DOMESTIC HOMICIDE OVERVIEW REPORT

MR FN

Executive Summary

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19th February 2014

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DHR Mr FN

1 Introduction

1.1 This Domestic Homicide Review was conducted following the tragic death of Mr FN as the result of domestic abuse. Our deepest condolences are sent to the family of Mr FN.

The circumstances of the domestic homicide are that on the evening of November 5th 2012, Mr FN and his partner, Ms NN, attended a bonfire party at their local pub in the village where they lived together. They appeared to be happy on the evening but were heard to argue by a person passing their home at around 8pm.

At approximately 9.40pm, the couple's next door neighbour heard them arguing sufficiently loudly for the television to need to be turned up and by just after midnight on the 6th November, the arguing had escalated further. Following that, the neighbour heard shouting and the sound of furniture being moved, then heard the sound of Ms NN sobbing uncontrollably.

The police and ambulance attended and found that Mr FN had been stabbed and transported him to hospital but he sadly died on the way. It has been established that Mr FN had been stabbed 22 times with a large knife, to his front and back, and that he died from a stab wound to his stomach. Ms NN was found guilty of Mr FN's murder and sentenced to life imprisonment with a recommendation that she serve a minimum of 15 years before being considered for parole.

1.2 This report examines the circumstances leading up to Mr FN's death and will consider agencies and others' contact and involvement with the victim Mr FN and perpetrator, Ms NN, from the period commencing July 2003 to the date of Mr FN's death on the 6th November 2012.

2. The review process

2.1 This summary outlines the process undertaken by the Leicestershire and Rutland Domestic Homicide Review Panel in reviewing the circumstances of the murder of Mr FN. Criminal proceedings are complete which resulted in the conviction of Ms NN for murder.

2.2 **Terms of reference and scoping for the domestic homicide review of Mr FN**

2.3 The terms of reference were established by panel members and have been fully discussed with family members.

2.4 **Domestic Homicide Reviews**
Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th

April 2011.

This DHR has been commissioned by the Safer Melton Partnership in line with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011.

2.5 **The purpose of this DHR is to:**

- Ensure the review is conducted according to best practice; with effective analysis and conclusions of the information related to the case
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including their dependent children
- Identify clearly what those lessons are; both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result
- Apply these lessons to service responses; including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children, through improved intra and inter-agency working
- Establish whether family, friends or colleagues wish to participate in the review.
- This review will also consider any child or adult safeguarding concerns should they arise and make appropriate recommendations to the respective safeguarding boards.

2.6 The scoping period for this review was initially set from July 1st 2003 to the time of Mr FN's death, November 6th 2012 because early scoping indicated Ms NN's relationships with the birth fathers of her children held evidence of potential aggression by Ms NN. Agencies conducted their internal reviews from 2003 and analysis has shown that the focus of learning within this DHR is from the relationship of Mr FN with Ms NN; and so this review concentrates on the later period from the end of 2010 whilst taking note of relevant information from the wider scoping period within agency analysis at section 3 of the main overview report. Any single agency recommendations which were made as the result of internal reviews from the earlier scoping period only have been incorporated into single agency plans for action and not reproduced in the main report.

2.7 **The specific terms of reference as they relate directly to the known facts in this case are:**

- Mr FN had no known contact with specialist domestic abuse agencies or services. The review will address whether the incident in which he died was an isolated incident or whether there were any warning signs, and also whether more could be done locally to raise awareness of services available to victims of domestic abuse and in particular, male

victims of domestic abuse

- To establish if any evidence of risk of serious harm to the victim existed that could have been identified, shared and acted upon by professionals.

- Ms NN's contact with local professionals and services will be reviewed to establish whether there were any warning signs or concerns that, should they have been acted upon would have minimised serious harm to her or others; to include where opportunities to engage existed but due to Ms NN having capacity to choose, did not so engage

- To establish whether appropriate agency support and/or services were identified and whether there were any opportunities for professionals to 'routinely enquire' as to any domestic abuse to the victim.

- To establish whether Mr FN and Ms NN or his/her family / friends / previous partners / colleagues knew how to access information about domestic abuse and/or managing potentially violent episodes that could cause harm to others. Identify any good practice or awareness raising requirements that will ensure a greater access to domestic abuse processes / services in Leicestershire.

