NORTH LINCOLNSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the death of Angela

June 2021

Independent Chair and Author: Simon Steel

Date of Completion: 17 December 2024

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the North Lincolnshire Community Safety Partnership (CSP), Domestic Homicide Review panel in reviewing the circumstances of the death of Angela who lived with her partner Fred who both were local residents at the time of her death.

1.2 The following pseudonyms have been in used in this review to protect their identities.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Angela	Victim	39	White-British
Fred	Perpetrator	38	White-British
Edith	Mum of Angela	Adult over 18	White-British
Rachel	Daughter of Angela	Child Under 18	White-British
Sonia	Ex partner of Fred	Adult over 18	White-British
Janet	Friend of Angela	Adult over 18	White-British

1.3 On a morning in June 2021 Angela was discovered at her home address by Rachel. She was subsequently found to have been murdered by Fred.

1.4 That morning Fred called police to hand himself in for the murder. The police attended the location he was at, and he was arrested for Angela's murder.

1.5 During the post-mortem, the cause of death was recorded as pressure to the neck (manual strangulation). Angela had a number of injuries to her body. The pathologist's opinion was that the findings were highly typical of being caused by pressure applied to the neck.

1.6 Humberside police referred this matter to the North Lincolnshire Community Safety Partnership (CSP) on the 30th of June 2021. The letter recommended that the case be considered for a Domestic Homicide Review. The Home Office were informed by the Partnership of their intention to carry out a Domestic Homicide Review into this matter. An Independent Chair was appointed to carry out the review in September 2021. At this time the Chair agreed with the Senior Investigating Officer that the review should not commence until after the trial. The Chair undertook some preliminary work and then informed the CSP in September 2022 that he was unable to continue due to ill health. The

CSP in conjunction with other partners attempted to commission another Independent Chair and worked with the Office of the Police and Crime Commissioner to raise issues with the Home Office around the shortage of chairs and the difficulties in securing an independent person to undertake the review. North Lincolnshire has now implemented a new procurement process through Advocacy After Fatal Domestic Abuse (AAFDA) to ensure there are no further delays in any future DHR's. A new process of identifying any early learning has also been put in place through the Local Safeguarding Partnerships.

1.7 The case was heard at Hull Crown Court and Fred pleaded guilty to the Murder of Angela and 2 counts of assault by penetration and was sentenced to life imprisonment with a minimum tariff of 27 years in June 2022. He was placed on the sex offenders register indefinitely. As this was a prosecution case, an Inquest was not held. All Coronial involvement has ended.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact directly or indirectly with Angela and Fred with the exception of the GP service, where a report was requested.

2.2 The following agencies who had contact and their contributions are shown below.

Agency	Contribution
Lincolnshire Children's Services	Chronology and IMR
GP service	Chronology and Report
End Domestic Abuse Now (EDAN) Lincs	Chronology and IMR
Humberside Police	Chronology and IMR

2.3 IMRs were completed by authors who were independent of any prior involvement with Angela and Fred.

2.4 The authors and panel members assisted the panel further, with one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Name	Role/Job Title	Agency
Simon Steel	Independent Chair and Author	Perse Perspective Consultancy Ltd
Catherine Slaughter	Detective Inspector Safeguarding Governance Unit	Humberside Police
Rebecca Holmes	Detective Inspector Safeguarding Governance Unit	Humberside Police
Helen Rose	Head of Adult Safeguarding	North Lincolnshire Council
Charlotte Morton	Designated Nurse for Children and Adults.	NHS Humber and North Yorkshire Integrated Care Board (ICB)
Rachael Cox	DCI – PVP/ Partnerships - DA Lead	Lincolnshire Police
Celia Madden	Chief Executive Officer (CEO)	End Domestic Abuse Now (EDAN)Lincolnshire
Phillipa Thornley	Information Governance Advisor and Data Protection Officer	North Lincolnshire Council
Charolotte Nugent	Safe Accommodation Project Coordinator	Lincolnshire County Council
Steph Price	CEO	The Blue Door Support Service CIC
Laura Bonner	Head of Service (Children's Transformation)	Lincolnshire County Council
Kathy Cairns	Violence Reduction Officer	North Lincolnshire Council
Tracey Coyne	Community Safety Partnership Board Manager	North Lincolnshire Council

