Domestic Homicide Review Report

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

Format of the Report

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Domestic Homicide Review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case, **including a chronology** to assist the reader in understanding how events unfolded that led to Lynne's death.

Section 3 will provide **overview and analysis of the information** known to statutory and voluntary organisations who held relevant information.

Section 4 will look at the information shared with the review by **Lynne's family and friends.** This section will specifically address the issue of identifying any **domestic abuse** that existed within the couple's relationship and in the perpetrator's previous relationships.

Section 5 will explore the issues relating to **the perpetrator.**

Section 6 looks at the measures in place to **safeguard Lynne.**

Section 7 and 8 draws together the **lessons learned and the recommendations** that arose.

Section 9 draws **conclusion** debated by the Review Panel.

Appendix One provides the **terms of reference** against which the Review Panel operated.

Appendix Two lists the **ongoing professional development** of the Chair and Report Author.

Where the review has identified an opportunity to intervene, this has been noted in a text box. Examples of good practice are in italics.

Preface

Norfolk's Community Safety Partnership and the Review Panel wish at the outset to express their deepest sympathy to Lynne's family and friends. This review has been undertaken in order that lessons can be learned; we appreciate the support and challenge from her family, friends and others throughout the process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this murder in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by Norfolk's Community Safety Partnership on receiving notification of the death of Lynne in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

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Section One – Introduction

1.1 Summary of Circumstances leading to the Review

1.1.1 This report of a domestic homicide review examines agency responses and support given to Lynne, a resident of the Norfolk Community Safety Partnership area prior to her murder in June 2020.

1.1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the murder, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to making the future safer for others.

1.1.3 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.

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

1.1.5 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.

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

1.1.7 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.

1.1.8 On a morning in June, 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.

1.1.9 As a result, at 12.44 pm 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, being declared deceased at 1.04 pm.

1.1.10 Having left the site, the perpetrator telephoned one of his children and asked them 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.

1.1.11 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 his ex-partner. 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'.

1.1.12 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.

1.1.13 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.

1.1.14 The subsequent murder enquiry revealed a history of violent, controlling, and coercive behaviour by this perpetrator to multiple previous partners.

1.1.15 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.

1.1.16 This review has sought to identify any trail of abuse within the relationship between Lynne and the perpetrator. It has also looked at his prior behaviour and abuse towards previous partners and why the real risk that he presented to Lynne was not identified.

1.1.17 The review has sought to look at what can be learned and what can be done to better protect others in the future. However, through all of that, it must be remembered that only one person is responsible for Lynne's death; that is this man who has been shown to be violent, manipulative, and controlling.

1.1.18 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed by domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand what happened in each case, and most importantly, what needs to change in order to reduce the risk of such incidents happening in the future.

[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

1.2 Reasons for conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, the perpetrator has been found guilty of murdering Lynne, his wife. Therefore, the criteria have been met.

1.2.4 The purpose of the Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.3 Methodology and Timescale for the Review

1.3.1 Norfolk County Community Safety Partnership was advised of the death by Norfolk Constabulary on 20th June 2020. This was a timely referral and demonstrates a good understanding by the police of the need for the referral to be made at the earliest opportunity.

1.3.2 In response to the notification, a gold meeting of the partnership was held on 14th July 2020. This meeting was chaired by the Chair of the Community Safety Partnership. At this meeting, the police provided a summary of the incident, and those partners present shared the initial information that they held in relation to Lynne and the perpetrator.

1.3.3 Having heard the contributions from the partners present, the Chair took the decision to hold the Domestic Homicide Review because it was clear that, given the information available at the time, there would be learning from this case. The Home Office was advised of the decision to hold a review on 20th July 2020. This decision demonstrates a good understanding by the partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

1.3.4 Gary Goose (Chair) and Christine Graham (Report Author) were appointed in July 2020 to undertake the review. Prior to the first meeting, The Chair and Report Author met with the police's senior investigating officer (SIO) to ensure that Section 9 of the statutory guidance was adhered to in relation to disclosure and criminal proceedings.

1.3.5 The Review Panel met for the first time on 18th September 2020 on Microsoft Teams. The following agencies were represented at the meeting:

- Broadland and South Norfolk Council
- GP practice for Lynne and perpetrator
- Leeway – specialist domestic abuse services
- Norfolk Adult Safeguarding Board
- Norfolk and Norwich University Hospital
- Norfolk and Suffolk Foundation Trust
- Norfolk and Waveney Clinical Commissioning Group[2]
- Norfolk Constabulary
- Norfolk County Council – Children's Social Care
- Norwich Connect -specialist domestic abuse services
- Office of Police and Crime Commissioner for Norfolk

1.3.6 At this meeting, the purpose of a Domestic Homicide Review was explained to the Panel and the Chair stressed that the purpose of the review is not to blame agencies or individuals but to look at what lessons can be learned for the future.

1.3.7 It was agreed that, due to the pending criminal proceedings, the review would continue in limited scope and that agencies would provide chronologies initially.

1.3.8 Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 2018 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.3.9 The Terms of Reference were agreed subject to the family being consulted.

1.3.10 The trial was held in December 2020 and Individual Management Reports were then requested from:

- Broadland and South Norfolk Borough Council
- Cambridgeshire Community Services (provider of health visiting services)

[2] Now Norfolk and Waveney Integrated Care System

- 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

1.3.11 The Review Panel met five times and the review was completed in March 2023.

1.3.12 It has not been able to complete the review within six months due to the delay whilst wating the outcome of the trial, the complexity of the information across a number of areas and the time allowed to include Lynne's family within the review which was delayed due to the COVID 19 lockdown.

1.4 Confidentiality

1.4.1 The contents and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved by the Home Office Quality Assurance Panel for publication.

1.4.2 To protect the anonymity of the deceased, their family and friends, the victim will be known, in the report, by the pseudonym, Lynne.

1.4.3 The children will be known as Child 1, Child 2, Child 3, Child 4, Child 5 and Child 6. This is to protect the identity of the children by not disclosing their gender.

1.4.4 As requested by Lynne's family, the person responsible for Lynne's murder will be known as the perpetrator.

1.5 Terms of Reference

1.5.1 This review set out to:

1.5.2 Consider in particular the factors affecting offenders who perpetrate acts of abuse on multiple partners

1.5.3 To review how much information was known by agencies of the perpetrator's past

1.5.4 To consider in particular any additional pressures placed upon relationships by the creation of a blended family.

1.5.5 The full Terms of Reference are available at Appendix One.

1.6 Dissemination

1.6.1 The following individuals/organisations will receive copies of this report:

- Lynne's family
- Norfolk Police and Crime Commissioner
- Statutory partners of the Community Safety Partnership
- Norfolk's Public Protection Forum[3]
- Senior Coroner for Norfolk

1.7 Contributors to the Review

1.7.1 Those contributing to the DHR do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of the person or body participating in the review to have regard for the guidance.

1.7.2 All Review Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the Panel or meeting for an interview.

1.7.4 The following agencies contributed to the Review:

- Broadland and South Norfolk Council - Panel member and IMR
- Department of Work and Pensions – Panel member and IMR
- GP for Lynne and perpetrator- Panel member and IMR
- Leeway – specialist domestic abuse services – Panel member and IMR
- Norfolk Adult Safeguarding Board – Panel member
- Norfolk and Norwich University Hospital – Panel member
- Norfolk and Suffolk Foundation Trust – Panel member
- Norfolk and Waveney Clinical Commissioning Group[4] -Panel member
- Norfolk Constabulary – Panel member and IMR
- Norfolk County Council – Children's Social Care – Panel member and IMR
- Norwich Connect -specialist domestic abuse services -Panel member
- Office of Police and Crime Commissioner for Norfolk – Panel member

1.7.5 The following individuals contributed to the review:

- Lynne's family
- Lynne's close friend
- Lynne's work friends

[3] This includes all Chairs of the vulnerability partnerships across the county
[4] Now Norfolk and Waveney Integrated Care Board (ICB)

- The perpetrator's previous partner was met on two occasions by the Chair and Report Author

1.7.6 The Chair and Report Author contacted the perpetrator, early in the process to invite him to contribute to the review. He did not feel able to do so.

1.8 Engagement with Lynne's family and friends

1.8.1 Family and friends are integral to any Domestic Homicide Review and therefore extensive effort has been made to engage with those who knew Lynne and the perpetrator.

1.8.2 On 9th July 2020 the Senior Homicide Case Worker who was supporting Lynne's family emailed to the Community Safety Partnership Manager to introduce herself and advised that she made the family aware that a DHR would take place and that she would be supporting them through the process.

1.8.3 On 4th August the Community Safety Partnership Manager advised the Victim Support worker that the Chair and Report had been appointed and made the introduction.

As the contact from Victim Support to the CSP came before the decision had been taken, the worker was advised when the Chair and Report Author had been appointed but no formal notification of the review was sent, by the partnership, to Lynne's family. The CSP recognises that this was an oversight. Since this time, the CSP has reviewed its processes and the Chair and Report Author are assured that, in future, families will be advised formally of DHRs regardless of how the initial contact is made.

1.8.4 In September 2020 the Chair and Report Author wrote to Lynne's family individually to introduce themselves with a view to seeing them once the trial had concluded. This letter provided the family with details of AAFDA (Advocacy After Fatal Domestic Abuse).

1.8.5 Due to the COVID 19 lockdown it was not possible to meet the family in person until the end of August 2021. At this meeting the Chair and Report Author met Lynne's mother, two sisters and Child 4 (from a previous relationship). The family were supported by their AAFDA advocate who joined the meeting over Teams.

1.8.6 The Chair and Report Author met the family in person on three further occasions.

1.8.7 As part of the process of drafting the overview report, Lynne's family were invited to comment on, and contribute to, the overview report. This was left with them to consider, supported by their AAFDA advocate. The Chair and Report Author met with the advocate on Teams on a number of occasions to ensure that the family's feedback was understood and incorporated.

1.8.8 The Report Author spoke with Lynne's close friend over the telephone and her work colleagues (from a previous job) provided written submissions to the Chair and Report Author.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

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	Policy Manager Senior Policy Officer, Vulnerability	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)

1.10 Domestic Homicide Review Chair and Report Author

1.10.1 Gary Goose 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, Gary served on the national Family Liaison Executive and 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. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.10.2 Christine Graham 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.

1.10.3 Gary and Christine have completed, or are currently engaged upon, a number of domestic homicide reviews across the county in the capacity of Chair and Overview Author. Previous domestic homicide reviews have included a variety of different scenarios including male victims, suicide, murder/suicide, familial domestic homicide, a number which involve mental ill health on the part of the offender and/or victim and reviews involving foreign nationals. In several reviews they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the Independent Office for Police Conduct (IOPC), NHS England and Adult Care Reviews.

