DOMESTIC HOMICIDE REVIEW

Into the death of Finn (Pseudonym)

In July 2022

OVERVIEW REPORT

Independent Review Chair/Author: David Warren QPM. LLB. BA. Dip. NEBSS
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TRIBUTE

“To Finn (pseudonym) from his parents

“As a parent you never expect to outlive your children, you will do anything in your power to protect them. (Finn) was our baby, the youngest of five children he can never be replaced.

He was a kind and beautiful person and sadly leaves two children behind that will never get to know their daddy.

To our (Finn), we love and miss you, more than anything in this world. Your shining light will always be in our hearts”.

PREFACE

The Independent Chair and the Domestic Homicide Review Panel Members wish to express their deepest sympathy to Finn's[1] family and all who have been affected by his death.

The Review Chair thanks the Panel and Individual Management Review (IMR) Authors who have contributed to the Review for their time, cooperation and professional manner in which they have conducted the Review. Particular thanks to the Review Administrator Sayma Bagum and to Sarah Cameron of the Domestic Homicide Service who has worked tirelessly to support Finn's family and ex-partner.

1. INTRODUCTION

1.1. Domestic Homicide Reviews (DHRs) came into force on the 13 April 2011, having been established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a Domestic Homicide Review should 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 learned from the death.

Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence'.

1.2. The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

[1] Pseudonym used for the deceased.

- Prevent domestic violence and homicide and improve service responses for all domestic violence, to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity to try to prevent future incidents.

1.3. Domestic Homicide Reviews (DHRs) are not disciplinary inquiries, nor are they inquiries into how a person died or into who is culpable; that is a matter for Coroners and Criminal Courts, respectively, to determine as appropriate.

1.4. This Review was held in compliance with Legislation and followed Statutory Guidance.

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1.5. The Review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Finn and Laura entering into the process from their viewpoint. This has ensured that the Review Panel has been able to consider the circumstances of Finn's death in a meaningful way and address with candour the issues that is has raised.

1.6. This Domestic Homicide Review (DHR) examines agency responses and support given to Finn, Laura and Alex (pseudonyms), residents of Portsmouth and Havant respectively prior to the point of Finn's death in July 2022.

1.7. In addition to agency involvement, the Review also examined the past, to identify any relevant background or possible abuse before Finn's death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the Review seeks to identify appropriate solutions to make the future safer.[2]

1.8. **Summary of the incident**

1.8.1. Laura and Finn were in a relationship. Laura who had an interest in violent crimes kept a knife next to her bed. At 5.00am on the morning of Finn's death, Laura had texted her friend Vera (pseudonym) stating she had a fight with Finn and he had gone home. Later at 7.45 am, Vera received a video call from Laura. They had a conversation and Vera was able to see Finn on the floor with his throat slit. Laura disclosed to Vera that she had cleaned up and the incident occurred a few hours earlier. Vera contacted her mother, who advised her to contact the Police. Vera reported what she had seen to the Police, who attended and found Finn deceased at 8.04 am. On their arrival, Laura had made a disclosure to the Police to suggest she was responsible and identified the knife used. At her trial, Laura claimed she had killed Finn in self-defence, however this was not believed as it was proven he was
asleep at the time of his death.

2. TIMESCALES

2.1. The Hampshire and Isle of Wight Police notified the Safer Portsmouth Partnership of the death on the 21 July 2022. A decision to undertake a Domestic Homicide Review was taken by the Safer Portsmouth Partnership on the 10 August 2022. The Home Office were informed of this decision on the 12 August 2022. The Independent Domestic Homicide Review Chair was appointed on the

[2] Home Office Guidance for Domestic Homicide Reviews December 2016.

11 October 2022. A pre-meeting of the DHR was held on the 13 October 2022 to agree process, timescales and Terms of Reference.

2.2. The Review was concluded on the 18 May 2023. Normally such Reviews, in accordance with para. 46 of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews National Guidance, would be completed within six months of the decision to initiate a commencement of the Review. However, the Review was delayed due at the request of the Police Senior Investigating Officer to adjourn the Review until the conclusion of criminal proceedings.

2.3. The Review Panel 'Teams' Meetings:

- 13 October 2022 - 10:00 to 11:30 (Pre-Meeting re ToR & Timescales)
- 23 February 2023 - (Postponed due to protracted criminal proceedings to 30 March 2023 - 09:30 to 12:00
- 4 May 2023 - 09:30 to 12:00

3. CONFIDENTIALITY

3.1. In accordance with Statutory Guidance, the Review has been conducted in a respectful, confidential manner by Panel Members and IMR Authors.

3.2. To protect the identity of the victim, his and the perpetrator's families, pseudonyms have been used throughout this report. With the agreement of his family, the pseudonym 'Finn' was chosen for the victim. The pseudonyms, "Laura" were chosen for the perpetrator and 'Alex' for her child. They were later agreed by Laura when she spoke to the Review Chair of 13 April 2023. The Perpetrator's housemate was given the pseudonym 'Marilyn' and her friend has the pseudonym 'Vera'. Dates of birth and Finn's death have also been redacted from this report.

3.3. Until this report has been approved for publication by the Home Office Quality Assurance Panel, the findings of this Review have been restricted to only participating officers/professionals, their Line Managers, Finn's family, Laura and with the agreement of the Home Office, a copy of the Overview Report has been provided to the Hampshire Police & Crime Commissioner.

4. TERMS OF REFERENCE

4.1. Agencies that have had contacts with the victim, Finn, the perpetrator, Laura or her child Alex, should identify any lessons to be learnt from those contacts, and set out provisional actions to address them as early as possible for the safety of future victims of domestic abuse, particularly those who are vulnerable through mental health issues, alcohol and/or other substance misuse or gambling.

4.2. This Domestic Homicide Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

4.3. Each participate agency's involvement with the following, from 1 May 2021 until the date of Finn's death in July 2022, as well as relevant contacts prior to that period:

Finn (pseudonym) who was 25 years of age at date of his death.

Laura (pseudonym) who was 26 years of age at the time of Finn's death.
Alex (pseudonym) who was 5 years of age at the time of Finn's death.

4.4. Identify what lessons can be learnt from their interactions and how they will be acted upon, and what is expected to change as a result.

4.5. Apply these lessons to service responses including changes to policies and procedures as appropriate.

4.6. Prevent domestic homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

4.7. Establish the facts that led to the incident, and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support the victim or manage the person who caused harm.

4.8. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. This is a matter for Coroners and Criminal courts.

4.9. The Review will consider any other information that is found to be relevant, and which may contribute to a better understanding of the nature of domestic abuse and adult safeguarding.

4.10. The Review will also highlight good practice.

5. METHODOLOGY

5.1. The method for conducting this Domestic Homicide Review (DHR) is prescribed by Statutory Guidance. Upon notification of Finn's death from Hampshire Police, a decision to undertake the Review was taken by the Chair and members of the Safer Portsmouth Partnership.

5.2. Agencies were instructed to search for any contact they may have had with Finn, Laura or their children. If there was any contact, then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review (IMR). This allowed the individual agency to reflect on their contacts, and identify areas which could be improved and to make relevant recommendations to enhance the delivery of services for the benefit of individuals in Finn, Laura or their children's circumstances in the future.

5.3. The Review Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating Agencies and Multi-Agency forums
- The Pathologist Report
- Transcript, Judge's Summing Up and Press Reports of Criminal Proceedings
- Discussions with members of Finn's family, ex-partner
- Discussions with Laura
- Discussions during Review Panel meetings

6. INVOLVEMENT WITH FRIENDS AND FAMILY

6.1. At the commencement of the Review, the Review Chair contacted Finn's parents and ex-partner by letter, which was delivered by their Homicide Service Key Worker. They were provided with a copy of the draft Terms of Reference and the Home Office and Advocacy After Fatal Domestic Abuse (AAFDA) leaflets explaining DHRs and available support. They agreed the ToR and the proposed pseudonym Finn, but stated that they did not wish to actively engage with the Review, but would remain in contact through the Homicide Service Key Worker. Through the Homicide Service Key Worker, they have provided the Review with background information relating to Finn which is included in this report. They declined the offer of an AAFDA Advocate.

