NORFOLK COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Lynne
in June 2020

Report Author: Christine Graham
March 2023

Contents

1 The Review Process

1.1 This summary outlines the process undertaken by Norfolk's Community Safety Partnership domestic homicide review panel in reviewing the murder of 'Lynne' who was a resident within their area.

1.2 The pseudonym of Lynne has been used in this review for the victim. The perpetrator will be known only as 'the perpetrator' to protect their identities and those of their family members. A number of children are referenced within this review, they are identified by way of numeration in order to further protect their identities.

1.3 Criminal proceedings were completed in December 2020 when the perpetrator was convicted of Lynne's murder. He was sentenced to life imprisonment, to serve a minimum of 23 years before he can begin to be considered for parole.

1.4 The process of review began with an initial meeting of the Community Partnership's 'Gold Group' on 14th July 2020 when the decision to hold a domestic homicide review was agreed. All agencies that had potentially had contact with Lynne, the perpetrator and their children prior to her murder were scoped for previous contact.

1.5 A total of ten agencies confirmed prior relevant contact and were asked to secure files.

2 Contributors to the Review

2.1 Individual Management Reports were requested from:

- Broadland and South Norfolk Borough Council
- Cambridgeshire Community Services (provider of health visiting services)
- Community Rehabilitation Company
- Norfolk County Council – Children's Social Care
- Norfolk County Council – Education
- GP for Lynne
- GP for perpetrator
- Leeway
- National Probation Service
- Norfolk Constabulary

2.2 The independence of IMR authors was confirmed by the Chair through the process of review. None of the IMR authors, the Independent Chair or Author had any prior involvement with the victim or the perpetrator.

2.3 Lynne's family engaged throughout the Review and the officers from the Review also spoke with a number of her friends. The review was assisted greatly by a surviving ex-partner of the perpetrator. The perpetrator declined to engage with the Review process.

3 Review Panel

3.1 The DHR Review Panel comprised the following members:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Sandra Thornley	Housing and Benefits Manager	Broadland and South Norfolk Council
Name not included to protect anonymity	Practice Manager and GP	GP Practice for Lynne and perpetrator
Margaret Hill	Community Services Manager	Leeway Domestic Violence and Abuse Services
Kim Goodby	Associate Director of Complex Health and Safeguarding	Norfolk and Norwich University Hospital
Saranna Burgess	Deputy Director for Patient Safety and Quality	Norfolk and Suffolk Foundation Trust
Gary Woodward	Adult Safeguarding Lead Nurse	Norfolk and Waveney Integrated Care Board
Lisa Gair	Deputy Designated Nurse Safeguarding Children	Norfolk and Waveney Integrated Care Board
Liam Bannon	Community Safety Officer	Norfolk Community Safety Partnership
Lewis Craske	Detective Inspector	Norfolk Constabulary
Pippa Hinds	Detective Chief Inspector	Norfolk Constabulary
Laura Stevenson	Detective Sergeant	Norfolk Constabulary
Tabatha Breame	Domestic Abuse Change Co-ordinator	Norfolk County Council
Walter Lloyd-Smith	Business Lead for Norfolk Safeguarding Adults Board	Norfolk County Council
Claire Farrelly	Advisor - Safeguarding - Education Quality Assurance & Intervention Service	Norfolk County Council – Learning and Inclusion Service
Sarah Adams	Head of Social Work, North Norfolk and Broadland	Norfolk County Council – Children's Services
John Lee	Service Manager	Norwich Connect
Amanda Murr	Head of Community Safety and Violence Reduction Coordination	Norfolk Community Safety Partnership Office of the Police and Crime Commissioner for Norfolk
Helen Johns	Communications Manager	Office of the Police and Crime Commissioner for Norfolk
Paul Reeve	Deputy Director	Probation Service (formerly Community Rehabilitation Company)
Leon McLoughlin-Smith	Co-Head of Norfolk and Suffolk NPS	Probation Service (formerly National Probation Service)

3.2 The review panel met five times and the review was completed in March 2023. The independence of all review panel members was established by the Chair as part of the review process.