1.10.4 Neither Gary Goose nor Christine Graham is associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[5]

1.10.5 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports as well as DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse). Full details of ongoing professional development can be found in Appendix Two.

1.11 Parallel Reviews

1.11.1 There were no parallel reviews.

[5] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

1.12 Equality and Diversity

1.12.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.12.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[6] According to a statement by Refuge, women are more likely than men to be killed by partners/Ex-Partners, with women making up 73% of all domestic homicides, with four in five of these being killed by a current or former partner[7]. In 2013/14, this was 46% of female homicide victims killed by a partner or Ex-Partner, compared with 7% of male victims.[8]

1.12.3 The majority of perpetrators of domestic homicides are men – in 2017/18, 87.5% of domestic homicide victims were killed by men[9]. Furthermore, in 2017/18, 93% of defendants in domestic abuse cases were men[10] and in 2017, 468 defendants were prosecuted for coercive and controlling behaviour, of which 454 were men and only nine were women[11].

1.12.4 **Pregnancy**

1.12.5 Lynne was pregnant twice during the time of her abusive relationship with the perpetrator. Pregnancy is known to be trigger for domestic abuse, and existing abuse may worsen during pregnancy or after giving birth.

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6 (Women's Aid Domestic abuse is a gendered crime, n.d.)
[7] ONS (2018), 'Domestic abuse: findings from the Crime Survey for England and Wales: year ending March 2018'. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018#the-long-term-trends-in-domestic-abuse November 2018.
8 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)
[9] Ibid
[10] CPS (2018), 'Violence against women and girls report, 2017-18). September 2018 https://www.cps.gov.uk/sites/default/files/documents/publications/cps-vawg-report-2018.pdf
[11] Ministry of Justice (2018), 'Statistics on women and the criminal justice system 2017'. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759770/women-criminal-justice-system-2017..pdf November 2018.

1.12.6 Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened when they were pregnant[12]. That said, 50-75% of women abused before pregnancy are abused during pregnancy[13].

[12] Lewis, G, Drife, J, et al. (2001) Why mothers die: Report from the confidential enquiries into maternal deaths in the UK 1997-9; commissioned by Department of Health from RCOG and NICE (London: RCOG Press) cited by SafeLives https://safelives.org.uk/policy-evidence/about-domestic-abuse/who-are-victims-domestic-abuse

[13] Saltzman, LE., Johnson, C.H., Gilbert, BC., and Goodwin, F. 'Physical Abuse Around the Time of Pregnancy: An Examination of Prevalence and Risk Factors in 16 States'. Maternal and Child Health Journal, Vol. 7, pg31-42. 2003. Cited by National Coalition Against Domestic Violence

Section Two – The Facts

2.1 Introduction

2.1.1 Lynne was an accountant by profession. She was a single parent who was working hard to make a life for her and her child. She ceased work when she began a relationship with the perpetrator seven to eight years ago. She then went on to form a family with him.

2.1.2 The family comprised of Lynne's child from a previous relationship, three children of the perpetrator from a previous relationship and two children that the couple had together.

2.1.3 The perpetrator had a number of previous criminal convictions including violence and threats of violence towards previous partners. However, his convictions do not in any way reflect the real danger that he posed to any woman with whom he engaged in a relationship. The police murder enquiry identified numerous previous partners. Where information was uncovered about those relationships it showed that the perpetrator threatened to kill five of the women, forced three to have sex with him, threatened four with weapons and was controlling of seven. This is explored further in Section 4 of this report.

2.1.4 A following chronology looks at the time from 2014 when the relationship began.

2.1.5 Every effort has been made to protect the identity of the children in this family therefore the chronology has been written in such a way as to protect their identity.

2.2 Chronology

2.2.1 The Review set the time from 1st January 2014 as the scope for this review. Information known to agencies outside of this scope is included where it helps us to understand the family.

2.2.2 **Outside of scope (prior to the perpetrator being in a relationship with Lynne)[14]**

2.2.3 **2012**

2.2.4 The perpetrator's children moved to Norfolk with him at the end of 2011 and those of school age enrolled at primary school in January 2012. The school records prior to the family moving to Norfolk demonstrate that, throughout their school history, the children had good attendance. The school records reflect concerns about the perpetrator's aggression to school staff, his refusal to allow the children to be spoken to in response to concerns raised by school staff and the impact of multiple parental relationships with mention of domestic abuse and the impact of alcohol on relationships.

[14] It should be noted that the children referred to from this point until 2.2.19 are the perpetrator's children

2.2.5 **2013**

2.2.6 An initial assessment was undertaken by CSC as there were concerns by the primary school about bruising on one of the children. A Section 47 enquiry[15] was completed, and clear accounts were given of how the bruising occurred. No further action was taken. Following this, a core assessment was completed, and referrals were made to housing due to the family being homeless and living in the Spixworth Motel and the case was then closed.

2.2.7 Two further referrals were received, and, after investigation, no further action was taken. During these investigations, the children spoke intermittently about their mother, the perpetrator's ex-partner. CSC were told by the perpetrator, that she had mental health issues and she saw the children only occasionally. There is no record that efforts were made to contact her or speak to the wider family.

2.2.8 **2014**

2.2.9 In February one of the schools raised concerns with CSC that one of the children had at least nine school placements and there were concerns that they may be moving to Liverpool. No further action was taken by CSC.

2.2.10 In March NSPCC received a referral from an anonymous source with concerns that the children were looking unkempt and had only just arrived back from Liverpool. No further action was taken by CSC.

2.2.11 By June the school was aware that Lynne and the perpetrator, and their children, were living together.

2.2.12 The NSPCC received an anonymous referral in July to say that they had heard the children crying in their bedrooms and there were lots of arguments. This information was passed to CSC, but no further action was taken by CSC.

2.2.13 The perpetrator's ex-partner contacted CSC in September seeking support as the perpetrator was being difficult about her having contact with her children who lived with him. She was advised to seek legal advice.

2.2.14 Between December 2014 and February 2015, one of the children talked to school staff on occasions about growing difficulties at home, with the perpetrator being unkind, feeding their breakfast to the dog resulting in them being upset and worried.

2.2.15 **2015**

2.2.16 In March, children spoke to school staff about an argument in the middle of the night between Lynne and the perpetrator following an evening at a social club.

2.2.17 The perpetrator's ex-partner contacted CSC again in March as the perpetrator would not allow her to see her children. She was advised to seek legal advice. A few days later in March

[15] Under section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard or promote the child's welfare

she rang CSC again to enquire why the school had advised her that she could not see her children and she was advised to ring the school.

2.2.18 In April Lynne and the perpetrator were seen by a health visitor at the antenatal visit. It was reported that the family would be moving in two weeks, but the perpetrator was reluctant to disclose the reasons for the move and was interpreted as defensive.

2.2.19 In May the couple's first child together was born.

2.2.20 In June, one of the children spoke to a member of staff at school about a further argument between Lynne and the perpetrator following an evening at a pub. They described the perpetrator shouting and swearing and the argument continued until 1am in the morning.

2.2.21 The couple had contact with the health visitor in July and September and there were no concerns expressed by the couple.

2.2.22 **2016**

2.2.23 In January police attended the family home as Lynne and the perpetrator were involved in a verbal argument. The five children were present at the time. Lynne had attempted to leave with the baby. She had put the baby in the car seat and walked out towards the car parked on the driveway. The perpetrator had followed her, and a tug of war has occurred over the car seat, with him trying to prevent her from leaving with the baby. Lynne said that he had elbowed her in the neck with force. During her statement Lynne said that he had mouthed to her 'you are going to die'. Lynne had reddening to her chest and neck area when the police arrived, however this disappeared by the time that photographs could be taken.

2.2.24 In line with protocol a DASH risk assessment was undertaken with Lynne and the risk was assessed as HIGH. Lynne stated, in her statement, that she was fearful of further injury or violence or that the perpetrator would kill her. She said that the physical assaults had increased, she was frightened of him and that he policed her in her own home. She disclosed that, on one occasion, he had told her that he had previously wanted to kill his ex-partner. She also described the debts that he had accumulated through gambling.

2.2.25 A referral was made to the MASH. Research was completed and there was no abuse history recorded between the perpetrator and Lynne but there were three reports noted for the perpetrator and previous partners. This information was added to the investigation log.

2.2.26 The DASH was secondary risk assessed in the MASH and the risk was reduced to MEDIUM as the perpetrator was in custody and Lynne confirmed that she had moved in with her mother. A referral was made to the IDVA service and partner agencies. A CAD marker was placed on the address. The case was closed by the police with no further action being taken and the perpetrator was released from custody.

2.2.27 Leeway's High-Risk Service received a referral for Lynne who was staying at her mother's address with two of the children. Her mother was looking after the perpetrator's children whilst he was in custody awaiting interview as he did not have any family to care for them. The IDVA did not complete a DASH at this point. No refuge place was available, and Lynne was offered temporary accommodation, but she decided to stay at her mother's house over

the weekend. Following this conversation, Lynne was phoned several times, but her phone was always answered by a male.

2.2.28 The same day in January, the perpetrator's ex-partner rang CSC (the Emergency Duty Team) and reported that that the perpetrator was being released from police custody that afternoon after being arrested the previous day following an altercation with Lynne. The children were said to be 'petrified' about his arrival.

2.2.29 On 18th January the school were told by one of the children that the perpetrator had been arrested at the weekend following an argument between Lynne and the perpetrator. The Designated Safeguarding Lead (DSL) contacted Multi Agency Support Hub (MASH) and subsequently attended a strategy meeting with the Police and Children's Services. It was said that, when the perpetrator returned home after his release, he had shouted one of the children downstairs and when they would not do this, the perpetrator dragged the child downstairs by their hair (or by the hand) and made them have a drink. The child reported that they had drunk half and thrown the rest away and ran back upstairs. They said that the children had been hiding, having overheard the shouting and the altercation between Lynne and the perpetrator. Lynne had now returned to the property.

2.2.30 At the strategy meeting, it was noted that Lynne had left the home with two of the children and was offered a refuge place but opted to return home. The DSL informed the allocated social worker about disclosures that the children had sustained injuries from falling down the stairs and tripping over a cone. The meeting agreed that this would be a single agency response by CSC.

2.2.31 The perpetrator's ex-partner contacted CSC again two days later. She reported that the children were scared that the perpetrator would be returning home after being in police custody after a domestic incident with Lynne. She said that Lynne had left the property with two of the children and the other children were left in the property with the perpetrator. An initial assessment was undertaken and closed in May 2016.

