Domestic Homicide Review Report

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

Review into the death of April
in January 2017

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Contents

(i) Preface

Norfolk County Community Safety Partnership wishes at the outset to express their deepest sympathy to April's family, particularly to the children. The Partnership is also cognisant of the effect upon members of the perpetrator's family; they did not commit the awful murder in this case but also have to live with the consequences. This review has been undertaken in order that lessons can learned; we appreciate the support and challenge from families and friends throughout the process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by Norfolk County Community Safety Partnership (NCCSP) on receiving notification of the death of April in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

(ii) Confidentiality

The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It remains confidential until publication by the NCCSP, following approval by the Home Office Quality Assurance Panel.

To protect the identity of the deceased, their family and friends, April will be used as a pseudonym to identify the deceased hereafter and throughout this report. The pseudonym, April, was chosen by the victim's family. The person who murdered her will be known as 'the perpetrator'.

Both April and the perpetrator were 'white British'. April was 32 at the time of her murder, the perpetrator was 26; they had been in a relationship for around eighteen months. April had two children from a previous relationship. The perpetrator also had two children from a previous relationship with whom he had no contact at the time of this incident.

(iii) Format of the Report

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Review. Ordinarily this section will also set out the process undertaken to complete the review, however, due to the complexity of this report, the process section appears at Appendix One in order that process does not detract from the findings.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to April's death.

Section 3 will provide **overview and analysis of the information** known to family, friends, employers, statutory and voluntary organisations and others who held relevant information.

Section 4 will address **other issues** considered by this Review

Section 5 will provide the **conclusion** debated by the Panel and will consolidate **lessons learned and the recommendations arising therefrom**.

Where the review has identified that an opportunity to intervene has been missed, this has been noted in a text box.

Appendix One
Appendix One will **explain the process** undertaken to complete it. The Review has been undertaken with due regards to the 2016 refresh of the Home Office Multi-Agency Statutory Guidance[1]; this section demonstrates its compliance and explains any departure therefrom that the Chair and Panel felt necessary in the circumstances of this case.

[1] Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016

Section One – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 This Review is clear from the outset that 'our' system failed to protect April despite the well-intentioned efforts of a number of agencies and individuals. Several agencies knew of this perpetrator's propensity for serious violence towards previous partners; some friends and family knew too; most importantly, so did April. We make it clear that 'our' system failed to protect her because agencies **did** take action, individuals **did** act, **as did** April, however, despite all that was done, the perpetrator exploited the system's weaknesses placing April and some agencies and staff in a position where they had done all they thought they could do, or were allowed to do, at the time to prevent further serious injury. It is, though, 'our' system because clearly the messaging that we, as a society, have continued to give about domestic abuse and violence being unacceptable is not being recognised and understood by those who are most vulnerable, and the wider community. The systems in place for safeguarding, criminal justice, rehabilitation and society's understanding of the seriousness of domestic abuse and violence were **all** unsuccessful in protecting a young woman from a serial abuser. We **must** learn from this case; and change.

1.1.2 In an effort to understand this case we have sought to identify those aspects that made April, and a number of other previous victims of the perpetrator, vulnerable to his control and violence. We have also sought to understand what caused this young man to embark upon a way of life that included serious and extreme violence to several vulnerable young women.

1.1.3 On an evening in early January 2017 the family of this victim, April, a 32-year-old woman from Norwich, were concerned as she had not fulfilled the arrangements for her children to be returned to her care by their father. Because of their concerns some members of her family went to her home; a flat she shared with her two young children.

1.1.4 The family found April lying on the floor the flat with obvious injuries to her head and face. They called for an ambulance and just before midnight ambulance staff and police arrived. April was found to have sustained substantial facial injuries and bruising to her neck. She was pronounced dead at the scene.

1.1.5 A murder investigation was launched by Norfolk and Suffolk Police Major Investigation Team. The inquiry resulted in her most recent boyfriend being arrested in the early hours of next morning. He was subsequently charged with her murder.

1.1.6 At only 26 years old, this perpetrator had a number of convictions for assault on numerous ex-girlfriends. At the time of April's murder, he was under three separate restraining orders against three separate ex-girlfriends, including April.

1.1.7 At trial at Norwich Crown Court in the summer of 2017, the perpetrator was found guilty of murder and sentenced to life imprisonment with a minimum term of 24 years.

Section Two – The Facts

2.1 Introduction

2.1.1 April was a young woman with family ties in Norwich. She lived in a flat with her two children. Her children spent most weekends with their father who lived in another part of the same city.

2.1.2 April's relationship with her children's father ended in 2009. It is clear that he remained a significant part of the children's lives and also hers. Their relationship remained amicable to the point where he spent most Christmas's with April and her family. They were, however, no longer partners and in the time between separating from him and meeting the perpetrator, April had a number of short-term boyfriends as well as one with whom she was in a relationship for two to three years.

2.1.3 It is in this interim period that April was almost certainly a victim of domestic violence at the hands of at least one of those boyfriends. Whilst she made no report to the police or other authorities she told her friends of the assault and received treatment in hospital and through her GP for a fractured jaw, in May 2011. She also suffered another facial injury in March 2013. On both occasions she told hospital staff that she was victim of an assault by other young ladies in a nightclub.

2.1.4 April's last boyfriend, the perpetrator in this Review, had been living in Norfolk for approximately seven years. He has two young children from a previous relationship; the mother of those children was one of the victims of his previous violence. He grew up in another part of the country where his mother and the mother of his children still live.

2.1.5 By the age of 26, the perpetrator is now known to have been violent and abusive to six girlfriends in total. He had a number of convictions for assault and at the time of April's death was the subject of three restraining orders for three different women (one of which was April). He was prone to heavy drinking and drug use.

2.1.6 At the time of his first risk assessment by probation services when he was just 18 years old it is recorded that, "he has the potential to inflict fatal harm upon his partner and his unborn child". In all the risk assessments that followed he was considered to present a high risk of harm to female partners.

2.1.7 At the time the perpetrator met April the following was in place for him:

- He was on 2-year community order and was subject to 2 years' supervision by xx Probation providers[2] for assaulting his previous girlfriend. He was subject to a restraining order and a Building Better Relationships programme (BBR) requirement.
- His name had been known to the Multi-Agency Risk Assessment Conference (MARAC) panel via a number of previous victims since 2008 (MARAC concentrates on safety planning for high risk victims, and not primarily on the perpetrator)
- He had been known to Children's Social Care since 2009 because of his involvement and violence with previous partners and the presence of his own and other children in those relationships.

[2] This is the Probation providers in the area that the perpetrator was living at that time. The name has been removed to protect the anonymity of his mother and children

- He had been subject to the County's Multi Agency Public Protection Arrangements (MAPPA) as a result of his violence towards his previous partners. He was de-registered from the scheme upon his prison release in early 2014 as he was no longer under supervision and it was felt that appropriate safeguarding measures for ex-partners at that time had been put in place. He was not the subject of further MAPPA meetings despite assaulting a new partner within four months of his release, subsequently receiving the sentence described above, and information being received that he was breaching restraining orders with other ex-partners (whilst on bail for the latest assaults).
- A pro-active disclosure about the danger he presented to potential partners had been given to a previous woman he was believed to be embarking upon a relationship with.

2.1.8 April and the perpetrator had been in a relationship since June 2015. After a few months the perpetrator moved in with April and her children in her Norwich home.

2.1.9 It is known that at least one friend told April about the perpetrator's assaults on past girlfriends when learning of their relationship.

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

2.1.11 It seems it was not long before he fell into a pattern of behaviour that a number of his previous girlfriends had faced. He became controlling, overbearing and then violent. The violence was severe. He began to bombard her with calls and texts, when he did not get a response he would turn to contacting her mother. The evidence of this is set out clearly within this report at paras 2.3.23 to 2.3.25. There were two incidents reported to the authorities of arguments between the two in early 2016 but although April was spoken to by police she would not disclose the full details of the incidents between them. It seems that April put up with a lot before she felt able to report a serious assault by the perpetrator to police. This occurred in July 2016. The perpetrator was arrested for the assault but after she had made the report and received treatment in hospital, April felt unable to make a formal statement or support a prosecution.

2.1.12 The case proceeded to court however and in October 2016 he became subject of a restraining order to prevent him from further contact with April.

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

2.1.14 In December, April attended a local council building with bruising to her face and admitted to the officer that her partner had assaulted her. The officer reported this to the police. April moved back in with her mother for the Christmas period and continued to tell her family and friends that it was over between her and the perpetrator and that she would not see him again. She would not however speak to the police about the assault and she failed to tell children's social care the truth about it when they were charged with ensuring the safety of her two children.

2.1.15 As will be seen later in this report, the police attempted to inform April of the full extent of the perpetrator's offending history but were unsuccessful. It will also be seen that April was very aware of his capacity for continuing violence and was very afraid for her future, telling a close confident that she knew 'he would kill her, but that she loved him'.

2.1.16 On the evening of the incident, April and the perpetrator had been out together again in Norwich. It has never been properly established why she went out with him that night. They were at a pub in the City centre and when the evening finished they returned to her home. It is there that he turned upon April and killed her by numerous punches to her head, effectively smashing every bone in her face. He left her dead or dying in the flat, but did not raise the alarm, going instead to a friend's house where he took more drink and drugs. April was found by her family the following day when they called at the house after becoming concerned that she had not made contact about the return of her children from their father's house. It is only by good fortune that her two young children did not discover April's body as they had attended the flat with other members of the family and, running ahead, found the door locked.

2.1.17 A full chronology of events and summary of the information known by family, friends and agencies will follow within this report.

2.1.18 The chronology relates solely to the relationship between April and this perpetrator. There is clearly a significant amount of information, both within agencies and amongst friends and family, about the two that exists prior to their relationship. Information that is thought to be relevant is included at various other sections of this report.

2.2 Chronology

2.2.1 April was 32 years old at the time of her death. The children's father looked after their two children after school one day in the week and then every weekend.

2.2.2 Everyone who has been spoken to as part of this review has spoken about April very warmly. She was said to be very sociable with lots of friends.

2.2.3 April began her relationship with the perpetrator in June 2015 and they would very soon do family activities with her children. At the time of her death family and friends believed that she had ended the relationship with him.

2.2.4 The perpetrator was 26 years old at the time of the incident and has two brothers. This review has been told that his father was an aggressive man who was physically violent towards his wife, normally following drink. His mother and father separated when he was a young boy after a very severe attack on his mother. He was very close to his father and took the separation very badly, blaming his mother for sending his father away and he continued to see his father regularly. It is widely accepted[3] that children who are exposed to domestic violence may suffer a range of severe and lasting effects, resulting in serious implications for their emotional wellbeing and development.

[3] Numerous studies also reveal that children who witness domestic violence are more likely to be affected by violence as adults, either as victims or perpetrators and consequently there is a strong likelihood that this will become a continuing cycle of violence for the next generation (*World report on violence and health – Krug, Etienne et el 2002*).

2.2.5 The perpetrator is described as not having a large group of friends as a child but was close to a small group. He attended a small rural primary school and was described as not being academic but being very practical. His behaviour deteriorated at school and the first signs of aggression that eventually turned into violence emerged. As a result, he was educated at a Pupil Referral Unit for several years. This Review has been told that only one teacher was able to work effectively with him; disappointingly the local authority in whose area he attended school has been unable to retrieve any records relating to his schooling and thus we have been unable to identify and speak with that teacher. We have therefore been unable to identify if agencies were aware of the domestic abuse in his childhood and therefore if he would have been treated differently today.

2.2.6 After leaving school he worked in the agriculture sector. He was said to be hard working and there is evidence that suggests that he continued to have a work ethic as his life progressed.

2.2.7 He was known to have been violent towards his previous partners. Below are details of his previous domestic abuse criminal history:

Date	**Offence as reported**	**Penalty**
2005 (aged 14)	Criminal damage (to the family home)	Final warning given
2005 (aged 15)	Domestic incident (female family member)	Victim declined to make formal complaint – given words of advice
2008 (aged 18)	Assault Punches to the head causing fractured skull. Girlfriend 1	12 months wholly suspended for 2 years
2008 (aged 18)	Assault Held breadknife to throat and punched to head. Girlfriend 1	6 months suspended for 2 years to run consecutively
2009 (aged 19)	Assault Pushed on stairs and attacked dog when girlfriend pregnant. Girlfriend 1	Order revoked resentenced to Young Offenders' Institute – 8 month suspended sentence activated
2011 (aged 20)	Assault and Criminal Damage Punched, kicked, threatened with a knife (in front of children) Girlfriend 2	2 year's imprisonment
2013 (aged 23)	Breach of restraining order Girlfriend 2	Guilty – no separate penalty
2013 (aged 23)	False imprisonment and assault Punches to the head, threw mobile phones out of window, held her against her will. Girlfriend 3	Charged – destroy and damage property – guilty False imprisonment – NFA CPS decision Battery – not guilty ABH – 2 years imprisonment
2013 (aged 23)	Assault. Smashed head into floor, punched, destroyed phone. Girlfriend 4	Imprisonment for 2 months Victim surcharge Restraining order - indefinitely

2014 (aged 24)	Assault Wouldn't let her leave house, spat at her, threatened to kill her, and took keys and phone. Girlfriend 5	Community Order – 24 months Supervision – 24 months Building Better Relationships requirement £100 compensation £60 surcharge Restraining order – 2 years
2016 (aged 26)	Assault Hit around the head, hands around the neck, prevented her from leaving. Girlfriend 6 (April)	Pleaded not guilty No evidence offered – dismissed Restraining order

2.2.8 The perpetrator had the following orders in place at the time of April's death:

- Protection from Harassment Order – no end date – issued November 2013 (previous partner)
- Protection from Harassment Order – 2 years – issued February 2015 (previous partner)
- Protection from Harassment Order – 18 months – issued October 2016 (April)

2.2.9 The offending history above shows clearly that it can be argued that the only time women were safe from the perpetrator was when he was in prison or under some form of supervision where he knew there could be consequences. There is barely a year that goes by without an assault on a different female partner. The table on the next page shows this graphically.

2.2.10 This Review considered carefully whether to seek to engage with all of his previous partners to look for areas of learning. After much discussion it was decided that we would seek information from some but not all. The evidence and nature of the convictions tend to speak for themselves. It is clear from the offending chronology and what we later learned about his behaviour from others that the state's provision for, and attempts at, rehabilitation with this man simply did not work.

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2004	Reprimand											
2005						Criminal damage Final warning				Words of advice		
2006												
2007												
2008					Assault			Assault	Assault SSSO	SSSO	SSSO	SSSO
2009	SSSO	SSSO	SSSO	SSSO	SSSO	SSSO	SSSO	SSSO	SSSO	SSSO	YOI	YOI
2010	YOI	YOI	YOI licence	YOI licence	YOI licence	YOI licence						
2011	Assault/CD	Assault								Prison	Prison	Prison
2012	Prison	Prison	Prison	Prison	Prison	Prison	Prison	Prison	Prison	Prison	Prison	Prison
2013	Prison	Prison	Prison	Prison	Prison	Prison		Assault	Assault	Prison	Prison	Prison
2014						Assault						
2015	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision
2016	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision Assault – no evidence	Probation supervision	Probation supervision	Probation supervision	Probation supervision	Probation supervision
2017	Probation supervision MURDER											

	Supervision in community
	Custody
	On bail

2.3 Detailed chronology from June 2015

2.3.1 When April and the perpetrator's relationship began in 2015 he was serving a 2-year community order, was under the supervision of The National Probation Service and subject to a restraining order following the assaults on 'Girlfriend 5', noted previously.

2.3.2 The perpetrator should therefore have been subject to regular face to face meetings with Probation. There is clear evidence that on a number of occasions after meeting April he lied to his offender manager, saying he was still single and if he had seen anyone there was no relationship as such. It was not until January 2016 that he first disclosed that he was in a relationship. The offender manager said that they needed to know the details of the person and on 19th January 2016 a police intelligence item[4] was created to the say that the perpetrator was in a relationship with April. **This is the first-time authorities became aware of the relationship.**

2.3.3 Just after midnight on the 25th March 2016 a report was made by a member of the public of a female screaming in the street, possibly being attacked. Upon Police arrival they located April who was emotional and explained that she had been out drinking and had had a disagreement with her boyfriend. She refused to give details of her boyfriend but was concerned that he might return. She stated that she had run from her house as she didn't have a mobile phone to call Police to assist to get her boyfriend to leave. An out of hour's number was obtained for Wherry Housing and officers remained at her home address until the locks had been changed. April did not disclose any assaults and stated that the relationship was over. A standard risk Domestic Abuse, Stalking and Honour Based Violence Risk Assessment (DASH) was submitted, and a Child Protection Investigation (CPI) submitted for her children, who were not present as they were staying with their father. The CPI was referred through to Children's Services.

2.3.4 The county's Children's Services social care team received the referral which was marked as 'for information only and no further action' on the basis that children were not present at the time of the incident and that April had told police that the relationship was over. The police are clear that she refused to provide any details of the other person. Children's social care have recorded a different name in their records. The name is, in fact, a previous partner of April's, not the perpetrator's, and when the next incident occurred she told police that she had been in the relationship with the perpetrator for 7 months.

2.3.5 This was the first opportunity April had to tell the authorities that she was in a relationship with the perpetrator. Children's social care had long been aware of the perpetrator because of his assaults upon the other ex-girlfriends who had children.

2.3.6 In May 2016, a member of the public called the police saying that a couple were arguing in the street. Police attended and found April who said she had been arguing with her boyfriend, this perpetrator, but said that no assault or anything else had happened.