4 Domestic Homicide Review Chair and Report Author

4.1 The Independent Chair for this Review was Mr Gary Goose MBE. Gary served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high- profile investigations, he led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. Since that time he has been involved full-time as a safeguarding review author.

4.2 The Independent Author for this review was Christine Graham. Christine worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

4.3 Christine and Gary have extensive experience as Chair and Author on multiple DHRs. Their training is detailed within the Overview Report for this Review.

4.4 Neither Christine nor Gary are connected to any agency involved with this Review and have no connection to the Community Safety Partnership, save for other DHRs in the area.

5 Terms of Reference for the Review

5.1 The full terms of reference for this Review are appended to the Overview Report. Given the circumstances that emerged in this case the Review sought to specifically focus upon the following areas:

- Factors affecting offenders who perpetrate acts of abuse on multiple partners,
- To review how much information was known by agencies of the perpetrator's past and how much remained hidden,
- To consider in particular any additional pressures placed upon relationships by the creation of a 'blended family'.

6 Summary Chronology

6.1 Lynne and the man responsible for her murder had been in a relationship since around 2014. For the purposes of this review, he will be known only as 'the perpetrator'. They had met after he had moved to Norfolk from the north of England, with his children. Upon relocation, his children attended the same school as Lynne's and the couple met through their mutual attendance at the school.

6.2 Lynne and the perpetrator went on to have two further children together and married.

6.3 There is clear evidence of significant abuse developing within the relationship; Lynne first making a report to the police about an assault in 2016. Then, in 2020, after the police were initially approached by her mother, Lynne made a further report which catalogued multiple and consistent controlling and coercive behaviour by the perpetrator.

6.4 The perpetrator was arrested for these offences but neither resulted in prosecutions.

6.5 Lynne separated from him in the months prior to her death but the evidence before this review is that out of fear, and as a way of managing him to keep herself safe, Lynne allowed him back into her life.

6.6 On a morning in June 2020, Lynne had planned to take the children to the beach and went to the perpetrator's home to collect one of the children who had stayed there overnight. When she arrived, with one of her other children in the car, it is described that he rushed out and took the child from the car into the house to be with his other children. He then 'jumped into the car' and ordered Lynne to drive to a local coffee shop. He is believed to have had two knives concealed on his body at the time he got back into the car. After buying their coffee he took her inside a nearby disused building and the perpetrator has subsequently said that it was his intention was to have sex with her. There he murdered her. He stabbed Lynne numerous times and made his escape when staff from a nearby hospital heard Lynne's screams and went to investigate.

6.7 As a result, Norfolk Constabulary received a call from the East of England Ambulance Service to report a woman in cardiac arrest. They then went on to say that she had been stabbed. Lynne died at the scene.

6.8 Having left the site, the perpetrator telephoned one of his children to bring his coat to him. He got into the car. The perpetrator drove home where he cleaned himself and took the children away in the car.

6.9 At just after 2.30pm the same day the police received a call from a woman who was an ex-partner of the perpetrator, she will be known for the purposes of this review as ex-partner 1. She reported that the perpetrator had called her asking her to go to an address in Stoke on Trent saying that there had been an incident between himself and Lynne at their home address. He told her that he had 'fucked up' and that he thought that 'he may have stabbed her to death'.

6.10 The perpetrator had driven away from Norfolk and was located at Cawley Services in Warwickshire with three of his children. He was arrested and the children were taken into

police protection. He was brought back to Norfolk and interviewed. He was subsequently charged with Lynne's murder.

6.11 The post-mortem concluded that Lynne had been stabbed more than twenty times which had been focused on her neck and chest (both front and back) and force towards the severe end of the spectrum had been used. No alcohol, medications, or drugs were found in Lynne's system. Lynne had cuts on her right hand which may have been defence wounds. The cause of death was given as hypovolaemic shock[1] and stab wounds to the neck and chest.

6.12 The subsequent murder enquiry revealed a history of violent, controlling, and coercive behaviour by this perpetrator to multiple previous partners. The trail of abuse uncovered by the murder enquiry has built upon by this review.