2.2.32 On 18th January the health visiting records were accessed by the MASH health practitioner for the MARAC meeting. One of the actions agreed was that professionals would not attend alone.

2.2.33 Later in January a joint visit to the family was made by the health visitor and social worker. Both Lynne and the perpetrator were present. They reported that the domestic abuse incident had been fuelled by the perpetrator drinking alcohol and had been blown out of all proportion. The next day, the health visitor contacted the social worker to express concerns that the perpetrator was controlling, and that Lynne had not disclosed the full extent of the domestic abuse. It was agreed that the social worker would speak to the children alone and report back to the health visitor. The social worker then advised the health visitor that she had spoken to the perpetrator's ex-partner who had said that the perpetrator was abusive to her and that she was frightened of him.

2.2.34 Lynne spoke to Leeway (DA Services) on 27th January and said that everything was OK and that she was back with the perpetrator and no longer needed support. She thanked them for their support and the worker believed that the perpetrator was present during the call. Leeway reported their concerns to the police and CSC.

2.2.35 On 28th January Lynne had a maternity review with the midwife at the GP surgery where she was accompanied by the perpetrator. It was noted that Lynne was taken out of the room and asked how things were at home. She reported that the recent incident was a 'one off row' and everything was OK.

2.2.36 On 22nd February the GP practice noted on both the perpetrator and Lynne's notes that they should not carry out lone visits due to documented entries of previous violence.

2.2.37 On 1st March, the perpetrator's ex-partner attended the school to collect one of the children having planned for them to move to live with her without the perpetrator's knowledge. The DSL contacted the police upon the perpetrator's arrival at school due to his refusal to allow the child to live with their mother. The ex-partner had parental responsibility and, in the absence of a court order preventing her from having custody of the child, they left Norfolk to live with her. One of the children described their sibling moving away because 'daddy was horrible to them sometimes' and that the perpetrator was going to 'call his mummy all day to make her change her mind'. The DSL informed the CSC Assessment Team Manager who advised that the previous social worker allocated had been temporary and an assessment had not yet been completed.

2.2.38 The police officer present at the incident noted that it was apparent, from talking with one of the children, that they were unhappy at home and felt that they were being abused emotionally by their dad. They explained that during a recent visit by CSC they had been told by the perpetrator to tell them that they were happy and that everything at home was fine. He said to the children that he would pay them £30 if they told the social workers that all at home was fine. The perpetrator's ex-partner spoke to the police officer and child protection staff at the school about the domestic violence that took place in her relationship with the perpetrator. She said all of this in front of a child who appeared to have heard it all before as they didn't seem surprised. She also said in front of the child that 'other things' happened in their relationship that she wouldn't talk about in front of the children.

2.2.39 The officer then spoke to the perpetrator who was in another part of the school, with his partner Lynne and their baby. The perpetrator was quite tense and said that there was no way he would allow his child to leave with his ex-partner. He was aggressive and agitated in his tone and manner but was not threatening. He had with him a 'section 8 contact order' from Norwich Court, however this only related to contact and not residency, and therefore did not state which parent the child had to live with. As the perpetrator and Lynne had to leave the school to feed the baby and pick up another child, they left the school but stated that the perpetrator wouldn't allow the child to leave with his ex-partner. The perpetrator stated that while he was away from the school he would attempt to speak to his solicitor and attempt to get an emergency injunction against his ex-partner.

2.2.40 It was confirmed that the perpetrator and his ex-partner had joint Parental Responsibility and so the child was able to leave with the ex-partner if they wished. At this stage the perpetrator's ex-partner became a little emotional as she was worried for her other children who she wasn't taking, however she realised that this was something they would have to decide for themselves, and nature would have to take its course.

2.2.41 Two officers visited the perpetrator at his home about his child going to live his ex-partner. The perpetrator was advised to seek legal advice, and he appeared keen to do this.

2.2.42 There were no Police offences disclosed on this occasion and referral was made to CSC via the MASH. No strategy discussion took place as there were no offences to discuss with Police.

2.2.43 The Team Manager advised the DSL that they should not discuss the matter with the perpetrator but wait for the Family Intervention Team to visit the home.

2.2.44 On 14th March the health visitor made the planned antenatal visit and both Lynne and the perpetrator were present. Lynne explained that she had to leave in ten minutes to go the GP. When the health visitor suggested rescheduling, the perpetrator said, 'can't we just get this over with'. The health visitor explained that the assessment would take longer than ten minutes to complete.

2.2.45 The rearranged antenatal visit took place on 22nd March. The health visitor noted that the perpetrator seemed to dominate the conversation. The health visitor spoke to him about the previous domestic abuse incident, and he said he knew that it should not have happened, and he did not want anything to happen like this again. They discussed support for his alcohol consumption and anger management, but this was declined. The health visitor liaised with the social worker about future support.

2.2.46 On 22nd March Leeway closed the file as they had no further contact from Lynne.

2.2.47 The police recorded an intelligence item on 23rd March that indicated that the perpetrator and Lynne would go out drinking (alcohol) and leave the children at home. It was noted that Lynne was pregnant. This intelligence was disseminated on 22nd March with the MASH and CSC as medium priority.

2.2.48 Between 23rd March and 19th April, the health visitor attempted to telephone the new allocated social worker on five occasions. At the 6th attempt, the health visitor spoke to the social worker who had not yet been able to review the case.

2.2.49 On 26th April the social worker advised the health visitor that the perpetrator would not allow them to see the children without him. The social worker reported that the perpetrator was controlling and that they would make a further visit to the children.

2.2.50 The child returned to Norfolk in April to live with the perpetrator and Lynne and resumed attendance at school having attended a secondary school in her mother's local area for a matter of days.

2.2.51 The one-year development review for the baby was undertaken by the health visitor on 27th April. Lynne appeared low in mood, but she reported that she felt well. It was noted that she appeared wary and cautious during the visit and often looked at the perpetrator whilst speaking.

2.2.52 In April the couple's second baby was born.

2.2.53 On 3rd May the health visitor discussed the case with the Safeguarding Team Leader and signs of safety were used to support a reflective discussion. It was agreed that the health visitor would contact the social worker to clarify the perpetrator's violent history and the social care plan. When the health visitor telephoned the social worker on 4th May, the social

worker advised that the assessment had been completed. It was explained that the information obtained was restricted as the assessment had not been undertaken in a timely manner and the perpetrator would not allow the children to be spoken to alone. They discussed his violent history, but this was unclear as the perpetrator had not given his consent to it being accessed. The social worker said that the children did not appear to fear the perpetrator and there were no further plans for action by social care.

2.2.54 The new birth visit for the new baby was undertaken by the health visitor on 10th May and there were no concerns with the way in which Lynne and the perpetrator interacted with the baby. It was noted that the couple only spoke when the health visitor asked them a question. A further visit was arranged for 18th May.

2.2.55 On 18th May CSC saw Lynne with the children. This was part of their assessment that had been instigated after the perpetrator's ex-partner's call to CSC on 18th January. The delay in completing the assessment was due to the social worker having left.

2.2.56 The health visitor saw the family again on 18th May and no concerns were observed with the way in which the couple interacted with either of their children.

2.2.57 On 23rd May Lynne saw her GP for contraceptive advice, asking about long-acting reversible contraception.

2.2.58 In June, one of the children disclosed to the DSL at their school that their father called them names, insulted them, and threw one of their crutches at the weekend. They said he also got angry with a sibling and threw their mobile phone resulting in a hole in the wall. The child talked about how the perpetrator could be scary when drinking and that they were worried about the incident in January 2016 when he was arrested. They consented for Children's Services to be contacted, noting that things had been better when they were involved, but did not want her father to be aware as they were worried, he would become angry with them.

2.2.59 The DSL contacted Children's Advice and Duty Service (CADS) on 14th June and was advised that Children's Services had recently closed their involvement following a social work assessment.

2.2.60 Following further exploration of the children's wishes and feelings, the DSL for the school contacted Children's Advice and Duty Service (CADS) and was advised by the CADS worker that the previous social work assessment had not been completed as the perpetrator refused consent resulting in Children's Social Care closing their involvement. The CADS worker advised the DSL that they should inform the perpetrator of the child's disclosure and offer support via a Family Support Plan as there was no evidence of significant harm of the children. The DSL outlined their concerns that this could cause the perpetrator to become aggressive towards school, risking an already difficult relationship and that he would refuse to engage resulting in children not being able to talk to professionals. The DSL discussed his concerns with the Headteacher, and they agreed they should not contact the perpetrator but monitor the situation with the children and inform Children's Services of school's decision. When the DSL explained to the child that they would not be talking to the perpetrator about their worries, they said they were pleased as they had been worrying about this. Later in the same month, the perpetrator's ex-partner and biological mother of

two of the children contacted the DSL to explain her views on what life is like for her child but that it was not possible for them to live with her at that time.

2.2.61 On 16th June the health visitor carried out the 6-8 week check on Child 6 and there were no concerns.

2.2.62 There were no concerns raised when the health visitor carried out the 3-4 month check for Child 6 on 10th August. The family were assessed as being appropriate for the universal pathway and were placed on the one year waiting list.

2.2.63 Between 2016 and 2019 PS2 recorded several concerns regarding one of the children's behaviour at school, their interventions to support their social and emotional needs and their liaison with the perpetrator and Lynne about the child. It is evident that the perpetrator's behaviour could be aggressive and intimidating at times during this period.

2.2.64 **2017**

2.2.65 On 6th June the one-year development review, for the youngest child, was undertaken by the health visitor. It was noted on the record that there was no domestic abuse enquiry as the perpetrator was present.

2.2.66 Lynne saw the nurse practitioner at her GP surgery on 1st September for a routine check of her contraception. She reported that the perpetrator was not willing to have a vasectomy.

2.2.67 On 14th December the two-year development review, for the couple's first child, was undertaken by the health visitor. The atmosphere was described as tense. The perpetrator was controlling by stating that they did not receive a questionnaire and that he did not have time to complete it now as he had to get back to work. As there were concerns about the child's speech a further meeting was offered. The perpetrator said that this was a waste of time and that they would post their questionnaire to the health visitor saying that the couple did not have a problem with the child's development. The health visitor described the perpetrator's voice as intimidating and said that Lynne appeared 'flat' in her manner.

2.2.68 **2018**

2.2.69 On 23rd July the couple's first child's 2-year 3-month development review was undertaken by the health visitor and both parents were present.

