated appointment times are of ten minutes duration and focus is on the self reported issues which the GP advises, refers and responds to.

5.2.10 GPs as community resources, providers of health care, gatekeepers to services and commissioners of other services are acknowledged as having a critical role in preventing and responding to abuse against women and the associated health impact. Under the current national contract the appointment time allocation will remain a challenge in the future for GPs to use professional curiosity and explore patient circumstances beyond those freely disclosed. The GPs Mrs F consulted did not record any knowledge or indications or concerns involving DA.

5.2.11 Mrs F consulted several GPs upon an increasing number of occasions with a variety of health concerns. Her last consulted GP advised that should presentations have persisted the practice would have considered whether mental health services would have been a further option to support Mrs F, however, the catastrophic event preceded any potential further consultation.

5.2.12 The transfer-in visit is recognised as an opportunity for assessment by LCHS to gather and share information, liaise with other agencies and develop a safeguarding action plan if necessary. There was a lack of professional curiosity and poor communication with regards to seeking information about the family from previous health visitors following the transfer-in visit and a lack of any robust handover from the previous health visitor. No practitioners routinely asked the question about DA and an assumption was made that because the parents no longer lived together that there was no further risk of DA incidents.

5.2.13 Historic information relating to DA was not analysed following the transfer-in visit when Mrs F alluded to her experiences of DA nor on receipt of the previous HV's records.

5.2.14 The HV's direct handover to the SN team would have been a further opportunity for assessment. However, as the HV had not identified the risks there was no verbal handover recorded when SF commenced school.

5.2.15 The lack of DA risk alert flags on SF and Mrs F's records led to a further missed opportunity at the OOH visit on 17 December 2012 to ask appropriate questions. At all LCHS contacts routine questions regarding DA should have taken place.

5.2.16 The OOH nurse did not explore the anxiety shown by Mrs F when she became aware Mr F was waiting outside the OOH department. Yet she recorded the anxiety. This was a missed opportunity to discuss the potential for DA with Mrs F in a safe environment and to refer on if appropriate and to alert the HV team.

5.2.17 When SF started school in September 2013 his behaviour became a focus for discussion between the class teacher, Parent Support Advisor, his mother and his father. A meeting was arranged following a request from Mr F and a concern from school. Despite evidence that the parents did not co-operate well and that Mrs F had approached the class teacher prior to the joint meeting expressing that she felt Mr F would not allow her to contribute to the meeting and may blame her for her son's behaviour, the head teacher decided that both parents should be present.

5.2.18 As the meeting was in relation to SF's behaviour and setting boundaries, it was not unreasonable to encourage both parents to attend, the aim being to establish consistency across the three environments, school, mother's home and father's home.

5.2.19 Whilst the joint meeting may have been working towards the best interest of SF both the class teacher and the PSA felt uncomfortable with this approach, knowing the couple were divorced in this case. There was a lack of professional curiosity and explorative questions by staff to gather information and understand what underpinned the dynamics that were affecting this family and possibly the child's behaviour. Had the school been aware of the history there may have been a different view to the couple meeting together.

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

5.3.1 The risk identification and grading levels reached were correct in the light of the decisions and information known at the time by both Essex and Humberside Police. It was appropriate to increase the risk level in November 2009 from standard to medium given the history provided and the unreported incidents of DA within the family.

5.3.2 The assessment in December 2011 identified risk categorisation as medium but with the proviso "Risk is involved here as they live together and years of DA has been detailed to Police. However, graded medium at this time, as the offender is in custody and therefore no current risk to Mrs F, however, depending on the outcome of the custody case against Mr F consideration needs to be given to the officer in charge re-grading this as High if warranted". This was considered good practice as the officers were thinking beyond the presenting issues to possible longer term risks. The child SF also made a comment whilst injury photos were being taken that "Daddy did it". Mr

F was interviewed denied the charge and released from custody. The rationale for this was the minor injuries, lack of witnesses, denial by Mr F and that further work will go into the family from the Domestic Violence Co-ordinator and NLCS

5.3.3 There was a delay in NLCS visiting until the following day. When they undertook a Section 17 assessment and in line with their findings did not take any further action although signposted to services available to assist. On reflection they consider the assessment would have benefitted from further analysis of the potential impact of the victim's culture and isolation upon her vulnerability and support needs. There was no further action taken by the Police. The incident was reviewed on 28 December however the categorisation was not increased despite earlier comments. Had it become “high risk” the case would have been referred to MARAC, a process which would have provided Mrs F with support and consideration of a protection plan and a multi agency assessment.

5.3.4 The Police had clearly identified a risk to NLCS. The communication from NLCS to NLAG HV gave the information about three incidents of DA. However, HV documentation does not evidence any single or multi-agency risk analysis or risk management of the case or consideration of intervention increasing from Universal to Universal Plus.

5.3.5 At the 19 November 2011 incident, officers informed Mrs F that they would arrange some help for her from the DV unit and external agencies. The incident occurred on a Saturday and at that time the DVU did not work weekends. The incident was marked for their attention on the Monday. From April 2015 staff work weekends within the DVU to deal with such requests so that they are not unnecessarily delayed.

5.3.6 Mrs F was contacted and spoke to DV Unit staff. The help given was contact numbers for legal advice . There was no risk management plan developed.

5.3.7 Lincolnshire Police took no action following the incident on 22 February and therefore no risk management plan was put in place. The decision was based upon the outcome of the DASH risk assessment which correctly categorised the risk as standard. No services were offered as referred to earlier. No PND check was made which would have led to further enquiries being made with Humberside Force.

5.3.8 Following the murder on 17 June, SF was placed with his father who was not a suspect at that time and who shared custody of his son with his ex wife by way of a Court Order. The lack of PND check meant that the history of DA in Humberside was not known by police making these decisions. There was a lack of reference or referral to Children’s Services during the early assessment and decision making of the enquiry which is considered as inappropriate.