6.2. Laura's Solicitor was contacted and notified of the Review. She was requested to pass a letter from the Review Chair together with the Terms of Reference, notifying Laura of the Review and inviting her to contribute to it. No response was received despite a follow up letter. The DHR Chair nevertheless tried again to contact Laura after the criminal proceedings had been completed though her Probation Case Manager. Laura agreed to speak to the Review Chair, who met with her by video link on 13th April 2023. He explained the Review process and findings to her. Laura stated that her Solicitor had not notified her about the Review or passed on the Chair's letter or the Terms of Reference to her. The first time she received them was from her Probation Case Manager.

6.3. Laura agreed the pseudonyms to be used in the Review Reports. She gave background information regarding her childhood, formative influences, her health, her child and her relationship with Finn. She said, she was being honest and open in the hope that it would help others and that one day her child, whom she loves very much, would understand and avoid the mistakes she had made. Later her Probation Case Manager gave her a copy of the Overview Report to read. Laura's comments are included in this report.

6.4. Police attempted to contact ex-partners of Laura, however they were not willing to provide a statement and they have declined to engage with the Review.

7. CONTRIBUTORS TO THE REVIEW

7.1. Whilst there is a statutory duty on bodies including the Police, Local Authority, Probation Trusts and Health Bodies to engage in a DHR, other organisations can voluntarily participate; in this case the following fifteen organisations were contacted by the review:

- **Advocacy After Fatal Domestic Abuse (AAFDA):** This Charity was contacted to provide an advocacy service for Finn's family, but the offer was declined by the family, as they had already developed a strong bond with the Victim Support Homicide Case Worker who they wanted as their link with the Review.

- **Adult Safeguarding Hampshire County Council:** This Department had no relevant contacts with Finn, Laura or Alex. A Senior Manager was a DHR Member.

- **Children's Social Care Hampshire County Council:** This Department had relevant contacts with Laura and Alex and an IMR was completed. A Member of this organisation who is independent of any contact with Laura, Alex or Finn is a DHR Panel Member.

- **Stop Domestic Abuse:** This domestic abuse support service had no relevant contacts relating to Laura or Finn. A Senior Member of this Charity is a DHR Panel Member.

- **Hampshire and Isle of Wight Constabulary:** This Police Force had relevant contacts with Laura, Alex and Finn and an IMR was completed. A Member of this organisation who is independent of any contact with Laura, Alex or Finn is a DHR Panel Member.

- **Hampshire and Isle of Wight Integrated Care Board (ICB) re Laura, Alex and Finn's GP Practices:** A Senior Member of this organisation who is independent of any contact with Finn, Laura or Alex is a DHR Panel Member. The ICB instructed IMR Authors to provide IMRs on behalf of a GP Practice in relation to Laura and Alex. There were no relevant contacts regarding Finn. The IMR Authors had no previous contact with Laura, Alex or Finn.

- **National Probation Service:** This Department had no relevant contacts with Finn or Laura. A Senior Member of this Agency is a DHR Panel Member.

- **Portsmouth City Council Housing:** This Department had no relevant contacts with Finn or Laura. A Senior Member of this Agency is a DHR Panel Member.

- **Portsmouth Multi-Agency Risk Assessment Conference (MARAC):** The current Portsmouth MARAC Chair responded to a DHR Memorandum of Agreement, confirming that whilst there had been no referral to MARAC in relation to Laura, there had been one MARAC referral in 2018 relating to Finn's ex-partner in which Finn was the perpetrator of domestic abuse. The MARAC Chair provided an IMR report setting out her review of this referral. She had no previous involvement with Finn, Laura or Alex.

- **Solent NHS Trust:** This Trust had no relevant contacts with Finn, Laura or Alex. A Senior Member of this Agency is a DHR Panel Member.

- **Southern NHS Trust:** This Trust had no relevant contacts with Finn, Laura but submitted an IMR relating to Alex. A Senior Member of this Agency is a DHR Panel Member.

- **South Coast Ambulance Service:** This Trust had no relevant contacts with Finn, Laura or Alex.

- **Treetops Sexual Assault Referral Centre - Solent NHS Trust:** This service provided an IMR in relation to a contact relating to Alex.

- **Victim Support Homicide Service:** This Charity provided a Case Worker who acted as Finn's family link with the Review.

- **Yellow Door:** This Charity had no relevant contacts and has provided an independent domestic abuse expert to advise the Panel.

7.2. Seven of those Agencies have completed IMR reports. All of the IMR Authors have confirmed that they are independent of any direct or indirect contact with any of relevant parties subject to this Review.

8. REVIEW PANEL

8.1. The Review Panel consists of experienced Senior Officers from relevant statutory and non-statutory agencies, none of whom had any prior contact with Finn, Laura or Alex.

8.2. Panel Members:

Name	Role	Organisation
Sayma Begum	Domestic Abuse Analyst	Portsmouth City Council
Rachel Windebank	Operations Director	Stop Domestic Abuse
Toby Elcock	Serious Case Reviewer	Hampshire Constabulary
Sarah Beattie	Head of Portsmouth & IOW Probation	Probation Service
Mark Fitch	Head of Local Authority Housing	Portsmouth City Council
Tracey Stovold	DA Expert Witness	Yellow Door
Michele Ennis	Designated Nurse Safeguarding Adults	ICB
Laura-Jane Osbaldeston	Designated Nurse Safeguarding Adults, Head of Vulnerable Adults	ICB
Kemi Awoyera	Designated Nurse Safeguarding Children	ICB
Kathryn Moloney	Specialist Adult Safeguarding Practitioner	Solent NHS Community and Mental Health Trust.
Susan Corley	Named Nurse, Safeguarding	'Southern Health NHS Foundation Trust
Debbie Key	Strategic Partnership Manager	Hampshire and Isle of Wight Safeguarding Children Partnership
Andrew Jacobs	Team Manager, Children's Reception Team and Multi Agency Safeguarding Hub	Hampshire County Council

9. CHAIR & AUTHOR OF THE OVERVIEW REPORT

9.1. The Chair of this Domestic Homicide Review is legally qualified and is an experienced Chair of Statutory Reviews.

9.2. He has no connection with the Safer Portsmouth Partnership and is independent of all the agencies involved in the Review. He has had no previous dealings with Finn, Laura or Alex.

9.3. He has an extensive knowledge and experience working in the field of domestic abuse and sexual violence at local, regional and nation level. Between 2004 and 2011, he was the Home Office Criminal Justice Manager for the Government Office South Wales. Amongst his responsibilities were the funding and monitoring of the delivery of local services to address domestic violence and sexual crime. He was a founder member of both the South West Regional Safeguarding Children's Board and the Safeguarding Adults Board. He was also a member of a number of Violence Against Women and Children policies, the national development and implementation of DHRs and the national funding of local domestic and sexual abuse services.

9.4. Since 2011, he has Chaired numerous Statutory Reviews including Serious Case Reviews, Safeguarding Adults Reviews, Mental Health Homicide Reviews, Drug Related Death Reviews and Domestic Homicide Reviews across the country. He has been a keynote speaker at several National Conferences on domestic and sexual abuse most recently on the particular issues facing Domestic Homicide Reviews in cases relating to suicides.

9.5. For a number of years, he carried out voluntary works as the Chair of a substance abuse Charity and has provided pro-bono legal work for a refuge and its residents.

10. PARALLEL REVIEWS

10.1. Criminal Proceedings concluded after a five week trial with Laura being convicted of Finn's murder. She was jailed for a minimum of 23 years.

11. EQUALITY AND DIVERSITY

11.1. The Panel and the Agencies taking part in this Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness, and transparency. All nine protected characteristics in the Equality Act were considered, and the Panel was satisfied that services provided were generally appropriate.

11.2. Section 4 of the Equality Act 2020 defined 'protective characteristics' as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

11.3. There is no information within organisations' records to indicate that any incident mentioned within this report was motivated or aggravated by disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion/belief or sexual orientation.

11.4. There was evidence that Laura's child, whilst only 4 years of age was abused by an 8 year old child. On learning of the abuse, Laura responded promptly by reporting the incident to Children's Services and her General Practitioner. As the 8 year old perpetrator was under the age of criminal intent, the Police were notified but were not able to take any criminal proceedings but did liaise with Children's Services.

