DOMESTIC HOMICIDE REVIEW - OVERVIEW REPORT

North Lincolnshire Community Safety Partnership

Report into the death of ANGELA

June 2021

Report produced by Simon Steel – Perse Perspective Consultancy Ltd

Report Completed on

17/12/2024

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The following tribute has been prepared by the family of Angela.

As a mother it is impossible to believe that I am having to write a tribute to my daughter. I still remember giving birth to Angela, I was so so happy as I had given birth to a one and only daughter. I am still unable to put into words how much Angela meant to me and the enormous impact her passing has had on our lives.

Angela's upbringing was full of love and laughter. She was brought up in a small village with her father, her older brother and myself. Angela was very sporty, and I was forever taking her to places for things like dancing, gymnastics, running, you name it she was doing it.

Angela was beautiful inside and out, she was kind, caring beyond words and would always do anything for anyone. Angela was always loyal to her family and friends, she loved and cared about. She never took life too seriously, she had a playful side and was always fun to be around.

Angela would be 43 now watching her own family grow up and mature into the children they are today. Her children could not have had a better mummy, she couldn't do enough for them, they were her whole world.

We are very deeply saddened by her passing, and we miss her dearly. She will forever be held in our hearts, your star is still shining Angela.

I will never get over the traumatic way i lost my daughter. I am so very very proud to be able to call her my daughter.

Tribute to my Mummy.

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My Mummy was a very beautiful, kind, loving, friendly, caring and independent woman who always put her family before herself and did her upmost best for her children. Mummy often took us on adventures and would play little jokes on my brother and I. These are all now very cherish-able memories which we keep very close to our hearts.

It is so hard to comprehend any words to put down within a couple of sentences of how much I miss my mummy. She will forever live on in our lives and never ever be forgotten.

From the day of mummy's passing our family has not been the same, without such a strong powerful woman no longer in our lives. No child should have to go through such a tragic and traumatic loss of losing their mummy at such a young age.

We miss you profoundly mummy, we wish you were still here. We hope you are proud of all the achievements we have accomplished since you're passing.

Your star is still shining brightly.
Love and miss you forever.
Rachel xx

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FOREWORD

North Lincolnshire Community Safety Partnership would like to express their condolences to all those affected by the sad loss of Angela. This review sincerely hopes the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar events happening again in the future.

The independent chair of this Domestic Homicide Review panel would like to thank all agencies who contributed to the process in an open and transparent manner. The panel is confident that the learning points and recommendations will provide a platform to help national, regional, and local agencies to implement measures designed to embed a preventative approach to addressing domestic abuse.

Following this death, there is emerging evidence of positive change at a local level. We all must do our utmost to take immediate action to protect the victim and to deal effectively with the perpetrators of domestic abuse and the chair would urge everyone to take note and act on the findings of this review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline, and community level to help bring these types of incidents to an end.

1. INTRODUCTION

1.1 This Domestic Homicide Review (hereafter "the review") was established under Sec 9(3) of the Domestic Violence Crime and Victims Acts 2004. It examines agency responses and support given to Angela who was a resident of North Lincolnshire prior to her death in June 2021.

1.2 The subsequent investigation led to the arrest and conviction of Fred (her partner) for Murder and 2 offences of Assault by Penetration at Hull Crown Court in June 2022. As this was a prosecution case, an Inquest was not held, and all Coronial involvement has ended.

1.3 The review will consider the agency contact and involvement with Angela and Fred from the 1st of June 2018. At the initial panel meeting agency members shared a summary of their engagement with Angela. This period was chosen to allow for an in-depth review of current methods and processes to be carried out and to ensure that recommendations and learning would be based on existing policies, procedures, and training. This timeframe also included the entire time period of the relationship between Angela and Fred. As a result, this was considered a proportionate timeframe however agencies were informed should they note anything relevant outside of that timeframe they were to include that detail in their individual management review (IMR.) The chair would constantly monitor this information and would amend the terms of reference (TOR) if required as a consequence. In addition to agency involvement, the review will also examine the past to try and identify any relevant background or trail of abuse, prior to the death, whether support was accessed, within the community. By taking this holistic approach, the review attempts to identify solutions that will make the future safer.

1.4 The key purpose for undertaking reviews of this nature is to enable lessons to be learned from deaths which occur in similar circumstances and with a related background. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand, fully, what happened following each death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

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1.5 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.6 The review panel wishes to express its deepest sympathy to the family and friends of Angela, for their loss and thank them for their contributions and support for this process.