3.2 The review panel met on 4 occasions.

3.3 Agency representatives were of appropriate level of expertise and were independent of the case.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Simon Steel. Simon has completed his Home Office approved training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 20 years-service with Thames Valley Police retiring at the rank of Detective Superintendent. During his service he gained significant experience in response to Domestic Abuse, Public Protection and Safeguarding.

4.2 Simon has no connection with the North Lincolnshire Community Safety Partnership, or any agencies involved in this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively North Lincolnshire's statutory agencies and Non-Government Organisations worked together in their dealings with Angela and Fred.

5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- 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 lessons are both within and between those agencies. Identifying timescales within which 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
- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life.

5.3 Case specific key lines of enquiry included the following:

1. Links between Mental Health and DA
2. Access to DA services in a rural community
3. Were services coordinated including cross border services.
4. Was COVID 19 a factor regarding access to services and were service changes communicated effectively.
5. Multi Agency Risk Assessment Conference (MARAC) was it utilised correctly.

6. SUMMARY CHRONOLOGY

Family & Friends Perspective

6.1 Following the decision to conduct this DHR the partnership and Chair then did extensive enquiries with supporting agencies to seek to understand if anyone was supporting the family. Victim Support (VS) were supporting Angela's mum Edith and via victim support the chair and the CSP reached out to Edith.

6.2 The chair initially spoke with Edith then travelled and met with her in person at her request. The chair throughout this process discussed Advocacy After Fatal Domestic Abuse (AAFDA) support available to Edith which included the home office leaflet which explains AAFDA's role. The chair maintained this offer throughout his engagements however Edith did not wish to be referred as she did not want to engage with another agency or individual and tell her story again. Also, the chair acknowledges the time it had taken to commission this review throughout his interactions and has apologised on behalf of the CSP. Understandably Edith was angry and upset at the time it had taken to commission this review and the Chair, and the panel understand this, and the chair has raised this with the CSP who have provided an explanation at paragraph 8.3 and supplied information of their systems going forward.

6.3 Edith did give the chair permission to speak with AAFDA for some tactical advice on how best to engage with Rachel. Again, the offer of support was given to Rachel however again it is important to understand the age of Rachel at the time of her mother's murder and her age when she engaged with and met the chair. Edith did not give her permission for any engagement with the younger child of Angela.

6.4 Edith was able to explain that Angela was her only daughter and Angela also had a brother. It was in fact her brother's house that she was murdered in. Angela had been renting this house for a number of years. Angela lived there with her 2 children Rachel and another child. The children's father and Angela had separated a number of years before after a lengthy relationship. Following the murder of Angela both children now reside with Edith and her husband, the children's grandfather, at Edith's home. Edith is the Legal guardian for the children.

6.5 The chair was particularly taken by the support that Edith gave this process despite the time span since her daughter's murder. Edith and her husband have stepped into the parenting role for the 2 children. Delays of this nature with DHR's are so significant for all families. The chair wishes to see that no review is delayed like this and made a promise to Edith that he would ensure since commissioning he would do all he could to expedite the process. A delay however did occur but that was with the agreement of Edith and was due to a stage of education that Rachel was at.

6.6 The chair travelled and met Rachel in person. Edith was in the house and joined the conversation after the chair had explained to Rachel the process of the DHR and how she could be involved should she wish. The chair again apologised on behalf of the CSP for the unacceptable delay.

6.7 Edith was able to tell the chair that she had lived with her husband in the same area of North Lincolnshire for many years. She had brought her 2 children up in the home she still lives in. Angela was her only daughter and went to school locally. Angela travelled extensively as part of work in the travel industry and eventually settled back in the local area. Angela's 2 children where her life and the loss of Angela is immeasurable to Edith. Edith did tell the chair that she had noticed that Fred drank a lot of alcohol and had optics (holders for spirits commonly seen in public houses) put in Angela's house.