11.5. Sex and Mental Health:

11.5.1. Laura as an adult, reported historic sexual abuse by a family member, when she was 10-12 years of age, subsequently she was diagnosed as suffering from post-traumatic stress disorder (PTSD). This was raised in the criminal proceedings, when it was inferred by her defence team that it may have impacted on her mental health at the time of the murder.

11.5.2. The Review considered if Finn being a male, resulted in agencies failing to identify him as a victim of domestic abuse. The Panel were satisfied that there was no evidence to indicate that any agency had any knowledge or indication of any connection between him and Laura. However, friends of Laura knew of the abusive relationship and the threats Laura made regarding Finn. The Review Panel questioned if they would have contacted agencies if he had been female?

11.5.3. The Panel noted that the Office for National Statistics figures show every year that one in the three victims of domestic abuse are male, equating to 699,000 men in 21/22 (1.671m women) yet 66% of the men who call the ManKind Initiative helpline had never spoken to anyone before about the abuse they were suffering and 64% would not have called if the helpline was not anonymous. (See also para 16.12.1.)

11.6. Disability

11.6.1. Laura was partially deaf and had worn hearing aids in both ears since the age of 11. This was the result of perforated eardrums which she had been told was probably the result of being held under the water for so long as a baby. (see para 14.3.1 for more detail.)

12. DISSEMINATION

12.1. Each of the Panel Members, IMR Authors, the Chair and Members of the Safer Portsmouth Partnership have received copies of this report. A copy has also been sent to the Hampshire and Isle of Wight Crime Commissioner.

12.2. In accordance with Statutory Guidance[3], the findings of this Review are restricted to only participating officers/professionals, their Line Managers, Laura, Finn's family and their

[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. para 72 (Home Office. December 2016**)**

Homicide Support Service case worker[4], until after this report has been approved for publication by the Home Office Quality Assurance Panel.

12.3. Laura, Finn's family and their Key Worker have been given electronic copies of the Overview Report and the Executive Summary to enable them to have the opportunity to read and respond to the reports if they wish to do so.

13. BACKGROUND INFORMATION (THE FACTS)[5]

13.1. Finn and Laura had been seeing each other for approximately six months and they shared an interest in bondage, dominance, sadism and masochism (BDSM).

13.2. There was a CCTV camera set up in Laura's bedroom which recorded them having sex. Some weeks before Finn's death, Laura sent three edited clips of the footage to her friend Vera, suggesting Finn was violent to her before raping her. However, on checking the unedited footage, Police later found that this was clearly part of consensual sex. Vera told the Police that Finn "had wanted the CCTV in the bedroom taken down because Laura was holding the videos she had, over his head because she kept on threatening to put them on Facebook and ruin his life." At Laura's trial, it was heard that when the CCTV recordings were viewed in context, "it contradicts the defendant's account of the three short video clips she sent to Vera saying there had been non-consensual sexual violence by Finn on her. It also contradicts what Laura told the Police – that he had tried to attack her, and it was not the first time she had video footage of him raping and beating her." Laura has told the Review Chair that whilst their rough sex was consensual in the main, there were occasions when Finn went too far and although she screamed for him to stop, he did not do so. She said this was acknowledged by the trial Judge in his summing up.

13.3. On the night of his death, Finn was sleeping at Laura's house with her in her bed. What triggered his death has not been fully established, although at the trial it was intimated that Laura was upset after she saw on Finn's phone, that he had been in contact with a girl who purported to be 13 years of age on Facebook. (The girl was later found to be 17years of age). It was highlighted by the Police, that as soon as the girl told Finn she was 13, he had ended the contact and blocked the girl. The trial accepted medical evidence, that as there were no defensive injuries found on either Laura or Finn,[6] it would appear he was asleep when Laura cut his throat with a knife and then repeatedly stabbed him 17 times in the chest.

13.4. What has been confirmed, is that at 5am on the day he died, Laura texted her friend Vera, stating she had a fight with Finn, and he had gone home.

13.5. At 7.45am, the same day, Vera received a video call from Laura. They had a conversation and Vera was able to see Finn on the floor with his throat cut. Laura disclosed to Vera that she had cleaned up and that the incident had occurred a few hours earlier.

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[4] The family stated they were satisfied with the support they were receiving from the Homicide Support Service Case Worker, who they asked to represent them in relation to the review and they declined the offer of an Advocacy After Fatal Domestic Abuse advocate.

[5] This section sets out the information required in Appendix Three of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016)

[6] Laura has challenged this, by alleging that she had several bruises, but they were not evident due to her being so heavily tattooed.

13.6. Vera telephoned her mother, who advised her to contact the Police, she did this and when they attended Laura's home at 8.04 am, they found Finn deceased. On their arrival Laura had made a disclosure to suggest she was responsible and identified the knife used. The Officers found no defensive injuries on either Finn or Laura.

13.7. Whilst the motive was unclear, the following information was considered during the criminal proceedings:

- Finn had inadvertently messaged a 13yr old girl on Facebook stating 'Hi' and that he had 2 children. The girl, informed Finn, she was 13 years old and told him to 'Get lost'. The contact was recorded by Laura on her phone.
- Laura had a fixation with knives and had ornamental knives in her bedroom. She also slept with a dagger under her pillow.
- 1-2 weeks preceding the incident, Laura had a conversation with a friend when she stated "I could have killed him last night. I could have slit his throat'. A few days prior to the incident, she had a conversation with Vera, stating she wanted to have him beaten.
- Laura had installed CCTV throughout the house including the bedroom. Police reviewed the footage which contained violent sexual intercourse between Finn and Laura. This included Finn physically hitting Laura, however after examining the footage available before and after sex, this appeared to have been consensual, although Laura told the Review that he would on occasions go too far and not stop when she told him to do so.
- Laura had made an allegation of rape, by Finn, to Vera and sent her a video. This video again appeared to have been edited, based on the footage before and after the incident and included both parties having normal sex afterwards.
- The Police investigation revealed evidence of jealousy from both partners, in relation to each other's sex-partners.
- Police attempted to contact ex-partners of Laura however, they were not willing to provide a statement.

13.8. Laura reportedly, had a fascination with serial killers and had framed pictures of a number of infamous serial killers hung around her bedroom walls. At her trial it was noted that she collected books on infamous criminals and was an avid viewer of true crime documentaries. It was put to her at her trial, that based on what she had learnt from these documentaries, she deliberately set up a false narrative of being abused by Finn and contacted her friend Vera in an attempt to create a false alibi and cleaned the crime scene.

13.9. The Pathologist in his report, identified that Finn's throat had been slit and that there was a total of 17 stab wounds to Finn's chest. The report confirmed the absence of any defensive wounds to Finn's hand or arms. He concluded that the cause of his death was catastrophic blood loss from a series of stab wounds to his neck and the front of his chest.

13.10. Laura was subsequently found guilty of Finn's murder and she was sentenced to life imprisonment with a tariff of 23 years.

14. CHRONOLOGY

14.1. The events described in this section explain the background history of Laura and Finn prior to the key timelines under review, as stated in the Terms of Reference. They have been collated from the chronologies of agencies that had contact with them and from information provided by Laura's and Finn's family and friends. Both Finn and Laura are white British residents of Hampshire.

14.2. **Re Finn**

14.2.1. Finn, the youngest of five children, lived with his parents until starting a relationship with Clare (pseudonym) with whom he had two children. He worked as a plumber and they were settled until Finn started to use cocaine and developed an online gambling habit. His family highlighted that he started to continuously borrow money from family and friends, and the changes in him became a concern. His partner Clare has stated that as Finn became more involved with drugs and gambling their relationship deteriorated and they separated in 2017.

14.2.2. On the 30 June 2018, the Police were called to an allegation of an assault by Finn on his then ex-partner Clare. Finn was arrested for assault occasioning actual bodily harm. He was interviewed regarding the matter and following CPS advice, he was charged with criminal damage and common assault. Police spoke to Clare, who stated she still had an amicable relationship with Finn and believed the incident was a drunken incident.

14.2.3. The case was referred to the Multi Agency Risk Assessment Conference (MARAC) and after a MARAC meeting on 18 July 2018, support was offered to Clare. Whilst she declined some of the help offered, she agreed that she would support a restraining order stopping Finn coming to her home or contacting her. This was subsequently imposed on Finn.

