DHR 2014C
Domestic Homicide Review
Executive Summary in respect of:
Mrs F.

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Independent Overview Author

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1. Introduction

1.1 The Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Mrs F in Lincolnshire in 2014. Lincolnshire Police and Paramedics received a telephone call from the partner of Mrs F. when he visited her home as she had not answered his telephone calls. He found her dead body lying on the floor in the dining room. It was later established she had died of head injuries. Ms F's ex husband was arrested, charged and convicted of her murder and sentenced to life imprisonment. Those involved in the review would like to express their deepest sympathy to the family and friends of Mrs F. for their sad loss in such tragic circumstances.

2. The Review Process

2.1 This Executive Summary outlines the process undertaken by the Lincolnshire Domestic Homicide Review Panel in reviewing the murder of Mrs F. Criminal proceedings were finalised in January 2015 when Mr F. was found guilty of murder following trial. He has since appealed against conviction and sentence .The appeal was dismissed in February 2016. He is serving life sentence with a minimum term of 28 years.

2.2 A DHR was recommended and commissioned by the Lincolnshire Community Safety Partnership in line with the expectations of the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013.

2.3 The Home Office were informed of the intention to conduct a DHR within a month of the murder taking place. A panel was convened which included representatives of Agencies that had had contact with Mr and Mrs F. and their young son. An independent Chairperson and an independent Overview Report Author were appointed to the Review Panel.

2.4 Agencies participating in the Review include:-

a) Essex Police

b) Humberside Police

c) Lincolnshire police

d) United Lincolnshire Hospital NHS Trust

e) South West Lincolnshire Clinical Commissioning Group

f) Lincolnshire Community Health Service

g) Education Services Lincolnshire County Council

h) North Lincolnshire Children's Services

i) Northern Lincolnshire and Goole NHS Foundation Trust Community Health Visiting Service

j) Northern Lincolnshire and Goole NHS Foundation Trust

k) Lincolnshire Children's Services

2.5 Children and Families Court Advisory Support Services (CAFCASS) were contacted and a request made via the Family Court Judge to provide information about their contact with the family but the request was refused by the Judge.

2.6 A Solicitors letter from Mrs F. to Mr F. sent immediately prior to the murder concerning contact and residency of their son was shared with the Panel and was included in the analysis.

2.7 The Immigration Compliance and Enforcement Team were contacted in relation to immigration issues and to provide advice.

2.8 In line with the Terms of Reference (TOR) the DHR has covered in detail the period identified as being in scope which was from February 2008 when Mrs F. came to this country to June 2014 when Mr F. was arrested in connection with the murder. To enable greater understanding of the case and the lessons to be learned, relevant information outside the scope period was shared with the Panel. Each Agency's report covered:-

a) A chronology of involvement with Mr and Mrs F. and their son, what was done and decisions made.

b) Individual Management Reviews (IMR's) considered analysis of involvement, effective practice, whether procedures were followed, made conclusions about lessons to be learned and recommendations for future practise from the Agency perspective.

3. Terms of Reference

3.1 The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the ways in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter agency working.

3.2 In addition the following areas were considered and addressed in each IMR and Overview Report.

1.	Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/alleged perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to MARAC?
2.	What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
3.	Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
4.	Is there evidence that historical information was analysed to provide an holistic assessment of risk.
5.	Did the agency comply with domestic violence protocols agreed with other agencies, including any information sharing protocols? Was inter and intra-agency communication efficient and effective?
6.	Were practitioners sensitive to the needs of the victim and the alleged perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect practitioners, given their level of training and knowledge, to fulfil these expectations?
7.	Did the practitioners seek, and were given, appropriate levels of supervision, advice and guidance during the decision making process. Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?
8.	When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies? Had the victim disclosed to anyone and if so, was the response appropriate?
9.	What was known about the alleged perpetrator? Had MAPPA been considered?
10.	Was the information recorded and shared, where appropriate?

11.	Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the alleged perpetrator and their families? Was consideration for vulnerable and disability necessary? How accessible were the services for the victim and alleged perpetrator?
12.	Have there been any other similar cases in recent years and are there any lessons that could have been learnt?
13.	To what degree could the homicide have been accurately predicted and prevented?
14.	What effective practice can be passed on to other organisations?