6.8 Via Edith the chairs details were passed to Angela's brother. The chair spoke with Angela's brother. He confirmed that Angela had rented his house for many years. Again, the sense of loss of his only sister was apparent.

6.9 Via Edith the chair's details were passed to Angela's best friend Janet. Janet had met Angela in secondary school, they were in the same form, and they remained friends ever since then. They were both sporty at school and played on the same sports teams. Both Angela and Janet travelled and worked abroad. They had worked on one occasion at the same place abroad and at different locations, however they always stayed in contact. Janet explained that Angela had met her husband (father of her 2 children) whilst working abroad on a ski season.

6.10 Janet went on to explain Angela met Fred through online dating. Not long before Angela had met Fred, Angela had rung Janet one night really upset as she wanted to find someone who loved her.

6.11 Janet recalls meeting Fred for the first time. They were at Janet's house, and they all got takeaway food. She recalled he drank a lot (Vodka) and he seemed to have a high tolerance for alcohol. She recalls Fred was constantly saying amazing things about Angela (felt over the top). There was a discussion around them moving in together. Fred had stated that he had just got back on his feet and didn't want to go back to the situation he was in before. Janet considered was this financial or a housing issue.

6.12 Janet recalls Fred talking about social media stating that Angela should not have ex partners on her site. He didn't want to see pictures on sites of Angela with ex partners. Fred set up a new social media profile on being with Angela. She also felt there may have been a duplication by Fred of one of Angela's social media sites.

6.13 Janet felt that Angela was "all in on Fred" and hoping he would propose. However, Fred did not like Angela talking to other males even friends. He would get drunk and be paranoid that Angela was talking to other males. Janet explained this was during

the pandemic times, and they had met during one of the lockdowns, and whether the isolation had affected decision making in terms of moving in together quicker than might have normally occurred due to the COVID19 rules that were in place across the country.

6.14 A former partner (Sonia) of Fred was identified at panel via information from the police. The panel identified that EDAN Lincs had worked with Sonia previously. The chair via EDAN Lincs reached out to Sonia. Sonia wished to speak with the chair. The chair had identified that appropriate support should be in place for Sonia and the panel are grateful to EDAN Lincs for the support they have given to this process. Sonia was given an opportunity to consider all of the material that referenced her and also to add anything should she wish. Again, the delay in this review has an impact for Sonia and we must again ensure that the commissioning of reviews is timely and understand the impact that this has on all parties.

6.15 The chair met with Edith in person and at her request read through the draft overview of this report with her. It was Edith's wish that once submitted to the home office she would be supplied with a copy however did not wish for other copies to be supplied in the interim and had no observations for the chair that what had already been discussed.

Perpetrator

6.16 On the 29th of July 2024 having written previously to Fred via the probation service at the prison the chair met with Fred virtually at his request. The Probation Service (PS) supported the call at the request of Fred. The chair explained the DHR process to Fred and his initial indication was not to take part due to concerns regarding publication. The chair checked back in with the Probation service and on the 10th of October 2024 the probation service informed the chair that Fred did not wish to take part.

LINCOLNSHIRE CHILDRENS SERVICES (LCS)

6.17 Lincolnshire County Council Children's Services involvement consisted of a period of Early Help intervention provided to Fred and his partner (Sonia). In January 2018 a request was made for an Early Help Worker and Team Around the Child (TAC) to be opened. In May 2018, a decision was made for the Lead Professional to transfer to the Early Help Worker who has an existing relationship with the family. During this time domestic abuse concerns were raised, with Fred being the perpetrator. At some point in January 2018 Fred left the family home. Despite leaving Fred would return to the house and let himself in, being a named person on the mortgage and having a key.