5.3.9 At the transfer in meeting the HV gave Mrs F advice on seeking legal advice in her own right and about local domestic abuse services. This was not followed up to discuss whether she had actioned this advice. Had previous HVs been contacted and information shared this would have contributed to a

risk assessment within the family being considered. There should have been an assessment of risk and appropriate help and support offered, or referrals on made for assistance.

5.3.10 The extent to which SF's mother was uncomfortable in the presence of his father was unknown. There was some evidence that communication was poor. In the light of the information that mother felt disempowered in a meeting with father, it would have been good practice for the school to follow this up with mother, however this did not happen before her death.

5.4 Is there evidence historical information was analysed to provide a holistic assessment of risk?

5.4.1 Humberside Police used historical information they had gathered from the parties to assess each incident of DA they were called to. The historic information about the Essex Incident in March 2008 was pre PND and therefore not available on the system and could not be used to inform the later assessment.

5.4.2 Lincolnshire Police searched their own force intelligence systems for information relating to Mrs F, Mr H and SF before the risk level was finalised. The Force Intelligence System contained no information about the victim's history of DA but a check of the Police National Database (PND) would have provided some of that information.

5.4.3 Lincolnshire Police "Use of PND policy and procedures document" states that PND checks should only be carried out after local intelligence systems have been checked. It provides guidance and confirms however that local business rules state that a check should be performed for "all suspects and offenders for child protection, vulnerable adult and domestic abuse".

5.4.4 The Force's Domestic Violence and Abuse Policy states in relation to the completion of the DASH risk assessment that the PND should be checked on all parties. Following a previous Serious Case Review in Lincolnshire during 2013 a lack of necessary PND checks resulted in a standardised procedure being introduced by the PPU and communicated to all PPU staff. The reviewing officer for the DASH did not pick up the issue that the PND had not been checked.

5.4.5 Had the Humberside information been analysed and taken into account as part of the holistic risk assessment it would have alerted officers to the fact the child SF had lived with DA when he resided with his father and potentially was experiencing it again. It would have allowed officers to consider whether SF was at risk of significant harm and to report those concerns if necessary via the Force's "Stop Abuse Process". This involves the referral of any concern to the PPU CRU who will undertake further research, record it and make a full referral if necessary.

5.4.6 This case demonstrates the value of undertaking PND checks in respect of all DA cases and the force needs to raise awareness of the value of the PND and ensure that policies, procedures and guidelines in respect of its use in DA cases are complied with.

5.4.7 Information gathering within NLAG HV service during this historical period did not promote the exploration of environmental and family factors. This is an area that has developed to support holistic assessment, neither was NLCS information about DA a trigger to liaise and reassess need and input due to the fact that the child was not considered to have additional health needs.

5.4.8 This multi-agency review has identified that the HV in April 2012 recorded in the child's System One Records an entry that "his mother had disclosed she had moved to the area to flee DA". This information would not, as standard practice, have been included onto the mother's record.

5.4.9 The GP practice at the time of Mrs F's death was utilising the same system but notes on the child's record would not have transferred onto other family members records without active input. Had this information been shared with the GP it would have enabled him to ask the questions and possibly make a relevant contribution to manage the DA.

5.4.10 The HV received the electronic "System One" records three months after the transfer in visit. She did review them and made a decision based upon her professional judgement and not on a risk assessment i.e. as the couple were no longer living together that there was a low risk and no need for intervention. Based upon research this view is not supported and the loss of the family and conflict over child contact etc can actually increase risk.

5.4.11 It is the responsibility of the school to ensure they have adequate information from a child's pre-school to support the school to meet the child's needs when they attend primary school. There was no evidence of concerns from the pre-school.

5.5 **Did the agency comply with Domestic Violence protocols agreed with other agencies including information sharing protocols? Was inter and intra agency communication efficient and effective?**

5.5.1 Humberside Police complied with protocols agreed with partner agencies in relation to the sharing of information around the incidents of Domestic Abuse. The intra agency communication following the incident of 6 December 2011 suggesting that the officer in charge re-assess risk following the outcome of the Court decision relating to Mr F did not appear effective. There was no evidence that the increase in risk categorisation to high was actively considered and recorded. Prosecution was not pursued although with hindsight it is considered that this should have occurred. NLCS liaised with Police, HV and the nursery regarding the outcome of their assessment and the next steps.

5.5.2 There was a lack of robust agency communication between NLAG HV and NLCS when information was shared about the Section 17 Initial Assessment. This was also true when the case was transferred from NLAG HV to Lincoln HV. This meant that the Lincoln HV did not have all the relevant information when the transfer-in home visit was undertaken.

5.5.3 Information was shared with Children's Services by Lincolnshire Police following the incident of 22 February 2014. However, in line with protocol this

did not involve Children's Services contact with the family. Had the PND information been checked and included then that information would also have been shared and may have engendered a different response.

5.5.4 Information about SF prior to Mr F's arrest was not shared appropriately by Police and the correct procedure was not followed initially. SF was placed with his father without Children's Services involvement via a strategy discussion or joint decision making around his care as would be expected in the circumstances. Once Mr F was to be arrested, three days later, appropriate protocols were complied with and the agencies worked together to place SF in a safe and secure situation.

5.5.5 Although there was a clear indication of previous domestic abuse from Mrs F and via records, the HV made an assumption that because the adults were no longer living together that there was no longer domestic abuse, therefore DA protocols were not considered or followed. Expectations would have been that the HV should have completed a verbal handover of the historic domestic violence information to the SN Team and informed them that both parents had shared contact and that handovers had the potential for difficulties.

5.5.6 Communication within school was efficient and effective. Issues were raised by school and parents and appropriate strategies put in place. Whilst there were different views about both parents attending the meeting it was discussed and a decision arrived at. The needs identified were in relation to SF's behaviour and were being met by the school initiatives.