2.3.7 In July 2016, April made her first formal allegation of assault by the perpetrator to the police. She reported that she and the perpetrator had been talking and she had said something he did not like, and he went mad, he then started hitting her, strangling her and put his hand over her mouth and hit her on the head. He stopped her from getting out of the house and

[4] The provenance of this intelligence item cannot be ascertained, and the information was not sufficient to justify creating a record for April

she thought that he had been trying to kill her. She told police that the whole incident lasted a few hours and then he calmed down and went to sleep. When he was asleep she managed to escape. April disclosed that she had been assaulted by him four times in the last few months, knew of his violent past and that he had been to prison for this and was scared of further attacks. She went to hospital for treatment. When police visited her later that day she declined to make a statement or allow them to take further photographs of her injuries (some had been taken initially). She also declined a range of safeguarding measures suggested to her by the police but did agree to speak with the Independent Domestic Violence Advocate (IDVA). The perpetrator was charged, and the Crown Prosecution Service (CPS) were content to embark upon a 'victimless prosecution'. He was arrested, charged and bailed not to contact her or enter the road in which she lived.

2.3.8 Two days later children's social care received notification from the hospital about April attending having been assaulted by her boyfriend and in particular that she did not want the children's father to know. They note that this is not the first time and that they are concerned that the children's father may not be able to protect the children if he is unaware of the attacks upon her. They send a letter, in line with standard procedure, to April reminding her of her parental responsibilities for protecting the children from emotional and physical harm.

2.3.9 A few days later, the case was discussed at MARAC (the specifics of this will be covered later within this report) and Leeway (a specialist domestic abuse provider for the city) continued to engage with April. Given that children lived at the address where the incident had taken place the county's children's social care team made an unannounced visit for assessment to April's home. There was no response, so they also visited the home of April's mother but were unable to make contact with her. April's mother was, therefore, never aware of these visits or concerns.

2.3.10 Four days later, Leeway attempted to contact April by phone but there was no response.

2.3.11 Two days after the previous visit, children's social care again visited and carried out an assessment at April's home. They observed that the children were healthy with plenty of food and the home was clean and well kept. The children were both observed to have a good relationship with their mother. April stated that, as the children had not been there at the time of the assault, she did not want their father to know about the incident. There is evidence that April downplayed the incident to the social workers and said that she was embarrassed and had no plans to see the perpetrator again. She told the social workers that she was willing to engage with Leeway and was seeking a restraining order against the perpetrator.

2.3.12 Over the next week or so, Leeway tried on a number of occasions to contact April but were unable to make contact with her. As they were concerned they spoke to the police who advised that the bail conditions had been lifted. This review has sought to clarify if and why this was the case. Police records indicate that whilst he was being investigated for the offence, and thus on police bail, there were non-contact conditions in place. When he returned to the police station at the conclusion of the investigation, he was charged with the offence and was bailed to court with no conditions. There is no explanation as to why this was the case and records indicate that the CPS advice was to charge and release to court on conditional bail. Further scrutiny of the records held by the police cannot provide any additional information about how this decision was made. The police advised Leeway that they had undertaken a welfare check, and all had been well. In fact, there is evidence of the

police contacting April again during the week after the incident and reiterating the safeguarding advice. At that time April was still adamant about not making a statement but that she had no desire to get back into a relationship with him.

> Releasing the perpetrator on bail without conditions is an opportunity that was missed to afford some level of control over his contact with April

2.3.13 At the beginning of August, the perpetrator contacted his offender manager (as he was still on the community order from the previous assault conviction in 2014 on Girlfriend 5) and to say that he had been charged with common assault and that he would be going to court at the end of September. He told his offender manager that he knew that he had messed up. When he attended the probation office two days later, the perpetrator said that he did not recall much about the offence due to his level of intoxication. He said that he had not been in touch with his former partner, but he would like to resume the relationship.

2.3.14 The next day, Leeway spoke to April on the telephone and she said that there had been no further issues and she had not had any contact with the perpetrator. She said, on this occasion, that she was happy to keep in touch with Leeway and it was agreed that further contact with the IDVA would be arranged when she is back from holiday. It was also agreed that she would contact the police if any further problems arose.

2.3.15 A week later, children's social care decided to close their case, sending a letter to April that if they became aware that she had resumed her relationship with the perpetrator they would consider child protection procedures. This will be returned to later within this report (see para 3.6.1.7 below).

2.3.16 In the third week in August, all the evidence in the case was reviewed by CPS and it was decided that a victimless prosecution should be brought and prosecuted robustly. This decision was taken based upon the fact that April had called 999 and the call was compelling.

2.3.17 At the beginning of September a letter was sent to April by the police about the forthcoming court hearing.

2.3.18 In the first week of September, April spoke to Leeway on the phone and stated that all was well, she was getting on with things and had no further contact with the perpetrator. The support available was discussed with April but she did not feel that she required anything.

2.3.19 At the end of September, a 'witness warning' letter was sent to April. The police had a short conversation with her on the phone (as she was at work) and she said that she did not want to attend court. They agreed that they would speak again the next day. A text was sent to her with the phone number asking her to call the Witness Care Unit. There is no record that there was any further contact until the end of October when April contacted the police as, although she was intending to attend court, she said that she had some concerns particularly that she could not remember what had happened during the incident and she was not even sure who had attacked her. She was advised that she should just tell the truth.

2.3.20 At the end of October, on the night before the court case, the perpetrator and victim rang the perpetrator's mother from what she describes as a 'swish' hotel. They told her that he was going to court the next day and they thought that he would be going to prison. They

told her they were having a wonderful time and had taken photographs of themselves. They sounded very happy and she had no reason to believe that this was not the case.

2.3.21 The next day, the perpetrator appeared in court charged with the assault upon April. She did not attend the court hearing and therefore no evidence was offered by the prosecution. However, a restraining order was made for 18 months. CPS sent a letter to April explaining that the case had been discontinued as she did not attend court. This will be discussed in detail later in the report (section 3.4.3).

2.3.22 This review has attempted to confirm the exact circumstances of contact with April on the day of the court case in order to clarify whether April went to the hotel with the perpetrator voluntarily with full consent or whether she went under some level of duress. This will be dealt with in detail later.

2.3.23 The subsequent police investigation into April's murder revealed not only the evidence of contact between April and the perpetrator on this particular day but also a quite astonishing volume of texts and calls from the perpetrator to April during the course of their relationship. The quantity speaks volumes for the overwhelming level of control which the perpetrator sought over April and the level of harassment that he would go to in order to achieve that control.

2.3.24 The senior police investigator reports the following:

2.3.24.1 On 27th October 2016 the perpetrator was required to appear at court in connection with the July assault on April. It appears that the couple went to stay in a hotel together the night before the court case. Between 08:16hrs and 11:37hrs on the morning of the court appearance there were 223 text messages sent between the couple discussing his court appearance. The conversation is generally loving in tone; she sent supportive and reassuring messages to him that 'hopefully we can get passed today and move on with making changes and making things better start making some proper plans love you xx'. It is clear that the perpetrator was at court as he was texting April; he was seeking reassurance from her that she would 'stick to the story' of telling anyone who may call from the court that she did not recall what happened and that it wasn't him that caused the injury.

2.3.24.2 At 9.45 April said, 'no one has rung me yet I was asked to arrive at 9.15'. She asked him for an update when he is going into court. A short time later she said, 'Just had a bloody missed call' which led to discussion as to whether she should phone the court or not. The perpetrator asked her again what she is going to say when they called to which she said, 'Just what I said to the lady, I was confused and really drunk and as things have been coming back to me since that night I remember turning up at the house like that so it couldn't of been you I have and had no idea what I said that night I just agreed to sign because I wanted to be left alone'.

2.3.24.3 The perpetrator told April that the prosecution was looking at dropping the case to which she replied, 'really that's good news'. She then told him that she had spoken to someone (*witness service*) who told her that the case is likely to be dropped if she doesn't attend and that the staff at the court were trying to get her to attend. The perpetrator was then told that he was given a court order and asks her how she felt about it to which she replied, 'we are just going to have to deal with it…wait to hear from social services…can't have them concerned about the children they will never close it and be on my case….tbf if we don't tell

anyone about it then no one knows…the only way there will be an issue is if the police get called which is not going to happen anymore is it'.

2.3.25 In the light of this information, the review asked the senior investigating officer to provide an overview of the text and call levels between the perpetrator and April during the last few months of their relationship. This report revealed that between May 2016 and December 2016 there were over 2500 voice calls and in excess of 19,000 text and chat messages from the perpetrator to April.

- Between July 2016 and January 2017, 847 calls were made to April which were unanswered calls of 0s duration
- Over the course of two days in November 2016 (shortly after the couple returned from Rome) there were 288 calls placed by the perpetrator to April, of which 280 went unanswered by her.

2.3.26 The text messages reflected a need for an instant reply from her by the perpetrator and demonstrable frustration turning to aggression when this did not occur. On occasions when April does not reply he began by sending emojis, then messages such as 'just gonna ignore me now', 'hellooooooooo?' 'What are you up to?' 'Well you have a nice time doing that I'll leave you alone' 'Actually ignoring me aren't you?' 'What the actual FUCK is your problem?' These messages were interspersed with phone calls until, it appears, she responds.

2.3.27 On other occasions he bombarded her with messages of '??' or simply 'Oi'. On one occasion in November 2016, there are over 30 single word, question mark or emoji messages sent one after another, some sent less than a second apart, after which time he proceeded to begin to text her mum in order to track down where she was.

2.3.28 In November 2016, despite the restraining order, the perpetrator and April went to Rome. Whilst at their hotel he threatened and assaulted her again. She was so scared that she escaped the hotel running into street intent on escaping him. She was found by refuse collectors upset and scared. They flagged down, and paid for, a taxi who took her to the airport. When she got to the airport the airline staff realised that she needed help and got her on the next flight home. By this time the perpetrator was after her and had begun calling her mother asking where she was and was chasing her to the airport. The airline staff refused to let him board the same plane. Her family describe the panic and rush they had to get to the airport to collect her before the perpetrator arrived on the next plane. She told her family that it really was the end and that she had no intention of ever seeing him again. None of this was reported to the authorities.

2.3.29 At the beginning of December 2016, April attended the local council offices to discuss her housing benefit. April had bruising to the left side of her face. The officer with whom she was meeting was aware that there have been problems in the past and so probed this with April and she reluctantly admitted that she had been assaulted by her ex-partner who was, at the time, subject to a restraining order. Following the meeting, the officer contacted the police and asked them to undertake a welfare check. The police attended her home and April was annoyed that they had been called and said that the injuries had been caused by an accident when she was in the car alone. She was adamant that she had not seen the perpetrator since July.

2.3.30 The police made a referral to children's social care as they were concerned about the risk being posed to April's children.

2.3.31 A couple of days later, April met with a friend. This particular friend knew her as a private person and says it took time for her to open up and tell her things. On this occasion though April was very tearful and distraught. She sobbed told her that she was 'scared shitless' of him and was desperate to stop communication. She had taken him off social media, but she could not stop him emailing her. She said to her friend 'I know he is going to kill me'.

2.3.32 Leeway were also advised of this incident and they tried to make contact with April on the telephone. Initially she did not answer but they eventually made contact in the middle of December. On that occasion she said she was unable to speak as she had the children with them and it was arranged that they would call back. When they spoke to her three days later she said she was not able to speak as she was collecting the children from school. The next day, Leeway were advised that Children's social care had spoken to April and that April had told them that the perpetrator had not caused the injury and she did not require any further support from Leeway. Leeway decided to refer her case back to MARAC and to continue to engage with her.

2.3.33 This same day, April contacted children's social care to find out why they wished to speak to her. She again reiterated that they are all incorrect in their assumption that the injuries were caused by the perpetrator. The same day also, the perpetrator's offender manager called him, and he advised her that he had been in contact with his former partner. He was reminded about the restraining order that was in place.

2.3.34 A couple of days later, Leeway spoke to April again and she told them that she sometimes feels uneasy in her property and wanted to look at the options for moving. She said that she was not under any immediate or direct threat. Leeway reminded her about the support that they could offer, and it was left that she would make contact in the New Year and arrange to meet. She did not talk for long enough for Leeway to complete the DASH risk assessment.

2.3.35 Just after Christmas, Leeway attempted to contact April with a view to completing a DASH risk assessment but did not get an answer.

2.3.36 Two days before the incident that took her life, children's social care attempted to contact April by telephone, but they found the number to be unavailable. They wrote to her regarding their intention to close their case.

2.3.37 April and the perpetrator were seen out together in Norwich on New Year's Eve and again on a Saturday evening early in 2017 when the incident occurred. Both parties are reported to have consumed a quantity of alcohol whilst visiting public houses in Norwich.

2.3.38 One witness described the fact that they were drinking in a public house for a number of hours. She described the perpetrator as being over attentive towards April to the point of being possessive. At around 10.30pm this same witness describes some sort of 'conflict' between them outside the pub and she checked with April that she was OK. Later in the evening, they then returned to April's home.

2.3.39 In the early hours of the next morning, the perpetrator contacted a friend and told her that April was hurt, and she told him to call an ambulance. He did not. A few hours later she spoke to him and he asked if he could go to her home and she agreed. He spent the time drinking and about 3 hours later he asked the friend to take him to April's flat. She agreed, and he went into the flat. He was gone a few minutes and he returned saying that she was

not there. They went back to the friend's house and remain there for the day. He is described as being in a 'good mood' and laughing and joking during the afternoon. That evening the friend felt unwell and went to bed leaving the perpetrator in her lounge.

2.3.40 That evening April was due to receive her children from their father where they had been spending the weekend. He had been unable to make contact with her and so he got in touch with her family. The family spent some time trying to contact April and made contact with a friend they believed she was going out with the night before. This friend said that there was no such arrangement. April's mother and brother went to her flat. On arrival, they found her in the flat and a significant amount of blood. They called an ambulance who found that she had sustained facial injuries, bruising to her neck and she was pronounced dead at the scene.

2.3.41 The police were called by the ambulance staff and arrived at 2240 hours.

2.3.42 The subsequent police enquiries suggested that the perpetrator was responsible for her death. He was arrested at the home of his friend where he had spent the day. When he was arrested, evidence of drugs was detected in his system.

2.3.43 Subsequently, the court was told that April had suffered 19 separate injuries to her face, including fractured cheek bones and jaws following a brutal, vicious and sustained attack.

2.3.44 The post mortem examination described injuries as 'severe blunt force traumatic injuries focused upon her face, consistent with a sustained physical assault'. Injuries indicating probable compression of the neck were also present. Internal examination revealed a large quantity of ingested and aspirated blood. There were no injuries of an offensive, defensive or restraint-type nature.'

2.3.45 In June 2017, the perpetrator was found guilty of murder and sentenced to life with a requirement to serve at least 24 years. In sentencing the judge said this was 'one of the worst cases of domestic violence that have come before the courts'.

Section Three – Overview and Analysis
Summary of information known to agencies, family and friends

This section will begin with information obtained by this review from those who are not members of or employed by any of the professional bodies engaged with April or the perpetrator in this case.

3.1 Information from family and friends about April and her relationship with the perpetrator

3.1.1 This review is indebted to those friends and family of April who have helped us learn the lessons from this awful case. April's mother has provided a few words to help us to know her daughter:

'April was my first child and only daughter and part of a large and loving family. April was full of a love of life, a sociable, fun loving girl with a heart of gold, who was a loyal friend who touched the lives of so many people. We were very close and would speak or see each other every single day. Above all of her great qualities sat her love for her children; she worshipped them and lived for them. They remember their mummy as awesome and everything. April had so much to live for, so much unfulfilled promise; she could have been anyone's loving daughter or mother. We were blessed to have had her in our lives.'

This section contains information obtained from family and friends in an effort to understand more about April and the inhibitors that prevented April from removing herself from the danger that it is clear she knew was presented by the perpetrator.

3.1.2 The following information is a collection of excerpts from their interviews. These have been merged together in order to protect the confidentiality of her friends.

3.1.3 **April and her relationship with the perpetrator**
April was kind, giving and proud – she did not like to take anything from you – she would give you her last £5 but would not like to take yours. April was very sociable and had lots of friends – birthdays were very important to her (her own birthday was a week-long event with lots of activities!) – although she did not go out so much when she was with the perpetrator she made a point of not missing her friends' birthdays. April was a good mum and a good friend. April was bubbly, lovable and happy-go-lucky. She hid her problems very well. April was a 'party-girl', but she always put her children first and her children are beautiful and well-mannered.

3.1.4 She was with her children's father for six or seven years and after they separated in 2009 she had two main boyfriends; one lived with her for two to three years and the other one was the perpetrator.

3.1.5 She had got to the point in her life where she was really scared of being alone but was also very private and very proud. She would not want people to know she couldn't cope and in particular would do whatever she could to protect the children. She suffered from a lack of confidence and a lack of self-esteem. She was excellent at convincing people she was ok.

3.1.6 April changed when she met the perpetrator – her friend said you could see in her eyes how sad she was, but she did not want to burden people with her problems.

3.1.7 A friend had known of the perpetrator before April went out with him. They knew that he had been violent to women in the past and told April as soon as she started to see him. April had told the perpetrator what she had said so he never liked that friend and she was not made welcome. When she told April about the perpetrator's violence to past girlfriends she said, 'if he ever touched me I would run a mile'. However, she liked men who made her feel protected therefore she would like a man who could 'clear a room with one look' (intimidating).

3.1.8 At the beginning of the relationship, the perpetrator was very intense with flowers every week, meals out and holidays. This was a surprise to some friends as April was usually so reserved with men when she first met them, and they joked about her having a two-month itch when she had enough of them. The perpetrator was 'golden' to April. Towards the end there were problems, but she was in love and infatuated with him.

3.1.9 **Violence in the relationship**

April did not often talk about the violence and when she did she would later retract what she had said. April said violence started about 8 weeks into the relationship. She did not think that April was frightened of him at this stage – she thought she could handle him and possibly change him. April's ex-partner only knew of two incidents and neither had happened in front of the children. On one occasion when April had been given a black eye, April and her ex-partner had made up a story to protect the children from knowing what had happened.