14.2.4. On the 13 August 2020, the Police were again called to Clare's home address and spoke with her. She stated that at approximately 01:30 hours, Finn had gone to her home and had an argument with her. Finn had become very angry and got a knife and used it to cut up the armrest on the sofa and also smashed up a canvas picture. She said he was drunk but confirmed that she did not want any further action taken against him and would not support a Police investigation. A standard DASH risk assessment was completed, and safeguarding advice given.

14.2.5. On the 24 August 2018, Finn pleaded "Guilty" to battery and was subsequently fined and a restraining order was imposed against him. The conditions were not to enter the road Clare lived in and to have no contact, direct or indirectly with Clare except via a third party to arrange child contact only. The order was in place until the 23 August 2019. There was no separate penalty imposed in relation to the criminal damage offence.

14.2.6. On the 24 September 2021, a neighbour reported a female shouting "Get out of my flat" at Clare's home address. On Police arrival, Clare explained that Finn had been at the property but had since left. They had been arguing about money that he owed her. Clare had not reported it to the Police as it had happened before and did not cause her any distress, she believed his debts were due to his gambling addiction.

14.3. **Re Laura**

14.3.1. Laura had a difficult time as a child. She told the Review that when she was about three months old, her father had attempted to drown her in the bath, consequently her

mother and father split up and she had little to do with him afterwards. She was brought up by her mother and a stepfather and one stepbrother who was about four years older than her. She was partially deaf and had worn hearing aids in both ears since the age of 11. This was the result of perforated eardrums which she had been told was probably the result of being held under the water for so long as a baby.

14.3.2. In 2006, Hampshire Children's Services had received a third-party allegation that Laura was being sexually abused. An investigation was undertaken, however there was no evidence to substantiate the concerns and Laura had denied that any abuse had occurred. (Laura told the Review that this was due to pressure from her mother to 'drop it'). However, on the 19 February 2018, the Police received a similar report that Laura had been subjected to historic sexual abuse by a family member when she was between the ages of 10-12. The Police confirmed that the allegation against the family member was fully investigated, but it resulted in no further action (NFA) due to lack of corroborative evidence.

14.3.3. In July 2010 Laura's stepfather took her to the GP after finding her self-harming by cutting her arms and legs. Children's Services had received information from Children and Adolescent Mental Health Services (CAMHS), that at the time Laura was diagnosed with bipolar/post-traumatic stress disorder (PTSD). The last record of her self- harming was early in the pregnancy with Alex.

14.3.4. On the 9 August 2016, Laura had presented to her GP with anger issues, claimed she was hearing a voice in her head, cutting herself, and also claimed to have attempted an overdose. There were, no details of when or what she had taken as she had not sought medical help. She stated that the voices had started subsequent to her using illicit drugs when she was 17years of age. The GP referred her to the community Mental Health Team (CMHT). Laura was partly assessed, but then never attended appointments and was eventually discharged.

14.3 5. Laura left home in her late-teens and started a relationship in which there was some abuse from her partner who was a substance abuser. She left him after the first signs, but it was not reported to any agency at that time. Later whilst in a relationship with Alex's father she sought help from Stop Domestic Abuse, and for a short time went to a refuge before leaving of her own accord.

14.3.6. Laura told the Review that whilst she was at school, she worked part-time with her mother who had her own cleaning business. After leaving school she had a variety of short time jobs including working in a food take away, a factory, the library, a coffee house and again working with her mother as a cleaner.

14.3.7. On the 13 August 2020, a neighbour reported that Laura had been walking alone to the local supermarket via an underpass in Portsmouth. There were three males in the underpass suspected to be dealing drugs. One of the males grabbed Laura around the throat and cut her face with some kind of razor leaving her with three scratch lines on her face. Laura did not wish to provide a statement to the Police, as she was worried about repercussions and did not want the Police to take any action. The Police tried to change Laura's mind, but she responded that she did not know the identity to the person responsible. Increased patrols were nevertheless made in the area, but no arrests were made.

14.3.8. On the 28 February 2021, Laura made a Domestic Violence Disclosure Scheme (DVDS) application to the Police concerning her then partner (not Finn nor Alex's father,) because she had heard he had been abusive to a previous girlfriend. A decision was made to disclose the personal information to her to safeguard her and her child. This was considered to be appropriate positive action by the Police.

14.3.9. On 29 June 2021, at about 21:54 hours, Police were notified of a domestic disturbance involving the occupants of a vehicle on Hayling Island, by a friend of Laura's. This was following the friend becoming concerned over the context of some Snap Chat messages she had seen. Upon Police arrival, Laura and a named male (not Finn) were engaging in sexual activity in the rear of the vehicle. There was evidence of alcohol in the vehicle and both parties were separated and spoken to individually. The male provided a positive specimen of breath for alcohol and was subsequently arrested on suspicion of drink driving.

14.3.10. A domestic abuse risk identification checklist (DASH) was completed by the Police Officer. Laura was not asked whether she would consent for the information to be shared with partner agencies and did not wish to support an investigation at that time. She did state that she was content with Police re-contacting her if necessary. Laura disclosed privately to the Officer that she was scared, as the male had forced her to take cocaine on the 24 June 2021 despite knowing that she was a recovering cocaine addict of five years. Laura also disclosed that the male had punched a kitchen cupboard in frustration causing damage. Laura stated that she was scared of further violence and would not allow the male to have contact with her child, Alex. The Officer recorded that Laura was not currently pregnant at that time. Laura stated that their relationship was not stable, but they were trying to rectify things. She was taken back to her home address and safeguarding advice was given. Both parties confirmed that no domestic dispute had occurred at that time. Police made an appropriate referral to MASH using a Public Protection Notice (PPN1) and the domestic abuse risk assessment was graded as "Medium".

15. OVERVIEW

15.1. Laura

15.1.1. In April 2022, Laura reported to a nurse at her GP practice, mental health needs and health anxiety. Whilst health education was offered during a routine smear test in response to high alcohol intake and smoking, there was no evidence to support any action regarding mental health and anxieties, other than referrals to physical health outpatient services. She did not attend any arranged contacts.

15.1.2. Laura has a 5 year old child, Alex from a previous relationship. During July 2022, Laura had a distressed telephone consultation with her GP regarding Alex having been abused for approximately a year. The perpetrator was 8 years of age. It had been reported to Children's Services, her GP and subsequently the Police, but no action could be taken against an 8 year old. (See para 11.4.)

15.1.3. Laura's friend Marilyn lived with her, and CCTV footage inferred a level of coercive control by Laura over her. There was a recording of Laura screaming 'Get me a cup of tea', which woke Marilyn in the middle of the night, Marilyn was seen getting out of bed and going to the kitchen, making Laura a cup of tea and taking it to her room. Marilyn also took Laura's child, Alex to school on a daily basis.

15.1.4. Alex was staying with paternal grandparents and was therefore not present at the time of Finn's death. However, the Police noted that when reviewing footage of consensual violent sexual intercourse between Finn and Laura, it was very likely that Alex would have overheard this, based on the proximity of the bedrooms and the timings it took place. Other concerns included Laura speaking inappropriately to Alex. For example, there was footage of Laura telling Alex to 'fuck off' after she had returned home from school. None of this information was known to agencies until after Finn's death.

15.1.5. Laura told the Review that she had been introduced to cocaine when she was about 17 by a boyfriend, who was a drug dealer. She had used it heavily for a while, but she had stopped when she was pregnant with Alex. Other than the slip up with the male friend at Hayling Island (see para 14.3.9.) she had not used it until she was with Finn who used it regularly.

15.2. **Finn**

15.2.1. Finn had two young children, who always resided with their mother (Finn's ex-partner) and were therefore not present at the time of his death. Their welfare and safety were considered, and a referral was made by the Police to Children's Services who were satisfied that the children had not been at risk. (See paras. 16.5.2. and 16.5.5.)

15.2.2. Family members have stated that in recent years there were concerns of gambling and substance misuse by Finn. He had started taking cocaine and a notable change had been seen in his behaviour and demeanour. Finn had a serious gambling addiction to the extent that he was constantly borrowing money from family and friends and had even asked his mother for £2.