5.6 **Were practitioners sensitive to the needs of the victim and the alleged perpetrator, knowledgeable about potential indicators of DA and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect practitioners given their level of training and knowledge to fulfil these expectations?**

5.6.1 In general Police in Essex, Humberside and Lincolnshire were sensitive to the needs of the victim and alleged perpetrator, were knowledgeable about potential indicators of DA and were aware of what to do if they had concerns about a victim or perpetrator. Appropriate levels of training had been given to those involved around domestic violence, indicators of abuse, risk identification analysis and risk assessment linked to force policy for dealing with Domestic Abuse.

5.6.2 In Humberside in December 2011 when Mr F was arrested he was released without charge, at this point officers could have considered asking Mrs F if she required the services of a refuge for her safety if Mr F intended to return home. There is no evidence this occurred. A referral was made to Children's Services and an assessment undertaken by them. Both Mrs F and Mr F were interviewed independently and information provided to Mrs F about services available to support her.

5.6.3 In November 2011 Mrs F informed Police when they attended that she had tried unsuccessfully to contact Women's Aid. Rather than providing details again given her language and cultural differences, her isolation and lack of

family support officers could have considered facilitating the contact to assist the process.

5.6.4 Neither NLAG HV or NLCS sufficiently considered the implication of Mrs F`s lack of English language and her isolation from family sufficiently. Also training for HVs has had an increased focus on DASH and MARAC as well as safeguarding risk analysis to aid the identification of DA and what to do in such circumstances.

5.6.5 In Lincolnshire in February 2014 the reviewing officer had considered whether Mr H should have been regarded as a victim of DA and whether a DASH risk assessment should have been completed in respect of him in view of the comments made on the incident log about his crying and pleading in the background.

5.6.6 However, it was Ms F who made the complaint and information suggested Mr H was the instigator of a verbal disagreement. In view of the circumstances the reviewing officer believed the incident had been assessed correctly and actions were appropriate.

5.6.7 There had been no disclosure of abuse to hospitals or the GP. The review explored whether GPs were sensitive and the entries confirmed appropriate responses to presenting symptoms and requests from the family. The only exception was the lack of professional curiosity and explorative questions when Mrs F disclosed anxiety and feelings of panic.

5.6.8 Within Lincolnshire there are plans for all GPs to train to Safeguarding Level 3 in both Safeguarding children and adults. Nationally the required standard for GPs remains at level 2, although the GP in this case had completed Level 3.

5.6.9 The Health Visitor was told by Mrs F that she moved to flee domestic abuse and whilst the HV gave immediate advice about seeking legal advice and the support that was available locally, she did not follow this up with any contact to review whether Mrs F had managed to pursue the advice and for an update on the situation.

5.6.10 The profile of DA within LCHS was raised by the appointment, in 2010, of the domestic abuse lead nurse. Domestic Abuse is high profile in the Trust Information was shared with all staff via the monthly team brief. It would have been reasonable to expect the HV, given the level of training and knowledge to fulfil DA practice expectations.

5.6.11 The school had good relationships with both parents. School responded to the parents enquiries and offered support both practically and advisory to support the issues raised in relation to SF behaviour.

5.6.12 No clear indicator of domestic abuse was recognised by the school. . There was a member of staff who was knowledgeable about potential indicators and would have been aware of what to do had there been concerns

5.7 **Did the practitioners seek and were given appropriate levels of supervision, advice and guidance during the decision making process?**

Was there sufficient management accountability for decision making? Were Senior Managers or other organisations and professionals involved at points in the case where they should have been?

5.7.1 There was evidence within the report from Essex Police that the supervising police officer checked the DASH assessment and agreed it. Also in the IMR from Humberside that was a confirmation that officers sought advice from supervisors in dealing with the incidents of DA on 14 November 2009 and 6 December 2011. There is also evidence of oversight by supervisors in relation to key points within the assessments. The referral to NL Children's Services was appropriate. There was evidence that the social worker received supervision including a clear and detailed written briefing regarding areas of possible concern to be considered. The assessment was signed off by a senior social worker who had responsibility for overall supervision of the case. However, in relation to the November 2011 police incident, the reviewing police officer did not challenge the absence of contact with Mr F and that the child was not seen or his welfare checked. This issue has been subject of changes to practice already made by Humberside Police.

5.7.2 Whilst supervision, advice and guidance is available three monthly for HVs this was not sourced in this case and therefore no management oversight was provided.

5.7.3 The Lincolnshire Police incident of 22 February 2014 resulted in a standard risk categorisation and did not require any supervision. The officer who reviewed the incident had been briefed and was supervised by the Sergeant in the PPU Central Referral Unit (CRU).

5.7.4 Following the discovery of Mrs F's body there was considerable evidence of supervision and management accountability at all stages within the Police. An accredited Senior Investigating Officer (SIO) was appointed and was accountable to a Gold Group.

5.7.5 A Gold Group is established to oversee major crime investigations considered to be critical incidents and likely to be of particular concern to the community. It was chaired by The Deputy Chief Constable on this occasion.

5.7.6 The issue of placing the child with his father without appropriate reference to the PPU CRU and to Children's Services and a strategy discussion taking place has already been covered in this report and is subject to a recommendation by Police. There has already been the opportunity to bring this issue to the attention of a cross section of SIO's in the East Midlands region at a meeting in March 2015 which the IMR author attended and provided an input. Compliance continues to be monitored by the East Midlands SOU regional review unit as part of its role of undertaking reviews and formal de-briefs of all homicide investigations.

5.7.7 The IMR author is satisfied that the SIO and all his staff acted in the best interest of the child SF at all times. There was an awareness shared that Mr F had a Court Order giving him custody of SF, he was not initially considered to be a suspect in the murder, as soon as he was his son was removed into the care of the Local Authority.

5.7.8 Each GP practice in Lincolnshire has an identified safeguarding lead, who offers advice and support. There is no national requirement for GPs to receive supervision although as detailed they have routes and sources for advice should they wish to discuss a case or seek guidance regarding management.