6.18 Whilst separated and with Fred not living in the home, in March 2018 Sonia shared with the Early Help Worker domestic abuse within the intimate partner relationship (Fred), describing he was frequently verbally abusive towards her, been historically

violent and has grabbed her by the throat. A DASH was completed with Sonia with responses of "tried to strangle 3-4 times over the past 10 years", response of "yes" to threatened to kill Sonia. Total Yes responses – 12 provided in this DASH which did not result in a MARAC referral, 14 or more yes answers are considered high risk, however professional judgement can be applied with a MARAC referral. The Early Help Worker noted the overall score of 12/27 with some of the answers relating to historic events over the past 10 years, with Sonia reporting at this time she does not need any current support regarding the domestic abuse but will inform professionals if this changes. Comment: many of the panel believe with the risk factors described, non-fatal strangulation and threats to kill that this case should have been referred to MARAC in 2018, however the panel acknowledge that there is now a broader understanding of non-fatal strangulation and believe were this to happen now with that information known it would be referred to MARAC.

6.19 During a TAC Meeting in April 2018, Sonia shared an incident the week prior, where Fred had entered the home unexpectedly and became verbally aggressive towards Sonia. Sonia then shared Fred "tried to force himself" on Sonia saying "you know you want it as much as I do" whilst touching her sexually. A DASH was completed with Sonia sharing that Fred used physical force to pin Sonia onto the bed. This DASH notes, "if he carried on, I guess it would have been rape". The DASH refers to an earlier incident on the 4th of April 2018 where Fred "flipped and punched a bed ".

6.20 Regarding Fred, the DASH notes alcohol as a previous concern and that he has previously seen a specialist in 'Combat Stress', and psychiatrists, with the Welfare Team from the forces being involved. Total Yes responses – 17, indicated an increase in the risk with this being considered high risk. Following this DASH for the victim (Sonia), referrals to MARAC and WLDAS (Domestic Abuse Service) were completed by the Early Help Worker.

6.21 On two occasions (26.09.2018 / 05.11.2018) Sonia shared with the Early Help Worker concerns Fred is not supporting financially with mortgage payments or child maintenance which placed her in financial hardship.

6.22 On the 21st of November 2018 a verbal argument between Fred and Sonia occurred when Fred did not return the younger children at the agreed time. In separate calls with the Early Help Team both parents were encouraged to work with the Family Group Conference service to explore a suitable arrangement for promoting contact and handovers.

6.23 Whilst the Early Help Worker was completing a visit (7th December 2018) to the family, Fred walked into the home without knocking. Fred is observed to appear shocked to see the Early Help Worker in the house reporting he needed the toilet and will go upstairs, but on return the Early Help Worker described him as appearing to be keen

to get into the front room and agitated whilst trying to see where Sonia was and what she was doing. The worker notes Fred sent the younger children into the front room to see Sonia and said he needed to go with them in a demanding tone. Fred made little effort to speak to Sonia or Child C but stood very close to Sonia, appearing slightly intimidating as she sat down avoiding eye contact. Fred left the property whilst the Early Help Worker was present and following this the worker spoke with Sonia alone. Comment: This was an opportunity to complete a DASH with Sonia due to the observed behaviours witnessed by the Early Help Worker however one was not completed.

6.24 Following the above visit, the Early Help Worker addressed with Fred (11.12.2018) his behaviour of walking into the home during the visit on 7th December 2018. Fred reported he could see the younger children and that the door was open. The Early Help Worker advised it was not and he should not just walk into the property, to knock and wait. On the same day (11.12.2018) Sonia reported to the Early Help Worker of an abusive call from Fred as he had received communication from child maintenance.

6.25 During December 2018 Sonia reports to the Early Help Worker constant bombardment of messages demanding that he has the younger children tomorrow and that she responds to him. Sonia reports to the Early Help Worker of being sick of the mental and verbal abuse from Fred.

6.26 In January 2019 Sonia stated contact from Fred had increased, however it has been civil and appropriate. She has noticed Fred is calling her more for no known reason with him saying he just wants to see how Sonia and the younger children are. Sonia describes this as "unusually polite". On the 3rd of February 2019 Early Help involvement ended and the case was closed to Children's Services.