16. ANALYSIS

16.1. Agencies completing IMRs were asked to provide chronological accounts of their contacts with Finn, Laura and Alex prior to the date of Finn's death.

16.2. Seven Organisations/Multi-Agency Partnerships have provided Individual Management Reports (IMRs) or reports detailing relevant contacts. The Review Panel has considered each carefully from the viewpoint of Finn, Laura and Alex to ascertain if interventions, based on the information available to them were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if any key lessons have been identified from the chronologies, and if so that they are being properly addressed. Consequently, some agencies have added to their lessons learnt and reviewed their action plans during the course of this Review. Good practice has been acknowledged where appropriate.

16.3. The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies (either stand alone or as part of a wider Safeguarding Policy) and is satisfied that those policies are fit for purpose.

16.4. The following is a summary of each report together with the Review Panel's opinion on the appropriateness of the agency's interventions.

16.5. Hampshire Constabulary

16.5.1. The IMR Author conducted a thorough examination of Police records in preparing his report. There were 63 occurrences involving Laura as a witness, victim and perpetrator up until the date of Finn's death in July 2022. These were wide ranging, including assaults, domestic incidents, child abuse referrals and sexual offences, however she has never been convicted of any criminal offence.

16.5.2. Finn has been known to Hampshire and Isle of Wight Constabulary since 2010. There were 15 occurrences involving Finn as a witness, victim and perpetrator up until the date of his death. These include Police stop checks, assaults, criminal damage and domestic incidents.

16.5.3. There were no occurrences relating to both Laura and Finn within the same incident. All occurrences which were reviewed involved either ex-partners or associates. The Police were never aware of any connection between Laura and Finn prior to his death.

16.5.4. On the occasion that Finn was arrested in relation to domestic abuse on his then partner, Clare. (See paras 14.2.2/3). Police made an appropriate referral to Portsmouth Children's Social Care using a Public Protection Notice (PPN1) concerning Clare's and Finn's children. The PPN1 is a national combined risk assessment form which includes child at risk, adult at risk and the DASH assessment for the level of risk of harm to victims of domestic abuse. The DASH risk assessment was also completed in line with Force policy. The attending Officers and Multi-Agency Safeguarding Hub (MASH) assessed the risk to Clare as "High". MASH coordinators quality-assure risk assessments submitted by Officers and Staff using the MASH Standard Operating Procedure and cross reference this with information available on Police databases. The MASH Standard Operating Procedure and Force policy defines "High Risk" meaning that there were identifiable indicators of being at risk of serious harm and the potential event could happen at any time and the impact would be serious. The IMR Author was of the view that this was the correct assessment at that time.

16.5.5. Police considered a number of safeguarding measures including flagging of Clare's address and the supply of alarms. A referral was made to a Multi-Agency Risk Assessment Conference (MARAC) and a request for an Independent Domestic Violence Advisor (IDVA) was made.

16.5.6. The case on the 30 June 2018, was treated as a priority and numerous efforts were made to arrest Finn until he attended Portsmouth Police Station by himself on the 2 July 2018. Following CPS advice, Finn was charged with criminal damage and battery on the same day. Finn was released on unconditional bail to attend Court on 19 July 2018. The IMR Author is of the opinion that this was a very positive investigation however, he saw no evidence that bail conditions were ever considered to protect Clare in the interim. It is the view of the Author, that this would appear to have been an appropriate additional measure with the risk assessment set as "High", however there would have been other potential powers to detain Finn such as witness intimidation if the need arose. The IMR Author has not spoken to the Officer regarding this because of the length of time that has passed between the incident and this Review. The Officer is unlikely to be able to comment on something he/she did or didn't do five years ago.

16.5.7. The IMR Author highlighted, that since this period, Force Policy on domestic Abuse has developed and all operational Officers have undergone domestic abuse training. The latest policy dated October 2022 (3.7.5.5) states;

Where proportionate and legally justifiable, the custody Officer should look to impose victim/witness focused bail conditions. They will speak with the investigating officers to help assess what conditions are required to best protect the victim/witness and the integrity of any evidence they have provided. The following conditions should be considered:

- *Not having any contact with the victim and where necessary fully explaining the terms 'directly or indirectly'.*
- *In stalking or harassment cases it will be appropriate to specify no social media, messaging or internet-based interaction with the victim.*
- *Not to go within a determined exclusion zone to encompass the victim's home address as opposed to simply naming the specific address.*
- *Not to go to any significant locations such as the victim's place of work or child's school. The exclusion area should be as large as is considered reasonable to maximise protection of the victim and any other connected person's i.e children, family members and witnesses.*
- *To reside at a specified and approved address.*
- *Reporting to a named police station or imposing a curfew, especially in stalking cases where the victim reports being followed or watched at certain times.*

16.5.8. After the incident on 13 August 2020, when Finn had used a knife to damage a sofa. (See para 14.2.4.) Police made a referral to Portsmouth Children's Social Care using a Public Protection Notice (PPN1). The referral focussed on Finn and Clare's children being children at risk. The DASH risk identification checklist was completed with Clare. It is of note that Clare answered "no" to questions regarding harassment, controlling behaviour, threats of suicide and whether Finn had ever been arrested by Police. The answer to these questions does bring into question the accuracy of the replies or the accuracy of the information recorded, because this was at direct odds to information supplied to Police previously. The referral was re-graded as "Standard risk" from "Medium risk" on basis of no violence or threats of violence used in the latest incident and the last domestic incident was in July 2018. "Standard risk" is defined as "current evidence does not indicate a likelihood of causing serious harm". The Author is of the view that a knife was used in this incident and therefore questions the grading to "Standard". Safeguarding advice was provided by Children's Sevices, but Clare did not wish to make a statement about the matter. The matter was filed, and the referral was forwarded to Portsmouth Child Social Care and Victim Support.

16.5.9. It is of note that there is no evidence that Finn was ever spoken to about the incident, however Clare had confirmed that she did not want any further action taken against Finn. It is the view of the Author that Finn could have been spoken to by Police and it may have been good practice in these circumstances, but this was not necessarily a deviation from Force Policy.

16.5.10. Since these incidents and prior to this review, Hampshire and Isle of Wight Constabulary have invested considerable resources into Domestic Abuse Training. Contact Management which includes police call takers have an induction course which includes recognising and responding to Domestic Abuse.
New recruits which includes those through the Police Education Qualifications Framework (POEQF) and Degree Holder Entry Programme (DHEP) receive mandatory training including a Domestic Abuse workshop which deals with attendance at domestic incidents and safeguarding. It also includes a vulnerability and risk masterclass which helps officers with identifying whether agencies are involved and the correct procedures for referral. It

also explains the importance of taking a full history including previous incidents that may have taken place which have not come to police attention. Police Community Support Officers also receive the same level of training. Police Staff Investigators also receive specific Domestic Abuse training including the importance of the PPN1 and how to complete it.
There is ongoing domestic abuse training for frontline staff and in 2022 officers received further training in Violence Against Women and Girls, Stalking, PPN1 and MASH Safeguarding. Hampshire and Isle of Wight Constabulary provide a "Hub" on their Force Intranet which provides useful documents to assist officers with all matters concerning Domestic Abuse. In addition to the training provided by Hampshire and Isle of Wight Constabulary, the College of Policing also provide a number of online packages specifically around Domestic Abuse.

16.5.11. In relation to Crime Data Integrity and the correct recording of crimes across Hampshire and Isle of Wight Constabulary there has also been considerable training in this area since these incidents and prior to this review. The current structure in 2023 includes mandatory online learning for all staff and an induction course for all police call takers. Hampshire and Isle of Wight Constabulary also provide a "Toolkit" on their Force Intranet which provides useful documents to assist officers with all matters concerning Crime Data Integrity.

16.5.12. With regards to Laura's allegations that as a child, she was abused by a family member (See para.14.3.1.) The IMR Author was satisfied that this was a victim focussed and a thorough investigation. It was initially allocated to a Specialist Unit (Operation Amberstone) which deal solely with sexual offences. Whilst this was a good investigation, the IMR Author is of the view that this investigation took too long to reach a conclusion. The length of this investigation was affected by factors such as waiting times for the forensic examination of digital devices, changes to the lead investigator halfway through the investigation and other operational commitments to "live" enquiries. It is the view of the Author that the decision to take "no further action" was nevertheless a sound one, as the case had not met the threshold to be forwarded to the CPS.