5.7.9 As detailed there is no evidence concerns with regards to DA within the family were disclosed to hospital and GP staff and as a consequence there was no request made to the safeguarding team for supervisory advice or guidance.

5.7.10 The HV in Lincoln attended for individual and group supervision for safeguarding as per LCHS supervisory policy. This case was not presented for discussion by the HV at supervision. The HV was aware of the need to complete MARAC training but has since left the organisation and has retired from nursing without completing the MARAC training.

5.7.11 The NN and OOH nurse did not raise this case for discussion in supervision or share concerns with their line managers. Other organisations were not involved although had a DASH been completed by the HV information may have been shared with other services to consider the risk posed and any intervention that may have been suitable.

5.7.12 The decision made in this case by the school focused around addressing SF's behavioural needs. Senior Management decided to involve a Parent Support Advisor to work with the family and Senior Management were consulted on and agreed the strategy to invite parents to meet, initiating a small group intervention and offering a parenting course. Support was offered to the father on a weekly basis. At this time the PSA left the school and there was an absent head teacher. There did not appear to be a replacement to continue the work. The school should consider having procedures in place for monitoring children for whom intervention is required.

5.8 **When and in what way were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies? Had the victim disclosed to anyone and if so was the response appropriate?**

5.8.1 There is evidence that Mrs F's wishes and feelings were ascertained by the Police Officers who visited in Essex and attended the 999 calls in relation to DA both in Humberside and Lincolnshire. This information was used in relation to decision making around actions taken. In Lincolnshire Mrs F did not give her permission for details to be shared with partner agencies. In Humberside she was prepared for the information to be shared.

5.8.2 Relevant information was provided to Mrs F both in written form and via telephone conversations by the Domestic Violence Co-ordinator e.g. she requested information in relation to seeking legal advice regarding custody of

their child. She was sign posted to other agencies e.g. Women's Aid. However, she did tell police following the November 2011 call out that she had been trying to contact them but had not been successful. Given her isolated situation and cultural differences positive action by the Police and NLCS in December 2011 to enable communication may have assisted her and helped her to explore the options, choices and support available to her. On reflection NLCS consider it may have been beneficial to have followed this up with Mrs F to determine whether she had a support network outside of her home situation.

5.8.3 NLAG HV service recognises that the use of interpreting services and asking specific questions about DA may have assisted Mrs F in making her wishes and feelings known and enabled options to have been identified and discussed with her. The family did not disclose any DA to the HV from North Lincolnshire. The HV service did not complete a follow up visit after the notification from NLCS that they had completed their assessment and no further action was to be taken. Although procedurally the HV service is not required to follow up the family it would be considered "good practice" for this to have occurred. In this respect this could be considered to be a missed opportunity for Mrs F.

5.8.4 The GP records do not detail any disclosure of DA by Mrs F to the GPs she consulted. The focus of the hospital and GP contact was her health concerns when her feelings and wishes were ascertained they led to the referrals and investigations as she requested.

5.8.5 Mrs F did make a clear disclosure to the HV in Lincoln during the transfer in visit. However, a poor quality risk assessment meant that Mrs F wishes and feelings were not obtained. There is no record of any options or choices being given to Mrs F to enable informed decision making. She was signposted to local Chinese families and church, local groups at Sure Start and how to access Women's Aid. Mrs F was informed about finding help in seeking employment advice and benefits advice. The HV advised Mrs F to seek legal representation in her own right in relation to the custody of her son and to contact her again if she needed support.

5.8.6 Mrs F had a good relationship with the school. She attended parents evening and approached the class teacher to discuss issues when necessary. Mrs F informed the class teacher that she did not want to meet with her ex husband because he would not allow her to give her views. The decision to hold a joint meeting was seen by the head teacher to be in the best interests of the child. The school had not identified domestic abuse as a feature of this family.

5.9 **What was known about the alleged perpetrator? Had MAPPA been considered?**

5.9.1 This case did not fit the criteria for a referral to MAPPA (Multi Agency Public Protection Arrangements).

5.9.2 Mr F did not have any previous convictions. He was not considered to present a risk of serious harm.

5.9.3 Mr F communicated regularly with school. He shared the contact rota for his son with the school and showed himself to be highly proactive in his parenting. He informed the PSA he wanted maximum involvement with his son's education and had put himself on the parenting course.

5.9.4 From the information available there were no further DA incidents after the one in December 2011 when the couple separated soon afterwards.

5.10 **Was information recorded and shared where appropriate?**

5.10.1 Information was recorded and shared as appropriate and in line with most agencies expectations. NLAG HV service found that their recording contained limited information following the telephone call and letter from NLCS and that there was no clear recorded plan of the next steps.

5.10.2 United Lincolnshire Hospital Trust noted that within SF documentations it refers to "both parents in residence on ward" when he broke his arm. However, there is no clarification as to whether this was his mother and biological father or mother and her current partner. Hospital staff members are always encouraged to provide accurate documentation and recording relating to those accompanying patients, especially children. This is reiterated through training modules and will be continually reinforced at every opportunity in light of this review.

5.10.3 Significant information was recorded by the HV in Lincoln and the records were available to subsequent staff i.e. nursery nurse, school nurse. In line with expectations there appears to have been gaps in verbal sharing of information at handover and pre assessment e.g. the transfer-in protocol. There was no sharing of information with other agencies as the lack of a quality risk assessment and DASH led to flawed decision making and did not trigger the risk management actions of making referrals to other agencies and the subsequent communications necessary to decide on the best way forward. The transfer-in protocol has been rewritten as a policy and ratified in April 2015.

5.10.4 The school shared information appropriately. There was evidence of how information was communicated to parents but no evidence was seen on SF's records of how his behaviour was being monitored. This issue is subject of recommendation for education arising from the review

5.10.5 The Police in Humberside and Lincolnshire did not check all sources of recorded information available to them in order to inform their risk assessment and to take account of historic events e.g. PND checks.