6.13 In December 2020 the perpetrator was found guilty of Lynne's murder and was sentenced to a life sentence with a minimum term of 23 years before he can be considered for release.

7 Key issues arising from the Review

7.1 This review has sought to identify any trail of abuse that existed within the relationship between Lynne and the perpetrator. It has also looked at the perpetrator's past history of behaviour. The evidence is clear, this is a man who is a serial abuser of women.

7.2 The Overview Report for this case details the various types of abuse this perpetrator was responsible for with all his previous partners, and Lynne. He was not only violent, he was controlling and manipulative. There is also evidence of financial abuse, isolation, stalking, and threats to kill.

7.3 His control and manipulation also spread to professionals who were required to engage with the family, so concerned were some that they recorded the fact that staff should not attend alone. This level of concern was not shared across the safeguarding network.

7.4 After establishing the facts of the case, the review sought to look at two main areas:

- One was the efforts to safeguard Lynne after she had made reports of his abusive behaviour, together with any barriers she may have faced in attempting to sever the relationship. Whilst it is clear that much work was done to safeguard her, there was a misplaced belief that she was safe because she had separated from him and thus the risk was reduced. It is clear that risk actually **increases** at the time of separation and when the conditions that assisted her in separating were eroded (bail conditions were removed) it seems that her only way of 'managing' him was to allow him back into her life.

- The second was to establish why the true risk posed by this perpetrator was not fully identified, including reviewing whether organisations should have known more about his history of behaviour. It is a fact that this man's previous convictions were no way representative of the true risk that he presented. The police murder investigation

[1] Hypovolemic shock is an emergency condition in which severe blood or other fluid loss makes the heart unable to pump enough blood to the body. This type of shock can cause many organs to stop working

identified the true nature of this man. Whilst much of his previous behaviour had never been reported to any organisation, it was the case that one of his ex-partners was anxious to ensure the authorities did know about him as he had care of their children. A combination of practice at the time (since changed) of not speaking with ex-partners at times of crisis and a belief that the law prevented some deeper level of enquiry contributed to that information not becoming known to agencies in Norfolk.

8 Lessons Identified

8.1 **BROADLAND AND SOUTH NORFOLK COUNCIL**

8.1.1 Lynne had to be moved from one temporary accommodation to another due to the impact of COVID-19 on the service. As Lynne was not happy with the second offer, she returned to stay with her mother. This did not, however, impact on an offer of a house being made to Lynne.

8.2 **CAMBRIDGESHIRE COMMUNIITY SERVICES (Children and Young People's Health Services – Norfolk Healthy Child Programme (NHCP) 0-19 years**

8.2.1 Coercive control and domestic abuse is challenging for professionals to identify and quantify the impact of this on children, victim and professional response.

8.2.2 Manipulation by perpetrators – challenge of working with hostile and violent males and the impact of this on decision making, interactions in the home and professional decision making about risk to children and adults.

8.2.3 Professionals need to take responsibility for participation in multi-agency assessment & intervention, inclusive of the need to escalate concerns, seek information sharing when assessments have been completed and be proactive in their response to new information received related to domestic abuse.

8.2.4 The need to triangulate information with other professionals within CCS & wider safeguarding partners to inform analysis and risk when there are domestic abuse concerns.

8.2.5 Professional access to information is imperative when domestic abuse is a concern.

8.2.6 When a multi-agency decision has been taken to safeguard staff (i.e. that professionals should not attend alone) it is imperative that this is followed by all staff.

8.3 **NORFOLK COUNTY COUNCIL - CHILDREN'S SOCIAL CARE**

8.3.1 Practitioners should ensure that the concerns of absent parents are considered where appropriate and assessed in the context of the all the information available. That concerted efforts are made to find those parents and given them the opportunity to share their views.

8.3.2 Challenging the perpetrator would have been more possible if All of the information available had been collated as part of a chronological building of information about the family.

8.4 **NORFOLK AND SUFFOLK COMMUNITY REHABILITATION COMPANY (NSCRC) NOW PROBATION SERVICE**

8.4.1 That a lack of professional curiosity, coupled with a lack of checks with social care and the police, can lead to incomplete information to inform risk assessments.