6.27 Within the review there are concerns noted of Fred's behaviour towards Sonia which has been witnessed or overheard by all of the children, these worries have been verbal abuse perpetrated by Fred to Sonia and controlling behaviours, including financial abuse/control. The Early Help Worker witnessed behaviours which caused her to challenge Fred in December 2018.

6.28 Following the separation this is when the domestic abuse concerns become more visible within the intimate partner relationship, with Sonia sharing her lived experiences with the Early Help Worker. The Early Help Worker completed a DASH in line with Lincolnshire multi-agency domestic abuse protocol. Appropriate referrals were made to MARAC and WLDAS by the Early Help Worker following the DASH in April 2018. There was an opportunity for a further DASH to be completed when the Early Help Worker witnessed Fred's behaviours when he entered this property unannounced (07.12.2018). The Early Help Worker appropriately become the Lead Professional in May 2018 due to the concerns regarding domestic abuse.

6.29 During the intervention from Early Help in 2018, Fred was engaged with appropriately during the intervention. He was not resident in the home address, however continued to have access. Appropriate safety planning was discussed with Sonia, and she was accessing support from appropriate domestic abuse services. Sonia took all appropriate steps to obtain new and secure accommodation for her and the children, along with seeking Legal advice.

6.30 When Sonia disclosed strangulation occurring in the intimate partner relationship it had occurred over 4 years ago, this was recognised by the Early Help Worker and a DASH was completed. Non-fatal strangulation is now recognised in law and practice, with the seriousness of such incidents being recognised and risks associated with this.

6.31 In the two DASH's completed in March and April 2018, information was shared by Sonia of Fred being ex-army, and that he has previously seen a specialist in combat stress and psychiatrists. Further exploration could have occurred regarding Fred's history, being in the army and a perpetrator of domestic abuse. The link between mental health and domestic abuse was clearly identified by the Early Help Worker. On the 3rd of February 2019 Early Help involvement ended and the case was closed to Lincolnshire Children's Services.

GP SERVICE

6.32 Angela had been registered with the same GP practice from 2009 until her death. She had no recent A&E activity and no recent GP contacts. She had screening in December 2019 (Smear) with subsequent follow up in November 2020. There were no recent prescriptions or waiting lists. No relationships were recorded apart from her 2 children.

6.33 Fred was registered from 2015 with his GP practice to the time of his imprisonment. There was no recent A&E activity and no recent GP appointments or prescribing. On the 18th of July 2018 a mental health support referral was made. He wanted support with PTSD. It was noted he was ex forces, served in Germany and Afghanistan. An IAPT appointment was made for the 8th August 2018 however he did not attend and this care episode did not continue.

END DOMESTIC ABUSE NOW (EDAN LINCS)

6.34 The time period of involvement with Sonia was for 8 months. EDAN worked with Sonia through their IDVA service. Sonia shared with the IDVA domestic abuse perpetrated by Fred being:

Criminal damage to joint property.

Angry outbursts and punching of walls.

Post Separation Emotional Abuse

Historical Abuse in 2011 of non-fatal strangulation

6.35 Lincolnshire MARAC: It is noted that Fred is recorded as a perpetrator on a MARAC referral by another agency on 30.4.2018. The referral shows Fred was medicated for mental Health and also recorded on the referral as consuming excessive alcohol and that DA continued post separation.

HUMBERSIDE POLICE

6.36 Humberside Police did not have any involvement with Angela or Fred prior to her murder. The police conducted a murder enquiry into the death of Angela and as a result have provided information to this review.