3.1.10 April told her she had been in a violent relationship previously (he had broken her jaw and she had told people that she had got into a fight with a young woman in a nightclub because she spilt her drink on her) and she wonders if this made April more blasé with the perpetrator. This previous boyfriend was violent when he had been drinking and taking steroids. She always said that the perpetrator was only violent when he had been drinking but when she put the pictures on Facebook this was when he had not been drinking – she believes that this was why she decided to leave because she could no longer excuse his violence.

3.1.11 The last time she saw April she spent about 2 hours with her. She describes this as the best conversation they had had in ages. April did not want to be with him any longer – she knew the relationship was wrong and she promised she would not see him again. April spoke in detail about the times when he had been violent. When she left April that night, she believed it was all OK and that she was going to leave him, however she believed that she was still in contact with him. She believes that April loved him and found it hard to walk away – she does not think that April realised how much danger she was in. At the trial, her friend discovered that April had been texting the perpetrator whilst they were having this conversation. This demonstrates the lengths to which she would go to conceal the ongoing contact.

3.1.12 The last time she saw April was early December. She learned a lot more about her relationship with the perpetrator on that day. April cried but said that she did not want to appear weak. She was distraught, her face was a mess (she said she was waiting for an operation following the assault). April said she had taken him off social media, but she could not stop the flood of emails. She was 'scared shitless' of him and was desperate to stop communication. April said, 'I know he is going to kill me'.

3.1.13 The friend recalled that three times she had offered April the chance for her and the children to come and live with her, but she would not go. She and April did argue about it, but she stopped pushing it as she was frightened of losing the friendship. She said that the children did see the violence.

3.1.14 The friend had said that the perpetrator could not control April– she wore make-up and she went out to work – he could not control her. However, she did say that when April had tried to leave him on a previous occasion he had told her he had a brain tumour. She made doctor's appointments, but he did not go.

3.1.15 **Barriers to engaging with professionals**
April did not engage with professionals. She was fearful that they would take her children away. She would not move as she wanted to protect the children and did not want to disrupt them. She did not want anyone to see them and recounted a time when social workers wanted to talk to the children at school and she would not let them.

3.1.16 After the incident when CPS did not proceed because she was not in court, and a further incident happened April did not go to the police because she did not believe anything would be done.

3.1.17 When April's friend was asked if she knew why April lied to her friends and family about still seeing the perpetrator, the friend said that April thought her friends were judgmental and did not know how to help her – they were angry. She also knew that her mum had been diagnosed with heart problems in the October and she wanted to protect her. April knew that if the perpetrator could not get hold of her he would pester her mum. She said that April knew she would never get away and she had signed her Facebook account over to her mum and taken out life insurance through her employer.

3.1.18 Professionals in the beauty industry who spoke to the review said that every 4th young woman they see professionally is a victim of abuse of some sort. They said that many young women expect to be a victim of domestic abuse in a relationship. Since April's death more people have spoken about their situation.

3.1.19 **Information from previous partners of the perpetrator**
One of the perpetrator's previous girlfriends was spoken to by this review and she provided information that has helped our understanding of what it was like for a woman to get involved with him. Whilst this information has come from one of his previous victims, information visible to this review would strongly suggest that the vast majority of his ex-partners would echo the views summarised below:

3.1.20 *'What first attracted me to him was that he was very charming, caring and very loyal. Nothing was too much trouble for him. I had come from a violent relationship previously so felt very safe around him. The early days were amazing, he would bring me flowers every day. He came across as a gentleman and always had the right words, fun, caring and loved to spend all his money on pleasing others he wanted people to like him. We started living together very soon after we met.*

3.1.21 *'The first time he hit me was about a month into our relationship. I had seen him lose his temper and be violent to friends but didn't think he would hit me.*

3.1.22 *'There were quite a few attacks before the one I finally reported. I felt I couldn't report or tell anyone for a number of reasons:*

- *At the time most friendships had already broken down, (isolated)*
- *I didn't feel like I wanted him punished at the time just for me to be safe,*
- *I felt ashamed and like I deserved it (it was my fault),*
- *I didn't want anyone to get hurt by standing up for me and I was never too sure if they could save/help me and was worried that if the perpetrator hurt them then I was left with a very angry perpetrator.*
- *Also, although there was no reason not to trust my friends and family any of them could tell him where I was.*

3.1.23 *'I went back to him a few times, even after going into a refuge. It's hard to explain but the control never left even if he wasn't around there are a few things that stick with me today like turning kettle off before it fully boils. Refuges were hard places, full off abused women and some were angry. When there was a problem at the refuge I would feel very scared and feel lost on what I should be doing so I would call him, within a few calls I would be back, back to what was normal if that makes any sense. When women would get angry with me at the refuge I would believe that the problem was with me because I made them angry too, so did believe if I just tried harder then he wouldn't get angry anymore. Only time in a refuge that I managed to stay away was the last time and I was in my own flat within the refuge so had time to rebuild myself without anyone threatening me.*

3.1.24 *'He had a great control over me, whatever he wanted me to do I would do and if I didn't want to do what he asked he only had to get angry and I would do it. He was very good at getting in your head it's not even the beatings that have really stuck I remember them but it's the emotional mind washing that's still affects me today.'*

3.1.25 **She was asked what people could have said or offered that could have better supported her?**

'It was only when he got sentenced for April's murder did I start to believe he was no longer coming for me. When I had (child) I was offered all sorts of buttons and alarms. If I was offered that sooner that may have helped. Protection of some type not from the police but my family and friends. In Norwich I had a social worker for (child) and she was so amazing she become more like my best friend and we would talk a lot, with her advice and friendship was the first time I started to think the situation was not the right way to be living – so more people like her; less judging and more helping.'

3.1.26 **She was asked what services she received?**

'I received the refuge help. The staff were great in all refuges it was just the women in one place all with problems, although once in (xxx) refuge had found me a place to live they just left me didn't even help me move my stuff to the new place I carried it all while I was 8 months pregnant.'

3.1.27 **She was asked what might they have done differently?**

'There should be more help once you left the refuge. The police would often want to question me straight away, like when I run away from the perpetrator it was the first time I had left that house in months and all I wanted to do was go home and bath, but was put in room and was told to wait for someone to take me statement which to me seemed like ages alone in this strange room, I was dying for the loo and didn't feel I could do anything about it cause they hadn't told me I could or where the toilet was. They just needed to be more understanding to the outcomes of being in a relationship like that, you need to be told and

offered even little things like a cup of tea them making you feel like you have reached safety or to have let me go home wash relax then come see me at home for the statement.'

3.1.28 **Information from friends and family of the perpetrator**
We have been told that the perpetrator's father was an aggressive man who was violent. There was violence and aggression towards his mother. The last attack on her was the most severe. They were recorded by the GP but not reported to the police. His mother thought that the perpetrator never witnessed the abuse, but they probably heard but were afraid to ask.

3.1.29 The perpetrator struggled at school and as his behaviour deteriorated he went to a pupil referral unit. As he got older he could be intimidating and then he started to break his mother's things. He got aggressive with his mother. By the time he was 14 or 15 the relationship with his mother became strained – he was smoking pot, hanging out with other lads and coming and going when he wanted. In his eyes, the perpetrator and his friend were 'hard' men as they lived in the small hamlet.

3.1.30 The review has been told that he had very low self-esteem and would often demonstrate a violent rage followed by tears. Drugs and alcohol fuelled his rage. The perpetrator could control himself when he was supervised, for instance when he and another ex-partner were being monitored by children's social care, the perpetrator and (partner) were doing well. Things were so bad however that we have been told that his mother had a code word with an ex-partner for when she needed help.

3.1.31 One person, close to the perpetrator said, 'It is clear that if someone is going back to court time and again it is clear that there is a problem and he should have been monitored wherever he was. Every time he was in a relationship there should have been some sort of intervention/training for him.'

3.2 Barriers faced by April when accessing support and safety

3.2.1 One of the questions that many ask about victims of domestic abuse is 'why didn't she leave him?' This is a complex question and not really the right question. For April, the question is what were the barriers that she faced which prevented her from leaving the perpetrator and made it difficult for her to disclose to those closest to her. The reasons were very complex and are very much based upon the type of man the perpetrator was. He is best described by Sandra Horley in the first line of her book, 'Power and Control – Why charming men make dangerous lovers'[5] when she says, '*The Charm Syndrome* is a distinct pattern of behaviour. It is a man's use of charm to gain control over a woman. Once he has achieved that control, Charm Syndrome Man may or may not continue to charm his partner. But what he will always do is assert and reinforce his control by emotional and sometimes physical abuse'. If you read this book in its entirety you will see that the person Horley describes **is** the perpetrator. The review acknowledges the insight of Horley in helping us to understand, in part, what life was like for April.

3.2.2 We know, from those who have spoken to the review, that when April first met the perpetrator he was intense and would shower her with gifts. On one occasion, he arrived with two bouquets of flowers. One friend described her as being 'bowled over by him' and having fallen 'madly in love with him'. We know that April was attracted to a man 'who could

[5] Power and control – Why charming men make dangerous lovers, Sandra Horley CBE, Vermilion, London,2007

clear a room with one look' (as described to us by another friend). He was charming – he paid her attention, he bought her gifts, he was good with her children, he was what she had been looking for. As Horley points out, charm is manipulative. 'Charm is used to influence, to bewitch someone, to bring them within their power. Ultimately to control them.' This is what the perpetrator did to April. He continued, throughout their relationship, to use lavish expressions of his love for her to control her, for example, taking her to Italy for her birthday in November 2016 which ended with her having to flee to the airport for her life.

3.2.3 The review has been told that April would have been devastated when she found that the perpetrator would be violent towards her. She had hoped that this would be the long-term, lasting relationship that she craved. She was a single mum with two children whom she adored and, whilst she loved to go out and have a good time, she also wanted the stability and security that a long-term relationship would bring her. She may have feared that she was getting to an age when the opportunity had passed her by and he may have convinced her that she could not cope without him. When she discovered that life with the perpetrator was not going to be as she hoped perhaps she was in too deep to get out. We know that the perpetrator bombarded April with an extraordinary amount of texts and telephone calls throughout their relationship (see paras 2.3.23 to 2.3.25). After the visit to Rome, in November 2016, family and friends believed that she was no longer seeing him. This police evidence shows that on the two days after she returned he phoned her 288 times and she ignored him on 280 occasions. She was trying to break contact with him. No-one, unless they have been in this situation, can imagine the pressure that such harassment can bring.

3.2.4 Having talked at length to those who knew and loved April, the review has begun to understand how and why she continued in the relationship with him. There are a number of factors that were, most probably, at play here – love, fear, acceptance and protection. We will explore these in turn.

3.2.5 Firstly, her over-riding emotion was *love*. She had strong feelings for the perpetrator – he made her feel good and special. On the face of it, he treated her children well and was good with them, thereby giving her those special family times that she longed for. We know that April knew something about the perpetrator's past, but are unable to quantify that level of knowledge, and that she would attribute his violence in the past to when he had been drinking or taking steroids. She could excuse his behaviour as 'it was not really him' and we know, from her family, that when he was with them he did not drink alcohol at all. Perhaps April believed that she could change him. If she could keep him from drinking alcohol to excess then he would continue to be the charming, family man she had fallen in love with. One of her friends told the review that when she met the perpetrator, April changed. There was, we are told, a sadness in her. Was this sadness because she had realised he was not going to be the person she had hoped that he would be to her and her children?

3.2.6 We can see, from what we know about how their relationship developed, that while the love did not disappear alongside came *fear*. April was fearful of the perpetrator, of what he was capable of, of what he might do to her and to those she loved the most. Horley refers to the fact that it is not uncommon for an abuser to beat up his partner's mother or sister, someone who is close enough to be seen as an extension of the person. She goes on to say that, 'the woman feels so frightened for that person that she would rather suffer loneliness and isolation than subject a loved one to danger'.

3.2.7 Whilst it might be hard for some to understand why April stayed with the perpetrator when she lived with so much fear, as Horley says, victims of this controlling behaviour become

paralysed by fear. It is the unpredictable nature of the violence that is most terrifying and debilitating. He could be violent, then caring and charming but having been hit by him once she would have lived in fear of it happening again. To quote Horley again, 'It is impossible to underestimate the effects that fear, bound up as it is with intense emotions, can have on a woman – especially when the situation is confused by the fact that, however frightening these men can be, this is only one facet of their characters'.

3.2.8 As it became more and more obvious to April how far the perpetrator would and could go, she was fearful that no-one could protect her from him. She did not believe that the agencies (police, probation and so on) could protect her. She had seen how he manipulated the system to suit himself and she did not have faith in any of them to protect her. When she had seen how he could manipulate professionals, she believed the threats that he made to her and then was fearful of the danger her family were in but also did not believe that they would be able to protect her either.

3.2.9 One of the most upsetting aspects of April's relationship with the perpetrator is the fact that there appeared to be an *acceptance* of the control within the relationship. Professionals in the beauty industry, who spoke to the review, talked about the fact that every fourth young woman they see is a victim of abuse of some sort. They described how they talk as though they almost expect to be a victim of domestic abuse in a relationship. This experience is borne out by research undertaken by the Girlguiding Association in 2013[6] which found that too many girls are ready to accept controlling behaviour and see it as a normal part of a 'caring' relationship. The research found that from a young age, girls regularly tolerate behaviour rooted in jealousy and lack of trust and have a tendency to reframe it as genuine care for their welfare. Julie Bentley, the Chief Executive of Girlguiding said, 'We know from our daily work with young women across the UK that expectations about relationships are often formed when girls are teenagers. Without the right support to interpret and examine their experiences, it is all too easy for girls to form unhealthy patterns of behaviour in relationships that they can take with them into adulthood.'

3.2.10 Given that we know, from friends, that April had been a victim of domestic abuse in relationships prior to meeting the perpetrator when she had, on two occasions, sought medical help and said that she had been involved in a fight with other young women, we might surmise that April too thought that this was part and parcel of an intimate relationship.

Lessons learnt

There remains a level of acceptance amongst some women that domestic abuse is 'just how it is' and that they will often confide in those within the beauty industry

Recommendation – Information Sharing and Fora for Discussion

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

3.2.11 Finally, we know that April would, at all costs, protect her children and her family. Without exception, everyone who has spoken to the review has talked of April's love for her children and her desire to do the best for them. After the incident in July 2016 a referral was made to children's social care by the police and an assessment was carried out. As April said she was not going to continue to see the perpetrator, a decision was taken to close the case but

[6] Care Versus Control: Healthy Relationships, A report from guiding, 2013

not before a letter was sent to her reminding her of her parental responsibilities. Presumably, this letter confirmed her worst fears that social workers wanted to take her children away and impacted upon the secrecy she developed around her relationship with the perpetrator and her unwillingness to report further incidents.

3.2.12 One of the issues that April's family and friends struggle to understand is why, not only did she stay with him, but why she kept this a secret from them, but we must not forget the overpowering sense of emotional dependency between the perpetrator and April that his behaviour will have generated. One of the questions that will surely stay with them is why she went out with him on that fateful night, but we know from the CCTV evidence from that night that they appeared to be laughing and loving towards one another and we must understand how April would have been drawn back to him by this. Once again, this is something that someone who has not been in an abusive relationship cannot fully understand but many women in this situation will talk about being less frightened if they stayed with their abuser than if they left – at least they know where he is. We know that in those last days of her life, the perpetrator stalked April with hundreds of phone calls and text messages. If she was out with him, at least these would stop, and she would not be wondering where he was, what he was doing and when he was going to make contact with her again. None of us can imagine the strain and level of fear that April lived under, particularly in those last days.

3.2.13 What is most important when we consider April, and her part in this tragedy, is that we *never* hold her responsible or 'blame' her for what happened to her. There is only one person to blame for the price that April paid with her peace of mind, her confidence, her self-esteem and ultimately, her untimely death and that is the perpetrator.

3.2.14 Agencies must improve their understanding of the dynamics of abuse particularly where there is coercive and controlling behaviour - so that they are better able to gain the confidence and trust of victims to work together to ensure effective safeguarding.

3.3 Detailed analysis of agency involvement

3.3.1 The chronology set out in Section 2 details how the information about April and the perpetrator's relationship, known to agencies, evolved. This section summarises the totality of the information known to agencies and others with influence during the years leading up to April's death. The detailed chronology will not be repeated here; rather this section will deal with an analysis of agency involvement.

3.3.2 The Chair of this Review would like to place on record again the scrutiny, rigour and thoughtful approach displayed by all agencies in this review. All have recognised the effect of this tragedy and their representatives have demonstrated a real desire to make a difference.

3.3.3 This section will be structured as follows:

3.4 **Criminal Justice agencies**
- 3.4.1 Police
- 3.4.2 The application of Clare's Law
- 3.4.3 The Crown Prosecution Service
- 3.4.4 Providers of probation services

3.5 **Health bodies**
- 3.5.1 General Practitioners for April and perpetrator
- 3.5.2 Hospital services

3.6 **Local Authority functions**
- 3.6.1 Children's Social Care
- 3.6.2 Housing Services

3.7 **Non-public sector organisations**
- 3.7.1 Leeway Domestic Violence and Abuse Services
- 3.7.2 Housing Associations

3.8 **Multi-Agency safeguarding and protection arrangements**
- 3.8.1 MAPPA (Multi-Agency Public Protection Arrangements)
- 3.8.2 MARAC (Multi-Agency Risk Assessment Conference)

3.4 Criminal Justice Agencies

3.4.1 Police (Norfolk Constabulary)

3.4.1.1 The circumstances addressed by this Review relate to one police service - Norfolk Constabulary.

3.4.1.2 Four of the perpetrator's six previous victims are from the Norwich area, a fifth moved to Norwich to be with the perpetrator. As a result, the local police were well aware of the perpetrator as a result of his continued violence towards his previous girlfriends. The police were a significant partner in the local MAPPA and MARAC arrangements both of which had featured the perpetrator on a number of occasions from 2008 onwards. MAPPA and MARAC will be dealt with as separate sections within this report.

3.4.1.3 In addition to his domestic violence offending, the perpetrator was known to police by association to his brother who had a number of serious criminal convictions and also lived in the Norwich area.