5.11 **Were procedures sensitive to the ethnic, cultural linguistic and religious identity of the victim, the alleged perpetrator and their families? Was consideration for vulnerable and disability necessary? How accessible were the services for the victim and the alleged perpetrator?**

5.11.1 Mrs F was born and brought up in China. Mr F was of Chinese heritage but born in Blackburn and brought up in the UK. Mrs F married on her birthday on 27 December 2007 and came to the UK in late February 2008. Initially

lack of English language was an issue. The use of family for translation purposes was clearly recorded during two GP consultations in the early part of 2009. It is now widely acknowledged that best practice would not support the use of a family member in the translation of health care issues. Today GPs all have access to online translation service as required.

5.11.2 During her six week routine post natal check Mrs F's English was documented as "poor and the majority of the consultation was conducted through her husband as translator". It would appear the longer she was in the UK the better her English language proficiency. By 2014 the GP Mrs F consulted prior to her death described her as being "fluent in English".

5.11.3 GP access to interpreters either locally or via telephone link services has developed as a response to significant inward migration and health guidelines have continued to highlight the need to use professional interpreters as opposed to family members or friends. The entry concerning her husband interpreting in the GP notes is five years old and should not occur today. Similarly, NLAG NHS Foundation Trust identify that if the contact happened today the level of enquiry and approach to language and translation would be different.

5.11.4 The Police in Humberside whilst not using an interpreter in 2009 and November 2011 took steps to ensure that both Mrs F and Mr F could understand both the spoken and written English. There were numerous entries within police records around the communication ability of both Mr and Mrs F. In speaking with officers in reviewing this case the IMR author confirms they stated that they were able to converse with the family and they understood what was being discussed.

5.11.5 Interpreters were not used for the first two incidents. However, when Police arrested and intended to prosecute Mr F the victim statement recorded from Mrs F was in Mandarin using an interpreter. It is recognised that having the interpreter enables a more detailed and thorough communication. Information about support agencies sent to Mrs F is not recorded as having been translated and were probably in English.

5.11.6 NLCS had recorded that an interpreter was not required. However it is recognised that their assessment would have benefitted from full analysis of the potential impact of the victims culture upon her needs.

5.11.7 NLAG HV service did not consider using an interpreter to ensure the quality of communication with Mrs F. On reflection the lack of her English may have led to maternal isolation and the potential to increase the control within an abusive relationship.

5.11.8 Three years on when Lincolnshire Police and Education had contact with Mrs F there was no evidence to suggest there was any ethnic, cultural linguistic or religious barriers and it is likely her communication skills had developed considerably. In the early days when Mrs F had recently come to the UK and had a very young child and was suffering DA her limited language must have isolated her further and acted as a barrier to her ease of communication with others e.g. In 2011 she told police she had tried to contact Women's Aid but

was unsuccessful. How much of this was down to language difficulties is unknown, but it may have been a factor.

5.11.9 There is no evidence that ethnicity, language or cultural issues were considered at the time of the HV transfer-in meeting in 2012 or that an interpreter was required. The HV may not have known about ethnicity until the transfer visit was taking place as records arrived after the visit took place and there was no verbal handover. Language lines and interpreting services are available if required. From the records it would appear to the IMR author that Mrs F has a good understanding of English and was able to communicate effectively.

5.11.10 School identified that Mr F's English language was fluent and Mrs F had a good command of English.

5.11.11 From research undertaken and information from Mrs F parents it is clear there are cultural differences between Britain and China in relation to DA.

5.11.12 DA and Divorce brings shame and dishonour to the Chinese family. Male chauvinism is ingrained in Chinese culture and women are largely expected to suffer in silence. This view was reiterated to Mrs F by her mother as per the family statement. It is recorded in an article in the Economist that it is widely accepted in China that a husband, as head of the household, has the right to hit his wife. There is a real risk of women losing custody of their children if there is a complaint and separation.

5.11.13 Most surveys show between 25% and 40% of women in china suffer DA but reporting is rare. There is some evidence the proportion could be much more.

5.11.14 It is difficult to say how the cultural differences impacted on this family. One can suggest it must have been far more difficult for Mrs F to disclose abuse, however, sadly we will never know how it affected her. In terms of agencies intervening in DA within a Chinese family one can see that the male partner may be resistant to changing what he sees and what is accepted in China as his right.

5.11.15 It is important for agencies dealing with a Chinese family and DA that they take steps to understand the cultural differences in order to have the right approach to maximise success of intervention. There does not appear to be evidence of any of the agencies that knew about the DA considering the cultural differences that might make a difference to ensure maximum effectiveness.

5.11.16 There is an issue in terms of accessibility of services in terms of language and understanding the processes and how to access services. There is a need for culturally and linguistically flexible help lines perhaps on a national basis to assist those suffering DA who do not speak English easily.

5.11.17 Consideration for vulnerability and disability was not necessary. The victim did not fit the definition of an adult at risk which has now replaced the term vulnerable adult.

5.12 **Have there been any other similar cases in recent years and are there any lessons that could have been learnt?**

5.12.1 There was a case in Lincolnshire where Mrs A was murdered by her son in her home in 2012. The circumstances of the case were very different and the intervention had taken place over a period going back many years however, there were issues raised in that DHR aspects of which recurred in this review to a much lesser degree e.g.

- A lack of historical information being analysed and taken into account during the risk assessment process – No PND check by Police.
- Missed opportunities to share information with other agencies and key opportunities to undertake a formal multi-agency approach to assess, analyse and manage risk. This occurred after the homicide when the Police placed SF with his father without consulting with Children's Services via a strategy discussion and when the HV undertook the transfer-in process.