2. Timescales

17.1 2.1 The 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.

2.2 Simon Steel was commissioned to provide an Independent Chair (hereafter 'the chair') for this review on the 10th of October 2023. The completed report was passed to the Community Safety Partnership (CSP) on 14th February 2025. It was submitted by the CSP to the Home Office Quality Assurance Panel on 24th February 2025.

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2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was extended for several reasons:

- To support engagement with the family as there was a critical period of education for Angela's daughter Rachel which the family wished to be able to pass.
- Due to delays within the CSP to allow agencies to service other outstanding DHR's.

3. Confidentiality

3.1 The findings of this review are confidential and will remain so until the Overview Report and Executive Summary have been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating professionals/officers and their line managers.

3.2 Details of confidentiality, disclosure and dissemination were discussed and agreed, between member agencies during the first panel meeting and all information was treated as confidential and nothing was disclosed to third parties without the agreement of the responsible agency's representative.

3.3 Each agency representative was personally responsible for the safe keeping of all documentation that they possessed in relation to this review and for the secure retention and disposal of that information in a confidential manner.

3.4 It was recommended that all members of the Review Panel used a secure email system, and that information should not be sent in any other way and was also password protected.

3.5 This review has been suitably anonymised in accordance with the statutory guidance. The pseudonyms were initially decided upon by the chair following discussions with Edith, the chair then consulted with Edith and some names were changed. The final names were agreed by Edith. The chair chose the name for the perpetrator.

Pseudonym	**Relationship**	**Age at the time of the incident**	**Ethnicity**

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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

3.6 As per the statutory guidance, the chair, author, and the review panel members are named, including their respective roles and the agencies which they represent. Agencies that provided information are also identified.

4. Terms of Reference

4.1 Following discussions at initial panel meetings the chair circulated the Terms of Reference (T0R), to the agencies that had contact with Angela and Fred. Details of the Terms of Reference are contained in Appendix 1. The review aims to identify learning from Angela's death and for actions to be taken in response of that learning with a view to preventing similar deaths and ensuring that individuals and families are supported in the future.

4.2 The review panel comprised of agencies from the North Lincolnshire Community Safety Partnership, as Angela lived in their area, at the time of her death. They were contacted as soon as possible after the review was established to inform them of the need to identify and secure records and for their participation within this process. Subsequently the panel was expanded to include members from the Lincolnshire CSP as Fred resided in that area during a period of this review time frame.

4.3 Key Lines of Enquiry: During the review the chair and panel have considered the 'generic issues' as set out in the generic guidance and those relevant to this case. Various discussions have led to the following case specific issues being agreed.

1. Links between Mental Health and DA
2. Access to DA services in a rural community
3. Were services coordinated including cross border services.

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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.

5. METHODOLOGY

5.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse. This review commenced after the Domestic Abuse Act receiving royal ascent in April 2021 and defines domestic abuse as:

- The Behaviour of a person (A) towards another person (B) if.

  I. A and B are each aged 16 or over and are personally connected to each other and.

  II. The behaviour is abusive.

- Behaviour is abusive if it consists of any of the following -

  1. physical or sexual abuse.
  2. violent or threatening behaviour.
  3. controlling or coercive behaviour.
  4. economic abuse (see subsection (4)).
  5. psychological, emotional, or other abuse.

It doesn't matter whether the behaviour consists of a single incident or a course of conduct.

Two people are Personally Connected to each other if any of the following applies.

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated).
4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).

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5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2).
7. They are relatives.

It is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse, psychological, physical, sexual, financial and emotional.

5.2 Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

5.3 Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

5.4 This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation and forced marriage and is clear that victims are confined to one gender or ethnic group.[1]

5.5 This review has followed the statutory guidance. On notification of the death, agencies were asked to check for their involvement with any of the parties concerned and secure their records. It was during this scoping process that chronologies were collated and combined. This document was reviewed by the chair, then Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Angela, were requested.

5.6 Document Reviewed

In addition to the combined chronology and IMR's, various documents and open-source research has been carried out including:

[1] https://www.gov.uk/government/news/new-definition-of-domestic-violence

- Website for commissioned service for domestic abuse support.
- Home Office Documents referring to key Findings from analysis of previous DHR's.
- Citizens Advice document regarding "What is Public Sector Equality Duty".
- NL CSP website – Domestic Homicide Reviews (last one published 2014).
- Lincolnshire CSP website – Domestic Homicide Reviews.
- The Cochrane Report – Screening Women for Inter-partner violence in Healthcare Settings
- The Royal College of Nursing – Roles and Responsibilities of Health care staff.
- The National Rural Crime Network report "captive and controlled"

5.7 Panel Meetings

Review Panel meetings took place on the 20th of November 2023, 5th of February 2024, 6th of June 2024 and the 21sth of October 2024. The chair held several individual agency discussions with panel representatives, and authors to seek clarification on points within agency IMR's and review Key Lines of Enquiry.