3.4.1.4 The last known police involvement with the perpetrator prior to him meeting April (in June 2015) was in June 2014 when he was arrested after assaulting a new girlfriend. The incident was reported to police, but police were unable to locate him at that time, so he was circulated as wanted on the Police National Computer. Numerous attempts were made to locate and arrest him, but he was not finally arrested until 31st July 2014 at which time he was charged and immediately remanded to court. Following the incident, police provided safeguarding measures to the victim with a mobile phone, a personal alarm, recommended that she stay away from her home address and is taken to a friend's address. He was charged with a number of offences and subsequently dealt with at Court in early 2015; receiving the orders previously mentioned within this report.

3.4.1.5 In August 2014 when another ex-partner's mother and grandmother contacted police saying that they suspected she was being held against her will by the perpetrator who was on a restraining order not to contact her. The police dealt with this incident and came to a conclusion that no offences had been revealed after speaking with the ex-partner who refused to provide any details and denied that anything had occurred. The police did raise a non-crime domestic incident to enable advocacy support for the ex-partner.

3.4.1.6 No referral to MAPPA was made following these offences by the police. At the time, this was out of the scope of normal practice. Whilst he had not yet been convicted of these offences it is a continuation of an offending profile similar to that from which he was de-registered in early 2014 when he was due for release from prison.

3.4.1.7 The first indication that the police had that the perpetrator is in a relationship with April is in January 2016 when an intelligence report was received.

> Given the perpetrator's previous convictions the lack of action in relation to this intelligence report is acknowledged by the police as a potential opportunity to consider a DVDS (Clare's Law) application to disclose to April his previous offending. Clare's Law[1] will be dealt with separately at the end of the police section.

3.4.1.8 On 25th March 2016, a member of the public reported to the police that a young woman was screaming in the street. When the police arrived and located April, she was emotional and explained that she had been out drinking with her boyfriend and they had a disagreement. She did not feel able to give details of her boyfriend but was concerned that he might return. She had run from her house as she did not have a mobile phone to call the police to help her making him leave. The officer obtained an out of hours number for her landlord and remained with her until the locks had been changed. A standard DASH risk assessment was submitted, along with a Child Protection Investigation (CPI) and a referral made to Children's social care in respect of her children who were not present at the time.

> The fact that the previous intelligence report had not been linked to the Athena record meant that this was a potential opportunity to confirm the relationship. It may have also altered the DASH risk assessment, and the CPI might have flagged that their mother was living with a violent perpetrator.

3.4.1.9 It must be noted, however, that the officer who attended the incident responded well by staying with her until the locks were changed. This indicates good victim support even with a victim who was refusing to provide details of the assailant and demonstrates a positive change in attitude by frontline officers to domestic abuse.

3.4.1.10 On 28th May 2016, a report was made by a resident of a male and female having a domestic argument in the street and the female being pushed. Officers attended and spoke to April, she denied that the assault had taken place and said that she had a heated argument with her boyfriend, this perpetrator. She did not wish to complete the DASH but was happy to speak to officers. A standard risk DASH was submitted. The officers did not ask April if she had any children, so a CPI was not submitted.

> This was a missed opportunity to ensure that all agencies involved in the safeguarding process had up to date and accurate information. Not submitting a CPI resulted in children's social care still being unaware that April's partner was a violent offender. There is no indication that a DVDS application was considered following this incident. The police acknowledge that there is no evidence of any checks having been run on either April or the perpetrator, which would have indicated the perpetrator's previous history. There is no indication on the CAD (police recording system) of any attempt having been made to re-contact the witness. If this had been done, the exact nature of the incident may have been ascertained to see if April was minimising the situation.

3.4.1.11 On 16th July 2016 April contacted the police saying that the perpetrator had assaulted her and that she had damage to her lip and he had tried to strangle her. This had happened 30 minutes earlier. She stated that there had been other incidents that she had not reported. The police attended and took her to the police station and then on to hospital. She said that they had been talking and she had something he did not like, and he had started hitting her, strangling her, putting his hand over her mouth and hitting her on the head. He had also prevented her from getting out of the house. She said that she thought he was going to kill her. She said that the incident had lasted for a few hours and that he had now calmed down and gone to sleep, which is when she managed to escape. He was arrested a short time later at her address.

3.4.1.12 A high risk DASH risk assessment was completed and a medium risk CPI, although the children were not present. The DASH indicated that she was isolated from her friends and

frightened of further attacks. She said she had been assaulted four times in the last year, but this was the worst time. She also said that she knew that he had hurt people before and gone to prison for it. The DASH was reviewed the same day in the MASH and initially reduced to medium. Whilst the rationale was documented, there does not appear to have been any discussion with a supervisor before the risk was reduced. The CPI was referred to Children's Services. April was offered a number of safeguarding measures which she declined but she did agree to speak to an IDVA. She would not provide a statement and did not want to press charges.

3.4.1.13 The perpetrator was interviewed and, having replied no comment to all questions, was released on pre-charge bail with non-contact conditions. Further scrutiny of the police considerations in this case, make it clear that a police supervisor felt that to release the perpetrator was incorrect and wanted him charged and remanded in custody. The police properly sought the advice of CPS Direct prior to making decisions about how to proceed. CPS Direct advised that further evidence was required, and an action plan was agreed. This action plan could have been addressed either by using the time remaining on the PACE clock or by bailing the perpetrator. The police decided to bail the perpetrator. It was agreed that this was a case that could proceed without April's consent.

3.4.1.14 When an officer visited April at home later that day, she still refused to make a statement and would not allow any further photographs of her injuries to be taken.

3.4.1.15 The case was referred to MARAC and heard on 22nd July. Following this, a supervisory review was undertaken, and the risk assessment was moved to high after supplementary information about his offending history was known. When spoken to a third time, April declined any support offered and said she did not wish to get back into a relationship with him.

3.4.1.16 On 8th September the risk was reviewed and reduced to medium.

3.4.1.17 The case came to Court in October 2016. The perpetrator attended and pleaded not guilty to ABH. As a result of a number of issues at Court on that day a decision was taken by the Crown Prosecution Service to offer no evidence. This aspect will be dealt with in the CPS section. He was issued with a Restraining Order until 26th April 2018 with conditions not to contact April or go to her address.

3.4.1.18 A 'Right to Know' Clare's Law application was submitted, and a disclosure decision made; ultimately the police were unable to make disclosure to April. **This is discussed in more detail in section 3.4.2 below.**

3.4.1.19 On 9th December 2016 an officer from Norwich City Council contacted the police to state that April had attended the council offices to discuss her housing benefit (we now have the benefit of knowing that April had been to Rome with the perpetrator and that a violent incident had happened there resulting in her returning home without him). The officer noticed some bruising on the left side of her face and, knowing she had been a victim of the perpetrator previously, probed further. She reluctantly admitted that she had been assaulted by her ex-partner who was the subject of a restraining order. At the request of the officer, the police undertook a welfare check and visited her home. The bruising was seen by the police officer, but April was annoyed that they had called, and said the injuries had been caused in an accident when she was in the car alone. She would not engage and

refused to answer any of their questions. The DASH was submitted as high risk and medium risk CPI despite the children not being present.

There is no record that the police spoke to the council officer again. If they had and he was certain of his earlier account a statement could have been taken which, along with the statement from the attending officer who witnessed her injuries may have been sufficient to warrant further investigation.

3.4.1.20 On 10th December a secondary risk assessment was undertaken in the MASH and the risk was reduced to medium, this was reviewed by a sergeant. The rationale recorded states that she 'categorically denies that the bruises were caused as a result of contact with the perpetrator' and 'she maintains that she has not seen or spoken to him since his last arrest in July'. She denied being in a relationship with him and said she had no desire to restart one with him. The IMR provided by the police identifies that this reduction in risk level was incorrect but was made by a non-DAST member of staff in the MASH. The CPI was referred onwards to Children's social care and a MARAC referral was submitted.

3.4.1.21 On the 16th December, the case was heard at the multi-agency daily MARAC meeting. Updates are recorded within the minutes from each agency. Of interest, under the update from the NNUH (Norfolk & Norwich University Hospital) it provides details of visits to the hospital and includes one date 01/12/2016 – injury to eye. This is obviously the day prior to April attending the Housing Office with the injury to her face, but there is no other detail within the MARAC minutes of the explanation behind the visit to the hospital. The update from children's social care also states that the allocated social worker wouldn't be able to call in as she was visiting the family – it is not clear if this is an actual visit to April herself or another family being dealt with by the same worker. The update from the social worker present at the meeting does state that they had also spoken to April and she was adamant that she had not seen the perpetrator since last September and stuck to the story of the injury being caused in her mum's car.

3.4.1.22 On 20th December 2016 two officers visited April and spoke to her at length about the incident. She still denied that any assault had taken place and that any mentions to the council worker of an assault related to historic incidents. With her consent, the officer searched her property and found no evidence of the perpetrator having been there recently. There is no evidence of house to house enquiries having been done which might have provided evidence of the perpetrator having been there and therefore in breach of the restraining order.

3.4.1.23 The visit on 20th December is the last known contact by the Police with April.

The review is satisfied that, whilst the police have identified occasions where the risk assessment level was reduced inappropriately, a different risk assessment level would have been unlikely to have impacted upon the outcome as April continued to minimise the violence and deny any contact with the perpetrator.

Norfolk Constabulary have identified some areas of potential opportunity in this case. We will never be able to say if they would have made any difference to the outcome. Given the nature of this offender and April's reluctance to provide details or support prosecutions it is likely it would not.

There are examples of a good working knowledge of domestic abuse and victim support shown by front line officers of Norfolk Constabulary; the fact that an officer waited with her whilst the locks were changed when she reported the first incident tend to show that the officer understood risk and wanted to support April.

3.4.2 The Police application of the Domestic Violence Disclosure Scheme (Clare's Law)

3.4.2.1 One of the questions that has been important for April's family has been to understand why, if the perpetrator had such a history of violence against previous partners, April did not know about his history. There is a scheme that would have allowed a disclosure to be made to April. This scheme is often called 'Clare's Law' after Clare Wood who was murdered by her former partner. Clare did not know that he had a history of violence against women and the scheme is designed to protect potential victims from an abusive relationship before it ends in tragedy. The scheme, introduced into all forces in March 2014, allows the police to disclose information about a partner's history of domestic abuse or violent acts. There are two elements to the scheme:

- **Right to Ask** – a person has the right to ask if their partner has a previous domestic history
- **Right to Know** – a person has a right to know if their partner has a previous domestic history. This is triggered when the police receive information from a third party. The police will judge if a disclosure should be made to safeguard the person

3.4.2.2 Under the Right to Know someone may receive a disclosure even if they have not asked for one. This is because, if the police receive information about the person they know which they consider puts that person at risk of harm of domestic abuse by their partner, then they may consider disclosing the information to the person or persons best placed to protect the potential victim. The decision to disclose information when a person has not asked for a disclosure is made by a multi-agency meeting and the disclosure will only be made if it is lawful and proportionate, and there is a pressing need to make a disclosure to prevent further crime.

3.4.2.3 It is acknowledged that police checks, or disclosures cannot guarantee safety. The police will give advice to the person about how to protect themselves and how to recognise the warning signs of domestic abuse. They will make sure that the person is aware of local and national support.

3.4.2.4 When someone receives a disclosure, they might feel that they want to tell their family and friends so that they can support them but when a person receives a disclosure, this is confidential. It is only given so that they can take steps to protect themselves. The information should not be shared with anyone else unless the person has spoken to the police, or the person who gave the information, and they have agreed that it can be shared.

3.4.2.5 The information can be used to:

- Keep the person safe
- Keep children involved in the situation safe
- Ask what support is available
- Ask advice about how to keep themselves and others safe

3.4.2.5 The police may decide not to share the information if they think it will not be kept confidential and the police can take action if the information is disclosed without consent,

which could include civil or criminal proceedings. The information will be shared in person, and nothing will be given in writing.

3.4.2.6 Norfolk Constabulary has been making use of this legislation with a view to providing better protection to victims of domestic abuse. The table below shows the number of disclosures made since the legislation came into force:

	2014[7]	2015	2016	2017
Right to ASK	32	34	34	69
Right to KNOW	18	32	176	263
Total number of requests for DVDS	**50**	**66**	**210**	**333**

3.4.2.7 In a recent review by HMICFRS in 2017[8], an analysis of the DVDS per 1,000 population was provided and this shows Norfolk Constabulary to be at the mid-point of performance within the country.

Nationally, HMICFRS found that more needed to be done to make people aware of the scheme. However, it is pleasing to notice that this Review also found that, despite an increase in the number of recorded domestic abuse related crimes, there did not appear to be a corresponding increase in the use of Clare's Law. This review agrees with the finding of HMICFRS that more needs to be done to ensure that members of the public and officers are aware of the scheme.

Lessons Learnt

The application and understanding of Clare's Law needs further embedding within both the organisations charged with its delivery and the general public.

Recommendation – Information sharing and Fora for Discussion

(2) It is recommended that the publicity within Norfolk surrounding the DVDS Right to Ask scheme is reviewed, with a view to ongoing and targeting awareness raising campaigns. Consideration should be given to adopting, and publishing on the police website, the explanatory leaflet used by a number of forces[9].

3.4.2.8 In this case, Norfolk Constabulary decided, after the attack on April on 16th July 2016 that an application under Right to Know should be made. At the multi-agency panel meeting, it was agreed that a disclosure to April would be lawful and proportionate and the application was approved.

3.4.2.9 The officer who was authorised to make the disclosure spoke to April on the phone and explained about Clare's Law and why he needed to see her. It was agreed that she would come to the police station but did not attend. Following more phone calls, another appointment was made and again she did not attend. The officer then visited her at her home to make the disclosure, but she would not let the officer in. Of course, we cannot know for certain that the perpetrator was not in the flat at this point. The officer phoned April on a number of times following this, but she did not answer the calls or respond to the messages left for her.

[7] These figures are for a calendar year

[8] A progress report on the police response to domestic abuse, HMICFRS, November 2017

[9] http://www.gmp.police.uk/content/WebAttachments/88A190F67550078780257A71002E5DC8/%24File/claire's%20law%20other%20people%20booklet.pdf

We know that early in December, April attended the offices of Norwich City Council to discuss her housing benefit and that, during this meeting, there was a conversation about bruises on her face. Following the meeting, the officer made contact with the police and asked them to undertake a welfare check, which they did, but on this occasion the Clare's Law disclosure was not made. This was a missed opportunity.

3.4.2.10 Enquiries undertaken as part of this review have established that Clare's Law disclosures are only made by specialist officers. Whilst the review understands and agrees with that approach it does mean, in this case, that when the officers attended her home to carry out the welfare check they would not have been aware of the outstanding Clare's Law disclosure.

Lessons Learnt

The main police database, accessed by frontline officers, does not record or indicate when a Clare's Law disclosure is approved and/or outstanding

Recommendation – Collaborative Working, Decision Making and Planning

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

3.4.2.11 We know that Leeway have now been granted funding to employ an Independent Domestic Violence Advocate to accompany police officers when the disclosure is made. Whilst this is welcomed it is too early to say if this will improve the numbers of disclosures made and the support that is offered to those who are the subject of a disclosure.

Recommendation – Collaborative Working, Decision Making and Planning

(4) It is recommended that the impact of this post is evaluated in order that its value can be clearly seen.

Recommendation – National

(5) It is recommended that evaluation of Clare's Law is commissioned to assess its use and effectiveness in protecting victims

3.4.2.12 We know, from speaking to others who knew April well, that she knew something about the perpetrator's history. The review acknowledges that it is painful for April's family and friends to know that she went out of her way to avoid hearing about the perpetrator's background. However, the Right to Know allows the police, in certain circumstances, to disclose information to both April or third parties who are in a position to help.

No information has been provided about whether, when April did not engage with the officer trying to make the disclosure, consideration was given to making the disclosure to her family. If they had understood the danger that the perpetrator posed to April, they may have been in a position to help her to break free from him. A disclosure to a third party, in these circumstances, would rely upon full consideration of a number of additional factors such as the application of the data protection principles, the Human Rights Act and wider considerations such as the potential for inappropriate community action such as vigilantism. It remains the view of the police that disclosure to a third-party in this case would not be lawful given that April was able to make 'informed choices'.

Recommendation – Ownership, Accountability and Management Grip

(6) It is recommended that, where a person is reluctant to hear a disclosure, that it is referred back to the DVDS panel for consideration to be given to making the disclosure to a family member who may be in a position to offer some protection to the victim, subject to the points made above.

3.4.2.13 The review also considers that an application under Clare's Law would have been appropriate in January 2016 when the police first knew that the perpetrator was in a relationship with April. We obviously cannot be sure what her reaction would have been if a disclosure had been attempted then, but it is possible that she may have been more open to this earlier in the relationship before his control on her became stronger.

3.4.2.14 According to the records, from the July incident onwards, both the perpetrator and April told every agency that they came into contact with that the relationship was over.

Lessons Learnt

It is evident that the police were not routinely updating intelligence about the relationships involving repeat perpetrators of domestic abuse.

Recommendation – Ownership, Accountability and Management Grip

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

The review considers that, whilst the DVDS scheme was used, it may not have been used to the extent to which it was intended and opportunities to protect April were missed.

3.4.3 The Crown Prosecution Service

3.4.3.1 The first involvement of CPS with April was the prosecution of the perpetrator for a reported assault on her in July 2016. He entered a plea of not-guilty and at the subsequent hearing, set aside for trial in October 2016 the prosecution offered no evidence. An 18-month restraining order was placed upon him.

3.4.3.2 Four prosecutors were involved at the following stages of the case: the charging decision, the case management review, the first hearing and in discussing the case with the agent prosecutor. The CPS instructed an agent to prosecute the case at the proposed October 2016 trial.