4. Keys Issues Arising from the Review and Lessons Learned

4.1 In November 2009 when the Police in Humberside were called to the first DA incident in their area although both Mr and Mrs F considered themselves victims only one Separation, Pregnancy, Escalation, Community Isolation, Stalking /Harassment, Sexual Abuse (SPECSS) and F913 DV form was completed identifying Mrs F as the victim. The DV Form has since been amended to identify and record counter allegations which can provide useful intelligence for future risk assessments.

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

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

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

4.5 The risk assessment in December 2011 was categorised as medium but it was suggested by the attending officers this was reviewed and could move to high if Mr F was released from custody. The DV staff who undertook the secondary risk assessment maintained the medium rating. Had the case moved to high risk there would have been a Multi Agency Risk Assessment Conference (MARAC) referral, the referral to Children's Services was

considered by Police to have met their responsibility to liaise with partner agencies.

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

4.7 NLAG HV service have identified areas of learning relating to the need to improve holistic assessment and recording via the Situation Background Assessment and Recommendation (SBAR) model and the increased use of the DA Screening tool to include the movement in /transfer in contact. The need for assurance that HV are accessing and implementing DA training and the need to remind staff about The Interpreting and Translation Services Policy. The guidance for transfer of records for children with additional/safeguarding needs is to be reviewed. These issues are subject to recommendations.

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

4.9 The second lesson relates to ensuring that all Senior Investigating Officers (SIOs) are aware of safeguarding policies and procedures during the investigation of homicides and recognises the value of making early contact with the Public Protection Unit, Central Referral Unit (PPU CRU) for advice, guidance and practical support to ensure that information is shared with and partner agencies are involved at the earliest and most appropriate time.

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

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

4.12 The importance of using independent professional interpreters to interpret health and other personal information e.g. evidence of DA is fundamental.

This is to ensure accuracy and an honest communication and to protect the individual's privacy.

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

4.14 There was a failure to routinely ask the question about DA at every contact with clients if safe to do so by Lincolnshire Community Health Service (LCHS) staff.

4.15 LCHS identified a lack of completing and updating risk assessments e.g. Domestic Abuse Stalking and Honour Based Violence (DASH) was not completed when Mrs F disclosed fleeing violence. There was an assumption incorrectly made that as Mr and Mrs F no longer lived together risk of DA diminished. Research confirms this is not the case and risk can increase due to difficult contact arrangements. As a result there was a lack of using alert flags to inform others of the risks.

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

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

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

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

4.20 Limited English language may have been a significant barrier in Mrs F seeking assistance from support agencies. Help lines in appropriate languages, possibly on a national basis e.g. one Chinese speaking help line

for the Country should be considered to facilitate the disclosure of DA and promote referral on towards a safety plan.

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

5. Conclusion

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

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

5.3 There were three reported incidents in Humberside in November 2009, November 2011 and December 2011. It is likely there were many other incidents that went undetected e.g. Mrs F told her parents in China that she "asked for a divorce" several times. She said she could not bear the pain and could not take the mental anguish any longer. She said "she must divorce him because he often hit her". Divorce in China is such taboo her parents said they persuaded her to stay. Obviously this advice is a source of anguish to her parents.

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

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

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

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

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

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

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

6. Changes already made by Agencies relating to lessons learned.

Humberside Police

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

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

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

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

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

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

6.6 CCGs/LA Commissioning

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

6.7 CCGs

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

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

6.9 NLAG HV

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

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

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

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

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

6.14 LCHS

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

6.15 NLAG NHS Foundation Trust

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

7. Recommendations

Lincolnshire Police

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

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

7.3 ULHT

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

7.4 CCGs

Lessons learned from this review will be taken forward through the newly formed contract management arrangements and assurance sought that the

necessary protocols and controls are in place to ensure that practitioners have the requisite competence and skill to recognise and act upon DA.

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

7.6 LCHS

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

Education

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

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust Health Visiting Service

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

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

7.13 Health Visiting Managers to remind practitioners to utilise The Interpreting and Translation Services Policy for work with those for whom English is not their first language in accordance with North Lincolnshire and Goole NHS Foundation Trust Policy.

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

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

Community Safety Partnership

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

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

Nationally

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

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INDEPENDENT REPORT AUTHOR

Glossary of Terms

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

SBAR	Situation Background Assessment and Recommendation
SIO	Senior Investigating Officer
SN	School Nurse
SPECSS	Separation, Pregnancy, Escalation, Community Isolation, Stalking /Harassment, Sexual Abuse – DA High Risk Factors
TOR	Terms of Reference
ULHT	United Lincolnshire Hospital Trust