2.8 Family members and the perpetrator Ms NN have provided additional background information pertinent to the wider scoping period which will also be commented on in the review.

2.9 Agencies were asked to provide:

- *A chronology and account of interaction with the victim, Mr FN and the alleged perpetrator Ms NN and her children*
- *A report of their involvement according to the terms of reference for the review*
- *Conclusions and recommendations from the agency's point of view.*

2.10 The accounts of involvement with Mr FN cover different periods of time prior to his death and some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

2.11 All 23 agencies requested to have involvement in this review responded. In total, 1 agency, Adults & Communities responded as having had no contact with either the victim or the suspect, or with any children involved.

2.12 Eleven agencies have responded with information of some level of involvement with Mr FN and/or Ms NN whilst in their relationship together that has relevance to the circumstances of the review; namely:

- Medical Practice 1
- East Midlands Ambulance Service
- Women's Aid Leicestershire Ltd
- Leicestershire Police
- Leicestershire County Council Children's Social Care
- Leicestershire County Council Education

- Children and Family Court Advisory and Support Service (CAFCASS)
- Leicestershire and Rutland Probation Trust
- Kent Police
- University Hospital Nottingham
- Rape Crisis (Jasmine House)

3 Key issues established

2.1 It is apparent from the review that violence between both Mr FN and Ms NN existed. The couple met towards the end of 2010 and the first reported incident of domestic abuse between them was in October 2011 and this was followed by a second in December 2011, a third in January 2012, two incidents in March 2012 and a final incident in May 2012. The police responded to the reports and on 4 occasions, Ms NN was identified as the victim in the case and a DASH risk assessment completed. Mr FN was identified as a perpetrator of violence on 2 occasions and interviewed for domestic related assaults and a criminal damage offence although he was not subsequently charged with domestic related offences.

This was a complicated relationship and in interview Mr FN informed the police, in his defence when being interviewed whilst under arrest, that Ms NN's behaviour was hard to manage and disclosed that she started arguments and had assaulted him; and he had some injuries to corroborate that. However, his reports were not formally recorded or a risk assessment undertaken as to his safety because although the police domestic abuse policies are robust and encourage positive action to protect victims, the DASH risk assessment forces officers to choose who the victim is and who the perpetrator is; and training and awareness at the time did not consider how to manage situations where both parties may be at risk of harm from the other. It has been recognised through this review that it is not easy to formally identify all victims when managing complex situations, especially when an assault is not formally reported but disclosed in a police interview when under arrest; but in interview Mr FN did disclose he was in a situation in which he was potentially vulnerable and he should have been identified as a victim and offered support services. Historical information relating to Ms NN from previous police involvement had not been consolidated and in consequence the potential for Ms NN to cause some degree of harm to Mr FN was not able to be identified or risk assessed.

2.2 At the time of the relationship between Mr FN and Ms NN, support services were available for both female and male victims of domestic abuse. Specifically in relation to male victims, a local project exists; the 'Adam Project', which provides individual support from an Outreach Worker for male victims of domestic abuse. The Adam Project cannot support those males identified as a perpetrator alone but it can support males who are jointly identified as a victim in the relationship, with a female partner receiving specialist services from a women's Outreach Worker, simultaneously. As such, this service may have been available to Mr FN had he been identified as a victim by agencies and signposted. This service was also available for Mr FN to access had he recognised his situation, but it is believed that he did not. Concerned family members report not being aware of available local services from which they could seek help and support. Work colleagues report having little understanding of domestic abuse.

Ms NN was offered support services and referred to Women's Aid Leicester and Leicestershire but she chose not to engage. Ms NN was also offered counselling to help her address potential issues of historical abuse but again chose not to engage.

Support for perpetrators of domestic abuse was available at the time for both male and female perpetrators, but only where criminal proceedings had been instigated and this, therefore, was not an option for either Mr FN or Ms NN.

2.3 One local agency was involved with Mr FN prior to his death; Leicestershire and Rutland Probation Trust (LRPT). LRPT were supervising Mr FN on a community placement imposed by a Magistrates Court for drugs related offences. LRPT risk assessed Mr FN and to do so, sought specific information relating to domestic incidents attended previously by the police. LRPT did not speak to Mr FN about his domestic situation because they assumed him to be the perpetrator and Mr FN told them he was single. LRPT had further opportunities to speak to Mr FN about his home situation but because he was assessed as a low risk of reoffending for drugs offences, their contact was minimal in line with their policies current at that time. Also at the time of Mr FN's placement, there was no requirement for LRPT to seek information from his placement supervisor and as such, they were unaware that Mr FN had presented with injuries on one occasion.