3.4.3.3 The first involvement was whilst the perpetrator was in custody having been arrested for the July assault. The police asked CPSD (Crown Prosecution Service Direct) to provide charging advice on the Threshold Test in the Code for Crown Prosecutors (an assessment by the prosecution as to whether sufficient evidence existed at the time upon which to base a charge). At the time, the police only had statements from the officers who were present at the perpetrator's arrest. The duty lawyer advised that the case was weak and further work should be done to build the case whilst the defendant was in custody or by bailing him. An action plan was set to seek further evidence.

3.4.3.4 The police bailed the perpetrator and resubmitted the case with the officer's statement, confirmation that April was adamant that she would not make a statement herself, details of the 999 call download, and a form containing evidence of the perpetrators bad character. The duty lawyer decided that a victimless prosecution could be brought and authorised a charge of assault by beating. The decision was based upon the 999 call, the first account given to the PC, the injuries which were fresh and extensive, April's demeanour, the perpetrator's demeanour on arrest, the 'no comment' interview and the bad character evidence which showed him to be a serial offender. Hearsay evidence was to be admissible under s114 Criminal Justice Act 2003 (CJA) (interests of justice) and s116 CJA (fear). Res gestae[10] was not explored at this point. The charging lawyer asked the police to provide the 999 recording for court and submit forensic evidence 'if resources allow'.

3.4.3.5 The perpetrator was charged to attend court on 23rd September 2016. The case was reviewed as an anticipated not guilty plea. The review indicated that the case could proceed victimless relying on the 999 call under the res gestae principle, but the review commented that this would be difficult. The review discounted admission under s116 CJA as April did not say she was in fear and made no mention of s114 CJA. The initial written account in the DASH book was not referred to and the res gestae principle was not explored further.

3.4.3.6 The reviewing lawyer decided that April should be witness summonsed to attend court. The Preparation of Effective Trial (PET) form was prepared for the first hearing confirming that the prosecution intended to rely upon the 999 call and April's account to the police officer under res gestae.

[10] **Res gestae** is "a statement was made by a person so emotionally overpowered by an event that the possibility of concoction or distortion can be disregarded", as set out in the common law exceptions retained under s118 of the Criminal Justice Act 2003.

3.4.3.7 At the first hearing the defence solicitor filled out a blank PET form. This indicated that the perpetrator denied causing any unlawful injuries and any injuries that were caused were accidental, in self-defence or self-inflicted. The form was signed to confirm that continuity of exhibits was agreed.

3.4.3.8 A witness summons was granted by the court for April and a special measure direction made for her to give evidence by live link. The bad character evidence was agreed, and the trial date was fixed for October 2016.

3.4.3.9 Three days before the proposed trial date, April confirmed to the witness care officer that she would attend court. However, she said she had been highly intoxicated (at the time of the incident), did not recall anything of the incident and did not know if it was the defendant who attacked her.

3.4.3.10 A single copy of the 999 recording was received from the police on 6th September. The 999 recording was not served on the defence ahead of the trial. No formal admission beyond the PET form was obtained to admit the fact of the recording.

3.4.3.11 April did not attend the court on the day of the trial. When contacted by the witness care officer she said she did not support a prosecution and would not attend as she did not want to be made a fool of as she could not be sure it was the perpetrator who had assaulted her. It transpired, after the trial, that the witness summons had not been sent to the witness care unit (WCU), so it had not been served. The agent prosecutor was advised that the witness summons had not been sent to the WCU by CPS. However, in fact, the witness summons should be sent directly to the WCU by the court not CPS. The court has acknowledged that it failed to do this.

3.4.3.12 The agent prosecutor decided that he could not rely on the 999 call as there was no statement to exhibit it and the defence advocate was not prepared to accept it into evidence when it was served on the day of the trial. The agent prosecutor tried to obtain a statement to exhibit the recording on the morning of the trial. He also asked the police officer attending if she could produce the exhibit, but she could not. The agent prosecutor formed the view that the case was compromised by April saying she was not sure who had assaulted her.

3.4.3.13 The agent prosecutor consulted with another prosecutor and they decided that the court was unlikely to grant an adjournment to get April to court, not knowing that it was the fault of the court that the witness summons had not been served. The decision was taken to negotiate a restraining order on acquittal and to offer no evidence.

3.4.3.14 The court made a restraining order prohibiting the perpetrator from any direct or indirect contact with April and from going to her home address for a period of 18 months.

3.4.3.15 The CPS has identified a number of lessons from this case:

> In particular, the undercharging of the offence as one of common assault and the decision not to apply for an adjournment when April did not attend court, which would have allowed the police to attend her address, serve the witness summons and find out the full reasons for her change of mind and non-attendance at court.

- The case was undercharged. The degree of bruising and swelling, the strangulation and suffocation, the sustained nature of the assault and April's fear that she would be killed merited a charge of Actual Bodily Harm (ABH)
- The police did not obtain scientific evidence from the hand swabs taken from the defendant
- The evidence of the defendant's bad character for violence towards his former partners provided grounds for a remand in custody application. More could have been done to encourage the police to resubmit the case for decision applying the Threshold Test, for example, obtaining a download of the 999 call
- The 999 recording was not served nor was there a formal admission as to the fact of the 999 recording or a statement to exhibit it
- Neither the charging decision nor the area review referred to the authorities on res gestae, in particular R v Barnaby and Ibrahim v CPS. Although the 999 call was made approximately 30 minutes after the assault ended there was ample evidence to show that April made the call and the comments to the police officer when she was still emotionally overpowered by the events, such that the possibility of concoction or distortion could be disregarded (s.118 CJA). The case of Ibrahim v CPS (Unreported 18 May 2016) confirms that the lapse of time between the event and the call is not the only factor. The other evidential features in this case would support the admission of the 999 call and the account to the police officer under the res gestae principle.
- The court has acknowledged that they did not send the witness summons to the WCU.
- Whilst it is clear that the agent prosecuting and CPS lawyer discussed asking for an adjournment, they took the view it would not be granted. However, the application could have been made to the court for an adjournment to later in the day to enable the police officer to visit April and serve the witness summons, the address was no more than a mile from the court. Her non-attendance was unexpected after the assurance she gave the WCU three days earlier. Clearly the decision to adjourn a case is a matter for the court, there was no entitlement to an adjournment or indeed certainty that it would be granted.
- At the same time the court and defence could have been put on notice that the prosecution would be relying on the 999 recording and the account to the police officer. It may have been possible to prove the 999 call by asking the police officer to confirm she recognised the voice on the recording as that of April.
- The court should have been reminded that the defence had indicated at 8.1 on the PET form that continuity of exhibits was not in dispute and the real issue with the 999 recording was not the fact it was made but its admissibility as res gestae and the weight to be given to this evidence. In any event, there was still an argument to admit April's account to the officer under res gestae.
- The prosecution could make an admission as to the fact of what April told the WCU about not remembering the incident, being intoxicated and not knowing if the defendant had assaulted her to overcome any objections by the defence.

The CPS had taken an early view that this was a case that could be prosecuted in the absence of the victim. However, it is the view of the CPS that it was right to seek her attendance in line with applicable case law[11], in particular given that April had indicated she would attend court only a matter of days before. However, no application was made for an adjournment to serve the witness summons and seek the reasons why she was now failing to attend the trial.

[11] Wills & Wills v CPS (2016) EWHC 3779 (Admin) and R v Andrews (1987) 84 Cr App R 382

It is clear that on the day of the trial CPS did consider a number of options to continue to proceed with the case in April's absence but came to a view that they could not. They took into account the conversation between April and the WCU where April said she was not sure it was the defendant who had assaulted her. The significance of this conversation was that it undermined the prosecution case and would therefore have to be disclosed to the defence pursuant to their statutory disclosure obligations. They formed the view that the court would be unlikely to grant an adjournment for the police to attempt to visit April, serve the witness summons and find out full reasons for her change of mind and non-attendance. Those charged with the responsibility for defending the perpetrator took a view that they would object to the prosecution's attempts to rely on the 999 call when it was not formally exhibited. Once this stance was taken and coupled with April's comments to the WCU then the prosecution felt it unlikely that they would succeed and thus offered no evidence, negotiating the restraining order in its stead.

In reviewing the facts of their involvement in this case the CPS consider that they should have applied to the Court for an adjournment to at least later in the day to enable the police to visit April and serve the witness summons. If this application was not successful consideration should have been given to seeking to prove the case as a victimless prosecution, despite the difficulties identified.

This point is of great concern to April's family as, after her death, they found a letter sent to her by the CPS. This letter (seen by the Review Chair and Author) states that the CPS is committed to victimless prosecutions and then, in the next paragraph, says that, as you did not attend court the case was stopped. The family has been caused a lot of heartache by this letter and the timing of this court appearance. It is possible that, if the case had gone ahead, the perpetrator would have received a custodial sentence; this would of course have been dependent upon a finding of guilt and a sentence of custody. Neither of these latter points could be guaranteed and it is acknowledged that a restraining order had been successfully applied for and was in place. Breach of a restraining order is a separate criminal offence which carries a sentence of imprisonment. The timing of this event in October prior to April's death in January is not lost on the family.

3.4.3.16 Since this incident, CPS has already begun to take action in relation to victimless prosecutions in domestic abuse cases and the following actions have been taken:

- Area and CPSD prosecutors have completed on-line Prosecution College Training on domestic abuse which included fact sheets for prosecutors to retain on res gestae, hearsay and hostile witnesses.
- The Area has delivered face to face training on 'evidence led prosecutions' focusing on building a case without the support of the victim in domestic abuse cases has been delivered to Area prosecutors and the presentation has been circulated to those unable to attend.
- Mock court advocacy drills on res gestae and dealing with hostile witnesses for new prosecutors. Consideration is being given to rolling out the training to agents and prosecutors regularly prosecuting domestic abuse cases.
- Changes have been made to the Area's review template to ensure proactive consideration and action is taken in respect of victimless prosecution.

Recommendation - Ownership, Accountability and Management Grip

(8) It is recommended that the East of England CPS review their practices for achieving evidence led prosecution without victim complainant (victimless prosecutions)

3.4.4 National Probation Service – Norfolk and Suffolk Local Delivery Unit (LDU) – South East and Eastern (SE&E) Division

3.4.4.1 The perpetrator was first known to Norfolk and Suffolk Probation Trust in December 2008. Following legislative changes in 2014 (TR) he automatically came under the management of the Norfolk and Suffolk LDU of the SE&E Division of the National Probation Service.

3.4.4.2 Whilst the engagement with the perpetrator from 2008 related to previous partners and the timescales are outside the scope of this review, there are a number of relevant points that will mentioned here.

3.4.4.3 In 2008 he was assessed as high risk of serious harm to his partner. He was sentenced to a Suspended Sentence Supervision Order (SSSO) which comprised of 2 years' supervision and completion of the Integrated Domestic Abuse Programme (IDAP). It was worth noting at this time he was 18 years of age. He did not, during this order, report as instructed or engage with the IDAP programme. His supervising officer made the following observation, *"... he has the potential to inflict fatal harm on both his partner and his unborn child"*. Due to his non-compliance he was appropriately returned to court and his SSSO was revoked and he was given a custodial sentence.

3.4.4.4 A pre-sentence report (PSR) prepared in 2011 assessed him as "high risk of serious physical and emotional harm to partners". The PSR identified an urgent need for treatment under the Integrated Domestic Abuse Programme (IDAP) and the report included a further proposal for SSO and IDAP. Unfortunately, this proposal not followed by the court, and 2 years imprisonment was imposed. Whilst in prison, he completed 7 out of 12 sessions on the IDAP programme as he did not begin the programme until well into his sentence and was released before it could be finished. (It is acknowledged that he did not complete the IDAP programme). His release was on condition that he resided at an Approved Premises, but he failed to arrive and was immediately recalled. He subsequently served his full sentence and therefore was then released without supervision.

3.4.4.5 The risk assessments contained within the preceding two paragraphs are a clear indication that, the previous sentencing policy allowed the release of dangerous offenders into the community without any form of supervision. It could be argued that those such as this offender who insist on completing their full sentence in the knowledge that they will be free from supervision upon release are exactly the ones that pose the greatest risk of reoffending and danger to the public.

3.4.4.6 In 2013, the perpetrator was again before the court and assessed as being high risk of harm. Once again, the PSR recommended a Suspended Sentence Order with the accredited programme Building Better Relationship (BBR), which replaced IDAP and once again, the proposal was not accepted, and he was given a prison sentence and he was released after three months with no statutory supervision.

This Review accepts that sentencing policy has since changed and the introduction of supervision for all offenders sentenced to more than one day in prison is welcomed as in this case it may have afforded the opportunity to complete the BBR in the community upon release. The sentence given here protected the public for three months but thereafter probably put them at additional risk as all his social ties and relationships would have been disrupted with no supervision or support upon release.

3.4.4.7 In 2015, he was sentenced to a 2-year community order with 2-year supervision requirement and completion of the Building Better Relationships Programme. It was during this community order that the incident occurred.

3.4.4.8 Any offender subject to a community order is initially assessed in order to allocate their case to either the community rehabilitation company (CRC) or to the National Probation Service (NPS). The perpetrator was assessed as high risk of harm towards intimate partners and, as such, should have been allocated to the NPS. However, due to an administrative error, he was allocated to the CRC probably owing to a confusion around the fact that the CRC deliver (under contract) BBR to NPS offenders. Therefore, between February 2015 and May 2015 he was supervised by the CRC and he was allocated to an appropriately trained and qualified probation officer. During his time with CRC, the perpetrator kept three office appointments and made himself available for office reporting. Arrangements were made to commence the BBR programme and a Women's Safety Officer (WSO) was allocated to work with the victim of that offence. Once the error in allocation to the CRC was discovered, arrangements were immediately made to transfer him to NPS. During his time with NPS, he kept two office appointments and made himself available for fortnightly telephone calls.

3.4.4.9 After he was transferred back to the NPS there should have been a significant difference in the level and nature of contact. As a high-risk offender there should have been frequent face to face contact with his offender manager but, for reasons that will be detailed later, this did not happen. The BBR should also have been completed but, again, this did not occur, and the programme was not commenced. It is acknowledged that employment is a stabilising factor for individuals and it is clear that the offender manager focused on this in the management of the case. The chronology and reasons for this are set out below:

8th May 2015	Started his community order
26th May 2015	Induction and pre-group session arranged at Lowestoft Probation Office – he did not attend as he could not get there after work. This became a recurrent theme and he provided evidence from his employer. As it was clear that evening appointments were not going to work, a 3-month deferment was agreed. A new starting date of November 2015 was agreed.
November 2015	There was no room on the programme and a new date was fixed for February 2016. This was agreed at beginning of January but a week later he stated his work commitments would not allow him to attend. There was discussion about whether or not this should be returned to the court.
May 2016	New starting date agreed but in April his working hours increased so he was not going to be able to attend. By this time, he had been arrested for an assault on April and it had been intended to propose a further BBR making it clear to the court that he needed to make firm arrangements with his employer to take the time off. However, the charges were dropped. A new start date of January 2017 was arranged but by this time the murder had occurred.

> Whilst it would be easy for this Review to criticise the National Probation Service for failing to get him to undertake his BBR requirement one does understand the fine balance that is necessary between enabling offenders to rebuild their lives and therefore reduce the pressures that can increase risk, against insisting on a course such as BBR that is also designed to reduce risk. However, he had been identified as a high-risk offender who had been given three different starting dates for what could have been an important step in attempts to rehabilitate him.

3.4.4.10 As already noted, supervision under the NPS began in May 2015 (before he met April) but the required level of direct supervision was not achieved. When supervision began he was living within the catchment area of one particular office but said he was working all over the country as well as Norfolk and, occasionally, London. He lived on his own in privately rented accommodation and was financially solvent.

3.4.4.11 A risk assessment conducted prior to sentencing studied factors linked to his risk of reoffending and risk of harm. All the criminogenic areas in his life were problematic and contributed to the degree of violence he inflicted on his intimate partners. He held negative attitudes towards women and was accustomed to asserting power and control within a relationship. He was considered to pose a high risk of harm towards women in a relationship and a risk management and sentence plan was drafted - both aimed to address and manage the risk he posed not only to women but also to children in a relationship at risk of psychological and emotional harm through witnessing violence in the home.

3.4.4.12 That risk management plan included liaison and information sharing between NPS, children's social care, the police domestic violence unit and the women's safety officer (attached to the BBR programme). Supervision appointments were to be offending and victim focused. A contingency plan in the event of any sign of risk escalation or deterioration in behaviour included an increased level of reporting, to notify police/children's social care and, in the case of non-compliance, immediately instigate breach proceedings.

3.4.4.13 The case was allocated to a qualified offender manager who was experienced in working with violent high-risk offenders, including domestic abuse. The frequency of contact, given the perpetrator's high-risk status, was initially set at once a week.

3.4.4.14 NPS staff considered the issue of MAPPA when the case returned to them. MAPPA will be dealt with as a specific section within this report as it involves a number of agencies and not just the NPS. However, in summary, the nature of the index offence for the case (common assault) did not automatically qualify for MAPPA but meetings took place between the offender manager, the senior probation officer (SPO) and the MAPPA co-ordinator. The intention had been to discuss the case, provide necessary guidance and identify any underlying or presenting problems that could trigger another MAPPA level 2 referral under category 3. It was agreed that no referral was to be made.

3.4.4.15 The perpetrator had been subject to his community order and supervision for almost two years when the murder of April took place.

3.4.4.16 The NPS undertook a Serious Further Offence (SFO) review and found all three areas of their risk assessment, risk management and offender management to be **insufficient**.

3.4.4.17 Below is a summary of why these findings were made:

(a) Risk assessment:

- Insufficient up to date information regarding the perpetrator's own children and the level of agreed access.
- Insufficient information sharing with children's social care at the start of the sentence i.e. to inform them that the perpetrator was assessed as high risk and subject to a further community order involving domestic violence. Similarly, with the police domestic violence unit.
- The initial risk assessment was not reviewed at critical points of the order such as the perpetrator establishing a new relationship, being charged with further offences involving domestic violence and ahead of a decision to reduce reporting to once a month.