6. Involvement of Family, Friends, Work Colleagues, Neighbours, and Community

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. Full details of contact between the chair and family are at Appendix 2.

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

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chair has raised this with the CSP who have provided an explanation at paragraph 17.5 and 17.6 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/

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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 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.

6.15 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

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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.

6.16 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. A copy of the report was subsequently supplied to Edith.

7. Contributors to the Review

7.1 The following agencies and their contributions to this review are:

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

7.2 Quality and Independence of the IMR authors. The IMR's were prepared by authors who were independent of any service delivery or case management regarding Angela and Fred. The IMR's were comprehensive and allowed the panel to analyse the contact with Angela & Fred. The detail ensured that the panel were able to identify learning and recommendations for this review and where necessary, follow-up meetings were held, and questions sent to agencies. Responses were received, prior to, or at, subsequent panel meetings.

8 Review Panel Members

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

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Kathy Cairns	Violence Reduction Officer	North Lincolnshire Council
Tracey Coyne	Community Safety Partnership Manager	North Lincolnshire Council

9 AUTHOR OF THE OVERVIEW REPORT

9.1 Simon Steel was appointed by the North Lincolnshire Community Safety Partnership as the Independent Chair and Author of this Domestic Homicide Review panel. Simon is a retired Thames Valley Police senior Detective. He has considerable experience in the field of Domestic Abuse, Public Protection and Safeguarding. His experience includes specialist, strategic and generic investigative roles across the Thames Valley. He has also led complex Domestic Homicide Investigations.

9.2 Since retirement, Simon has established his own consultancy business and has now chaired multiple Domestic Homicide Reviews.

9.3 Simon also has worked as the Head of Adult Support for an Autism Charity within the voluntary sector who are commissioned by Local Authorities and Integrated Care Boards (ICB). Simon also worked as a Learning Disability and Autism Champion for an ICB. Simon believes his work alongside statutory, non-statutory and voluntary sector organisations provides him an enhancement to his policing portfolio.

9.4 Simon has completed Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse in 2022. Simon has also completed the newly commissioned Home Office training facilitated by AAFDA in August 2024.

9.5 Simon has no connection with North Lincolnshire Community Safety Partnership.

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10 PARALLEL REVIEWS

10.1 Criminal Trial: 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.

11 Equality and Diversity

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11.1 The review panel considered all 9 protected characteristics under the Equality Act 2018 i.e.

- Age
- Disability
- Gender Assignment,
- Marriage and Civil Partnership.
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation.

11.2 The panel reflected upon each of these in evaluating the various services provided to Angela. It is incumbent on this review to consider the duty on public authorities to; [2] remove or reduce disadvantages suffered by people because of a protected characteristic, meet the needs of people with protected characteristics, encourage people with protected characteristics to participate in public life and other activities.

11.3 Each protected characteristic was analysed by both individual agencies and the panel, against policies and procedures that were in place at the time of the death of Angela.

11.4 The protected characteristic that the panel agree was pertinent to this review was to examine the circumstances through the lenses of sex.

11.5 Sex: The panel identifies that women and girls are disproportionally impacted by domestic abuse and forms of gender-based abuse, whilst also recognising that other genders also suffer similar issues of violence and abuse. Analysis[3] reveals gendered

[2] https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/

[3] Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk)

victimization across both intimate partner and familial homicides with females representing most victims and males representing most perpetrators.

11.6 Angela was female, and Fred is male. The gendered nature of domestic abuse is reflected in a number of reports and also by specialist organisations. An analysis[4] of DHRs reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators. Women's aid reports[5], "There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2020A; ONS, 2020B)."

11.7 It is against the background of concerns raised in such reports, that the review will consider the circumstances of Angela's death.

12. Dissemination

12.1 Once finalised by the Review panel the Executive Summary and Overview Report will be presented to the following CSP panel members for approval. Upon approval they will be sent to the Home Office for Quality Assurance.