2.2.70 On 7th August 2018, the perpetrator was sentenced to a 12-month Community Order with a single requirement to complete 120 hours of Unpaid Work (UPW). This was in relation to failing a provide a specimen of breath. Lynne and the perpetrator had gone into the city for a night out. Lynne had planned that they would get a taxi home. When Lynne got to the taxi, the perpetrator said that he wanted to stay out longer. She later found out that he had taken her car keys from her handbag. Following a non-injury road traffic accident, the police tracked the offending vehicle to the perpetrator's address where he admitted that he had driven home whilst intoxicated. There was no evidence that there was anyone else in the vehicle.

2.2.71 On 28th November an OASys Review was completed by an officer not previously mentioned within the contact log. There is also no record of the perpetrator being contacted by this

officer or his probation officer to discuss his circumstances at the time of this review. This review outlines that there is no further regular planned contact for the case from that point onwards. The reviewing officer did not identify that there were no safeguarding or domestic abuse intelligence checks undertaken with the police, and this continued to remain unchecked.

2.2.72 **2019**

2.2.73 Lynne has stated that on 1st August 2019 one of the children told her that the perpetrator had hit them on the leg with a tennis racquet. Lynne had not asked the perpetrator about this at the time as she was fearful of his anger, but she had seen a bruise on the child's leg. Whilst this offence occurred on 1st August 2019, it was reported to the police on 21st January 2020. *(The action taken is recorded in sequence on 21st January 2020).*

2.2.74 On 6th August the perpetrator's probation order was terminated, and the Termination Review was completed without any contact with the perpetrator. It was noted that no breaches or offences had taken place.

2.2.75 In October, following watching a Newsround video one of the children asked questions of a member of staff such as *'Who is better? The Taliban or ISIS? Who killed more people? Who are the Nazis? What is a Swastika? Is it a bad thing?'* The child said their dad had a tattoo of a swastika on his body and another that says, *'white powder'*. The DSL contacted CADS. CADS confirmed a week later that the contextual safeguarding concerns for the family were historic and advised a referral to PREVENT and the local community policing team. The DSL did not make a PREVENT referral as they believed the child was opening up about their feelings and emotions and was worried that police intervention may have been detrimental to their wellbeing; they did not believe that the child was at risk of radicalisation.

2.2.76 **2020**

2.2.77 On 21st January Lynne's mother reported to the police that she was concerned about the coercive and controlling behaviour of the perpetrator towards Child 4. She said that over a period of 3 years, the perpetrator had threatened violence towards Lynne to control her. He had placed a tracker on her phone, and he never let her do anything on her own. He had threatened to take the children away from Lynne and never let her see them again. The perpetrator would make Lynne feel bad to make sure that she stayed with him. They had, at that time, five children living at the house.

2.2.78 Police attended the address and Lynne was spoken to. Body worn footage of Lynne showed her state that she was aware he had met his ex-partner with their child whilst armed with a knife and she was fearful he may do the same again. The perpetrator was arrested. A DASH risk assessment was completed and assessed as HIGH risk. Lynne said that she was scared of the perpetrator and that if she left him, he would take revenge. She said that he would alienate and stalk her. She also said, 'he could murder me'. Within the DASH an incident of assault was disclosed against one of the children which was subsequently recorded as a crime. (This was the incident that occurred on 1st August 2019).

2.2.79 A referral to CSC was made on the same day and appropriate action was taken to refer to partners from the MASH. The crime was reported to the school via Operation Encompass the next morning.

2.2.80 There was an early review of the investigation undertaken to identify the outstanding lines of enquiry. These included obtaining statements from Lynne's sisters, speaking to the school and the children to see if they had witnessed any incidents.

2.2.81 On 22nd January, the MASH reviewed the DASH risk assessment, and it remained as HIGH. This would then have been reviewed on a weekly basis by the allocated safeguarding officer.

2.2.82 Lynne left the home she shared with the perpetrator on 22nd January and moved in temporarily with her mother. A statement was taken from Lynne's mother, and this detailed the controlling behaviour of the perpetrator. She said that two of the children had met with her in secret and had asked to be taken away from the perpetrator. Reference was made to one of the children wanting to kill themselves. There were three exhibits provided by Lynne's mother – a diary entry from one child, two screen shots of conversations between Lynne's mother and the two children. These all corroborated Lynne's account.

2.2.83 The perpetrator was released on conditional bail which was initially for 28 days.

2.2.84 Leeway received a referral for Lynne on 22nd January. It was noted in the referral that over the previous three years, the perpetrator had been threatening violence towards Lynne to control her. He had a tracker on her phone and never let her do anything on her own. He had threatened to take the children away and never let her see them again. The perpetrator would make Lynne feel bad to make her stay with him. One of the children had been hurt in the latest incident.

2.2.85 Leeway telephoned Lynne on 24th January, and she engaged with support and stated that she wanted accommodation locally as she had heard that refuges were not nice. Leeway reassured her that they were OK and were safe. They discussed the housing situation with Lynne as she was with her mother and the house was overcrowded, and the tenancy was about to end. Leeway suggested applying to transfer the tenancy into her name, but Lynne said this would not be possible as she had an Individual Voluntary Agreement[16]. She said that she had also been in business with the perpetrator so was now out of work. Temporary accommodation was discussed and the IDVA agreed to meet with Lynne. Lynne said that the perpetrator was abiding by his bail conditions, and she had not heard from him.

2.2.86 The MASH contacted Lynne on 24th January to check on her welfare and she confirmed that she had moved in with her mother and asked if she could have contact with the children who had remained with the perpetrator. She was advised that she could do this if she did not have contact with the perpetrator.

2.2.87 Lynne informed the school that her child may be tired in school as the perpetrator had been arrested for coercive and controlling behaviour the previous day, but Lynne minimised this as nothing serious. Both schools the children attended received Operation Encompass[17] notifications about Lynne's reporting of the perpetrator's controlling behaviours over the past three years including threats of violence and preventing Lynne from seeing the children. One of the children talked to school staff about what had happened and their feelings. The

[16] https://www.iva.org/what-is-an-iva

[17] Operation Encompass is a Police and Education early information sharing partnership enabling schools to offer immediate support for children and young people experiencing domestic abuse. It was launched in Norfolk in 2016 following a recommendation from a Serious Case Review (Case Q 2016; NSCB Serious Case Reviews).

records indicate that they were trying to make sense of this significant event in their family life; '*I don't know why they were separated but have you heard of domestic abuse.... but I don't understand why he has been arrested because he has never hurt her…. I looked through photos of dad last night and cried and went to sleep at 2am as I am bothered by all of this*'.

2.2.88 The school DSL reported the information to Children's Advice and Duty Service (CADS) and was informed that the perpetrator had been released with bail conditions until February 2020, Lynne had taken protective measures and was living with maternal grandmother with three of the children, however two of the children remain in the family home with the perpetrator.

2.2.89 The following day, the social worker advised the DSL that Children's Services were closing their involvement as they did not believe the perpetrator would consent to a social work assessment and did not have enough evidence to indicate the situation met the Section 47 threshold. The headteacher offered additional support for the child to the perpetrator, as advised by the social worker, and the perpetrator stated he would come into school to discuss this if he felt it was needed.

2.2.90 Lynne contacted DWP on 27th January to make a claim for Universal Credit using the online portal. In her Universal Journal she said 'I was self-employed with my husband in a partnership. He was arrested last week for controlling and coercive behaviour towards me, so we no longer have a business. There's bail conditions in place for him not to contact me or the children. Really worried I may bump into him at the jobcentre during my appointment. As I'm sure he will also be claiming. I'm currently homeless, Temporarily crammed into my mother's house. Leeway are helping me. (Just thought I would give you background info, on why I'm currently not job searching) terrible circumstances at the moment. Thankyou'.

2.2.91 On 28th January a MARAC meeting was held.

2.2.92 Lynne's mother reported to CSC on 28th January that Lynne had taken three of the children with her and that three had remained in the home with the perpetrator. One child reported that Lynne had left the home and that their father had been in prison overnight and they were aware that there was arguing. This was discussed with the perpetrator, and he agreed to support the child through these events.

2.2.93 The IDVA met with Lynne on 28th January. Lynne was grateful for the opportunity to meet and talk things through. It was noted that Lynne had an appointment with Broadland District Council on 21st February to discuss her housing situation. The IDVA agreed to contact the council to see if she could be seen earlier.

2.2.94 Lynne was concerned about taking action against the perpetrator due to the impact that it would have on the children. She was aware that he knew his rights and, once the bail conditions ended, he could just collect them from school. Lynne was provided with details of a solicitor, and she said she would call them as soon as possible to discuss child contact arrangements. Lynne was determined that the relationship was over, and a DASH was completed, which was assessed as high risk along with safety planning. She said she had received no contact from the perpetrator but that he did speak to the children on the phone. Lynne continued to engage with the IDVA.

2.2.95 On 29th January the MASH reviewed the DASH risk assessment, and the risk was reduced to MEDIUM as the perpetrator had bail conditions and Lynne had moved in with her mother and was receiving support from the IDVA.

2.2.96 Over the next two weeks, the perpetrator reassured the school that he would abide by bail conditions and not attempt to collect the children with Lynne from school. The children expressed to their respective schools how they were struggling with the family separation.

2.2.97 Lynne attended her new claim appointment at Norwich Jobcentre on 30th January. Her ID was verified, and she was given support to navigate the Universal Credit system. It was noted that she was being supported by Leeway.

2.2.98 On 31st January Lynne's work coach sent a journal message to Lynne in reply to the message she had left on 27th January. The message said, 'Hi Lynne. Thank you for your message and updating me with your circumstances - I am so sorry to hear of your upsetting circumstances. Could you give me his name if that is okay, and then I can make sure that you do not attend at the same time as him so there is limited chance of bumping into him. I would suggest, due to your circumstances and all the worry, to obtain a Fit Note from the Doctor to sign you off as unwell, then this will relieve the pressure of having to look for work at the moment on a daily basis, as this is the last thing you will be thinking of at the moment….'. This was then followed up with another message from the work coach that asked Lynne to bring the children's birth certificates in.

2.2.99 On 4th February Lynne attended her appointment at Norwich Jobcentre. Lynne's claimant commitment was amended so that Lynne was not required to look for work, Lynne's commitment was to keep her work coach updated in any changes to her personal circumstance such as changing address. Lynne also agreed to provide a fit note from her GP as she explained that she was not emotionally strong enough at the moment to seek work and would keep in regular contact with Leeway for support. The work coach had also made notes on Lynne's file to record that Lynne was a vulnerable customer, who had just escaped from a coercive relationship with her ex-husband, he was on bail regarding his behaviour. She said she was currently living with her mother but could only do so until April as her mother was in rented accommodation and the house was being sold so Lynne and her three children would need to move out. Lynne said she was engaging with Leeway who were being very supportive. Her next appointment was booked for 26th February.