(b) Risk management:

- Initial error in allocation to CRC that led to a twelve-week period of contact by responsible officers untrained to work with high risk offenders.
- Evidence of a gap of almost three months of face to face contact with the perpetrator between his last interview with the CRC on 16.3.15 and his first appointment with the NPS on 9.6.15.
- The risk management plan was largely dependent on previous assessments and included little up to date information in relation to specific named contacts from the police and children's social care and failed to include specific plans for information sharing or shared tasks.
- There was no evidence that information sharing or liaison with the named agencies took place. Children's social care were not made aware of the perpetrator's new relationship with April and nor were the police domestic violence unit.
- The Offender Manager (OM) failed to make attempts to meet April (although they did refer the matter to the multi-agency safeguarding hub "MASH").
- Weekly contact was not maintained. The perpetrator rarely attended the office for face to face meetings and the order was largely managed via frequent, pre-arranged, telephone calls from the OM. In addition, the content of the conversations were not, as planned, victim or offence focused but more geared to updates about the perpetrator's current circumstances regarding his work and accommodation.
- BBR was not commenced as per the risk management plan but also as per the legal requirement of the community order.
- The offender manager did not present a full picture of the perpetrator's circumstances and current risk factors to the MEF and also failed to follow through on MEF actions such as: completion of risk reviews, commencement/termination of BBR and, specifically, to transfer the case to Norwich (this office was closer to his work location so may have facilitated engagement and compliance).

(c) Offender Management:

- The sentence plan lacked sufficient detail – the objectives did not specifically address the identified criminogenic needs of: thinking and behaviour; relationships; lifestyle and attitudes; drug relapse or emotional well-being.
- An insufficient investigative approach to the perpetrator's stated working locations and his stated inability to attend the office.
- Failure to oversee a transfer to Norwich probation office that may have enabled more frequent and more meaningful office supervision meetings.

3.4.4.18 **Analysis of the findings:**

(i) The incorrect allocation to the CRC was assessed as a genuine error made by a member of staff getting used to new procedures following the introduction of transforming rehabilitation (TR) that required offenders for the first time to be allocated on the basis of their risk. Since this date, a dedicated report writing team has been established at the court and the SFO review found systems were embedded and therefore the risk of a similar mistake happening again was greatly reduced.

(ii) An incorrect initial assessment conducted by the CRC is likely to have been a contributing factor for the delay in returning the case to the NPS.

(iii) NPS OM, who took on the perpetrator's case, acknowledged that they did not properly read his file and therefore was unaware of the full background in relation to his history of domestic violence. They wrongly assumed that his transfer from the CRC was due to a recent escalation in risk and not due to the earlier error at court. This led to a further false assumption that the perpetrator was not as high risk as he actually was and that 'protective factors' such as employment, accommodation and stable finances would play a significant role in preventing further offending. He apparently gave plausible accounts for his whereabouts and his circumstances sounded genuine. Similarly, when the perpetrator told the OM about his new relationship they felt he was telling the truth when he said that he was taking things slowly and that things were "good". The OM should have been far more investigative in their approach in all areas of this order but, in particular, they should have been more probing and challenging in this respect. The reason they were not, and indeed the reason for almost all of the listed deficiencies, was due to the significantly high caseload they were working with.

(iv) The SFO reviewer was provided with statistics and records of the OM's caseload and also that of the whole office. These proved that every member of the team, including the perpetrator's OM, had been working far in excess of the recommended levels of the national workload management tool (WMT). The WMT works on averages and capacity of an OM's caseload and in the South East and Eastern (SEE) division the aim is to amend an officer's caseload if, over a three-month period, their WMT is consistently above 90 – 110%. The review found that the team had worked consistently higher than 110% for two years. The perpetrator's OM had started in 2015 at 118% and around the time when the SFO was committed their WMT stood at 167%. At the time the review was drafted this had increased to 192%. The WMT for the whole office collectively stood at 180%.

(v) The reason behind the high caseloads was caused by long term staff shortages and a problem to recruit to the specific office in the Norfolk and Suffolk LDU. The office should have been staffed by 9.5 offender managers and 4 probation service officers but instead it was running on 6.4 offender managers and one probation service officer (with the prospect of one offender manager leaving and another about to go on maternity leave).

(vi) It was the SFO reviewer's opinion that the OM was overwhelmed at the time with their work load and, compared to other more high-risk presenting cases, the perpetrator was seemingly a relatively stable case. He had somewhere to live, was in full time and well-paid employment and regularly kept in contact albeit on the telephone. All this enabled the OM to develop a false sense that things were as the perpetrator presented them and, over a period of time they allowed them self to unwittingly manage the order with a relatively light touch.

(vii) For example, the circumstances of this office were well known to the region's senior leadership team and as a measure to help ease work load pressure, the head of Norfolk/Suffolk local delivery unit gave authorisation for limited telephone contact with high risk cases. It was never the intention for this to replace face to face supervision but, combined with the perpetrator's work commitments that apparently prevented him from keeping even early evening appointments, a situation arose where the OM fell into a habit of relying on telephone contact and focusing more on other more actively prominent cases. This led to the perpetrator's case being insufficiently prioritised and this, in the reviewer's opinion, was why the OM did not appreciate the degree of risk the perpetrator posed to women or the level of manipulation and deflection he was capable of.

3.4.4.19 **Effective practice and lessons learnt**

After completion of the SFO, the head of Norfolk/Suffolk local delivery unit acknowledged that in addition to the number of serious deficiencies in the OM's practice, the case also highlighted the much wider organisational issue of sustained reduction in resourcing and the subsequent strains that were passed on to staff. They went on to note that the offender manager in question was experienced and someone who had worked to a high standard in the past and was regarded as a valued member of the team. However, because their practice in this particular case was short of anything that could be expected an independent disciplinary investigation was carried out and a full audit of their caseload was undertaken.

This Review accepts the analysis and lessons learnt identified by the Serious Further Offence review. It wishes to make it clear, however, that whilst there were individual errors on the part of the offender manager, the person ultimately responsible was the perpetrator. At the time of the offence, an additional review was commissioned internally which reviewed all cases of the OM and found that there were no serious deficiencies found to be present in any other cases.

The fundamental changes to the structure of probation services arising from the Transforming Rehabilitation agenda seem to have caused a period of instability amongst services that contributed to unsatisfactory workloads, a misunderstanding of new processes; this may have contributed to the errors in this case. The perpetrator took advantage of this and was able to avoid the level of supervision and control that the community order, supervision order and Building Better Relationships requirement were meant to bring.

It is clear that previous attempts at rehabilitation with the perpetrator have failed. Some of this will have been as a result of previous and now discontinued short-term sentencing policy. On 22nd February 2018, the Sentencing Council issued new sentencing guidelines for domestic abuse related offences. This review welcomes these guidelines, in particular the fact that the new guideline brings a distinct change in emphasis in relation to seriousness. The previous guideline stated that offences committed in a domestic context should be seen as no less serious than those in a non-domestic context, whereas the new guideline emphasises that the fact an offence took place in a domestic context makes it more serious. This is because domestic abuse is rarely a one-off incident, it is likely to become increasingly frequent and more serious the longer it continues and may result in death. It can also lead to lasting trauma for victims and their children.

Whilst too late for April this may prevent others from serious harm or worse in the future.

Recommendations – Ownership, Accountability and Management Grip

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

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

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

3.5 Health

3.5.1 General Practitioner services

3.3.1.1 The GP surgery providing care for April engaged with this review. The GP providing services to the perpetrator between July 2010 and February 2011 has engaged with the review and provided an IMR. There is no other GP information in relation to the perpetrator.

3.5.2 General Practitioner services provided to April

3.5.2.1 April was seen by her GP three times during the time that she was in a relationship with the perpetrator. Firstly, in July 2015 when she saw the GP with a recurrent medical problem and advice was given. In January 2016 she attended the surgery to deal with an issue of what is recorded as 'unscheduled vaginal bleeding'. Whilst this may not appear relevant to this Review she also made comment about having problems in conceiving; the relevance of that is that it tends to add weight to the assertion of her friends that she was beginning to feel like a woman in her 30s with time passing her by, but also indicates the information that will appear later in this report about the perpetrator's need for an intense personal relationship.

3.5.2.2. In July 2016 April was triaged over the phone by a GP. She advised that she had been assaulted in the last week by a previous partner. She reported that she was making good progress but understandably she was mentally affected as well. She did not feel able to go back to work and so was provided with a medical certificate to excuse her from work for seven days. From this date, there was no further contact with the surgery. There is no record of any additional professional curiosity by the GP exploring, for instance, if April had told the police or pointed out other professional support services for victims of domestic abuse. These conversations may have taken place but there is no evidence of it. If we are all to play a part in reducing domestic violence and abuse, then all professionals need to think of the wider aspects of their roles. For effective intervention the underlying causes must be considered, rather than just dealing with the presenting symptoms.

3.5.2.3 In preparing their IMR, April's GP surgery did not feel that there was anything they could identify in the records or narrative of these visits that could have alerted the surgery to the incident that would follow. Whilst we agree with that view the issue of domestic abuse, its triggers and signs, referral routes and support that is available are all things that front-line professional across all agencies should be aware of. We should strive to ensure that those adults who are vulnerable to, or who have suffered, abuse should be recognised with the same safeguarding ethos as that now embedded with safeguarding children. One can imagine that had April reported to say that one of her children had been assaulted by her partner and she needed time off work to deal with the psychological effects then action would have been taken by the surgery to ensure that other safeguarding professionals were aware of the situation. We thus recommend that adult safeguarding (including domestic abuse) is an area for awareness raising across GP practices in Norfolk.

Lessons Learnt

April's GP did not demonstrate professional curiosity in relation to potential for domestic abuse within the relationship when she attended with non-accidental injuries

Recommendation – Professional Curiosity

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

3.5.3 General Practitioner services provided to the perpetrator

3.5.3.1 In July 2010, the perpetrator presented and was seen by a locum GP complaining of low mood. The appropriate risk assessment was carried out, his medication was changed and there was a plan put in place to review this. However, the perpetrator did not attend for the planned review.

3.5.3.2 The GP practice identified, in its IMR, that there could have been more follow up when the review appointment was not attended. It was also identified that the locum GP would have benefitted from an opportunity to discuss cases with a regular GP.

Recommendations – Ownership, Accountability and Management Grip

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

(13) It is recommended that DNA (Did Not Attend) processes in GP surgeries are reviewed to ensure their effectiveness for safeguarding purposes

3.5.4 Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH)

3.5.4.1 In October 2015, April attended A&E with an injury to her face. She stated that she had fallen over the night before and hit her face on a hoover, causing a laceration to her lip. It was noted that she had obvious laceration to the inside of her mouth and swollen lip, loose teeth, bony tenderness to her jaw, had bruising to her scalp where her head had hit the wall. She was discharged with analgesia and there was no record, in the notes, of any discussion about domestic abuse.

3.5.4.2 In July 2016, April attended A&E reporting that she had been assaulted by her ex-boyfriend. A bruise was noted on bilateral inferior orbital floor (eye) and she reported that it was very tender. Following x-ray, no abnormalities were detected. Staff at A&E called the MASH (Multi-Agency Safeguarding Hub) to report that April was in hospital and required treatment following an assault by a former partner. A separate NSCB1 referral was made regarding her two children as she had been a victim of a domestic assault. This stands out as an incident of notable practice as both the risk to the mother and the children as a result of domestic abuse was comprehensively documented and acted upon in a timely fashion with referrals to MARAC and children's services.

3.5.4.3 NNUH contributed to a MARAC meeting on 22nd July 2016, as would be done on a regular basis, and noted that she was not willing to support prosecution or provide a statement to the police.

3.5.4.4 On 1st December 2016, April attended A&E having been punched in the face. A diagnosis was made of a possible left zygomatic fracture (cheekbone). The report stated, 'comparison is made with the previous film of July 2016, difficult assessment due to the left sided soft tissue oedema. The lateral wall of the left maxillary sinus is discontinuous, and the left

interior orbital wall is slightly depressed in keeping with fractures. A possible air fluid level is present in the left maxillary sinus and left orbital/peri-orbital emphysema. The left zygoma appears grossly intact.' April was referred to the Oral Health outpatient department. April stated she had been assaulted by another female and there is no evidence of domestic abuse being considered.

3.5.4.5 That same day, April attended the Oral Health outpatient department. She disclosed that she had brought herself to hospital following multiple punches to the left side of her face. She stated that the police were not involved. When asked if she was safe at home she stated that she was. It is standard practice to always ask patients if they feel safe at home.

3.5.4.6 On 13th December 2016, April returned to the Oral Health outpatients department and a decision was taken not to proceed with surgical treatment at the time and she was referred back to her GP.

3.5.4.7 NNUH contributed to a MARAC meeting on 16th December 2016 and gave details of her most recent attendance.

3.5.4.8 As part of its IMR, NNUH has identified a lack of 'professional curiosity' during some of the attendances that April made with assault injuries. Initial explanations provided were taken at face value and not explored further. It was also not documented if domestic abuse had been considered.

3.5.4.9 The IMR also identifies the difficulty that staff have in readily accessing information about previous attendances at A&E. This raises the risk of assaults being treated in isolation and a pattern of abuse not being identified. Whilst staff check on previous attendances for any children with a Safeguarding Alert this does not happen for adults.

3.5.4.10 The Trust began, as part of an ongoing review of safeguarding training, to train Domestic Abuse Champions in September 2016 and since then 50 Domestic Abuse Champions have been trained across the Trust. Specific training for staff began early in 2017 but prior to this, staff relied on mandatory adult and child safeguarding training which included domestic abuse, along with other safeguarding concerns. It became clear, as part of the review undertaken by NNUH, that there was a need for more specific training specifically on how to use the DASH form which would prompt staff to apply 'professional curiosity'. Guidance is now available on the Intranet for staff who are concerned that someone may be a victim of domestic abuse. Unfortunately, this training was not thoroughly embedded when April attended the hospital.

3.5.4.11 The IMR also identified that when April attended A&E in December 2016 there was no facility for 'free text' to be added to the record to explain the mechanism of injury or to document any safeguarding concerns. The nurse who saw April said that it would be standard practice to consider these risks but that there is not always time to record concerns and resulting discussions.

3.5.4.12 It was noted that when a patient is referred from A&E to the Oral Health Department a copy of the notes from A&E are not routinely sent to the department which can be problematic both for clinical reasons and when an assault has been disclosed.

3.5.4.13 It was also noted by staff in the Maxillo-Facial Department that, although it is recognised as good practice to separate suspected perpetrators from victims during consultation, this is not always possible without drawing attention to the fact that domestic abuse is suspected.

Recommendations – Professional Curiosity

(14) It is recommended that A&E staff are trained in domestic abuse, including how to ask the abuse question and how to complete the DASH form

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

Recommendations – Ownership, Accountability and Management Grip

(16) It is recommended that a 'safeguarding' box is added to Symphony[12] as a mandatory reporting field. This should include if there are any safeguarding concerns and identify whether the concerns relate to a child, adult or domestic abuse

(17) It is recommended that A&E staff are identified to train as Domestic Abuse Champions

(18) It is recommended that domestic abuse information is displayed in public areas, specifically toilets which should have contact details for charities and support services

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

(20) It is recommended that the Trust considers Domestic Abuse Awareness becoming a mandatory training requirement for patient facing staff, acknowledging the pressures that exist for different mandatory training

The review is satisfied that NNUH has taken on board the lessons to be learned and is seeking to improve practice accordingly.

[12] Symphony is the A&E electronic patient record system

3.6 Local authority functions

3.6.1 Norfolk County Council, Children's Social Care

3.6.1.1 The records of children's social care indicate that the perpetrator was involved with four different families and mothers and six different children in Norfolk (this is obviously only the relationships that are known about). These contacts span eight years from 2009 to 2017.[13]

3.6.1.2 Records show that there were serious concerns about his contact with all of these children as a result of his history of domestic abuse. Only two children were subject to child protection planning as a result of their mother's relationship with the perpetrator and this came to an end when they moved out of Norfolk.

3.6.1.3 April and her children first came to the attention of children's social care in August 2016 when a referral was made by the police following an assault on her. At this time, a social work assessment was carried out and she stated that she was not going to continue the relationship with the perpetrator. She did not want the children's father to know about the assault and the decision was taken to close the case.

3.6.1.4 The IMR prepared for this review, identifies that, given his history, it would have been expected that a decision would have been taken to complete a piece of work with April and her children to ensure that she was better equipped to safeguard herself and her children in the future. It is also identified that making contact with the children's father would have contributed to the assessment and helped to safeguard the children. It is important to note that the children's father was very disappointed to discover that children's social care had been involved and he had not been informed. He had shared custody of the children and felt he would have been able to assist with safeguarding them in the future.

> By not involving the children's father this was a potential opportunity that may have afforded April better protection by a wider knowledge amongst the family unit of the issues she was facing

Recommendation – Ownership, Accountability and Management Grip

(21) It is recommended that non-abusive absent parents are routinely advised of any concerns and involved in any assessments that are undertaken

3.6.1.5 Children's social care received a further referral in December 2016 and again, a social work assessment was completed. Supervision records show that the plan was to close the case as April stated that she was no longer in a relationship with the perpetrator, but this did not occur before the incident.

> The IMR identifies that, given the knowledge that children's social care had about the history, it could be argued that child protection procedures should have been instigated. It is thought to be unlikely that the records had been cross-referenced to aid the decision making.

[13] The details of all of these cases are known to the review but will not be referred to in detail to protect the anonymity of the mothers and children who have now moved on with their lives

3.6.1.6 The IMR also identifies, very importantly, that it is not clear from the records what the women involved understood about the perpetrator and his history or how well they were helped to understand his way of operating. This will, obviously, have been compounded if social workers themselves did not understand the history.