12.2 The recommendations will be owned by North Lincolnshire Community Safety Partnership who will be responsible for disseminating learning through local professional networks as well as managing progress of the Action Plan which is created at the conclusion of this review and in response to the recommendations that have been made. The North Lincolnshire Community Safety Partnership will be responsible for engaging with the Safer Lincolnshire Partnership to ensure any recommendations for their area of responsibility are actioned.

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[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

[5] Domestic abuse is a gendered crime - Womens Aid

12.3 The following individuals and agencies have been identified as recipients of these reports.

Agency
North Lincolnshire CSP
North Lincolnshire Safeguarding Adults board
North Lincolnshire Health and Wellbeing board
North Lincolnshire CSP DHR Recommendations Working Group
North Lincolnshire Children's Safeguarding Board
North Lincolnshire Domestic Abuse Partnership Board
NHS Humberside & North Yorkshire ICB
Humberside Police & Crime Commissioner (PCC)
Lincolnshire CSP
Lincolnshire Safeguarding Adults board
Lincolnshire Health and Wellbeing board
Lincolnshire CSP DHR Recommendations Working Group
Lincolnshire Children's Safeguarding Board
All Panel Members
The Domestic Abuse Commissioner

12.4 The report will be published online, on the North Lincolnshire CSP website.

13 Background Information (The Facts)

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13.1 At the time of her death Angela was a 39-year-old woman living in the North Lincolnshire CSP area.

The Death

13.2 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.

13.3 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.

13.4 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.

14 Combined Narrative Chronology

14.1 The following section summarises contact between Angela, Fred and various agencies in the TOR timeframe leading up to Angela's death. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are pre-faced with the lead agency to identify the source of information and assist the reader. The review period starts in January 2018 when the perpetrator left his previous partner and continued to abuse her post separation. This is done to better understand the events leading up to Angela's death.

Organisation	Role	Pre-Face
GP service	Primary Care	GP
Lincolnshire Children's Services	Children's Services	LCS

14.2 January 2018

14.2.1 **LCS.** During this month Fred leaves a home he had established with Sonia.

14.3 March 2018

14.3.1 **LCS.** During this month 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.

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14.4 MARCH 2018

14.4.1 **LCS.** During a Team around the child (TAC) Meeting Sonia shared incidents that had occurred with Fred including being verbally aggressive towards her and also trying to force himself on her by pinning her to the bed whilst touching her sexually. A MARAC referral was made (held May 2018). Work with the family continued until February 2019 when the case was closed to children's services.

14.5 JULY 2018

14.5.1 **GP.** Fred requested support for PTSD and a referral was made.

14.6 AUGUST 2018

14.6.1 **GP.** Fred did not attend his Improving Access to Psychological Therapies (IAPT) therapy appointment.

14.7 DECEMBER 2019

14.7.1 **GP.** Angela is seen for a smear test.

14.8 NOVEMBER 2020

14.8.1 **GP.** Angela is seen for a smear test follow up.

15. OVERVIEWS

This section summarises what information was known to each agency, and the professionals involved, within the review period. Any other relevant facts or information is also included in this section.

15.1 LINCOLNSHIRE CHILDRENS SERVICES (LCS)

15.1.1 In preparation for this DHR, the author has reviewed and analysed records (Mosaic) related to the service provision for the perpetrator Fred and family who received a service from Children's Services. The author of the IMR is a qualified Social Worker and is employed as a Head of Service in Lincolnshire County Council. They are able to confirm that they have not had any involvement or supervisory responsibility for anyone involved in this case. They were able to confirm they had not been involved with Angela or her family.

15.2 INTEGRATED CARE BOARD FOR GP SURGERY

15.2.1 Angela had been registered with the same GP practice from 2009 until her death. Fred had been registered with the same GP practice since 2015. There were minimal interactions with GP services for both Angela and Fred.

15.3 END DOMESTIC ABUSE NOW (EDAN LINCS)

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15.3.1 EDAN Lincs are the commissioned service for Lincolnshire. They are a DA charity formally known as West Lincolnshire Domestic Abuse Service (WLDAS). An Individual Domestic Violence Advocate (IDVA) Service and Outreach service are provided. They do not work, support, or engage with named perpetrators on referrals to the Domestic abuse service, nor do IDVA's who work within the MARAC arena. Therefore, as an agency they had no involvement with Fred other than being recorded on the organisations internal systems as a named perpetrator to a different female victim (Sonia) who was supported by EDAN Lincs. The time period of involvement with Sonia was 8 months.

15.4 HUMBERSIDE POLICE

15.4.1 Humberside Police have reviewed all contacts with Angela and Fred. Research has been conducted of the NICHE Crime and Intelligence Database and there were no previous contacts prior to Anglela's murder.