2.2.100 On 15th February the police contacted Lynne and she said that she wished to retract her statement due to feeling guilty about what would happen to the perpetrator's children if he were found guilty. She said that she also wanted her younger children to be able to see their father. The officer advised Lynne to give this some thought and to speak to her family and children, who were described as also potentially being a victim of the perpetrator's behaviour.

2.2.101 The perpetrator's bail conditions were lifted on 20th February, and Lynne told the IDVA that she met with him after he contacted her to sort everything out. The children were playing up and she could not hear him on the phone so had picked him up and they went to a public place to talk. She had allowed two children to stay with him for two nights. She said that her mother was very angry about this and had said that she was not welcome to stay any longer. Lynne said she was jobless and homeless and was having suicidal thoughts and had been

reported as a missing person, although she had assured everyone that the thoughts were flippant, and she has her children to look after.

2.2.102 The Leeway Anchor Project sourced emergency accommodation for a few nights, and she then moved into a local motel provided by Broadland Council.

2.2.103 On 21st February Lynne attended an appointment at Broadland District Council with a member of the Housing Solutions Team, having previously advised them that she had staying with her mother on a temporary basis since 22nd January having fled from the accommodation she was sharing with the perpetrator.

2.2.104 On 25th February Lynne messaged her work coach to request that she could move her appointment on 26th as the children were at home from school as they were ill. Her work coach replied to say that she had rebooked the appointment for 5th March and reminded her about the Fit Note from her GP so that she could be excused from looking for work.

2.2.105 Lynne and her children moved into temporary accommodation provided by Broadland District Council on 27th February. The next day, 28th, a Housing Solution Officer wrote to Lynne to advise her that the council had accepted a Relief Duty to her in respect of her homelessness.

2.2.106 In February one of the children talked to a teacher about how Lynne had returned the children to the perpetrator's care resulting in maternal grandmother throwing them out of her home as she disagreed with Lynne's decision. They explained they have been living in hotels, relying on foodbanks and Lynne had run out of money. The child was worried about where they were going to stay and how she would be able to complete her schoolwork. The child was supported by DSL who made unsuccessful attempts to contact Lynne. The following day, Lynne informed the school that the perpetrator's bail conditions had been lifted and he could collect his children from school again.

2.2.107 On 2nd March Lynne spoke to the IDVA and said she was very happy in the motel, and she seemed more settled. She had been in contact with the perpetrator, and this had been fine, and she and her mother were now talking again. Lynne then started to disengage from support and no longer answered phone calls or text messages.

2.2.108 Lynne's family provide the following information as further context around the various moves and reasons for it during this period.

2.2.109 January 2020 - Lynne, Child 4 and two children leave family home, move in with Lynne's mother.

2.2.110 In around March 2020 – her mother asked Lynne to leave her home. After staying in temporary accommodation including hotels/motels one of the children moved back to Lynne's mother's home. Lynne returned to family home with her other two. Child 4 thinks this was probably because of the continued bombardment of CCB from the perpetrator to her. She wanted to try and put 'the fire out' to stop the controlling and coercive behaviour by going back to him. She was probably self-managing the situation. She did not have to face the constant bombardment because she was with him and he knew where she was.

2.2.111 After Lynne was in the family home for about one month, Child 4 or her mother (it is unclear which) received a call from Lynne. She was crying down phone, she was in a car park at Sainsbury's. She had left her other two children in family home and said she would go back to get her stuff. She was told 'no', and that they would go together as they were afraid for Lynne's safety. Her mother and Child 4 went back with Lynne and collected her belongings from family home and brought her back to her mother's home with the other two children.

2.2.112 Lynne didn't say why she left the family home again. Lynne stayed in her mother's house until she moved out into a flat in May with the children.

2.2.113 In last two months of her life, Lynne was stressed and anxious. She was really on edge because he was watching every move. Although they were not living together, he exerted the same level of control over her. He watched her all the time using Life 360.

2.2.114 The family were fearful for the children. They said that they didn't know what he was capable of. The incident when he had threatened her with a knife was always on Lynne's mind which is why she kept going back to him. She would go back to him on demand in a heartbeat.

2.2.115 Lynne's child was still afraid of him because didn't know what he was capable of especially when drunk it could not be predicted what he would do.

2.2.116 Lynne saw her GP on 2nd March and requested a note to certify that she was not fit for work. This was issued for 2nd March – 1 April and the diagnosis was stress at home.

2.2.117 On 5th March Lynne attended her appointment at Norwich Jobcentre. She provided a Fit Note and advised that she had moved to Spixworth Motel. The work coach updated the relevant systems.

2.2.118 In March, a member of staff reported that one on of the children had been upset at drop off times. The school discussed their worries with Lynne who advised that they were collected by the perpetrator after school so they could have time together and then they returned to the hotel to be with her overnight. Lynne said everything was fine now and did not understand why the child was so upset, but she agreed it had been an unsettling time.

2.2.119 On 7th March the police officer in the case recorded on the investigation log that he had spoken to Lynne over email and that she would like to withdraw her support for the investigation. The email read as follows:

Hi PC xxx,
I have myself been struggling to contact you, apologies!
When you have previously called me, my young daughter has been playing games on my phone and she likes to delete my calls to carry on her game!
I would like to retract my statement mainly because of the reasons I put in my last email. But also, now the bail conditions have been lifted [the perpetrator] and I are getting on OK.
He didn't react as badly as I thought he would to me leaving the home and he has maintained a good relationship with our children.
I appreciate I may have wasted a lot of your precious time, but I was genuinely in need of help to leave the home and I was worried about the repercussions of this.
Thank you so much for everyone's help and support!

2.2.120 Lynne's Housing Register application was activated on 13th March, and she was placed in the highest band possible, called High Band.

2.2.121 From 20th March all schools in England entered a period of partial closure with attendance prioritised for children of key workers and children deemed to be vulnerable. Some of the children were offered places but Lynne and the perpetrator did not accept them and there was no legal compulsion for them to do so. During this period, the children were taught remotely.

2.2.122 On 23rd March the first national lockdown began.

2.2.123 On 31st March, the DSL contacted the perpetrator as one of the children had not logged into his online learning. She enquired if he and Lynne were still separated, and he said they were *'together but not living together'*. The perpetrator said he did not know about the online learning, so the school sent a link to activate the online learning which was activated the next day.

2.2.124 On 16th April Lynne received a letter from Broadland Council (that was sent to every applicant living in temporary accommodation) advising that, due to pressures on the temporary accommodation at the time because of the COVID 19 pandemic, it may be necessary for some residents to be moved into alternative temporary accommodation.

2.2.125 Lynne was advised on 17th April that the council had accepted the Main Housing Duty in respect of her homelessness and would work with her to secure longer-term accommodation.

2.2.126 Leeway closed the case on 19th April as there had been no further contact with Lynne.

2.2.127 The Housing Solutions Officer wrote to Lynne on 23rd April to advise that she would need to move from the motel to temporary accommodation at RAF Coltishall the following day. Lynne emailed the officer to ask if she really had to move as she felt disappointed with this. The next day, Lynne sent a further email to explain that she had been to RAF Coltishall and that she felt that it was like a detention centre. She said that she had made up with her mother and was moving in with her instead of moving to the temporary accommodation.

2.2.128 On 30th April, a member of school staff called the family for a 'check in' conversation in line with their practice in response to the partial school closure. The perpetrator answered and then passed the phone to Lynne who reported that one of the children was '*a bit hormonal*' and was not wanting to get out of bed. They discussed how the children were getting on with their schoolwork and Lynne said they only had one iPad making home schooling difficult. The DSL offered to print work out for Lynne to collect from the school office.

2.2.129 On 15th May Lynne was advised by the council that she had been nominated for a property, through the Housing Register, at Hellesdon. This property was owned by Clarion Housing Association and on 8th June they advised the council that they could not provide a date when the house would be ready.

2.2.130 Lynne contacted her work coach on 15th May to advise that the was being moved to Cottishall and therefore she was going back to her mother's. She explained that she was still

on the homeless list and was trying to home school her children. She said that due to COVID-19 she had not been able to get a Fit Note and asked if she would be sanctioned. Her work coach replied promptly telling her not to worry about the Fit Note. This was the final communication between Lynne and her work coach.

2.2.131 The DSL unsuccessfully attempted to contact the perpetrator and Lynne on 15th June to discuss the possibility of the children returning to school as schools were reopening for some classes. She was able to talk with the perpetrator and Lynne the following day. Lynne talked about how it would be good for their wellbeing for the children to return, but the perpetrator would not allow one of the children to return as they had asthma. The DSL arranged for Lynne to come into school on 19th June 2020 to collect activity packs and food vouchers.

2.2.132 Lynne was murdered a few days later.

Section 3 – Analysis of agency involvement

This section summarises the totality of the information known to agencies.

3.1 **BROADLAND AND SOUTH NORFOLK COUNCIL**

3.1.1 The only contact that the council had with Lynne was in the last few months of her life, after she had left the perpetrator.

3.1.2 The council's involvement with Lynne was carried out in line with relevant housing legislation. She was offered interim accommodation in line with Section 188 of the Housing Act 1996. The Relief Duty was accepted in line with Section 1889B (2) of the Housing Act 1996. The Main Housing Duty was then accepted in line with Section 193(2) of the Housing Act 1996.

3.1.3 Following Lynne's death, the council reviewed their involvement and, in a meeting with staff. Whilst the council had acted in line with their policy, it was observed that the notes were not as clear and concise as they could have been. The importance of clear and concise note taking in all cases for a clear audit trail to be in place was stressed.

3.1.4 The council already had mechanisms in place to train their staff about domestic abuse. This case has highlighted the need to ensure that, whatever the pressures, it is important for the training to be regularly reviewed and updated. To ensure ongoing professional development, the council has been working with Leeway to provide additional training to the Housing Solutions Officers, particularly in completing DASH risk assessments.

3.1.5 The council has now appointed a Domestic Abuse Support Specialist who will be based in the housing team. Part of their role will be to provide advice and guidance to officers.

The review notes that the Council acted promptly, and in line with the legislation, to meet their duty towards Lynne. Their self-instigated review after her death shows a real desire to learn to better protect others in the future.

3.1.6 The review notes that Lynne had to be moved due to the pressures on housing in the COVID 19 pandemic.

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

3.2.1 The family first became known to the NHCP when Lynne was pregnant with Child 5. This was Lynne and the perpetrator's first child together. It was determined that the family would receive the Universal Health Visiting Pathway as, at the time, it was considered there were no safeguarding or vulnerability concerns and therefore their needs could be met under the universal offer. The Universal HCP offers five mandated contacts with every family in Norfolk. These contacts include – Antenatal, New Birth, 6-8-week review, 9-12-month developmental review and 2-year developmental review.