3.6.1.7 As has been discussed earlier at 2.3.15, a letter was sent to April upon the decision to close their case. This letter reminded her of her duties as a parent to protect her children. The Review Panel discussed, at length, the phraseology used within this letter and recognised the fine balance needed in protecting children whilst not increasing the pressure on April which led to her no longer reporting.

Lessons Learnt

Some victims of domestic abuse fear that the involvement of 'social services' will automatically lead to their children being removed.

Recommendation – Ownership, Accountability and Management Grip

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

3.6.1.8 Children's social care have identified a number of lessons that have been learnt from this case:

- The need to take into account April and perpetrator's history in decision making
- The need to cross reference records to ensure that there is an understanding of perpetrator and victim's network
- The need to involve absent parents in assessments
- Opportunity to be made available to ensure that potential victims understand the history of the perpetrator and support to be given to help them respond to that information and safeguard themselves and their children
- The need to be sufficiently curious and not just accept things at face value
- Better use needs to be made of child protection procedures including strategy meetings to share information and make multi-agency decisions about the planning of a case where there is known to be a concerning history regarding a perpetrator

Recommendations – Ownership, Accountability and Management Grip

(23) It is recommended that a series of workshops and communications is implemented to share the learning identified

(24) It is recommended that procedures are reviewed to ensure the learning is captured in future practice

(25) It is recommended that a specific learning event is held for those in the service who were directly involved in the case

3.6.2 Norwich City Council, Housing Services

3.6.2.1 There was minimal involvement of the housing services department other than the previously mentioned issue of December 2016 when the housing officer noted bruising to her face, asked her about it and referred the matter on to the police.

The review notes that this was an example of good practice and demonstrates that training and awareness in relation to domestic abuse and staff's professional curiosity is being undertaken and that an instance of good practice, such as this, should serve to reinforce the value of that training.

3.7 Non public sector organisations

3.7.1 Leeway Domestic Abuse and Violence Services

3.7.1.1 On 17th July 2016 Leeway received a referral from the police following an assault on April by the perpetrator. She was assessed by the police as high risk of further harm. When the IDVA made contact with her by phone, April said she was very tired and overwhelmed by what had happened and she was staying with her mum and her children were with their dad. She said that the perpetrator had bail conditions to stay away from her and she would contact the police if he contacted her or breached the bail conditions. She was given safety planning and advice and told about the support that Leeway could offer her. She agreed to a referral to the IDVA in Norwich. A MARAC referral was also done by Leeway.

3.7.1.2 Three days later the IDVA telephoned April but she said she could not talk as she was with family. The IDVA offered to call back the next day but she said she would text when she was able to talk. That same day the IDVA Co-ordinator attended a Domestic Violence Scheme Panel[14] meeting and updated on their involvement.

3.7.1.3 On 22nd July 2016, a MARAC meeting was held, and it was agreed that Leeway would continue to try and engage with April. A further call was made to her on 26th July but there was no answer. When contact could still not be made on 31st July, the police were advised that they had not been able to make contact. A further call was made on 3rd August, without success.

3.7.1.4 On 11th August, as they still had not been able to make contact, the IDVA asked the police to carry out a welfare check. At this point, Leeway were advised that bail conditions had been lifted and April was back at her home address but had declined a police alarm. When the police undertook a welfare check, they advised Leeway that they had seen April through the window, whilst she appeared well, she would not answer the door.

3.7.1.5 The next day, the police advised Leeway that they had spoken to April and she had no further issues with the perpetrator. When Leeway called again, April answered the phone and said that she was happy for Leeway to contact her. It was agreed that, as the IDVA was about to go on leave for a week, they would arrange further support when she returned. She was advised to contact Leeway if she needed anything during the intervening week.

3.7.1.6 Following a couple of unanswered calls to April, on 8th September contact was made and she advised that she was fine, and she was getting on with things and had no further contact with the perpetrator. Support was discussed but she felt she did not need anything and would phone Leeway if she needed any support. The case was then closed.

3.7.1.7 On 9th December 2016 a message was left on the Leeway Helpline. This was from Norwich City Council to say that April had attended a meeting to discuss her housing benefit and she had heavy bruising and other facial injuries. She had inferred they had been caused by her partner and that there was a restraining order in place, but she had said she did not want to discuss her injuries. The caller stated that the police had also been informed and were attending the address to talk to April.

[14] This is Clare's Law which is discussed in section 3.4.2

3.7.1.8 On 11th December a referral was received to IDVA service who called April but there was no answer. On 12th December it was possible to speak to April on the phone who said that she had just picked the children up and was unable to talk because they were with her. She agreed that the IDVA could call back. When a further call was made on 15th December, April was picking up her children and was unable to speak. It was agreed to call back the next day. When a call was made the following day, there was no reply. At this point, the IDVA made contact with Children's social care and was advised that they had met with April and she was adamant that she did not want any support from Leeway and her injuries had not been caused by the perpetrator. Leeway told Children's social care that they would continue to try and speak to her.

3.7.1.9 On 16th December, a repeat referral was received from MARAC.

3.7.1.10 On 19th December, an IDVA was able to speak to April. She said that she had been to the council to talk about moving as she sometimes feels uneasy in her property, although she did not feel under any immediate or direct threat. Again, the IDVA explained the support that they could offer and asked her if she would like to meet up, which she agreed to do in the New Year. As she worked, it was agreed that a date would be arranged over text and safety advice was given. The plan was for the IDVA to keep in touch with April with a view to meeting her after Christmas. An attempt to speak to her was made on 28th December but contact was not made.

The review is satisfied that Leeway followed their procedures to try and make contact with April and engage her in the service. It is clear that when they found this difficult it was escalated to the police.

3.7.2 Circle 33 Housing Trust Ltd

3.7.2.1 Circle 33 Housing Trust is a registered provider of social housing and is part of the Clarion Housing Group. April began her tenancy with Circle 33 in December 2010.

3.7.2.2 On 25th March 2016 the police contacted Circle 33 to request that the locks on April's home be changed as there had been a domestic dispute at the property. This was, it appears, dealt with as a routine repair and maintenance issue by the customer services centre. There is no record of a safeguarding alert having been raised or a report to the Anti-Social Behaviour Team having been made, to be actioned by the Neighbourhood Team.

3.7.2.3 Circle 33, in their IMR, acknowledge that this incident should have prompted a more intrusive approach from them to better understand the extent and nature of the domestic abuse so that support could have been put in place and the information shared with other agencies.

3.7.2.4 As well as working with other agencies, Circle 33 are able to use powers under the Anti-Social Behaviour, Crime and Policing Act 2014 to protect victims of domestic abuse and they have done this in other cases. It appears that the opportunity was lost by the domestic abuse not having been identified.

Recommendations – Ownership, Accountability and Management Grip

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

(27) It is recommended that Neighbourhood Officers are reminded of the Domestic Abuse and ASB policies and their relevance to this case

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

(29) It is recommended that the Clarion Group considers a Community Safety Strategy which prioritises domestic abuse and identifies improvements to the current offer to its customers

3.8 Multi-Agency safeguarding and protection arrangements

3.8.1 Multi-Agency Public Protection Arrangements (MAPPA)

3.8.1.1 The Criminal Justice Act 2003 established Multi-Agency Public Protection Arrangements (MAPPA) across England and Wales. The purpose of MAPPA is to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require local agencies to work together in partnership in dealing with these offenders. There are three categories of offenders who will fall within the remit of MAPPA:

- Category 1 - Registered Sexual Offenders
- Category 2 – Violent Offenders
- Category 3 – Other Dangerous Offenders

3.8.1.2 The first stage of the MAPPA process is to identify offenders who may be liable for management under MAPPA as a consequence of their caution, conviction or sentence. Those offenders who are managed under MAPPA are managed under three levels according to the agency involvement needed and the number of agencies involved.

Level	Management required	How management achieved
Level 1 (the majority of MAPPA offenders)	Ordinary agency management (Managed by a single agency – usually the police or probation)	Information sharing but no multi-agency meeting required
Level 2	Active multi-agency approach required	Discussed at MAPP meetings Attended by operational officers/managers from each agency
Level 3	Active enhanced multi-agency approach required Level of authority to commit resources needed	Discussed at MAPP meetings Attended by senior representatives from each agency

3.8.1.3 There are strict criteria for offenders who will fall into the management of MAPPA and this will depend on the offence for which they have been convicted or cautioned. For this reason, the perpetrator was not managed by MAPPA at all times.

3.8.1.4 Once an offender is being managed by MAPPA, the main focus is the risk management of that offender, seeking to protect past and potential victims from the risks that the person poses.

3.8.1.5 Below is a chronology of the MAPPA management of the perpetrator:

2nd August 2011
The perpetrator was identified at MEF (MAPPA Eligibility Forum) as case that should be referred to Level 2 Category 2 prior to release from custody

15th November 2011
Referral received and endorsed by MAPPA Manager as Level 2 MAPP[15] case

14th March 2012
The first Level 2 meeting was held
His index offence was ABH x 2 on partner and criminal damage and he had served a two-year custodial sentence
Meeting agreed that victims would be protected by the licence conditions on release and there would be an exclusion of Norwich. He was to be required to reside at the Approved Premises in Ipswich where he would be subject to signing and curfew restrictions
Next meeting was set as 22nd May 2012

22nd May 2012
The second Level 2 meeting was held
Information was supplied by the prison that he was making lengthy daily phone calls to a female (not the victim in the offence)
Plans were made for his release and it was agreed that he would complete the IDAP domestic violence programme in Suffolk
Next meeting set for 3rd July 2012

3rd July 2012
The third Level 2 meeting was held
Meeting advised that he had been released from prison and had been recalled the same day as he had absconded, failed to attend probation or arrive at the Approved Premises and subsequently arrested in another part of the country
Disclosure was made to the person that he said he was in a relationship with
He was deregistered by MAPPA as he was in prison and a re-referral from probation would be reconsidered in December 2012 when he would be released

No further involvement with MAPPA until November 2013

25th November 2013
Referred to MAPPA by police following assault on girlfriend and breach of restraining order on a previous victim
Had received 6 months in prison on 21st November 2013 for 3 x common assault and breach of a restraining order

28th January 2014
Initial Level 2 meeting held
He was due for release on 19th February 2014 but would not be subject to any licence conditions or probation supervision
He was saying he was planning to live in Norwich – all safeguarding measures and CAD markers were in place to protect victims.

[15] For clarity, level 2 offenders are those who are assessed as posing a high or very high risk of serious harm and require involvement and co-ordination of interventions from other agencies to manage the presenting risks

3.8.1.6 It was reported that the Mental Health In-Reach Team said he had an Emotionally Unstable diagnosis and would be referring him to the Community Mental Health Team on release. It was agreed to de-register him as MAPPA Level 2 management (he would have remained as a MAPPA Level 1) with the caveat that, should the risk increase, he could be re-registered.

3.8.1.7 Six MAPPA eligibility forum (MEF) meetings were held between the offender manager, their manager and the MAPPA co-ordinator. The purpose of these meetings was to discuss the case, provide necessary guidance and identify any underlying or presenting problems that could trigger another MAPPA level 2 referral under category 3 (other dangerous offenders[16]).

3.8.1.8 Whilst six MEF meetings were held to provide guidance to his offender manager, the SFO review of this case undertaken after April's death found that:

- A current picture of his circumstances and current risk factors were not presented to the MEF
- Actions agreed by MEF were not followed through at the time, such as completion of risk reviews, commencement/termination of Building Better Relationships and to transfer the case to Norwich (which was closer to his work and therefore might have facilitated better engagement and compliance). The MEF process is now much more robust

There is no mention of MAPPA after January 2014

The escalation of the perpetrator to MAPPA Level 2 after the 2015 conviction would have allowed a greater co-ordination of efforts to subsequently protect April from danger. It should certainly have been considered again after his arrest in 2016, he had after all re-offended whilst on a two-year supervision order, and whilst under two restriction orders against two other victims. These were potential opportunities.

Escalation would have enabled a greater level of information sharing and ensured that the probation service was not alone in attempting to manage his risk. A greater level of information sharing may have identified their relationship sooner, therefore allowing children's social care to afford a greater level of protection to April's children and a more co-ordinated and earlier consideration of a Clare's Law disclosure.

[16] Category 3 are dangerous offenders who index offence is not a sexual or violent offence specified under Schedule 15 of the Criminal Justice Act 2003

3.8.2 MARAC (Multi-Agency Risk Assessment Conference)

3.8.2.1 The MARAC is a multi-agency meeting which considers those cases of domestic abuse that are considered (using the DASH risk assessment) to be high risk. Its aim is to provide a multi-agency response to protect victims of domestic abuse.

3.8.2.2 In the period from 2008 to 2016, MARAC considered six different cases in which the perpetrator in this case was named as the perpetrator. There were eleven separate meetings at which a woman involved with the perpetrator was discussed.

3.8.2.3 April was discussed at MARAC on two separate occasions – 22nd July 2016 and 16th December 2016.

3.8.2.4 The cases that the review looked at, consistently did not have minutes or actions from the meeting available for scrutiny. It had already been acknowledged by the MARAC Steering Group that the process around MARAC needed improvement and this work had already begun prior to this review. The review has seen that since 2013 there have been minutes and actions available. The MARAC has now moved to meeting on a daily basis which ensures that high risk cases are considered in a timely fashion.

3.8.2.5 It was noted by the review that for the past three years those high-risk cases that repeatedly come to note have a summary of previous offending on the file which allows CPS to have a picture of a perpetrator's previous offending.

3.8.2.6 This review has identified that there is little or no interaction between the MARAC process (which is concerned with victims), the MAPPA process (which is concerned with perpetrators) and the safeguarding process (which deals with children involved).

Recommendations – National & Local

(30) It is recommended that consideration is given to how the needs of the whole family can be managed effectively across the processes of MARAC (focusing on the victim), MAPPA (focusing on the offender) and safeguarding (focusing on the children involved)[17]

[17] The review acknowledges that this recommendation has already been made in a Serious Case Review

3.9 Other issues considered

3.9.1 For reasons covered earlier in the report, the review has not sought to make contact with all of the perpetrator's previous partners but, from information from April's friends and family and an ex-partner we can see similarities and begin to paint a picture of the perpetrator and his approach to relationships. He is articulate and socially aware and on first meeting presents as charming and caring. He has a tendency to move very quickly in his relationships and makes great shows of affection for example, buying flowers every week, meals out and holidays. April's mother recalled one of the first times she met him when he arrived to pick up April and had two big bouquets of flowers, both of which were for her. She made a comment about them being for April and he said that they were for her. She felt this was a bit unusual and 'over the top'. The ex-partner also said that 'in the early days he would bring me flowers every day'. He was described as being fun and caring and he loved to spend his money on pleasing others.

3.9.2 In all of the relationships that we have been able to consider, we see the perpetrator move the relationship on very quickly. His first partner said that they started to live together within a couple of weeks of the relationship starting. We also see that the control and violence in relationships also began very early in the relationship. The ex-partner said that he first hit her one month into their relationship – we have been told that the violence against April began about eight weeks into the relationship.

3.9.3 We see the level of violence escalating very quickly within the perpetrator's relationship and there being very little that would exert control over him. For example, on more than one occasion we know that he assaulted his partners when their mother was present. Interestingly, we do not see any evidence of him being violent in front of other men and his mother felt that this might be a prohibitive factor for him.

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

3.9.5 His physical violence was always interpersonal, with punches and kicks to the face and head; it was not the use of weapons. The feeling of his fists causing the damage may have fuelled him in some way.

3.9.6 We are very clear in this Review that the coercion and control over partners, as well as physical violence, was prevalent within this perpetrator's relationships. He attempted to continue the control and fear even when the relationship had ended – by texts, emails and turning up in the street in his van. His level of charm and manipulation cannot be overstated. If there is one final incident that demonstrates this manipulation completely, it was during his court appearance for the murder of April. When returned to prison after the verdict and awaiting sentence he convinced the prison staff that he was not needed back in Court. Thus, on the day when the Judge was due to pass sentence, in the presence of April's family, he did not appear at Court. This caused delay and undue and unnecessary additional anguish for her family.

3.9.7 We have looked at what turned this individual into such an extreme perpetrator of domestic violence.

It is clear that a number of factors were present:

- He was exposed to domestic violence as a child and witnessed the break-up of his family group
- He seemed to resent his mother and began to display difficult emotional behaviour during his school years; he dropped out of school early
- He became a user of drugs and alcohol
- He was exposed to an older brother displaying significant criminal behaviour.

There are of course a large number of young men who suffer similar home circumstances; most do not end up displaying the same behaviour as the perpetrator.

3.9.8 The perpetrator had reached a point in his life where he was an extreme bully of vulnerable women. He was selfish, manipulating, controlling, and extremely violent. He was a very dangerous young man to any woman who fell for his charms.

3.9.9 The issue for society, and authorities in particular, is how we identify those who are dangerous and how we protect those who are thus vulnerable.

3.9.10 The Probation Service had recognised his risk and suggested sentencing options to the Courts when he came before them. The Courts sentenced in line with sentencing policy at the time. That policy did little to help protect the public, other than short periods of time in prison. Unfortunately, whilst it is true to say he could not harm anyone whilst he was in prison the sentences were not long enough to allow effective rehabilitation and he was often released without any form of supervision.

3.9.11 This Review sought to understand the detail of what attempts had been made in prison to rehabilitate the perpetrator. Unfortunately, the prison service has been unable to provide that information.

3.9.12 This Review welcomes the changes to sentencing policy announced on 22nd February 2018. The policy change recognises that assaults that occur in domestic circumstances are often more serious than those that do not because of their effect upon victims. This is a step-forward in terms of protecting the public.

3.9.13 This Review, however, would go further and suggest that the type of serial, repeat, violent offending as displayed by this defendant should automatically be considered an aggravating factor and longer-term prison sentences should follow for repeat offenders with mandatory rehabilitation courses whilst in prison. There has to be a deterrent.

Recommendation – National

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

3.9.14 We have looked at why April in this case did not feel confident enough to truly exit the relationship and this is considered in detail in section 3.3 above.