5.12.2 Lack of professional curiosity and routine enquiries about DA were issues picked up in the previous case. There has been a programme of mandatory training for LCHS which commenced in April 2014 and ran until end of March 2015 to raise the awareness of DA and included the need to take every opportunity to ask the question of service users. The contact with Mrs F happened before the training took place.

5.12.3 The issues raised by this case and review are not a reflection upon the work undertaken by staff in Lincolnshire to bring about improvements to knowledge and practice from the Mrs A review. Further evidence of the improvements brought about since the Mrs A case relate to DASH risk assessment. Previously the quality of DASH risk assessments in Lincolnshire Police was considered to be poor and risk assessments were not always completed. In this case the DASH was completed fully and accurately in accordance with force policy.

5.13 **To what degree could the homicide have been accurately predicted and prevented?**

5.13.1 The last incident of DA involving Mrs F and Mr F was in Humberside on 6 December 2011 some 2 years 7 months before her death. There was no clear evidence or indication known to any of the agencies that Mrs F remained at risk from her former husband. Both were in new relationships and sharing the care of their son as agreed by the Court. Therefore, the murder was not predictable by agencies.

5.13.2 It is alleged by the media that the Solicitors letter from Mrs F concerning decreasing Mr F's contact with their son was a trigger for the murder which was planned and executed to avoid detection. There is also reference to this in the judges sentencing remarks. Certainly conflict over arrangements for care of the children in an abusive relationship is an indicator of an increase in risk. It is unknown whether Mrs F recognised that the risk of physical abuse may increase and that it would be wise to have a safety plan in place. It is clear from her contact with Mr H's family that she was very anxious that Mr F

would be angry about the Solicitor's letter and at least would be verbally aggressive. She was confused when he did not berate her. However, given the method of her murder it is unlikely any plan could have kept her safe and prevented her death when there was a cold and clear determination by her ex husband to kill her.

5.14 **What effective practice can be passed on to other organisations?**

5.14.1 There was much routine good practice in the management of this case but nothing specific about effective practice to be passed on to other organisations.

6 Lessons learned from the Review

6.1 In November 2009 when the Police in Humberside were called to the first DA incident in their area although both Mr and Mrs F considered themselves victims only one SPECCS and F913 DV form was completed identifying Mrs F as the victim. The DV Form has since been amended to identify and record counter allegations which can provide useful intelligence for future risk assessments.

6.2 At the second incident in November 2011 police interviewed Mrs F in the street near her home. They did not visit her home to interview the alleged perpetrator and ensure the young son was safe and well in order to gather all information and complete a full assessment. The reviewing officer from the domestic abuse unit did not pick up on either of these short comings at the time of the reviews.

6.3 In 2011 the Domestic Violence Unit in Humberside Police did not work weekends and therefore reports from Friday night until Monday morning had to wait until Monday unless urgent. This practice has been reviewed and has since April 2015 been changed so that staff do work weekends.

6.4 At the last Humberside incident in December 2011 although Mr F was arrested he was later released without charge. With hindsight and in line with their Positive Action Policy Police now consider he should have been charged.

6.5 The risk assessment in December 2011 was categorised as medium but it was suggested by the attending officers this was reviewed and could move to high if Mr F was released from custody. The DV staff who undertook the secondary risk assessment maintained the medium rating. Had the case moved to high risk there would have been a MARAC referral, the referral to Children`s Services was considered by Police to have met their responsibility to liaise with partner agencies.

6.6 NLCS recognise that it may have been beneficial to have explored more thoroughly with the victim the potential impact of her culture and isolation upon her situation.

6.7 NLAG HV service have identified areas of learning relating to the need to improve holistic assessment and recording via the SBAR model, the increased use of the DA Screening tool to include the movement in /transfer

in contact . The need for assurance that HV are accessing and implementing DA training and the need to remind staff about The Interpreting and Translation Services Policy. The guidance for transfer of records for children with additional/safeguarding needs to be reviewed. These issues are subject to recommendations.

6.8 There are two areas from which lessons can be learned from the input of Lincolnshire Police. The first related to the lack of police consulting the PND as part of their information gathering on which to base a full assessment. Force policy and procedures are clear in relation to the importance of the use of PND in Domestic Abuse cases. However, policy was not followed on this occasion.

6.9 The second lesson relates to ensuring that all SIOs are aware of safeguarding policies and procedures during the investigation of homicides and recognises the value of making early contact with the PPU CRU for advice, guidance and practical support to ensure that information is shared with and partner agencies are involved at the earliest and most appropriate time.

6.10 The quality of recording by hospital staff should be improved. The importance of accurate and sufficiently detailed information being recorded on documentation relating to those accompanying patients, especially children, should be reiterated. This is particularly important where parents are in new relationships and especially where DA may be a feature.

6.11 Where DA within a family is recognised and entered into the records through Children's Services e.g. HV, SN and Maternity Services, a further entry should be logged and linked to the parent's records to share information with those working with the adults. This entry should be made, where possible, with the acquired consent of the adult.

6.12 The importance of using independent professional interpreters to interpret health and other personal information e.g. evidence of DA is fundamental. This is to ensure accuracy and an honest communication and to protect the individual's privacy.

6.13 There was evidence of a lack of the use of professional curiosity and explorative questions to enable staff to explore the possibility and level of DA in an attempt to diagnose DA and provide preventative and safety input. Examples included were when the HV was told Mrs F was fleeing DA. The GP when Mrs F requested medication for anxiety and panic. The OOH nurse when Mrs F was anxious at Mr F being outside.

6.14 There was a failure to routinely ask the question about DA at every contact with clients if safe to do so by LCHS staff.

6.15 LCHS identified a lack of completing and updating risk assessments e.g. DASH was not completed when Mrs F disclosed fleeing violence. There was an assumption incorrectly made that as Mr and Mrs F no longer lived together risk of DA diminished. Research confirms this is not the case and

risk can increase due to difficult contact arrangements. As a result there was a lack of using alert flags to inform others of the risks.