16.5.13. On the 28 February 2021, Laura made a Domestic Violence Disclosure Scheme (DVDS) application to the Police concerning her then partner. It is the view of the Author that there was some good practice and sound decision making in relation to the DVDS application.

16.5.14. In the case of the alleged domestic incident, (See paras. 14.3.4/5) the only recorded crime was one of the drink /driving relating to the male. Whilst all documents were attached to this occurrence, the Author would have expected a second occurrence to have been created as a non-crime domestic incident. A PPN1 including the DASH risk assessment and child at risk element was completed and tasked to the MASH for review. This was however titled as a "PPN Medium Risk DA". The significance of this is that all MASH referrals are dealt with in a priority order, high risk and children at risk taking priority. If the Officers had titled the task as "PPN Child at Risk" it is likely to have been actioned and shared earlier. There is a disparity on the form because it refers to Laura not willing to provide consent, but later it states that consent was not discussed, and Laura would be content to speak on another occasion. All medium and standard risk graded PPN1s without consent are not shared with partner agencies. In this case, this notification was not followed up by domestic abuse Support Services or Police and the information was not shared with Children's Social Care. On the 2 July the occurrence was submitted for filing by the CID Detective Sergeant who in preparation for filing, closed down all

- Not Classified -

associated tasks prematurely. In doing so, the MASH never saw the PPN1 and was therefore never in a position to assess its accuracy or risk. This was a missed opportunity to safeguard and engage with Laura.

16.5.15. The IMR Author spoke with the Detective Sergeant who electronically filed the investigation, and they have no recollection of events, but did add that it is more likely that they closed the tasks down because they were under considerable pressure to reduce workloads of open investigations within their department. The Officer agreed that a second recorded occurrence would have prevented this from occurring. The Author has spoken to the arresting Officer in relation to the male driver. His colleague who spoke with Laura, has since left the organisation and therefore has not been approached for comment. It is the view of the IMR Author that the poor recording on the DASH risk assessment and non-recording of crime is an individual error on behalf of the Officer. The IMR Author is satisfied that the organisation has undergone comprehensive training in respect of Crime Data Integrity and the completion of DASH risk assessments.

16.5.16. The IMR Author would have also expected a safe and well check to have been completed on Alex. The child was not seen by Police and was not with Laura at the time. There is no evidence that the immediate child's safety had been considered in these circumstances, albeit Alex was correctly included as a child at risk within the PPN1. Due to the absence of the attending Officer, it is difficult to comment on why this did or did not happen and this may be an individual error. The IMR Author has spoken to the arresting Officer who fully understands the need to check on the welfare of children in these circumstances.

16.5.17. With regard's the report of historic abuse to Alex (para. 151.1.) It is the view of the Author that this was an appropriate Police response. The incident was not a criminal investigation because the children were under the age of responsibility. Both parents had demonstrated a clear approach to safeguarding their children, by stopping any further sleepovers to prevent the opportunity for such an occurrence happening again. The most effective organisation to take this matter further was Children's Social Care which was agreed at the initial strategy meeting with Police.

16.5.18. The Review Panel thanks the IMR Author for his detailed and transparent report.

16.6. Hampshire County Council Children's Services

16.6.1. An IMR was completed which confirmed that the Service was not aware of any relationship between Finn and Laura. The sole contact was in relation to concerns raised by Laura regarding her child, Alex, which have been previously been referred to in this report (See para. 15.1.1.) The allegation was correctly shared and discussed with Police and the GP Practice. There was no suggestion this was linked to Finn.

16.6.2. The IMR Author was of the opinion that Laura's report appeared to show an ability to want to protect Alex and to ensure her safety. Nevertheless, the Author noted that there is a requirement to consider if there were any unknown adults who may be in the home and have open discussion with parents and other professionals to allow for further checks to be undertaken, where it is deemed appropriate to do so. In this case whilst it was not immediately relevant, discussion should have been held in respect of who might be attending the home. Such checks may have revealed a new partner with a history of domestic violence, drug misuse etc. While it is understood from Laura these discussions were had and Laura had shared she was not in a relationship at that time, it was not

documented in case files that this occurred. Hampshire Children's Services practitioners have been reminded of the need to document when such enquiries are made. The HSCP Unidentified Adults Toolkit has been reissued to staff.

16.6.3. The Review Panel is satisfied that the IMR Author has conducted a thorough and transparent review and agrees with the identified lesson and recommendation to address it.

16.7. NHS Hampshire and Isle of Wight Integrated Care Board

16.7.1. The IMR Author confirmed that Laura and Alex had been registered at the same GP Surgery during the time set in the terms of reference of this Review, and that there had been no documentation or alerts placed regarding domestic violence, abuse or coercive control in GP notes for either Laura or Alex. Nor were there any causal or consequential links between any unmet social care needs or substance use. The IMR Author noted that on 29th August 2007, when Laura attended the Practice for a medical examination it was recorded 'no concerns about abuse, the patient was appropriate throughout examination with Mum present as a "chaperone".

16.7.2. The first mention of mental health concerns was raised in June 2017, after Laura had disclosed sexual abuse by a family member when she between the ages of 10-12 years of age. The matter had been reported to the Police, (See para. 14.3.2.) but no further action was taken due to lack of evidence. Laura was offered trauma therapy but opted for emotional coping skills group therapy. Laura did not engage and never responded to attempts to contact her. She was invited to engage with a Compassionate Resilience Course, but never attended or responded to the invitations to engage. The IMR Author is satisfied with the actions taken to engage with Laura.

16.7.3. Within the period of Review, there were concerns reported by Laura to the GP Practice that her child, Alex, may be a victim of abuse which was shared appropriately with other key agencies. (See para. 14.3.2.) This was within six months of sexual health concerns being raised by Laura to the GP Practice and a self-report of high alcohol intake. Furthermore, Laura discussed the possibility of sterilisation with the GP in April 2022, with reference to anxieties that a cancer diagnosis may be given. This may have been an opportunity to discuss family dynamics and relationships and a missed opportunity to consider a family approach to safeguarding.

16.7.4. With regard to Laura contacting the GP Practice after being informed that Alex had been abused by an 8 year old, the GP at first contacted the Sexual Assault Referral Centre (SARC) and was given advice as to the appropriate action. This initial lack of understanding about the existing Hampshire and Isle of Wight policy on such cases has been identified as a lesson learnt.

16.7.5. The Review Panel were impressed that the IMR Author whilst acknowledging that the Practice had no knowledge of any connection between Finn and Laura, nevertheless identified lessons that could be learnt from circumstances uncovered during the Review, i.e. information given by patients should on occasions trigger a professional curiosity which may disclose risks to be addressed. Information sharing needs to be better understood and sexual abuse training in primary care needs to be improved. The Panel is satisfied that the action plan recommended if properly implemented will effectively address those issues.

16.8. Portsmouth MARAC

16.8.1. The MARAC Chair responded to a Memorandum of Agreement by completing an IMR confirming that whilst there had never been a referral to MARAC in relation to Laura, in 2018 there had been one heard relating to reported domestic abuse to Finn's ex-partner in which Finn was the perpetrator. The MARAC Chair reported that the MARAC meeting was well attended and that appropriate actions were set and carried out efficiently. Finn's ex-partner confirmed she was satisfied with the outcome of the interventions.

16.8.2. The MARAC Chair drew attention to the fact that although Laura had never reported domestic abuse from Finn and had not been the subject of any MARAC referral relating to previous partners, she was aware of the Domestic Violence Disclosure Scheme (DVDS) as she had completed one in respect of another male prior to meeting with Finn.

16.8.3. The Review Panel thanked the MARAC Chair for providing a report on the historic MARAC meeting in which Finn was the perpetrator. There are no lessons to learnt nor recommendations for the MARAC to make.

16.9. Solent NHS Trust

16.9.1. The Trust prepared a short report for the Review as it had no record of any contact with Finn and no relevant contacts with either Laura or Alex.