3.9.15 It is absolutely clear that we must do more to make domestic violence and abuse socially unacceptable. The Government's Green Paper 'Transforming the Response to Domestic Abuse' published on 8th March 2018, appears to be a huge step forward in this respect. It seeks to address domestic abuse at every stage from prevention through to rehabilitation. The Government is consulting on this document as they wish to harness the knowledge and expertise of victims and survivors, support organisations and research experts, as well as professionals from statutory bodies.

The main aim through this work is to **prevent domestic abuse** by challenging the acceptability of abuse and address the underlying attitudes and norms that perpetuate this. The consultation asks questions under four main themes with the central aim of prevention running through each:

- **Promote awareness** - to put domestic abuse at the top of everyone's agenda, and raise public and professionals' awareness
- **Protect and support** - to enhance the safety of victims and the support that they receive
- **Pursue and deter** - to provide an effective response to perpetrators from initial agency response through to conviction and management of offenders, including rehabilitation
- **Improve performance** - to drive consistency and better performance in the response to domestic abuse across all local areas, agencies and sectors[18]

This review wholeheartedly supports the proposals.

[18] A full briefing prepared by Christine Graham can be found at http://bit.ly/2FB05qJ

Section Four - Conclusions

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

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

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

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

4.5 The perpetrator's criminal convictions prior to the murder do not adequately represent the risk he posed to his victims and the fear he instilled within them. The evidence of the volume and nature of texts alone indicate his need for control and his childlike tantrums, which are far more dangerous as a violent grown man; when he does not receive a response the level of aggression in his texts is quite astonishing. Had he been charged and convicted with a more substantial offence for the July 2016 assault upon April he may have received another prison sentence, this may have prevented the murder of April. Had he been under the scrutiny of MAPPA at the time it may have meant more cross agency resources were alive to his potential and this may have had a deterrent effect. None of these things are certain and it would be wrong to blame any individual for failings in this case that led directly to the tragic events that resulted in April's death. There is only one person to blame for that death; that is the perpetrator.

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

Section Five – Recommendations

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

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

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

5.2 Professional curiosity

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

5.2.2 That A&E staff are trained in domestic abuse, including how to ask the abuse question and how to complete the DASH form[19] (Recommendation 14)

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

5.3 Information sharing and Fora for Discussion

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

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

[19] DASH form is the Domestic Abuse, Stalking & Harassment risk assessment completed to identify risk level

5.4 Collaborative Working, Decision Making and Planning

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

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

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

5.5 Ownership, Accountability and Management Grip

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

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

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

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

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

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

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

5.5.7 That a 'safeguarding' box is added to Symphony[20] as a mandatory reporting field in the hospital. This should include if there are any safeguarding concerns and identify whether the concerns relate to a child, adult or domestic abuse (Recommendation 16)

[20] Symphony is the A&E electronic patient record system

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

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

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

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

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

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

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

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

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

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

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

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

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

5.6 National Recommendations

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

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

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

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

Appendix One

1 Reasons for conducting the Review

1.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2 The review must, according to the Act, be 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 was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.3 In this case, the perpetrator has been found guilty of the murder of April. Therefore, the criteria have been met.

1.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

2 Process and timescales for the Review

2.1 In January 2017 Norfolk County Community Safety Partnership (NCCSP) was advised by Norfolk Constabulary that the death of April had occurred.

2.2 On 6th February 2017, a DHR Partnership meeting was held chaired by the Chair of the NCCSP. The purpose of the meeting was to formally consider whether a DHR was appropriate in this case.

2.3 It was agreed at this meeting that a review should be held and that an independent chair would be appointed.

2.4 On 7th February 2017, the Home Office was informed of the decision to hold a review. The family of both April and the perpetrator were advised of the Domestic Homicide Review.

2.5 The Coroner was advised of the review on 7th February 2017.

2.6 Christine Graham Consultancy Ltd was contracted to undertake the review. The review was chaired by Gary Goose supported by Christine Graham who has written the overview report.

2.7 The Review Panel met for the first time on 2nd May 2017. As this would be the first review with which some organisations had been involved, the purpose and process of the review was explained. The agencies in attendance at this meeting were:

- Clarion Housing Group Ltd
- Leeway Domestic Abuse and Abuse Service
- National Probation Service
- NHS England
- Norfolk and Suffolk CRC
- Norfolk and Suffolk Foundation Trust
- Norfolk and Waveney Clinical Commissioning Group
- Norfolk Constabulary
- Norfolk County Council
- Norwich and Norfolk University Hospitals
- Norwich City Council

Apologies were received from:

- Norfolk Safeguarding Adults Board
- Office of Police and Crime Commissioner

2.8 At the first meeting it was agreed that, given the complexity of this case and historic domestic abuse by the perpetrator, a full chronology would be completed going back to look at the time from his birth. At this stage, it was identified that another community safety partnership in the place of his birth and childhood would need to be involved.

2.9 The Panel considered the detailed chronology to determine those agencies that would be asked to complete an IMR.

2.10 The Chair and Report Author led on the contact with family and friends of both April and the perpetrator.

2.11 It was known that the perpetrator had a number of previous partners towards whom he was violent. Whilst the Review Panel felt it was really important to consider the perpetrator's offending history, it was very alive to the danger of vicarious victimisation of these women who had moved on with their lives. One of the perpetrator's previous partners engaged with the Chair and Report Author and it was felt, on balance, that her insights provided the background needed.

2.12 The review was not completed within the six-month period as stated within the statutory guidance for the following reasons:

- At the time the review was commenced there were ongoing criminal proceedings and following discussions between the chair and the police it was agreed that there was far too high a risk of undermining those criminal proceedings should interviews in relation to this review take place prior to the trial
- The complexity, significant agency background and geography necessitated trawls of historic agency records that were not readily available

3 Dissemination

3.1 The following individuals/organisations will receive copies of this report:

- April's family
- The perpetrator's family
- Norfolk Police and Crime Commissioner
- Chief Constable, Norfolk Constabulary
- Chief Executive, Norwich City Council
- Director for Children's Services, Norfolk County Council
- Chief Executive Officer, Leeway Domestic Violence and Abuse Service
- Chief Executive Officer, Norfolk and Waveney Clinical Commissioning Groups
- Chair, Norfolk Health and Wellbeing Board
- Chair, Norfolk Domestic Abuse and Sexual Violence Board
- Independent Chair, Norfolk Safeguarding Adults Board
- GP practice for April
- NHS England Midlands and East (East)
- Members of Norfolk County Community Safety Partnership
- Senior Coroner for Norfolk

4 Terms of reference

4.1 The terms of reference were agreed by the Review Panel on 27th June 2017. It was at this meeting that the Review Panel agreed that the Domestic Homicide Review would consider the period from the perpetrator's birth.

Terms of Reference for the Domestic Homicide Review into the death of April

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Norfolk County Community Safety Partnership (NCCSP) in response to the death of April which occurred in January 2017.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the NCCSP has appointed Mr Gary Goose MBE to undertake the role of Independent Chair and Overview Author for the purposes of this review. Mr Goose will be supported by Mrs Christine Graham. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

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

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

2.3 Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 8th January 2017; suggesting changes and/or identifying good practice where appropriate.

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

3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with, any on-going criminal justice investigation and the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how April died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

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

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

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

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

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

4.6 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Norfolk County Community Safety Partnership will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

5 Methodology

5.1 Norfolk County Community Safety Partnership was advised of the death by Norfolk Constabulary early in January 2017. This was by way of a DHR 1 report. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity.

5.2 In response to the notification, a DHR meeting was held on 6th February 2017. This was chaired by the Chair of the Community Safety Partnership. At this meeting, the police provided a summary of incident and those partners present shared the initial information

that they held in relation to April and the perpetrator. It was clear from the information shared at this meeting that the perpetrator was known to services as a domestic abuse perpetrator with offences relating to a number of partners. April was known to services, having engaged with her housing provider and Leeway in the months leading up to the incident.

5.3 Having heard the contributions from the partners present, the Chair took the decision to hold the Domestic Homicide Review because it was clear that, given the information available at the time, there would be learning from this case that would increase the understanding of abuse not only in the county but also nationally. The decision was taken within one month of April's death and therefore complied with the statutory timescale for the decision. The Home Office was informed of the decision to undertake the review. This decision demonstrates a good understanding by the Chair of the Partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

5.4 Gary Goose and Christine Graham were appointed in May 2017 to undertake the review and the Review Panel met for the first time on 17th July 2017. The Panel met again on 11th September and 9th November to review progress, commission IMRs and add challenge and rigour to the process. On 25th January 2018, the panel met to review the IMR submissions. The final meeting of the Panel was on 19th March 2018.

5.5 At the meeting on 17th July 2017 all members of the panel were present with apologies from Norfolk Safeguarding Adults Board and the Office of the Police and Crime Commissioner. At this meeting, the process of the Domestic Homicide Review was explained to the panel with the Chair stressing that the purpose of the review is not to blame agencies or individuals but to look at what lessons could be learned for the future. Prior to this meeting, the Chair had met with the police's senior investigating officer (SIO) to ensure that Section 9 of the statutory guidance was adhered to. It was agreed that the review could continue in limited scope until the conclusion of the criminal proceedings. The limited scope involved agencies in securing and preserving any written records. It was agreed that the review would re-commence fully after the legal proceedings had concluded.

5.6 Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

5.7 At this meeting the Terms of Reference were agreed subject to the families being consulted. It was agreed that the Chair and Overview Report author would make contact with both families with an introduction via the police family liaison officers.

5.8 A letter was sent to April's mother on 31st May 2017 introducing the Chair and Report Author and explaining about the review. The letter advised that the Report Author would be attending the court case and would make herself known to the family. This duly happened, and, over the course of the court case, conversations were held with a number of the friends and family of April.

5.9 On 18th August 2017, the Chair and Report Author met with April's mother, step-father and uncle. At this meeting, the review was explained to the family and the Terms of Reference were discussed with them. Home Office leaflets were shared with the family. It was agreed, at this meeting, that a further meeting would be held with other members of the family but, due to the health of April's mother, this did not take place.

5.10 April's mother provided contact details for a number of April's friends who would be willing to meet. The Report Author met with two of her friends and these discussions have been fed into the review.

5.11 The father of April's children has also contributed to this review.

5.12 A face to face meeting was held with the perpetrator's mother and contact through email and telephone calls was made with a previous partner of the perpetrator.

5.13 The Chair and Report Author have met with the family of both April and the perpetrator to share the report. A copy has been left with both families to allow them to read the report in peace and at their own pace.

6 Contributors to the review

6.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

6.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

6.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

6.4 The following agencies in Norfolk contributed to the review:

- Cambridgeshire Community Services NHS Trust
- Circle Housing
- Crown Prosecution Service
- GP surgery for victim
- Leeway Domestic Violence and Abuse Services
- MAPPA Co-ordinator
- National Probation Service
- Norfolk and Suffolk Foundation Trust
- Norfolk Constabulary
- Norfolk County Council – Children's social care
- Norfolk MARAC

6.5 The following agencies contributed to the review and are based in the county of the perpetrator's birth and early life[21]:

- Children's social care
- Healthcare
- Police

6.6 The following individuals contributed to the review:

- Victim's family
- Friends of victim
- Father of April's children
- Mother of perpetrator
- Previous partner and mother of perpetrator's children

7 The Review Panel

7.1 The members of the DHR Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Nick Bennett	Neighbourhood Manager	Clarion Housing Group Ltd
Sue Stavers	Head of Operations	Clarion Housing Group Ltd
Hayley Griffin	Head of Localities, Norwich and South	Children's Services, Norfolk County Council
Paul Corina	Head of Social Work, Norwich	Children's Services, Norfolk County Council
Punam Malhan	Deputy Chief Crown Prosecutor	East of England Crown Prosecution Service
Margaret Hill	Community Services Manager	Leeway Domestic Violence and Abuse Services
Charlotte Belham	Senior Operational Support Manager	National Probation Service
Hannah Waghorn	Senior Probation Officer, Internal Investigations Team	National Probation Service
Jane Ross	Patient Experience and Quality Lead	NHS England Midlands and East (East)
Emma McKay	Director of Nursing	Norfolk and Norwich University Hospital
Paul Reeve	Deputy Director	Norfolk and Suffolk CRC
Saranna Burgess	Head of Patient Safety and Safeguarding	Norfolk and Suffolk Foundation Trust
Pippa Harrold	GP Adult Safeguarding Lead	Norfolk and Waveney CCG
Lucy Parsons	Deputy Designated Named Nurse – children	Norfolk and Waveney CCG
Gary Woodward	Adult Safeguarding Lead	Norfolk and Waveney CCG
Jody Balme	Detective Sergeant	Norfolk Constabulary
Marie James	Detective Chief Inspector (SIO)	Norfolk Constabulary
Claire Winchester	MAPPA Co-ordinator	Norfolk Constabulary

[21] Location has been removed in order to protect the identity of the perpetrator's mother and children

Julie Wvendth	Detective Superintendent, Safeguarding	Norfolk Constabulary
Dawn Jessett	Community Safety Assistant (DHR Administrator)	Norfolk County Council
Jon Shalom	CCSP Business Lead	Norfolk County Council
Walter Lloyd-Smith	Business Lead for Norfolk Safeguarding Adults Board	Norfolk County Council
Lee Robson	Head of Housing	Norwich City Council
Gavin Thompson	Director of Policy and Commissioning	Office of Police and Crime Commissioner for Norfolk

8 Domestic Homicide Review Chair and Report Author

8.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

8.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Healthchecks which provide an independent view of partnership arrangements. Christine is also a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 & 3 meetings as well as engagement in Serious Case Reviews.

8.3 Working together, Christine and Gary have completed one review, with nine reviews (excluding this one) currently in progress. In addition, Gary has completed six reviews working alone.

8.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[22]

8.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017

[22] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

9 Parallel Reviews

9.1 At the first meeting of the Review Panel it was established that the following internal reviews were also being undertaken:

- Norwich and Norfolk University Hospital – internal serious incident investigation
- Her Majesty's Prison and Probation Service – Further Serious Offence investigation

It was agreed that both of these reports would form the basis of the IMR for these organisations.

10 Equality and Diversity

10.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

10.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[23] Women are more likely than men to be killed by partners/ex-partners. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[24]

23 (Women's Aid Domestic abuse is a gendered crime, n.d.)
24 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

Appendix Two
Glossary

Athena	Project Athena is a framework agreement for police IT systems to enable data sharing between forces
BBR	Building Better Relationships – rehabilitation programme run by probation services for perpetrators of domestic abuse
Clare's Law	Also known as the Domestic Violence Disclosure Scheme (DVDS). This allows the police to disclose information on request about a partner's previous history of domestic abuse or violent acts that could protect someone from being a victim of attack
CAD	Computer Aided Despatch – police recording system for dealing with requests for service and officer attendance
CPI	Child Protection Investigation
DASH	Domestic Abuse, Stalking and Honour based violence risk assessment model introduced to all UK police forces since 2009
DAST	Domestic Abuse and Stalking Team, Norfolk Constabulary
DHR	Domestic Homicide Review
DHR 1	Standard form used by Norfolk County Community Safety Partnership for written notification that a death has occurred which may meet the criteria for a Domestic Homicide Review
DVDS	Domestic Violence Disclosure Scheme, also known as Clare's Law (see above)
IDAP	Integrated Domestic Abuse Programme, rehabilitation programme run by probation services for perpetrators of domestic abuse – replaced by the BBR programme (see above)
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review – this is a review undertaken by an organisation to look at their interaction with the victim or perpetrator and identify good practice or lessons learned
MAPPA	Multi- Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference

MASH	Multi-Agency Safeguarding Hub, which enables agencies to share information where there are safeguarding concerns
MEF	MAPPA Eligibility Forum – this is a meeting where offenders are discussed to consider their eligibility for registration under the MAPPA scheme
NCCSP	Norfolk County Community Safety Partnership – this is a statutory partnership comprising agencies serving the county and is responsible for community safety within the county
OM	Offender Manager
SFO	Serious Further Offence, relating to those already under probation services supervision
TR	Transforming Rehabilitation – this is a Government programme which saw parts of the Probation Service being run by private providers and high-risk offenders continuing to be managed by the National Probation Service
WCU	Witness Care Unit

Appendix Three
Letter from Home Office Quality Assurance Panel

Public Protection Unit
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Jon Shalom
Norfolk County Community Safety Partnership (CCSP) Business Manager
Public Health
Norfolk County Council
3rd Floor (East)
County Hall
Martineau Lane
Norwich NR1 2DH

28 September 2018

Dear Mr Shalom,

Thank you for submitting the Domestic Homicide Review (DHR) report for Norfolk ('April') to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 26 September.

The Panel was grateful to you, the review chair, Gary Goose, and the review author, Christine Graham, for attending the meeting and providing helpful background on the sensitivities in relation to this review and for clarifying queries the Panel raised on some of the detail in the report.

The Panel concluded this is a well-presented, professional review of a complicated case which merited the level of scrutiny and detailed examination of the facts. The report conveys compassion and respect and the Panel praised the engagement of family, friends and others in the review which provides important insight of the victim as a person. The Panel also commended the large review panel which they felt was proportionate to the extensive agency involvement with the perpetrator. The resulting action plan is detailed and relevant and the Panel was keen that it should be published alongside the report to share best practice, disseminate the learning and enable progress to be monitored.

As identified at the meeting, there were some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider before publication:

- Review of some of the language used in the report and the Panel provided examples of where this may be relevant;

- Explicit inclusion in the report of equality and diversity and the nine protected characteristics within the Equality Act;

- Confirmation that the family were involved in choosing the pseudonym for the victim.

The Panel does not need to review another version of the report but, as discussed at the meeting, if you would find it helpful, members of the Panel are happy to review revised sections and comment on the amended language.

I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Hannah Buckley
Joint-Chair of the Home Office DHR Quality Assurance Panel