3.2.2 Within these five universal mandated contacts questions around domestic abuse, relationships and family dynamics should have been asked in line with CCS Domestic Abuse and Child Protection Investigation processes and practitioners' responsibilities 0-19 (2021)[18].

3.2.3 **17th April 2015**

3.2.4 The health visitor attended for an antenatal visit and both Lynne and the perpetrator were present. The perpetrator said that the family was moving in two weeks' time but was reluctant to disclose the circumstances around the move and was interpreted by the health visitor as being defensive.

3.2.5 Whilst Lynne's records would have been checked prior to this visit there was no record of the perpetrator's violent history. At this routine appointment, an enquiry about domestic abuse would have been made but it was recorded that this was not possible as the perpetrator was present.

> The review has considered, as there was no record of domestic abuse, whether the health visitor may have been able to ask about the relationship in a respectful and sensitive manner with the perpetrator present. This may have enabled a more open dialogue about the parental relationship at the introduction of the service. However, we are acutely aware that it is also possible that asking questions, even in the most respectful and sensitive manner, may have unknowingly been a 'red rag to a bull' as far as what we now know about this perpetrator is concerned.
>
> This demonstrates that at times staff must make such decisions not knowing the history of some of the most violent offenders.

3.2.6 **26th May 2015**

3.2.7 The health visitor attended for Child 5's new birth visit and both parents were present. Lynne said that the perpetrator was at home and was supportive. It was not noted whether there was a discussion about relationships.

> The IMR author noted that a discussion about relationships should ordinarily be held at every opportunity as it would support further open dialogue, especially given that the family dynamics would have changed with a new-born baby in the home.

3.2.8 **2nd July 2015**

3.2.9 The 6-week review for Child 5 was undertaken. The perpetrator was not present, and Lynne reported that she had no concerns. Consent was given for the SystymOne records to be shared with the GP.

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[18] IMR author accessed through CCS intranet

3.2.10 ***This is an example of good practice as it supports information sharing.*** **The review is unable to come to a view as to whether this consent would have been given if the perpetrator had been present.**

This is the first time that Lynne was seen alone without the perpetrator and there is no record of whether she was asked about domestic abuse. That of course does not mean that she wasn't, rather it was not recorded.

3.2.11 **22nd September 2015**

3.2.12 The health visitor spoke to the perpetrator on the telephone for the 3-4 month contact in relation to Child 5. He reported that there were no concerns about his development or health, and it was agreed the next contact would be at the one-year review.

3.2.13 **18th January 2016**

3.2.14 There was a MARAC meeting held following a report that Lynne had made. The health visiting service was not present at the meeting but were provided with the minutes which noted that professionals should not attend the family alone.

At this point Child 5 was 8 months old and Lynne was 24 weeks pregnant with Child 6. The Norfolk Safeguarding Children Board (NSCB) Pre-Birth Protocol should have been initiated (DoH, 2018). The unborn baby should have been included in the children's services assessment and, if this had been followed, a joint assessment with midwifery and health visiting services would have been undertaken.

Recommendation

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.

3.2.15 **27th January 2016**

3.2.16 A joint visit was made by a health visitor and social worker[19]. ***This is an example of good practice.*** Both parents were present. The couple reported that the domestic abuse incident had been fuelled by the perpetrator drinking alcohol but that they felt it had been blown out of all proportion.

3.2.17 Child 2 and Child 4 were spoken to by the social worker, and they said that their home environment was positive, and that the perpetrator had thrown all the alcohol in the home away.

[19] Norfolk =Safeguarding Children Partnership (2019) 3.12 Protocol for undertaking joint visits and assessments by Social Workers, Health Visitors and Midwives, for children under 5. Accessed: https://www.norfolklscb.org/about/policies-procedures/3-12-protocol-for-undertaking-joint-visits-and-assessments-by-social-workers-health-visitors-and-midwives-for-children-under-5/

3.2.18 When Child 1 and Child 3 were spoken to by the social worker it was noted that both were quite guarded. It was agreed that the social worker would see Child 1 in school. (the children were not seen alone).

3.2.19 The HV agreed to provide another HV with the outcome of the initial assessment. The second health visitor would then contact the family to arrange the one-year review for Child 5 and an antenatal assessment for Lynne.

3.2.20 At this point the family were placed on the Universal Partnership Plus Pathway. This is the pathway which families are placed on when there is more than one professional working with the family and where there are safeguarding concerns identified. Families placed on the Universal Plus Pathway will receive the five mandated contacts as per Universal Pathway and then in addition support visits and targeted reviews at the home address.

There is no record as to whether a DASH risk assessment was considered; it was available to CCS practitioners at the time. There is no record that a Health Needs assessment for the school age children was offered and therefore a referral to 5-19 practitioners was not made. This would have provided another opportunity for the children to be seen alone in school.

3.2.21 **28th January 2016**

3.2.22 Following this meeting, the HV raised concerns with the social worker via the telephone that the perpetrator was very controlling. The HV was concerned that Lynne had not disclosed the full extent of the domestic abuse. The social worker agreed to speak to the children on their own and report back to the HV. The social worker also informed the HV that they had spoken to the perpetrators Ex-Partner who had said that she had been abused by him and that she was frightened of him.

The 'signs of safety' template[20] could have been used to discuss the concerns in safeguarding supervision. The escalation policy[21] could then have been triggered if necessary. A discussion in safeguarding or case management supervision would also have provided the opportunity for collective thinking about how best to work with the family and address the barriers being put in place by the perpetrator.

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[20] The Signs of Safety® approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children. https://www.signsofsafety.net/what-is-sofs/

[21] Norfolk Safeguarding Children Board (2013) Resolving Professional Disagreements. Accessed: https://norfolklscb.org/about/policies-procedures/3-5-child-protection-enquiries-section-47-children-act-1989/resolving-professional-disagreements-policy/

3.2.23 **14th March 2016**

3.2.24 The HV arrived at the family home for a pre-planned antenatal appointment with Lynne. She said that she had to leave in 10 minutes to take Child 3 to the GP. When the HV asked if she could reschedule her appointment, the perpetrator said, 'can't we just get it over with'. HV stated that she needed more than 10 minutes to complete the visit. There was the potential to see Lynne alone if the perpetrator had taken Child 3 to the GP. Had two HV's visited, they may have felt safe to challenge this.

3.2.25 **22nd March 2016**

3.2.26 A HV met with Lynne and the perpetrator for an antenatal appointment. It was noted that the perpetrator dominated the conversation. When the HV discussed the previous domestic abuse incident, the perpetrator said that he knew that it should not have happened and that he did not want anything like this to happen again. They discussed support for his alcohol use and managing his anger, but he declined.

3.2.27 The HV was to liaise with the social worker about future support.

The HV talked about anger management for the perpetrator. Anger management is contraindicated for domestic abuse[22]. Seeking supervision with the safeguarding team may have identified what may have been a knowledge gap in frontline practice at the time.

3.2.28 Between 23rd March and 19th April, the HV attempted to telephone the new allocated social worker five times. On the sixth attempt a conversation was held, and the social worker advised that she had not yet reviewed the case.

We recognise the health visitor's persistence in this regard. The NSCB Resolving Professional Disagreement Policy (2013)[23] could have been used at this point to prevent further professional drift.

3.2.29 **27th April 2016**

3.2.30 The Health Visitor completed the one-year development review on Child 5. Both parents were present, and it was noted that Lynne appeared to be low in mood but reported that she felt well. The HV noted that Lynne appeared wary and cautious during the visit and often looked at the perpetrator whilst speaking.

[22] https://johnhoward.on.ca/kawartha/wp-content/uploads/sites/9/2021/07/Difference-between-Anger-Management-and-Domestic-Violence-Programs.pdf
[23] Norfolk Safeguarding Children Board (2013) Resolving Professional Disagreements. Accessed: https://norfolklscb.org/about/policies-procedures/3-5-child-protection-enquiries-section-47-children-act-1989/resolving-professional-disagreements-policy/

3.2.31 **3rd May 2016**

3.2.32 Safeguarding Supervision was held, by the team leader, with the HV primarily involved and the 'signs of safety' template was used to support a reflective discussion. ***This is an example of good practice.*** Concerns were raised about why Child 1, Child 2 and Child 3 were not living with Lynne. There was a sense that the perpetrator was controlling Lynne and dominated the conversations when home visits were undertaken.

3.2.33 It was agreed that HV would contact the social worker to seek clarification about the perpetrator's violent past and the plan that CSC had in place.

> The notes of the supervision do not clearly highlight if the controlling behaviour of the perpetrator was having an impact on the response of professionals.
>
> When reviewing the records, there was little focus on the impact of his controlling behaviour on the lived experience of the children.

The IMR author notes that the organisation had been going through a period of change and this transition would have also led to a level of increased risk (HSE, 2021)[24]

3.2.34 **4th May 2016**

3.2.35 The social worker spoke to HV on the telephone and said that they had completed their assessment. They said that, as the report had not been completed in a timely manner the information had been restricted. The perpetrator would not allow the social worker to speak to the children alone and therefore this had also limited the information available.

3.2.36 The social worker discussed the perpetrator's violent past, but this was unclear as he had not given permission for this to be accessed. The social worker advised that, as she had observed that the children were not afraid of the perpetrator, CSC planned to take no further action.

> There was no single agency assessment shared by CSC and the request for this information should have been pursued and challenged. The escalation process provides a framework to do this.
>
> The health visiting service was unable to understand and manage the risk without this information.
>
> There is no record of why the police were not approached to provide information about the perpetrator's violent past.

[24] Health and Safety Executive(2021) Human Factors: Organisational change. Accessed: https://www.hse.gov.uk/humanfactors/topics/orgchange.htm

Recommendation

It is recommended 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.

3.2.37 **16th June 2016**

3.2.38 When HV saw the family for Child 6's 6-8-week review, this was the third time they had been seen since 10th May. There were no concerns raised about either Lynne or the perpetrator's interaction with Child 6. Lynne reported that she was feeling well and had no concerns with anxiety.

> It is noted by the IMR author that the lack of concerns was possibly due to professional optimism and may have been related to several factors such as the changing organisation leading to increased workloads, disguised compliance by Lynne and the perpetrator and the HV not wanting to think the unthinkable (Daniel Pelka, 2013)[25]

3.2.39 **10th August 2016**

3.2.40 The family were seen by HV for Child 6's 3–4-month development review. She was assessed for the Universal pathway and was booked to be seen in 12 months' time.

> Other than the perpetrator's controlling behaviour (between May and August) there were no reported observations within the home environment that raised further concerns about domestic abuse.