2.4 Kent Police received a complaint from the father of Ms NN's youngest child on October 17th 2012 to report that Ms NN had sent him threatening texts and voice mail message. Kent police did not assess a crime to have been committed and recorded the circumstances as a domestic incident. They completed a DASH risk assessment but did not complete background checks with Leicestershire or the Police National Computer and so were unaware that Ms NN had been previously cautioned for assaulting a police officer. The risk assessment was therefore flawed as was the decision that no criminal offences had been committed.

2.5 The role of the GP has been considered in this review. Ms NN's GP supported her through clinical depression and prescribed anti-depressants throughout the scoping period. However, there does not exist any guidelines for GP's to direct them to consider associated issues such as how a patients depression affects others, notably their children or partners or how they are coping generally. In this case, as the result of Ms NN describing her situation to her GP, Ms NN's GP was in possession of relevant information from 2008 to indicate a propensity for her to cause harm with a weapon but this was not referred as a safeguarding concern and remained hidden to agencies until this review. At the time, the medical practice did not hold safeguarding meetings to consider concerns but this has now changed.

2.6 It was established at Ms NN's murder trial that Ms NN suffers from an undiagnosed Emotionally Unstable Personality Disorder of the borderline type but this could not have been known to agencies because Ms NN chose not to consider that she had mental health issues and did not seek help to address her behaviour until she entered prison. There had been two opportunities for Ms NN own needs to be assessed by Children's Social Care but this didn't happen because the focus was on Ms NN as a victim of domestic abuse and how that impacted on her ability to parent. Wider issues in relation to known mental health, drug and alcohol abuse were not considered once Ms NN's children were known to be safe with their respective fathers.

2.7 The family of Mr FN and Ms NN, work colleagues and Ms NN herself have contributed to this review and through them; information previously unknown to agencies was gained. The last reported incident of domestic abuse was May 2012, but family members and work colleagues have reported being aware of violence between the couple up to the weekend before Mr FN's death. Family have reported being aware that Mr FN suffered injuries from Ms NN and

advised him to leave the relationship but he made it clear that he wished to be with her. Ms NN's family have also reported being aware that Ms NN suffered injuries from Mr FN and advised her to leave the relationship but she would not do so. Ms NN herself informed the review that she knew she should not be with Mr FN if she wanted to have her children with her but she was unable to finish the relationship.

3 Key Learning from the review

3.1 Complex relationships where domestic abuse exists between couples.

3.1.1 The fact that violence existed between Mr FN and Ms NN has been a considerable area of learning for this review and one which highlights that all relationships should be assessed on the merits of information known, currently and historically, and risks considered to both parties where there is evidence of harm to more than one person in the relationship. This is necessary to ensure that all victims are identified and protected and that opportunities are made available for access to support services. This learning has been reflected in the DHR recommendations and specifically in the police IMR.

3.2 Access to domestic abuse services

3.2.1 The review reinforces the need for continued awareness-raising to the public at large to highlight issues of domestic abuse, aimed at enabling individuals affected, family members and concerned others, to know what support and advice is available and know where to go to seek that support.

3.3 The role of the GP

3.3.1 The role of a GP enables them to be in possession of information provided by a patient that may indicate risk of harm to others. GP's need to consider safeguarding arrangements and proactively make referrals where the facts indicate that others could be at risk. Conversely, to be aware of concerns held by other agencies, the GP needs to be informed so that they have the opportunity to assess the full circumstances and any safeguarding concerns and local arrangements need to consider how best this may happen.

4 Conclusions

4.1 Was Mr FN's death predictable and preventable?

4.1.1 It is the conclusion of the review panel, after giving this careful thought, that Mr FN's death was not predictable. This is because although family and friends perceived some risks to Mr FN and there were opportunities to identify some risk by agencies, it was not possible that the level of risk ultimately posed could have reasonably been foreseen. In terms of preventability, there were some risk factors evident to agencies and others which could have prompted access to support services for Mr FN but ultimately, Mr FN made the choice to be with Ms NN. Ms NN was offered support at key points of agency interaction but sadly, she chose not to engage and seek to address the underlying issues that affected her behaviour. The reported incident in Kent two weeks before the tragedy was an opportunity for Ms NN to enter the

criminal justice system but this wouldn't have happened quickly and therefore could not have impacted on the outcome. As such, agencies cannot be held responsible for Mr FN's death which was caused by an act of uncontrolled anger by Ms NN.