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16. ANALYSIS

HINDSIGHT BIAS

16.1 As the report author, the chair has attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias's and evaluating the quality of a decision when its outcome is already known. However, I have made every effort to avoid such an approach wherever possible.

16.2 The analysis of the combined chronology, IMR's and discussions with panel members and IMR authors revealed themes that are further explored within the individual agency analysis that follows.

16.3 DOMESTIC ABUSE

Pattern of Abuse

16.3.1 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was able to determine there was not a history of reported Domestic Abuse in Angela's relationship with Fred. This conclusion is based on all the information provided. However, the panel are mindful of the information provided by Janet and the controlling behaviour that Fred showed towards Angela. The panel also considered the information in regard to the relationship with Sonia which quite clearly shows Fred as a perpetrator of Domestic Abuse.

AGENCY INVOLVEMENT

16.4 LINCOLNSHIRE CHILDRENS SERVICES (LCS)

16.4.1 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.

16.4.2 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.*

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16.4.3 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 ".*

16.4.4 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.

16.4.5 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.

16.4.6 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.

16.4.7 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.*

16.4.8 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

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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.

16.4.9 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.

16.4.10 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.

16.4.11 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.

16.4.12 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.

16.4.13 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.

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16.4.14 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[6] is now recognised in law and practice, with the seriousness[7] of such incidents being recognised and risks associated with this.

16.4.15 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.

Learning Consideration: LCS – To recognise that mental health challenges for perpetrators are a risk factor in DA.

16.5 Integrated Care Board for GP Surgery

16.5.1 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.

16.5.2 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.

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[6] New non-fatal strangulation offence comes into force - GOV.UK (www.gov.uk)

[7] IFAS - Institute for Addressing Strangulation

16.6 END DOMESTIC ABUSE NOW (EDAN LINCS)

16.6.1 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

16.6.2 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.

16.7 HUMBERSIDE POLICE

16.7.1 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.

16.7.2 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

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people in the pub told him to leave around 2100 hours. He was seen heading towards another pub.

16.7.3 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.

Key Lines of Enquiry

16.8 **KLE1**- Links between Mental health and DA.

16.8.1 Mental health is regarded as a risk factor in perpetrators of DA by the College of Policing (COP) approved professional practice (APP)[8]. Safelives report on the impact of mental health on response to perpetrators of DA[9]. "*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?"*

16.8.2 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.

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.

16.9 **KLE2**- Access to DA services in a rural community

16.9.1 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

[8] Understanding risk and vulnerability in the context of domestic abuse | College of Policing

[9] Impact of mental health on the response to perpetrators - SafeLives

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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[10] 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.

16.10 **KLE3**- Were services coordinated, including cross border services.

16.10.1 KLE5 discusses MARAC and recording. However, there is no evidence outside of KLE5 presented to the review that identifies cross border being relevant in this review.

16.11 **KLE4**-Was COVID 19 a factor regarding access to services and were service changes communicated effectively.

16.11.1 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.

16.12 **KLE5**- Multi Agency Risk Assessment Conference (MARAC) was it utilised correctly.

16.12.1 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

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

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grabbed Sonia around the throat on a number of occasions and attempted to strangle Sonia. The minutes show there has been witnesses to this.

16.12.2 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.

16.12.3 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.

16.12.4 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[11] 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)[12] 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.*

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[11] DVDS guidance (accessible) - GOV.UK

[12] Investigative development | College of Policing

16.12.5 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.

16.12.6 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.

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.

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.

16.12.7 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 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.

16.12.8 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.

16.12.9 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.

16.12.10 Within the same COP article at 16.8.1 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.

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.

16.12.11 Again within the COP article at 16.8.1 strangulation is recognised as a risk factor in perpetrators of domestic abuse. The offence of non-fatal strangulation[13] 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.

16.12.12 In a recent publication the institute for addressing strangulation[14] 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*

[13] New non-fatal strangulation offence comes into force - GOV.UK (www.gov.uk)

[14] https://ifas.org.uk/wp-content/uploads/2024/09/Guidance-for-Police-Management-of-Strangulation- final-September-2024.pdf

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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.

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.

17. Conclusions

17.1 Angela's death was a tragedy and has affected her family deeply.

17.2 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.

17.3 Review Panel would like to extend their sympathies to all those affected by Angela's death.

Lesson Learnt

17.4 The review identified several learning points that build upon agency IMRs. However, if an agency has already introduced the learning into their practices as a result of the review process, then the need to include a formal recommendation in this review isn't deemed to be necessary.