3.2.41 **6th June 2017**

3.2.42 Child 6 was seen for their one-year development review and a different HV noted that they had a low score for fine motor skills, but this was due to the parents not completing the activities and Child 6 was reaching the rest of the developmental milestones. Child 5 was also seen, and parents expressed concern about speech and diet. They were advised to continue to share books with Child 6 to encourage communication. Regarding diet, it was suggested that they should continue offer foods throughout the day. It was noted on Lynne's record that domestic abuse was not asked about as there were 'others present'.

> When reviewing the case, the IMR author noted that there is no further mention of lone working risk in the notes. The policy advises that any changes to the risk assessment which had initially deemed potential risk to lone workers in the home require review by a team manager.

[25] https://pdscp.co.uk/wp-content/uploads/2020/02/SCR-Daniel-Pelka-2013.pdf

The IMR author notes that practice now enables a health visitor to explore domestic abuse within a relationship with both parents. Conversations around the relationship are explored rather than direct questioning about domestic abuse.

3.2.43 **4th December 2017**

3.2.44 Child 5's 2-year development check was completed by a further, different HV. The atmosphere in the home was described as tense. The perpetrator was controlling the visit by stating that they did not receive a questionnaire and didn't have time to complete one as he had to get back to work.

3.2.45 Concerns were raised about Child 5's speech and a follow up visit was offered. The perpetrator said that it would be a waste of time and that they would post the questionnaire back. He went on to say that they did not have a problem with Child 5's development. the HV recorded that his voice was intimidating, and that Lynne appeared 'flat' in her manner.

> There is no recorded evidence of further consideration of the impact of this behaviour on the children's lived experience.
>
> Whilst the perpetrator's behaviour was recorded, there was no further exploration of what this might mean in relation to domestic abuse.

3.2.46 **24th January 2020**

3.2.47 The service received a police report detailing the perpetrator's controlling and coercive behaviours. The practice guidance directs that the service should review the information being shared and consider if there is a need to support the children and family within the service. As there had been no involvement with the family since July 2018 it was deemed that no further follow up was required. The family remained on the Universal Pathway.

> This was an opportunity to seek further safeguarding supervision/advice due to the historic concerns within the service.

3.2.48 **28th January 2020**

3.2.49 The case was discussed at MARAC and was attended by a MASH practitioner.

The IMR author notes that, for MARAC to be effective, the MASH practitioner must have a full understanding of the role of health visitors and the support that could be provided to children and families.

3.2.50 **Assessment and pathway allocation**

3.2.51 When reviewing the case, and this review agrees, the IMR author acknowledges that, with the benefit of hindsight, decisions about the pathway allocation could have been different. If the allocation had been different, the family were likely to remain difficult to engage with

in any meaningful intervention, but it would have provided an opportunity to identify the continuous impact the domestic abuse was having on Lynne and the children. This may have informed an identified tipping point for a need to escalate to multi-agency assessment and management.

Recommendation

It is recommended that HCP ensure that the identification of the pathway for care is reviewed as part of the ongoing service review

3.2.52 **Discussions about healthy relationships and domestic abuse**

3.2.53 Historically there has been an expectation in this service that routine enquiry about domestic abuse is made at appropriate contact and recorded on the Systmone record. If it was inappropriate to make the enquiry this should be clearly recorded on the Systmone record. This was supported by NICE guidelines (2016)[26] that recommend that domestic abuse enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.

3.2.54 Following a previous Serious Case Review and Domestic Homicide Review an action was identified to upskill practitioners in community services in domestic abuse awareness.

3.2.55 The IMR author notes from interviews with one of the HV's that it was recognised that it would have been easier to explore domestic abuse in the relationship now that practice enables a health visitor to explore domestic abuse within a relationship with both parents as they now base their conversations around the relationship rather than direct questioning about domestic abuse.

Recommendation

It is recommended 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.

The review is aware that this change was introduced alongside the NICE Domestic Violence and Abuse Guidance 2016, and then has been reiterated, since 2021, as part of the Domestic Abuse Level 3 Adult and Children training where routine enquiry is discussed. The guidance given is that if practitioners are unable to have a conversation privately about any experiences of domestic abuse they will have a general conversation around how the relationship is and be curious around this from a perspective of the impact on the child.

3.2.56 When the HV was asked about whether they had considered completing a DASH risk assessment on 27th January 2016, they said that this would not have been possible as the perpetrator was present.

3.2.57 There is evidence that the perpetrator attempted to manipulate a number of professionals and that they felt unable to challenge him.

3.2.58 Working in isolation may have impacted on the professionals' ability to challenge the perpetrator and joint visiting may have reduced its potential impact on the workers. The

[26] National Institute for Health and Care Excellence (2016) Domestic Violence and Abuse. Published: 29/02/2016. Accessed: 01/04/21

opportunity to discuss the observations during supervision may have awarded the workers time to reflect on the guarded behaviour of the victim and children and consider this in the context of the abuse that they were experiencing.

Recommendation

It is recommended that staff are supported to discuss the manipulation by perpetrators on their day-to-day practice within supervision, team meetings and training.

3.2.59 Safeguarding supervision was provided by the Team Leader with agreed outcomes that were task focused to gain further information about any historic domestic abuse by the father and ascertain the plan from children's Social Care.

The review is advised that the safeguarding supervision model in place at the time has been reviewed and a revised supervision model is now in place. The model facilities a deeper reflection from both the supervisee and supervisors inclusive of the intrinsic and extrinsic factors that impact on the case and professional decision making. The revised model allows for additional support to be put in place for complex cases and facilitate management oversight which will better support professional development and awareness of the human behaviours of professionals that may impact on their decision-making abilities.

3.2.60 **Current practice**

3.2.61 Since Lynne's murder there have been several changes to the practice within the service.

3.2.62 The records show a lack of evidence on the focus of the lived experience of the children and health visitors are now encouraged to make use of tools such as 'A Day in the Life of a Child' to support their ongoing assessments to remain child focused.

Recommendation

It is recommended that these tools are revisited considering any published guidance alongside the Domestic Abuse Act 2021 which emphasises that children should be considered as victims of domestic abuse.

Recommendation

It is recommended that practitioners should, seek 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.

3.2.63 Domestic Abuse Champions are now present in the six localities of the HCP to support and disseminate further learning to practitioners when working with domestic abuse. The Champions encourage staff to ask curious questions around relationships as well as provide supervision and support with completion of DASH forms.

3.2.64 CSC have been completing work 'around working with fathers' and practitioners are now encouraged to open father's records as part of any assessment. Groups and relationships within Systmone records need to be linked, linking father, mother, and children. To support this work CCS have developed a 'think family' approach to practice which enables all practitioners to consider the 0-19 age range and for a health needs assessment to be offered accordingly. The implementation of the Working Together to safeguard Children (2018) and

the Norfolk Threshold Guide along with the practice model encouraged a think family approach which has been adapted across CCS.

3.2.65 CSC has developed a combined adult and child domestic abuse development package of refresher level 3 training for staff and is supportive of the Think Family approach. The session contents focus on both adult and children as victims of domestic abuse, incorporating the need of multi-agency approach, DASH and MARAC & learning from DHRs. This training commenced in April 2021 and continues to be rolled out Trust wide, early end of day evaluations have been very positive. Learning from this DHR will be incorporated into this training.

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

3.3.1 The perpetrator was sentenced to a 12-month Community Order with a single requirement to complete 12 hours of Unpaid Work (UPW) on 7th August 2018.

3.3.2 Within this order, the perpetrator worked a proportion of his hours through an individual placement in a charity shop and his Delius contact log demonstrates consistent compliance as he did not fail to attend any of his sessions. His apparent compliance led to the reduced likelihood of occasions in which he would be contacted by his probation officer to check on his circumstances. Even though the perpetrator was having regular contact by undertaking his hours as directed, the Delius logs demonstrate that very little information was being shared in relation to what he was specifically saying or doing during these sessions.

3.3.3 Throughout the order the Delius record suggests he had direct contact with CRC staff (other than CP Officers) on four occasions. One being his Initial Induction, two being other members of staff discussing his working days and once with his allocated probation officer at the review stage of the order.

Whilst contact with service users is often more limited with Stand Alone UPW cases, the lack of frequency in the contact the perpetrator had with staff may have inhibited the effectiveness of his risk assessment and sentence management. Given that the last 8 months of his order were spent with no contact from his probation officer, it is reasonable to state that any changes in circumstances – other than further arrest or court work, went unchecked at termination stage.

3.3.4 Whilst the Delius record demonstrates that the perpetrator was asked about his relationship status and it was recorded that Lynne was his partner, the logs also suggest there was no further exploration into his relationship dynamic, his opinion of his relationship or view of its overall health.

A general lack of professional curiosity continues to remain a theme running through the contacts the perpetrator had with the service. This coupled with the omission of relevant social care and police checks meant that potentially there would have been more information available that would have helped better inform each probation officer of the current circumstances and risk.

The review is advised that, since 2019, safeguarding checks with social care and police domestic abuse intelligence have been incorporated as standard practice with all cases, regardless of banding or tier. This ensures that probation officers receive better information relating to the domestic situation and history of all cases.

The IMR author notes that, because the perpetrator presented as compliant, completed his hours efficiently and responded co-operatively to planned telephone contacts asked of him, this did not raise concerns about his conduct. It is possible that there would have been some indications of relationships being an area of risk for him and therefore clearer information could have been included within the Risk Management Plan had the following actions been undertaken:

- **Safeguarding checks had been completed at induction stage**
- **More information had been known about his relationship with his ex-partner**
- **More professional curiosity had been employed to explore his circumstances with him in more depth**
- **More information had been requested in relation to his previous offending**

This in turn may have led to greater focus on victim safety planning, monitoring and support.

Recommendation
It is recommended 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.

Recommendation
The review is aware that since the commencement of this case, 'Think this, Do this' guidance aimed at increasing staff curiosity around safeguarding has been implemented but it is recommended that further training is provided to all staff in professional curiosity, including support staff, UPW staff and operational partners including those responsible for supervising IP placements.

Recommendation
It is recommended 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.

3.3.5 Whilst current policy is to terminate Community Orders upon completion of the UPW hours, there are cases that will remain open due to active safeguarding concerns. In 2019 medium risk cases were expected to remain open for the duration of the order regardless of whether the hours had already been completed.

Recommendation
It is recommended that, in these instances, 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.

3.4 **CHILDREN'S SOCIAL CARE**

3.4.1 Prior to his relationship with Lynne, CSC had three interactions with the perpetrator which are of note to this review.

3.4.2 In January 2013 concerns were raised about bruising seen on Child 2 and a Section 47 enquiry was undertaken and it is recorded that clear accounts were provided about how the bruising occurred and no further action was taken.