6.37 The day before Fred murdered Angela the police were able to establish that Fred went to a pub. There was a mix up with him signing in (COVID regulations) and when explained he apologised saying he hadn't been to a pub for 2 years. He ordered a pint of lager and took a seat in the pub. He sat on his own but began talking to others in the pub. Parts of his conversation has been recorded as he had said he was having a bad day as he believed his girlfriend was cheating on him. He said he had spoken to his girlfriend about it and she had told him that they were just friends. He went on to explain that he knew her pin for her phone and that he had been checking her phone. He said he believed his girlfriend when she said they were just friends. He went on to say that he had a great relationship with his girlfriend after they'd met on a dating application a year ago and that they lived together even though he had his own house. Fred then went back into the pub and kept repeating himself, telling others in the pub that his girlfriend was cheating on him. He continued to order pints of Lager. He had ordered 3, then went on to buying a pint of Lager with a whiskey as well. The others in the pub told the landlady to keep an eye on the male as he was becoming annoying. He'd been asked to wear a mask several times and to sit in his seat and a couple of people in the pub told him to leave around 2100 hours. He was seen heading towards another pub.

6.38 The information is added to the analysis as it shows what Fred perceived in his relationship and his controlling behaviour and thoughts even in a public location.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 Tragically it has not been possible to build a picture from Angela's perspective. The review has had to rely on anecdotal reports collated by involved agencies. However, the review has been fortunate that close family members have participated, and the

best friend of Angela along with a former partner of Fred. The panel remain indebted to them for feeling able to share their memories, views and thoughts with the review panel.

Links between Mental health and DA.

7.2 Mental health is regarded as a risk factor in perpetrators of DA by the College of Policing (COP) approved professional practice (APP)[1]. Safelives report on the impact of mental health on response to perpetrators of DA[2]. "*Supporting perpetrators to take responsibility becomes more complicated as soon as the possibility of their own mental health problems playing a role in their abusive behaviour arises. Are their mental health problems being presented as an excuse not to take responsibility for their behaviour, or are they an important factor in this behaviour?"*

7.3 Accepting the complexity that Safelives report on, the reality with Fred is there is no evidence presented to this review that shows any work was considered or explored. The panel notes a missed appointment with IAPT however at that time no wider link to DA. The panel however note the metal health as a factor at the MARAC meeting in May 2018 and see no evidence of any wider work or consideration in this area. There were no mental health concerns identified for Angela.

Access to DA services in a rural community

7.4 There is no evidence found in this review that the location of Angela and Fred was a barrier in accessing support. The location of Angela's property was not rural and as such was very close to major services. Angela knew the area well, had lived there many years, had grown up close by and the house was owned by her brother. They both had access to their own cars. The panel however are all alert to and conscious of the under reporting within rural communities. The national rural crime network reports[3] that there are hidden victims, isolated, unsupported, and unprotected. Victims are being failed by services, systems and those around them. In response to this the CSP are committed to their rural community and working with the Domestic Abuse Board to ensure that services are accessible to all and that information advice and guidance referral pathways take account of any rurality issues.

[1] Understanding risk and vulnerability in the context of domestic abuse | College of Policing
[2] Impact of mental health on the response to perpetrators - SafeLives

[3] Captive & Controlled - Domestic Abuse in Rural Areas - National Rural Crime Network

Were services coordinated, including cross border services.

7.5 There is no evidence outside of MARAC (which is analysed separately) presented to the review that identifies cross border being relevant in this review.

Was COVID 19 a factor regarding access to services and were service changes communicated effectively.

7.6 Angela's relationship with Fred started during the pandemic. More and more evidence is being presented that due to various restrictions, lockdowns and social bubbles that were in place at various times, that the vulnerable were disproportionality effected. The panel have considered that the reality is Angela would at times have been less able to see family and friends due to restrictions, and as a result less opportunities for her to disclose or for family and friends to observe Fred. It cannot be ruled out that Angela allowed Fred to move into her home earlier because of the pandemic. Given this on the balance of probabilities the panel believe the COVID19 pandemic had a disproportionate effect for Angela. However, the panel are content with the service change communications during the pandemic.

Multi Agency Risk Assessment Conference (MARAC) was it utilised correctly.

7.7 This review has identified that Sonia was referred to MARAC in May 2018. The chair has accessed the minutes of that MARAC meeting. The minutes show that Fred had grabbed Sonia around the throat on a number of occasions and attempted to strangle Sonia. The minutes show there has been witnesses to this.