4.2 Local domestic abuse procedures

4.2.1 Primarily, local domestic abuse procedures appear to have been properly followed. Existing procedures appear robust and worked well for Ms NN and she acknowledged that she received full support throughout. These need to be built upon to ensure that all victims of domestic abuse are identified and offered the same opportunities to access services. Local policies need to reflect that there may be more than one victim in a relationship; that an alleged perpetrator may also be a victim; and that a victim can be male.

4.3 Public understanding of domestic abuse

4.3.1 Awareness-raising is needed on a local level to promote the availability of help and support to those affected by domestic abuse and their friends and families. Specific awareness campaigns are needed to inform the public that males can also be victims of domestic abuse, aimed at breaking down barriers that may prevent identification of male victims in the community and work place.

5 Recommendations

Having considered all of the information provided to the DHR the Review Panel made a number of multi-agency recommendations and these are outlined at section 5.1. The recommendations will be overseen by the relevant strategic boards.

In the process of completing their internal reviews, agencies have developed specific recommendations relevant to their own findings and taken action accordingly. A number of the more pertinent single agency actions have been recorded in section 5.2 which demonstrate that learning is being taken forward by individual agencies.

5.1 The DHR panel made the following recommendations:

1. The Domestic Abuse Strategy Board to incorporate the learning from this review into their business planning; and specifically consider:

   a) all staff within agencies need to know what to consider when presented with Domestic Abuse and associated linked issues. A clear process and good practice guide, applicable across all agencies and supported by appropriate internal and multi-agency materials, training and awareness of domestic abuse, would support staff. Good practice should include consideration of male victims; safety and support where there are concerns for more than one victim in the relationship; opportunities for routine enquiry about domestic abuse and other aspects of learning from the review.

   b) To assist in the development of good practice and commissioning, consider researching local prevalence of male victims of domestic abuse and complex

relationships where violence is apparent to more than one victim to ensure a shared understanding of terminology and approach.

c) Reviewing MARAC processes to ensure that thresholds and criteria for referral are consistent with the resources available; in turn ensuring that medium and standard risk cases that do not reach the MARAC threshold have appropriate referral routes for enhanced services where needed for victim and perpetrator management, on a multi-agency basis.

d) Ensuring agencies identify an appropriate approach to Domestic Abuse in line with developing local good practice and implement the DASH risk assessment tool; underpinned by appropriate training and understanding of domestic abuse.

e) Developing strategies that continue to inform the public about domestic abuse; services available and where to seek help. Awareness raising regarding males as victims to be specifically considered.

f) Developing a partnership approach with local businesses to encourage the adoption of domestic abuse policies in the work place.

2. The Leicestershire Safeguarding Adults and Leicestershire Safeguarding Children Board to incorporate the learning from this DHR into their review processes and consider ensuring:

a) Agencies review their information sharing processes and staff confidence to share information and discuss concerns that maximise opportunities for multi-agency engagement and effective safeguarding.

b) Agencies review their local procedures to ensure that where mental health and/or substance abuse is a factor, agencies are aware to include this in assessment and that specialist services are engaged to contribute and support.

c) Agencies review their record keeping and recording processes in relation to safeguarding to ensure that full history and background is collated for assessment and is available for holistic and accurate assessments in the future.

5.2 Agency specific recommendations relevant to the learning from this review:

5.2.1 Leicestershire Police to consider:

- Examining how it uses DASH in conjunction with professional judgement to ensure officers understand the way in which a risk assessment should take into account, not only DASH, but all the facts and circumstances available at the time; including previous history, so that a well-reasoned risk management plan can be formed.

- Ensuring that, as an investigation progresses and additional information comes to light, supervisors instigate a review of the risk assessments, investigations and risk

management plans in domestic related incidents and crimes, and record the rationale for their decisions on the crime report.

- Ensuring that where the police make decisions to take no further action in respect of domestic related crimes the rationale for that decision is detailed either on the custody record or the crime report by the supervisor making it. The rationale should include all the evidence available at the time and the explanations given within the interview by the suspect.