17.5 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.

17.6 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.

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17.7 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.

The themes identified are:

Links between mental health and DA.
Links between Alcohol misuse and DA.
Links between non-fatal strangulation and DA.

18. Recommendations

National

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.

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.

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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.

APPENDIX 1
Terms of Reference

Terms of Reference

Domestic Homicide Review

1 Commissioner of the Domestic Homicide Review

1.1 The chair of the North Lincolnshire Community Safety Partnership has commissioned this review, following notification of the death Angela.

1.2 All other responsibility relating to the review, namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Review Panel.

1.3 The resources required for completing this review will be secured by the independent chair commissioned by the North Lincolnshire Community Safety Partnership.

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2 Aims of Domestic Homicide Review Process

2.1 Establish what lessons are to be learned from this domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard people in similar circumstances.

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies.
  - the observations (and any actions) of relatives, friends, and workplace colleagues relevant to the review.
- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

3 Timescale

3.1 Aim to complete a final overview report by July 24 acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair.

4 Scope of the review

4.1 To review events up to these domestic abuse related deaths. This is to include any information known about their previous relationships where domestic abuse is understood to have occurred.

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4.2 Events should be reviewed by all agencies from 01 June 2018. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

4.8 Review relevant research and previous domestic homicide reviews (including those in North Lincolnshire) to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar homicides occurring in future.

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5 Key Lines of Enquiry

5.1 The following themes have been prepared by the chair and discussed with the panel. Their purpose is to focus the review upon areas of learning and opportunities to improve service. They have been reviewed and discussed at various stages of this review.

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

6 Role of the Independent Chair

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. *(Consider Home Office leaflet for family members, plus statutory guidance (section 6))*
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that reviews incorporate suggested the outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP

7 Domestic Homicide Review Panel

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7.1 Membership of the panel will comprise:

7.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website *before* joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

8 Liaison with Media

8.1 North Lincolnshire Community Safety Partnership will handle any media interest in this case.

8.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

8.3 **Confidentiality**

All panel members are bound by the agreed confidentiality agreement.

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APPENDIX 2

Glossary of Terms

Adult Social Care	ASC
Community Mental Health Team	CMHT
Community Safety Partnership	CSP
Domestic Homicide Review	DHR
Domestic Abuse Stalking & Harassment	DASH
General Practitioner	GP
Individual Management Reviews	IMR

Mental Health Social Care Team	MHSCT
Multi-Agency Risk Assessment Conference	MARAC
Multi Agency Safeguarding Hub	MASH
Police National Database	PND

APPENDIX 3

Family Contact

When and by whom	Who to	Method
18/10/23 Chair	VS	EMAIL/TELEPHONE
30/10/23 Chair	EDITH	TELEPHONE/Emails
10/11/23 Chair	Edith	CSP letter email
17/11/23 Edith	Chair	Telephone- re CSP Letter
22/11/23 Chair	Edith	Chair – Update panel
23/11/23 Edith	Chair	Reply to previous
3/1/24 Chair	EDITH	Emails
14/1/24 Chair	EDITH	Emails
18/1/24 Chair	EDITH	In person visit
25/3/24 Chair	EDITH	Emails
2/4/24 Chair	Best Friend	Emails
2/4/24 Chair	Brother	Emails
3/4/24 Chair	Best Friend	Telephone Call

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26/6/24 EDITH	Chair	Emails
30/6/24 Chair	EDITH	Emails
18/7/24 Chair	EDITH	Emails
26/7/24 Chair	EDITH	In person visit
29/7/24 Brother	Chair	Emails
2/8/24 Chair	EDITH	Emails
5/8/24 Chair	Brother	Telephone call
5/8/24 Chair	EDITH	Emails
9/8/24 Chair	EDITH	Emails
5/9/24 Chair	EDITH	Emails
7/9/24 Chair	EDITH & Rachel	In person visit
13/9/24 Chair	EDITH	Emails
1/10/24 Edith	Chair	Emails reply 2/10/24
10/10/24 Chair	Edith	Emails
23/10/24 Chair	Sonia & EDAN	Virtual
23/10/24 Chair	Edith	Emails
3/11/24 Chair	Best Friend	Emails
5/11/24 Chair	Best Friend	Telephone calls
7/11/24 Edith	Chair	Emails
13-18/11/24 Chair	Edith	Emails
16/11/24 Chair	Edith	In person visit

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