7.8 The minutes show that Fred had poor mental health, however, was unmedicated and unsupported for this through his own choosing. The minutes also showed that he drank regularly. Also, the minutes identify that despite leaving the family home in January 2018, he regularly let himself in. On one of these occasions, he had pinned Sonia down on the bed touching her "all over" whilst Sonia was saying no. Eventually, she was able to get him off her.

7.9 The panel discussed around the non-recording of these offences by Lincolnshire Police. The panel of course understand such disclosures by DA victims have to be managed appropriately and the panel representative was able to expand. In the past (as was the case in 2018) when victims disclosed offences to other agencies not all offences where historically recorded by police. In effect to ensure the wishes of the victim were considered. However, the panel representative was able to confirm (Op Komoran) which was introduced in July 2023. As a result, had those offences been heard at MARAC since July 2023 they would have been recorded on NICHE (local recording system) and then further recorded on the Police National Database (PND) for national viewing and disclosure where required. The panel therefore were

reassured with the current process around such disclosures made to another agency that they would be recorded on police systems.

7.10 This however led to a discussion around PND and its use. The panel were told that for many officers it would not be a matter of checking PND when dealing with incidents. The panel were informed that however both forces DVDS's[4] teams would check PND. The panel considered that there may be information on PND that is not being checked when police attend incidents regarding Domestic Abuse. The College of Policing (COP) Approved Professional Practice (APP)[5] is very clear "*Officers should check the PND when a perpetrator is known to live or have lived in other police areas*". *Where no information is available, officers should contact other relevant forces directly for warnings and any other pertinent information that might be recorded on their local systems.*

7.11 One example of PND Lincolnshire Police were able to update on is within the custody APP there is a requirement for detainees to be checked on PND and an endorsement made on the custody record and the originating force updating where appropriate. This of course is useful when a perpetrator is brought to custody clearly not so when not.

7.12 The panel are also mindful of the challenges with PND. There are a limited number of licences across both forces and staff trained to use the system. The chair is aware from his own research that challenge does not just sit with the 2 forces who are part of this review. It seems implausible that in 2024 the system of PND is what it is, with challenges with licenses and operators. The panel believe that with current technology there must be improvements that can be made to the system to support officers. In particular the front line who often are the officers who struggle to get access. The very officers that attend the majority of DA calls for service. This has led the panel to a national recommendation for the COP and local recommendation for the 2 police forces who are part of this review. The panel recommend to the home office that the College of Policing are tasked with a review of PND and its fitness for purpose in 2024 and how can it be better enabled to support front line policing.

7.13 The panel then considered what had been the effect of not recording these offences and did that impact on keeping Angela safe. One scenario that could have occurred is had Angela requested a DVDS disclosure, on checking Humberside Police would not have seen any information relating to Fred's offences as the perpetrator back in 2018 as none were recorded. There is no evidence presented to this review to say that question was asked, and Humberside police confirm their only interaction with Angela

[4] DVDS guidance (accessible) - GOV.UK
[5] Investigative development | College of Policing

and Fred was at the point of her Murder. However, had that situation happened now Humberside Police as part of DVDS would check PND and have seen the information.

7.14 The panel also considered the possibility that between the separation from Sonia and the murder of Angela that Fred could have been in relationships with others. Again, had a DVDS disclosure been asked for elsewhere (and we may never know if that was the case), no information would have been given to the other party who was in a relationship with this dangerous offender. There were behaviours identified at the MARAC meeting in May 2018 that show the threat level that Fred posed to women.

7.15 The panel also discussed DVDS teams. Both police forces were able to confirm that the teams work as muti agency teams and would check with other partners for information. However, unless there was known reasons they would not check out of area and as a result makes PND even more critical as a point of reference for information such as in this case.