16.9.2. There were no lessons or recommendations to make.

16.10. Southern Health NHS Foundation Trust

16.10.1. An IMR was completed but identified no relevant contacts for Laura, Alex or Finn, but noted Alex was reviewed in line with delivering the 'Healthy Child Program' during the Covid-19 pandemic and health information effectively shared within MASH processes for Alex.'

16.10.2. Health information was effectively shared within MASH processes for Alex.

16.10.3. The Review Panel acknowledges the good practice identified and that there were no lessons or recommendations to make.

16.11. Treetops SARC Hampshire & IOW (SARC)

16.11.1. The SARC Clinical Lead provided the Review with a report and IMR which confirmed that the SARC had no record of a telephone call relating to Alex noted down. If a call had been received giving information which suggested historic non-penetrative abuse of a young child, the response would have been to confirm that the SARC could not accept such a referral, and to signpost the referrer to have the child seen for a medical examination in the community.

16.11.2. The Clinic Lead pointed out that best practice based on policy would have been for the GP to follow the flowchart set out in the Hampshire, Isle of Wight, Portsmouth and Southampton (**HIPS**) safeguarding children procedures manual.

16.11.3. The Report Author thought the incident flagged the need to ensure the HIPS Manual is constantly used by both internal and external practitioners. To that end on 9

February 2023 a whole SARC team training session took place where best practice was reinforced using the HIPS guide and referral form.

16.11.4. The Review Panel agreed with this and has recommended that all local agencies that work with individuals who may need to be referred to a SARC, ensure that personnel are reminded of the HIPS Manual guidance.

16.12. Review Panel

16.12.1. The Panel considered the following keys issues stemming from this Review:

A. Whether Finn **being a male,** made it less likely that agencies would have considered that he could be a victim of domestic abuse and controlling behaviour by Laura. Whilst latest research indicates that 23% of victims of domestic homicides are male,[7] there is significant research that indicates that professionals are less likely to consider a male being a victim of domestic abuse than a female[8], in this case no agency was aware of the connection between Finn and Laura. Children's Services acknowledges, with the benefit of hindsight, that an early visit to Laura's home to check on Alex's welfare (after Laura had reported the historic abuse of Alex by an 8 year old, 10 days prior to Finn's death), may have triggered questions about the environment Alex was living in, but this is tempered in the knowledge that whilst a visit was planned, it was not deemed urgent, as it was Laura who had acted responsibly in reporting the abuse and who had taken positive action with the other child's mother, to ensure that there would no further sleep overs where the abuse had occurred.

B. The extensive research into **why women are violent towards their partners**. These focus on risk factors, mental health and substance abuse problems that are common amongst women who use violence, they include:

- Childhood trauma[9], *(In this case, there are reports that Laura had been abused as a child (see para. 14.3.1.)*

- Fear of violence, Women indicated that 35% of the time they used violence, was to retaliate for being emotionally hurt by their partners, while 20% of the time the motive was to retaliate for being hit first.[10] *(Laura had been the victim of domestic abuse in the past. Later she sought a DVDS disclosure on a previous partner who was involved in drugs. Whilst Finn and Laura had engaged in rough sex, it was evidenced, through her CCTV recordings, as being primarily consensual, however Laura pointed out to the Review that there were occasions when Finn went further than she wanted and refused to stop when she shouted for him to stop as he was hurting her. At her trial, she*

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[7] Domestic Homicide Reviews - Quantitative Analysis of Domestic Homicide Reviews October 2020 – September 2021 Also, The Mankind Initiative cites the Office for National Statistics figures show: "*every year one in three victims of domestic abuse are male equating to 757,000 men (1.561m women) and of domestic abuse crimes recorded by the Police, 26% were committed against men. This equates to c155,000 offences per year".*

[8] E.g 'male victims have often been overlooked, and remained a "hidden" victim group, despite some researchers, and government statistics, evidencing their existence for decades" (Cook, 2009). "little is known about the nature of the incidents where men are recorded as victims and women as perpetrators" Who Does What to Whom? Gender and Domestic Violence Perpetrators Professor Marianne Hester.

[9] A review of research on women's use of violence with male intimate partners: SC Swan, LJ Gambone, JE Caldwell 2005

[10] Abused women or abused men? An examination of the context and outcomes of dating violence Follingstad, Wright, Lloyd, & Sebastian

claimed that she stabbed Finn to protect herself, but this was discounted as it was proven that Finn had made no attempt to defend himself as he was 'probably asleep' at the time of the attack. (Finn had no defensive injuries which would have been expected if he had been conscious of the attack).

- Psychological Functioning, in particular depression, anxiety, substance abuse, and post-traumatic stress disorder have all been recognised as factors in relevant research studies. [11] *(Laura was diagnosed as suffered from PTSD, subsequent to having been abused as a child. It is noted that this was challenged during her trial. She was known to use controlled drugs and had self-reported having a high alcohol intake - para. 16.7.2.)*

- In Swan's study of women who used violence against male partners, it was found that 69% met criteria for depression on a screening measure. Almost one in three met criteria on a post-traumatic stress disorder screen. Nearly one in five were suffering from alcohol or drug problems and 24% of the participants took psychiatric medication. *(In this case, at Laura's trial, her defence team attempted to explain Finn's death by alleging:*

- *That Laura had been diagnosed with bipolar disorder and complex post-traumatic stress disorder (PTSD).*

- *That she had been sexually abused as a child, suffered nightmares and flashbacks, and had self-harmed "for years".*

- *That she had an interest in serial killers. Laura explained she had a "dark and twisted sense of humour", liked watching murder documentaries, and said the pictures of serial killers on her bedroom walls were aimed to "shock people."*

- *Laura claimed they had both consumed alcohol and cocaine. That she was 'angry, upset, and confused 'after finding a message on his phone from a 13 year old girl and this tipped her over the edge.' She said, she had threatened to put one of the videos, in which she said she was raped, online and go to the Police. "It made him really angry, his whole demeanour and body language changed, you could see it in his eyes, he was raged. He grabbed me by the throat and pinned me to the bed on the headboard." Laura's use of camera technology to threaten Finn with is not uncommon. Since Covid, the Domestic-violence charity Refuge has reported that more than 70% of those it provides support to have reported tech-related abuse within a relationship.*

- The Panel acknowledged that having been brought up in an environment where she was abused at home and due to her deafness, bullied at school, combined with her early substance abuse, attracted her into a number of short term chaotic relationships where violence and abuse was the norm, gave her little opportunity to experience or understand healthy relationships. Notwithstanding her fascination with violent crime and her collection of weapons was not typical and should not be considered to be excuses for her violent murder of the sleeping Finn.

[11] Patterns in Relationship Violence Among African American Women: Future Research and Implications for Intervention: John k. Williams, Gail E. Wyatt, Hector F. Myers, K. Nicole Pressley Green & Umme S. Warda.

C. Laura and Finn's reported indulgence in **BDSM[12] ('rough sex**') which on occasions went beyond the bounds of consent, was highlighted in Laura's court case. It was acknowledged during the trial that it typically involves one partner taking on a more dominant role during sex, while the other is more submissive but can stray further than agreed.

According to a 2016 study, nearly 47% of women and 60% of men have fantasised about dominating someone in a sexual context. The same study found that BDSM sex was slightly more prevalent in couples on the LGBTQ spectrum, but researchers otherwise determined that BDSM sex was practiced across different ages, genders, and ethnic backgrounds. (cf. Joyal & Carpentier). While many reported BDSM fantasies, only 7.6% identified as BDSM practitioners. Another study found similar rates of BDSM related fantasies, with over half of all participants reporting at least one BDSM-related fantasy (Joyal, Cossette, & Lapierre,

D. **Lack of reporting** the controlling behaviour and threats to Finn.

It is clear that Laura made a number of threats to harm Finn, by claiming he raped her, by talking of having him beaten, and stating she could have stabbed him while he slept. Yet her friends treated her remarks about wanting to hurt Finn, as 'just talk' and never reported them to the Police or any other agency. This resulted in agencies having no reasons to predict that Laura would murder Finn, and therefore have little opportunity take any action that would have prevented his death.

17. CONCLUSIONS

17.1. The Review Panel assessed the Individual Management Reviews and other reports as being thorough, open and questioning from the viewpoints of Finn. The Panel is satisfied:

- That all of the agencies that participated in the Review used the opportunity to review their contact in line with the Terms of Reference of the Review.