6.16 There was evidence that the HV did not follow the Transfer-in protocol 2011 in terms of direct contact with the previous health visitor to gather information to make a full assessment etc. This has now been rewritten as a policy and ratified in April 2015.

6.17 The school identified that most staff had not completed the on line DA training recommended, this is important to increase awareness and knowledge of indicators of DA. The school should refer to guidance provided by The Local Safeguarding Children's Board Five Year training programme and ensure staff are trained appropriately.

6.18 There was a lack of clarity about the role of Parent Support Advisors (PSA) with no obvious monitoring of involvement or succession planning for when the PSA leaves. Consideration needs to be given to whether and how their work will be covered in order to provide consistency of input and service.

6.19 There appeared to be little or no consideration given by agencies involved to the cultural differences between China and the UK that could impact on the recognition, disclosure and prevention of DA. Appropriate advice should be sought by practitioners when dealing with immigrants where cultural differences are significant to their seeking help.

6.20 Limited English language may have been a significant basis in Mrs F seeking assistance from support agencies. Help lines in appropriate languages, possibly on a national basis e.g. one Chinese speaking help line for the Country should be considered to facilitate the disclosure of DA and promote referral on towards a safety plan.

6.21 The intervention of the Solicitor’s letter may inadvertently have triggered events leading up to the murder. Solicitors should increase their awareness of the likely impact of challenging custody and contact arrangements in already abusive relationships. Consideration to be given to an appropriate risk assessment and safety plans being developed in such cases before communication takes place.

Conclusion

7.1 There is evidence that DA became a feature of the relationship between Mrs F and Mr F soon after their marriage in 2007. The first incident recorded by Essex Police in March 2008 involved a verbal argument and as no offences were committed there was no further action. Coercive control was not recognised as a form of DA then but was included in the criteria in 2013.

7.2 By November 2009 when the first incident of DA was reported to Humberside Police the couple referred to previous abuse and that knives had been used.

7.3 There were three reported incidents in Humberside in November 2009, November 2011 and December 2011. It is likely there were many other incidents that went undetected e.g. Mrs F told her parents in China that she "asked for a divorce" several times. She said she could not bear the pain and

could not take the mental anguish any longer. She said "she must divorce him because he often hit her". Divorce in China is such taboo her parents said they persuaded her to stay. Obviously this advice is a source of anguish to her parents.

7.4 Despite three incidents being reported in Humberside none resulted in charges. DA support information was provided to Mrs F, she told police she had tried unsuccessfully to contact Women's Aid. There were no DA support agencies involved with the family.

7.5 Language and cultural difference may have acted as a barrier to full disclosure of abuse and seeking help from services other than the police. As well as these obvious differences Mrs F was new to the country, had no network of friends to support her and no family support. Also she had the restrictions of a young child and her husband's alleged determination to control her so that she should not study English or develop friendships.

7.6 It was to her credit and determination that Mrs F finally left her husband after 4 years of marriage and went to another city to start a life without him.

7.7 Mr F was fluent in English and used his Solicitor to arrange a separation agreement regarding custody of their young son and the splitting of assets. Mrs F did not have an independent Solicitor at that time.

7.8 Whilst living apart the couple did meet on occasions to hand over their son for shared residency and contact. This arrangement was an order of the Court made in September 2013 following their divorce. Once their son started school the hand over happened at school and direct contact was likely reduced to holiday times.

7.9 There is speculation that the trigger for the planned murder of Mrs F by her ex husband Mr F was a Solicitor's letter regarding contact arrangements and the possible reduction of time Mr F spent with his son. This motivation has not been confirmed as Mr F maintains his innocence although he has been convicted and sentenced for murder.

7.10 Despite a history of DA the last recorded incident between Mr and Mrs F was in December 2011, two and a half years before her brutal killing. Whilst the Solicitor's letter received by Mr F just days before the murder is likely to have increased tensions between the couple, no agency could have foreseen that the catastrophic events of 17 June would occur. In the event that the sudden resurgence of abuse could not be predicted it is not reasonable to consider that any agency could have taken steps at that time to prevent the tragic outcome.

8. **Changes already made by Agencies relating to lessons learned.**

Humberside Police

8.1 Since the case Humberside Police are now using the DASH risk assessment and have had training relating to this model, DA risk factors, children and coercive control in relationships.

8.2 Officers have had further training in relation to the actions required of them at the scene of a Domestic Abuse incident.

8.3 The Domestic Violence Unit staff are now available seven days a week having been contracted to work weekends from April 2015.

8.4 Humberside Police have recently inspected by Her Majesty's Inspectorate of Constabulary in relation to Domestic Violence and Child Protection during which the Force Policy around DA and links to Child Protection was reviewed and reinforced. They were inspected again in July 2015 to ensure necessary changes have occurred. Further inspection around vulnerability will be undertaken in Autumn 2016.

8.5 The Policy regarding sharing information between the Police and the four Local Authorities in the Humberside area has recently been updated following consultation. The secondary risk assessment made by the Domestic Violence Co-ordinator will be shared with NLCS where cases reach a threshold for a Section 17 or Section 47 referral these are progressed by the Detective Sergeant working in a co-located multi agency safeguarding team within the Local Authority.

In the light of the above changes there are no new recommendations to be made for Humberside Police as a result of this review, all are covered in changes already made.

8.6 CCGs/LA Commissioning

During the timescale of this review the commissioning of health visiting services has transferred through devolution of powers from NHS England to the Local Authority. Aligned to this ,the Local Authority has looked to integrate its early years health provision with the transfer of school nursing from Public Health to Children`s Services. Within Lincolnshire there is a joint funded Chief Children`s Commissioning Officer post established as a component of an ongoing collaborative approach. At this point in time maternity services remain commissioned through the NHS.

8.7 CCGs

Access to interpreters either locally or via telephone link services have been developed since 2009 as a response to the significant inward migration of a range of ethnic groups. Guidelines have continued to highlight the need to use professional interpreters as opposed to family members or friends.