8.4.2 An offender who presents as compliant and completes their requirements can lead to indications of risk being missed

8.5 **DEPARTMENT OF WORK AND PENSIONS**

8.5.1 A light touch and understanding interaction with her work coach enabled Lynne to engage well with the service.

8.5.2 There was a lack of understanding about the domestic abuse easement in the department

8.6 **NORFOLK COUNTY COUNCIL – EDUCATION DEPARTMENT**

8.6.1 It is important that schools and colleges are included in multi-agency risk planning to support a shared understanding of risk.

8.6.2 The positive benefits of Operation Encompass were noted but the information contained in the reports can be confusing or limited.

8.6.3 Schools need to be supported where the thresholds for statutory intervention for children are not met or parents are unwilling to engage with voluntary services, but the children continue to experience the effects of domestic abuse.

8.6.4 A Critical Incident Notification System is in place in the event of a death of a child, but the system does not include serious incidents relating to parents and carers.

8.7 **NORFOLK CONSTABULARY**

8.7.1 Had regular contact been maintained with Lynne, and the IDVA had been made aware that she was planning to retract her statement, she may have been supported to continue with the action.

8.7.2 That research has shown that separation increases the risk to a victim of domestic abuse rather than reducing it.

8.7.3 That it is important that, as well as focusing on protecting victims, the actions of perpetrators are challenged.

9 Recommendations

9.1 **PROFESSIONAL CURIOSITY**

9.1.1 **Cambridgeshire Community Services**

9.1.1.1 That staff are supported to discuss healthy and unhealthy relationships with both parents/carers and to support their understanding of the impact of domestic abuse on children.

9.1.1.2 That staff are supported to discuss perpetrator manipulation on their day-to-day practice within supervision, team meetings and training.

9.1.1.3 That practitioners should, hear the child's voice and reflect their lived experience in cases where there are elements of coercive control and view the children as victims of domestic abuse.

9.1.2 **Norfolk and Waveney Integrated Care System (ICB)**

9.1.2.1 That the ICB works in partnership with specialist services to ensure the availability of domestic abuse training

9.1.2.2 That the ICB includes domestic abuse (identification/response etc) in the primary care adult safeguarding exemplar policy.

9.1.2.3 That the ICB supports practices to each establish a domestic abuse champion and ensure that a supportive network is created to maintain and develop this role.

9.1.3 **Norfolk County Council – Children's Social Care**

9.1.3.1 That CSC ensures that children are seen alone and potentially away from the home to gather their views and that there is a plan of action to achieve this.

9.1.3.2 That parents/carers that are potential victims of abuse are seen alone so that they can talk freely about their experience.

9.2 **INFORMATION SHARING AND FORA FOR DISCUSSION**

9.2.1 **Norfolk County Council – Education Department**

9.2.1.1 That schools and colleges are included in multi-agency risk planning.

9.2.1.2 That a single point of contact for Operation Encompass would be a beneficial further improvement.

9.2.1.3 That support for schools and colleges is developed where the content of reports is confusing and/or thresholds for statutory interventions for children are not met and parents are not willing to engage with voluntary services, but children continue to experience the devasting consequences of parental conflict and domestic abuse and violence

9.2.1.4 That a system is put in place to ensure that schools and colleges are involved in the immediate planning following include serious incidents such as murder of a parent or carer.

9.3 **COLLABORATIVE WORKING, DECISION-MAKING, AND PLANNING**

9.3.1 **All agencies**

9.3.1.1 That, as NIDAS develops, the comments made about MARAC within this report are part of the future planning of service delivery.

9.3.2 **Cambridgeshire Community Services**

9.3.2.1 That practitioners need to be able to demonstrate that they have contributed to the assessment process jointly with children services including the seeking of the outcome of assessments and challenging decision making when there is a professional disagreement.

9.3.3 **Norfolk and Waveney Integrated Care System**

9.3.3.1 That the ICS supports a primary care system wide review of health visitor/social worker escalation processes and establish effective protocols, as necessary.