- That those organisations that conducted all of their contacts with Finn, Laura or Alex in accordance with their established policies and practice, have no lessons to learn.

- That the other organisations have used their participation in the Review to properly identify and address key lessons that can be learnt from their contacts with Laura, Alex or Finn.

17.2. The Panel has after discussion, accepted the recommendations made by the individual agencies and Local Partnerships, and has added further cross agency recommendations to remind Practitioners that males can be victims of domestic abuse and controlling behaviour, and to encourage the public to report domestic abuse. These actions which address the needs identified during the Review, should improve the safety of domestic abuse victims in Portsmouth.

18. LESSONS LEARNT

[12] BDSM is a term used to describe sex that involves dominance, submission, and control. The practice often known as 'rough sex'.

18.1. **Hampshire Constabulary**

18.1.1. This Review has identified positive practice including a clear approach to supporting victims of domestic violence using the IDVA service and the positive approach by Police in prosecuting offenders of domestic abuse.

18.1.2. The Author has identified that in the main, risk assessments have been completed accurately, however there has been regrading incorrectly on occasion by the MASH coordinators.

18.1.3. Many of the incidents that the IMR Author commented upon, were prior to the scoping window of April 2021 to July 2022, and training and processes has changed over the last five years. (See paras 16.5.7. 16.5.10. and 16.5.11)

18.2. Hampshire County Council Children's Services:

18.2.1. There is a need to document enquiries considering if there are any unknown adults in the home and record the open discussions with parents and other professionals.

18.3. Hampshire and IOW Integrated Care Board

18.3.1. **Effective Practice -** GP took concerns seriously and approached for advice to appropriate agencies. The GP referred the child, Alex, immediately to Social Services to highlight concerns for child sexual abuse

18.3.2. It has been identified with hindsight, that there were indicators of vulnerability and mental health needs, and that windows of opportunity were presented for further professional curiosity. This highlights the importance of triangulation of the holistic presentation of both the individual and the wider family to inform domestic abuse risk assessment and care planning.

18.3.3. An interagency referral (IARF) to MASH should be made when there may be a suspicion of Child sexual abuse.

18.3.4. Patients may not engage with primary care services for prolonged periods of time, despite being vulnerable and/or having unmet needs. This means that primary care, are reliant on the information they receive from other agencies to inform risk assessments.

18.4. Treetops SARC Hampshire & IOW (SARC)

18.4.1. The Review highlights a lack of knowledge amongst practitioners regarding the HIPS Guidance manual on when, where or how to refer a victim of a sexual assault.

18.5. Safer Portsmouth and Stop Domestic Abuse

18.5.1. Members of the Public, who witness or hear of domestic abuse taking place or being planned are often unsure of what action, if any, they should take.

18.5.2. It is recognised, that males are less likely to report incidents of domestic abuse and in addition, professionals may not always consider males as possible victims of domestic abuse and controlling behaviour.

18.5.3. Information sharing between Agencies was identified as being wanting on occasions.

19. RECOMMENDATIONS

The DHR panel's recommendation and up to date action plan at the time of concluding the Review on 4 May 2023 are detailed in the template below. After publication of this report, the Safer Portsmouth Partnership will discuss with partner agencies how other existing cross agency strategies can build on these recommendations.

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
There is an apparent lack of public understanding on the course of action to take if a third-party, witnesses or hears an incidence of domestic abuse occurring. This should be addressed with a Portsmouth wide campaign involving family, friends and communities to raise public awareness on what to do if they are aware of domestic abuse taking place to victims who may be male or female.	Local	The Partnership will utilise the following campaigns: 1."This Love" https://www.facebook.com/watch/?v=724390662501961 / https://twitter.com/SaferPortsmouth/status/1637760613949612033 2.Ask ANI: https://www.gov.uk/guidance/ask-for-ani-domestic-abuse-codeword-information-for-pharmacies 3. UK Say No More Portsmouth spaces listed here Safe Spaces Locations - UK SAYS NO MORE	Safer Portsmouth Partnership and Stop Domestic Abuse	To include 20 day White Ribbon Campaign in November 2023		**Ongoing**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
Domestic abuse training for practitioners should include:- a) other training resources, such as trauma-informed approach, homicide timeline, child sexual abuse, and engaging with perpetrators of domestic abuse. In addition: a) a reminder that males can be victims of controlling behaviour. b) that technology including CCTV can enable abuse and digital stalking. c) that BDSM ('rough sex') can mask domestic abuse.	Local	Partner agencies to ensure that domestic abuse policies and training needs to include males as possible victims.	Safer Portsmouth and Stop Domestic Abuse.	To be discussed at Partnership meetings.	Ongoing	**Ongoing**

Domestic abuse training for practitioners should include:- a) other training resources, such as trauma-informed approach, homicide timeline, child sexual abuse, and engaging with perpetrators of domestic abuse. In addition: a) a reminder that males can be victims of controlling behaviour. b) that technology including CCTV can enable abuse and digital stalking. c) that BDSM ('rough sex') can mask domestic abuse.	Local	Reissue HSCP toolkit unidentified adults across Children's Services Department. This toolkit promotes professional curiosity in considering who else may be significant within the household.	Hampshire County Council Children's Services.	Unidentified Adults toolkit reissued.		**May 2023**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
Review of the Ghost patient process.	Local	Scope and develop Ghost patient process.	Named GPs / Hampshire ICB.	Confirm definition of Ghost Patient. Scoping data regarding the prevalence of Ghost patients. Risk assessment for Ghost patients developed. Ghost patient response pathway developed.	Sep 2023	
Domestic abuse training for primary care, with a focus on professional curiosity, routine enquiry, indicators of abuse and thinking family.	Local	Designate and third sector commissioner training for practice to include direct learning from DHR.	HIOW ICB Designated Nurse GP Surgery Hampshire and IOW ICB System	Scoping/business case development. Project Planning	Sep 2023	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
		Designated Nurse DA Portfolio Lead, to develop training opportunities business case, to include commissioning of training offer.		Programme implementation.	Sep 2023	
Implementation of the ICB recommended Primary Care Domestic Abuse and Sexual Violence Toolkit.	Local	Designate and third sector commissioned training for practice to include direct learning from DHR. Designated Nurse DA Portfolio.	HIOW ICB Designated Nurse GP Surgery Hampshire and IOW ICB System	Scoping/business case development. Project Planning. Programme implementation.	Sep 2023	
Family approach reviewed within practice vulnerable patient meetings.	Local	Develop a template for implementation at vulnerable patient meetings.	HIOW ICB Named GP Hampshire and IOW ICB System	Proforma developed. Proforma shared with PCNs and practice safeguarding leads.	August 2023	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
Operation Amberstone Lead may wish to audit investigation times to ensure investigations are being conducted diligently and expeditiously.	Local	None.	Hampshire & Isle of Wight Constabulary	Tri-Force data arrangements provide insight into the timeliness of investigations at various stages. Key Performance Indicators have been set to improve timeliness of investigations. This is subject to thematic review on a monthly basis at the Amberstone Performance meeting as well as within the VAWG WESSEX arrangements. NFA scrutiny panels have been raised attended by Police, CPS and advocacy partners exploring the		**Dec 2022**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
				efficacy and timeliness of decisions. Senior District Crown Prosecutors (SDCP) and RASSO Supt scrutiny of cases that have entered the CPS. The scrutiny occurs after 90 days and may include cases that have only reached the Early Investigative Advice stage. There are multiple reports that are examined on a monthly basis for the purpose driving investigative activity and improving communication		

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
				with CPS Forensic examination of digital devices specifically in relation to Rape are prioritised within the Phone Examination Unit.		

Appendix A

Abbreviation - Explanation

CAMHS: Children and Adolescents Mental Health Service
DASH: Domestic Abuse Stalking and Harassment Risk Assessment model
DAS: Domestic Abuse Service
HIPS: Hampshire, Isle of Wight, Portsmouth and Southampton (**HIPS**) safeguarding children procedures
IDVA: Independent Domestic Violence Advocate.
MARAC: Multi Agency Risk Assessment Conference
PIDs: Personal identifiable data (**PID**)
SARC: Sexual Assault Referral Centre

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