- Reviewing and reissuing guidance in respect of unwilling victims of domestic abuse so that it is clear to officers and staff what needs to be considered in respect of the criminal investigation and prosecution, of such cases.

- Ensuring a system is in place that ensures repeat victims of domestic abuse are identified and are subject of supervisory review. This review should consider all the facts and circumstances of current and previous history to ensure that the risk assessment, risk management and criminal investigation is effective and due consideration given to a multi-agency response to risk management.

- Reviewing and reissuing guidance to officers regarding the importance of being open minded as to who the perpetrator is when conducting investigations into domestic abuse. Officers should be alive to the possibility of more than one victim in the relationship and that the suspected victim may in fact be the perpetrator. This is particularly relevant when considering whether the male 'perpetrator' could in fact be the victim. Officers should be aware of how to deal with counter allegations when they are made by suspected perpetrators and ensure that the investigation reflects the information and evidence that is available. The decision making rationale should be fully recorded.

- Consider providing advice and guidance to officers and staff investigating linked safeguarding investigations that ensures a primary investigator oversees the full circumstances. Ensuring the learning from Leicestershire Police's IMR is embedded in the training of police officers and staff to make clear the standards of investigation, risk assessment and risk management expected from them in order to safeguard victims of domestic abuse and vulnerable persons.

- Acknowledging the good work of officers who have recognised the child protection issues and made referrals in respect of the children in this case as it is clear that they were at risk of neglect and being exposed to moral danger when in Ms NN's care especially when she was under the influence of drink/drugs.

5.2.2 Children's Social Care to consider:

- Ensuring that record keeping includes dates of visits made by social care staff; when they are completed and who is present; and these should be clearly recorded in case notes even if the detail of the visits are clearly recorded within an assessment or case conference report.

- All cases that have received an assessment from social care should have an effective and clear closure date with Team Manager supervision and closure.

- Ensuring clear guidance and training on the use of DASH assessments and how they should be used to assess risk. Staff should be confident and knowledgeable on the expectations of its use; including where a DASH assessment has not been completed. In line with this social care should ensure that all agency social workers are trained in domestic abuse and are able to undertake effective risk assessments.

5.2.3 The Clinical Commissioning Group/NHS England should:

- Provide guidance to GP's to ensure that when a patient's anti-depressant medication is reviewed, enquiries are made to establish whether the patient is coping with dependent children or adults and if potential risk exists to the patient or others.

- Ensure that GP's use peer review where there are safeguarding concerns apparent and which includes domestic abuse as a marker of risk. Where children are known to have been affected by domestic abuse GP's to refer any children in the family to Children's Social Care.

5.2.4 Leicestershire and Rutland Probation Trust to consider:

- Ensuring they contact individual placement providers to ensure that information is requested to identify concerns; such as the reporting of visible injuries observed

- Ensuring that where a court order is made for unpaid work only and there is a history of, or elements of domestic violence known; that a higher level of risk assessment is carried out.

5.2.5 Kent Police to consider:

- Ensuring that when domestic related incidents are reported which may involve parties who have connections with locations outside of Kent then, wherever possible, a Police National Computer check should form part of the information gathering process. Consideration should also be given to making contact with colleagues from other Force Area's and where relevant, that the Police National Database is also checked.

- Ensuring the revised Kent Police policy on domestic abuse includes the requirement for Response Sergeants to supervise all reports of domestic abuse occurring during their tour of duty.

- Ensuring all frontline staff are aware of their duty to fully complete DASH questions at Domestic Abuse incidents and identify children subject of domestic abuse either as victims or as being present when domestic abuse occurred. Also to ensure those cases are referred to the Public Protection Unit - Central Referral Unit for assessment against the Kent and Medway Safeguarding Children Threshold procedures.

5.2.6 Leicestershire Education to consider:

- Ensuring the development of a procedure within primary schools applicable to situations where children are routinely dropped off and picked up from school alone by taxi; that this is investigated and recorded, and the Designated Safeguarding

Practitioner made aware for consideration of wider safeguarding issues.

6 This executive summary reflects the summarised findings of the full DHR into the death of Mr FN. For a more thorough understanding of the facts, analysis and conclusions that led to the review recommendations please refer to the full report. (*A link to the web version to be added here when published*).