8.8 Currently within the DA partnership there is a project underway to strengthen the primary care response specifically working with GP practices to provide specialist training and support in completion of what was the CAADA – DASH risk assessment form and is now called the DASH risk assessment.

8.9 NLAG HV

From 2014 The NLAG NHS Foundation Trust Health Visiting has implemented a DA Screening Tool.

8.10 Practice documentation has been developed to incorporate The SBAR model (Situation, Background, Assessment and Recommendation)supporting holistic assessment of children and families.

8.11 Information is now provided to all families via the Parent Held Record about DA services that are available.

8.12 The Trust Domestic Violence Policy has been reviewed and strengthened to include information on the DA Screening Tool, DASH Assessment and MARAC process.

8.13 A policy relating to Interpreting and Translation Services has been implemented in 2014.

8.14 LCHS

The issue of using professional curiosity and exploratory questioning to identify DA together with the expectation of completing and recording risk assessment have recently been addressed by the organisation. There has been a programme of mandatory training across LCHS for all staff that commenced the beginning of April 2014 and ran until the end of March 2015. Training will continue to ensure that all new starters to the trust receive DA training in their first year.

8.15 NLAG NHS Foundation Trust

A & E now has an independent Domestic Violence Advocate to assist staff to screen high risk concerns. Also there are regular audits of the implementation of the NLAG Domestic Violence Policy.

9. Recommendations

Lincolnshire Police

9.1 SIOs should be reminded of the need to consider safeguarding policies and procedures during murder investigations and of the resources available to them in the Public Protection Unit Central Referral Unit for advice, guidance and co-ordination with partner agencies.

9.2 Lincolnshire Police should take steps to raise the awareness of all officers and staff as to the value of the PND and ensure that policies, procedures and guidelines in respect of its use in DA cases are complied with.

9.3 ULHT

To audit paediatric and A & E records to assess whether information relating to those who are accompanying a child into hospital is adequately recorded.

9.4 CCGs

Lessons learned from this review will be taken forward through the newly formed contract management arrangements and assurance sought that the necessary protocols and controls are in place to ensure that practitioners have the requisite competence and skill to recognise and act upon DA.

9.5 Where DA within a family is recognised and entered into the child`s records through Children's Services e.g. HV SN and maternity services or following a conviction a further entry should be recorded, flagged and linked to the parents records.

9.6 LCHS

LCHS to audit whether the routine enquiry of DA and appropriate action is now embedded as part of all practitioners practice.

Education

9.7 The school to provide evidence that it has an effective system in place for allocating cases to the Parent Support Advisor and for monitoring, recording and feeding back to senior management.

9.8 Schools will review their Safeguarding Policy in line with the recently amended model policy provided by the Local Authority and taking into consideration the guidance on the new Ofsted inspections.

9.9 That the Safeguarding Officer in all schools is trained in Domestic Abuse.

9.10 Ensure all staff inviting both parents to joint meetings understand that where parents are estranged and there is potential for conflict or coercive control that the potential risk of that activity is recognised and merited and careful consideration is given to how such a meeting is managed

Northern Lincolnshire and Goole NHS Foundation Trust Health Visiting Service

9.11 The Domestic Abuse Screening Tool now used in Health visiting in NLAG to be expanded to also be used for "movement in contacts" to assist in the early identification of DA.

9.12 All Health Visitors to receive DASH training to ensure that they are equipped in the identification and assessment of DA.

9.13 Health Visiting Managers to remind practitioners to utilise The Interpreting and Translation Services Policy for work with those for whom English is not

their first language in accordance with North Lincolnshire and Goole NHS Foundation Trust Policy.

9.14 Review Health Visitor recording to confirm it is completed using the SBAR format following contact with Children and Young People`s Services

9.15 Review the North Lincolnshire and Goole NHS Foundation Trust guidance for the transfer of community health records for children with additional/safeguarding needs.

Community Safety Partnership

9.16 The Community Safety Partnership through the DA protocol and training to ensure practitioners are aware of the need to consider the effect of cultural differences experienced by those suffering DA to improve service delivery and understanding.

9.17 To offer training to Solicitors who work on divorce, custody and contact arrangements where DA is an issue. The purpose of the training would be to improve the awareness that parental separation is a known risk factor which increases risk in DA situations and to challenge the thinking that abusive behaviour can be separated from parenting ability in the assessment of risk.

Nationally

9.18 Consider developing DA help lines in a range of languages for those for whom English is not a first language in order to facilitate the disclosure of DA and enable access to services that aim to support and work towards protection of the victim and family.

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Glossary of Terms

ACPO	Association of Chief Police Officers
CAADA	Co-ordinated Action Against Domestic Abuse
CCGs	Clinical Commissioning Groups
CAFCASS	Children and Family Court Advisory and Support Service
CRU	Central Referral Unit (Police)
CSP	Community Safety Partnership
DA	Domestic Abuse
DASH	Domestic Abuse Stalking and Honour Based Violence
DV & A	Domestic Violence and Abuse
DHR	Domestic Homicide Review
FAST	Family Assessment and Support Team (Lincolnshire Children's Services)
FCR	Police Force Control Room
GP	General Practitioner
HV	Health Visiting
IMR	Individual Management Reviews
LCHS	Lincolnshire Community Health Service
LSCB	Local Safeguarding Children`s Board
NLCS	North Lincolnshire Children`s Service
NLAG	North Lincolnshire and Goole NHS Foundation Trust
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
NHS	National Health Service
PCT	Primary Care Trust
PPU	Public Protection Unit Police
PSA	Parent Support Advisor
SPECSS	Separation, Pregnancy, Escalation, Community Isolation, Stalking /Harassment Sexual Abuse – DA High Risk Factors

TOR	Terms of Reference
ULHT	United Lincolnshire Hospital Trust