7.16 Within the same COP article at 7.10 of risk factors, substance abuse is identified. Whilst it is noted in the MARAC minutes Fred was drinking the notes do not expand further. Janet of course tells the review about that she thought Fred had a high tolerance for alcohol. The police were able to determine the night before he murdered Angela, he drank a lot in a pub and was asked to leave.

7.16 Again within the COP article at 7.10 strangulation is recognised as a risk factor in perpetrators of domestic abuse. The offence of non-fatal strangulation[6] is now a stand-alone offence as of 7 June 2022. It was not a stand-alone offence at the time of the MARAC however was still a criminal offence.

7.17 In a recent publication the institute for addressing strangulation[7] report "*Domestic abuse charity SafeLives estimates that more than 20,000 victims in the UK experience strangulation each year Almost 19% of people attending St Mary's Sexual Assault Referral Centre (SARC) in Manchester who had been assaulted by a partner or ex-partner had experienced strangulation as part of the assault In the decade to March 2020, strangulation or asphyxiation was consistently the second most frequent method of homicide for women killed by men In the first year of legislation, there were more than 23,000 police reports of strangulation and suffocation across England and Wales*. Strangulation was again a factor recorded at MARAC and subsequently a factor in the murder of Angela.

[6] New non-fatal strangulation offence comes into force - GOV.UK (www.gov.uk)
[7] https://ifas.org.uk/wp-content/uploads/2024/09/Guidance-for-Police-Management-of-Strangulation-_final-September-2024.pdf

8. LESSONS LEARNED

8.1 In approaching learning and recommendations, the Review Panel has sought to do two things. First, to try and understand what happened and consider the issues in Angela's life that might help explain the circumstances of her death. Second, to use this case to consider a wider range of issues locally, including provision for victims of domestic abuse.

8.2 The review identified several learning points that build upon agency IMRs. Information provided by the agencies involved in this review would appear to demonstrate that there are several themes that need to be considered because of Angela's death. There are various themes within the review, each of these have been explored, during this process and the various learning points and recommendations are intended to support victims and survivors facing similar difficulties and challenges. In approaching these learning points and recommendations the Review Panel has sought to try and understand what happened and recognise the issues in the life of Angela.

8.3 Nationally there have been delays in conducting DHR's partially due to delays associated with the pandemic and the non-availability of suitably qualified DHR Chairs. This included some delays in DHR reviews in North Lincolnshire This lack of availability of Chairs was raised through the Office of the Police and Crime Commissioner who in turn raised this with the Home Office. North Lincolnshire has now implemented a new procurement process through Advocacy After Fatal Domestic Abuse (AAFDA) to ensure there are no further delays in any future DHR's. A new process of identifying any early learning has also been put in place through the Local Safeguarding Partnerships.

8.4 The Community Safety Partnership would like to offer its condolences to the family of Angela and sincerely apologise for the delay in completing this review.

The themes identified are:
Links between mental health and DA.
Links between Alcohol misuse and DA.
Links between non-fatal strangulation and DA.

10. RECOMMENDATIONS

Local Recommendations

All

Recommendation: All agencies – To recognise and respond that mental health challenges for perpetrators are a risk factor in DA . This should include assessing risk to others. All agencies are to ensure training reflects this and reinforce through a communication campaign within their organisation – Completed and Ongoing.

Recommendation: All agencies – To recognise and respond that alcohol misuse for perpetrators is a risk factor in DA. This should include assessing risk to others. All agencies are to ensure training reflects this and reinforce through a communication campaign within their organisation – Completed and Ongoing.

Recommendation: All agencies – To recognise that non-fatal strangulation is a significant risk factor in DA and ensure training reflects this and reinforce through a communication campaign – Completed and Ongoing.

Police

Recommendation: Humberside & Lincolnshire Police should remind officers of the requirement to check PND when attending a Domestic Incident when the perpetrator is known to live or have lived in other police areas – Completed.

National Recommendations

National Recommendation: The College of Policing are tasked with a review of PND and its fitness for purpose in 2024 and how can it be better enabled to support front line policing – Completed and ongoing with The College of Policing.