9.3.3.2 That the ICS supports a primary care system wide review of responses to notifications of domestic abuse and high-risk concerns and establish effective protocols as necessary

9.3.4 **Norfolk Constabulary**

9.3.4.1 That when a victim indicates that they are considering withdrawing their statement the IDVA (where engaged in a case) is advised so that specific support can be provided.

9.4 **OWNERSHIP, ACCOUNTABILITY AND MANAGEMENT GRIP**

8.4.1. **Cambridgeshire Community Services**

8.4.1.1. It is recommended that a regular audit of domestic abuse cases is undertaken to evidence the use of the Pre-Birth Protocol/Joint Assessment of children and young people to ensure joint decision-making and understanding of the impact of domestic abuse on unborn babies, children and young people.

8.4.1.2. That HCP ensures that the identification of the pathway for care is reviewed as part of the ongoing service review.

8.4.1.3. That tools used to assist a child focus are revisited considering any published guidance alongside the Domestic Abuse Act 2021 which emphasises that children should be considered as victims of domestic abuse.

8.4.2 **Norfolk And Suffolk Community Rehabilitation Company (NSCRC) now Probation Service**

8.4.2.1 That all staff, including support staff and those responsible for supervising IP placements undertake domestic abuse training. The training should ensure that staff are fully trained and confident in their ability to identify any signs of domestic abuse, along with an understanding of how and where to share this information appropriately. This should be an ongoing process to ensure that all new staff receive training.

8.4.2.2 That the Probation Service reinforces the current requirement of UPW supervisors to update records, relating more specifically to what he/she did/said during sessions. This could significantly increase the quantity and quality of information known about individuals and

would be particularly beneficial with SA UPW cases, where contact with probation officers is often more limited. Probation managers should undertake case dip samples to ensure that records are made and appropriately detailed.

8.4.2.3 That regular and structured Planned Telephone Contacts be made until termination. This will ensure that the current situation and risk of serious harm be monitored accurately for the entire duration the cases are open.

8.4.3 **Norfolk County Council – Children's Social Care**

8.4.3.1 That policies and procedures are reviewed to ensure that absent parents are contacted when referrals are received, and they are given the opportunity to give their views.

8.4.4 **Department of Work and Pensions**

8.4.4.1 That staff are reminded about the domestic violence and abuse easements reminding them of the relevant guidance and implementation.

8.4.5 **Norfolk Constabulary**

8.4.5.1 That Norfolk Constabulary ensure that any significant changes in circumstances (such as a perpetrator being released from custody or bail conditions removed) lead to a review of the DARA risk assessment and further safeguarding actions.

8.4.5.2 That Norfolk Constabulary continues with the development of the Domestic Abuse Perpetrator Partnership Approach (DAPPA) that has now been established in the county.

10 Conclusions

10.1 This has been a particularly complex and traumatic case to review.

10.2 The victim in this case was murdered by a man who has shown himself to be manipulative, controlling, and violent in the extreme. His actions, and his actions alone have left a family devasted and children without their mother.

10.3 His history of behaviour towards previous partners is appalling to see within the pages of this report. This is another case where a person's conviction history does not represent the true risk they present.

10.4 This review has sought to identify his trail of abuse. It is clear that Lynne found out only too late the real risk that he presented.

10.5 It seems clear that Lynne, after making brave steps to rid herself of him, allowed him back into her life only out of fear, intimidation, and control and as a way of trying to manage him.

10.6 Services make efforts to protect Lynne, but it seems likely she felt that despite those efforts, in particular after she had taken the steps to report her concerns and protective measures had been put in place and they appear to have had little impact, that she could not be protected and thus set about trying to manage him herself.

10.7 The review identifies once again that the point of separation is when victims are at their most vulnerable. All those charged in the safeguarding process need this point uppermost in the delivery of their services.

10.8 The review has also sought to understand why a man with so much previous history was able to move between areas with so little of that apparently coming to light.

10.9 We make a number of recommendations that we believe will help make the future safer for others.