3.4.3 Concerns were raised in March 2013 about the perpetrator's girlfriend of the time attending a drug and alcohol appointment with Child 1 and Child 2 and her speech was slurred. Following an assessment in which no concerns were raised the case was closed.

3.4.4 There was a further referral in October 2013 after the perpetrator took an overdose. It was recorded that this was due to him feeling depressed after the death of his sister. He accessed support, the children were spoken to, and the case was closed.

3.4.5 On all occasions the children were spoken to, and nothing was aired that caused worry for CSC about their homelife or the care provided by the perpetrator.

The children spoke intermittently about their mother and the account was given that she had mental health concerns and only saw the children occasionally. There is no evidence that she was contacted. There is no evidence that checks were made of the perpetrator's previous offending history.

The IMR author has noted that CSC should ensure that they discuss with absent parents their concerns and worries. Not only that, when undertaking an assessment, CSC need to make concerted efforts to find those parents and given them the opportunity to share their views. However, given the nature of the referral in this case, firstly that an explanation was provided for the bruises that was accepted and that the others did not relate to harm towards the children, at this stage it can be understood why this action was not taken.

Unfortunately, not triangulating the information from the children at this stage also had the capacity for potentially incorrect information about their mother's mental health being included upon records. That, in turn, had the potential, without further checks, to influence future decisions that related to her.

Recommendation
It is recommended that policies and procedures are reviewed to ensure that absent parents are contacted when referrals are received, if appropriate, and they are given the opportunity to give their view.

Since that time, guidance has evolved and now makes use of the Family Network Approach as per the Family Network Quick Guide November 2021, Genograms Quick Guide November 2021 and Chairing a Strategy Meeting Quick Guide April 2022.

3.4.6 In 2014 and 2015 the perpetrator's ex-partner contacted CSC on two occasions seeking help in seeing her children. Both times she was advised to obtain legal advice.

Little information is recorded about the circumstances such as why she was not seeing the children and her worries.

3.4.7 In January 2016 the perpetrator's ex-partner contacted CSC again as she was concerned that there had been an altercation between the perpetrator and Lynne, and he had been kept in custody. She said that the children were scared that he was coming home.

There is recorded contact between CSC and the perpetrator's ex-partner in February 2016 when she spoke about having not seen him since 2014. She said the perpetrator wanted her to see the children more often but that finances prevented this. It was confirmed that a previous court hearing (2012) had determined residence for the children. There is no recorded evidence that the perpetrator's ex-partner relayed any safeguarding concerns at this time. The review has been made aware of further management oversight in March 2016 when including the perpetrator's ex-partner's views and any concerns were recorded.

3.4.8 As part of the Initial assessment that was completed in May 2016, Lynne was seen with the children on three occasions, 21st January, 29th April and 4th May 2016. The initial assessment was started due to information that the perpetrator had been arrested after an altercation that started at a pub; the family had been asked to leave due to the children's behaviour and they then returned to the family home. It was at this point that Lynne decided to leave due to the perpetrator becoming aggressive. She took Child 4 and Child 5 who was 8 months old with her. It was noted that there was an altercation in which the perpetrator elbowed Lynne in the chest and Lynne caught him in the throat whilst trying to get Child 5 into the car. The police were called at this point and the perpetrator was arrested.

3.4.9 By the time of the visit completed in January Lynne had returned with Child 4 and Child 5. Child 4 and Child 3 talked about feeling scared and sad by the incident but that both parents had decided not to drink anymore and had removed the bar in the home. It was recorded that since then the house had been a lot calmer. Child 1 was more reluctant to talk and seemed subdued.

There is no recorded evidence that attempts were made to speak to Lynne on her own. The records show that the social worker appears to be centred on working with the perpetrator who was controlling in his attitude. The issues often centred around consent to assessment, and working hard on gaining that consent and if this was not completed, what other actions could be taken, namely, to take it to Section 47, where the need for

consent would be negated the need for consent to gain a multi-agency view of the concerns, and potentially further information. There is a lack of recorded consideration of exploring the domestic abuse. This does not mean it did not happen, but the records are focussed upon the perpetrators attitude.

Valuable time was lost in the gap between January 2016 and the next visit in April 2016 due to the social worker leaving. There were no visits undertaken and the assessment was not completed. The perpetrator's ex-partner was not contacted despite the records being peppered with worries that she had not seen her children.

There is little evidence of Child 1 and Child 3 being seen alone and Child 3 being observed to understand what he thought. The IMR author acknowledges that there could have been more impetus on understanding the child's experience in living in the home, talking with children alone, talking with Lynne alone and looking at the risks for the children in both the short and long term.

The review is aware of the Triax Procedures that ensure that the child/young person is seen on their own where this is appropriate for their age and understanding at least once between reviews. If the child/young person is not seen alone this must be recorded. Where the child/young person is not seen alone, and the social worker has concerns this should be reported to the team manager.

Recommendation
It is recommended that CSC reinforces the guidance and that were appropriate 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.

Recommendation
It is recommended that parents/carers that are potential victims of abuse are seen alone so that they can talk freely about their experiences. This is something that now features in the Domestic Abuse Toolkit (April 2022).

3.4.10 The family were then seen on 25th April, 29th April and 4th May, when the Initial assessment was completed. Observations were then made that the children seemed happy and chatty and did not reveal any worries. Lynne, when spoken to about the altercation with the perpetrator, stated that she left as she needed to protect her children, but the records show that little further was discussed.

3.4.11 The case was closed in May 2016 as the children were reporting that things were fine at home. Lynne had recently given birth and was saying that there were not issues. However, professionals did record their level of on-going concern for the children in revealing notes, set out below:

All the children remain at risk of emotional and physical harm, xxxx having made an allegation of possible assault by his father, following episodes of domestic violence between [the perpetrator] and Lynne which the children witnessed directly,

We are worried about Lynne and [the perpetrator's] relationship domestic violence is presented as a feature and Lynne is understood to have recently been physically harmed following an altercation. We are worried about the nature of their relationship and the physical and emotional impact this is having on all of the children. [The perpetrator] and

Lynne have spoken to the previously allocated worker and disclosed alcohol is the 'cause of their arguments'. It is understood Lynne had been drinking during the recent incident and she is pregnant. Please refer to CF records regarding the views of the children... there is concern they are exposed to significant control by 'the perpetrator'.

There is no information to suggest that information was shared with other agencies.

3.4.12 A further referral was made to CADS (Children's Advice and Duty Service) by the school in June 2016 after Child 2 said that there had been an argument and the perpetrator had become angry. The referral was not progressed from CADS as it was suggested that the school undertake some 'wishes and feelings' work with Child 1 and Child 2.

This course of action, well-meaning as it was, placed huge responsibility on the school and the children, rather than looking at the risk for the children and the parent's ability to be protective and understand the impact for the children.

3.4.13 It is during this period that family court proceedings were on-going, and the family feel strongly that the lack of understanding of this perpetrator's past behaviour and thus risk, was not identified by any agency involved and thus left one of the female children particularly at risk of continued emotional abuse as she was placed with the perpetrator during this period.

3.4.14 The next involvement was in January 2020 when CADS (Children's Advice and Duty Service), were notified of a MARAC meeting on 28th January in which the case was discussed following a further altercation between Lynne and the perpetrator, resulting in Lynne leaving the home.

No referral was made from MARAC to CSC

3.4.15 Information is also on Child 3's file to say that Lynne attended second primary school (PS2) with Child 3 saying that the perpetrator was arrested the previous night. Child 3, at this point, discussed with the school that he is aware that his parents are fighting, and no one is on Dad's side. The school were informed to continue to monitor the situation but that the referral did not meet the threshold for CSC.

3.5 **DEPARTMENT OF WORK AND PENSIONS (DWP)**

3.5.1 Lynne contacted DWP on 27th January 2020 when she left the home she shared with the perpetrator. The work coach continued contact with Lynne until 15th May. During this time the work coach responded promptly to Lynne and was empathetic to her situation and immediately advised her to obtain a Fit Note from her GP so that she would not be required to be actively seeking work. ***This is an example of good practice.***

3.5.2 **Domestic violence and abuse easements**[27]

The domestic violence and abuse easement should have been applied to Lynne as soon as she notified Universal Credit that she was a victim of domestic abuse – 27th January 2020. This easement would have initially applied for 13 weeks, and its application could have been extended for up to 26 weeks.

3.5.3 The guidance states that all work-related requirements must be, temporarily switched-off for 13 weeks if the claimant is or has been a victim of domestic violence and abuse, providing the:

- incident or pattern of domestic violence and abuse occurred within the previous 6 months
- incident or pattern meets the definition of domestic violence and abuse
- claimant is not living at the same address as the abuser
- claimant has not had requirements switched-off as a result of previous domestic violence and abuse within the last 12 months
- claimant provides written evidence within one month of the date they discussed the matter

3.5.4 If the claimant provides the relevant evidence and is responsible for a child, children or qualifying young person(s), the switch-off period is extended to 26 weeks from the date the claimant discussed the matter. Claimants can attend voluntary work focused interviews after the first 13 weeks of the switch-off period. Those in the Intensive Work Search and Light Touch regimes are offered voluntary work focused interviews after the first 13 weeks, if they have children and are eligible for the 26-week switching-off.

3.5.5 **What this would have meant for Lynne**

3.5.6 The domestic violence and abuse easement was unfortunately not applied to Lynne. If this easement had been applied, all work-related requirements would have been switched off initially for the first 13 weeks. In principle this would have meant that Lynne would not have been expected to conduct any work-related activities.

3.5.7 Although the domestic violence and abuse easement had not been correctly applied in Lynne's case, Lynne's claimant commitment had been amended and stated, '0 hours looking and preparing for work'. From this statement it was clear that Lynne was not expected to be undertaking any work-related activity. Lynne accepted her claimant commitment.

Lynne's interaction with the department was on a light touch basis to ensure that she continued to receive any additional support she might have required.

Recommendation

It is recommended that staff are reminded about the domestic violence and abuse easements reminding them of the relevant guidance and implementation.

[27] https://www.gov.uk/government/publications/domestic-violence-and-abuse-help-from-dwp/help-available-from-the-department-for-work-and-pensions-for-people-who-are-victims-of-domestic-violence-and-abuse

3.5.8 **The Impact of COVID-19 lockdown**

3.5.9 Contact with clients moved on line and some appointments were postponed but this did not impact upon the service that was delivered.

3.5.10 There is evidence that clients were regularly kept informed about changes to the way in which services were delivered.

3.6 **NORFOLK COUNTY COUNCIL, EDUCATION DEPARTMENT**

3.6.1 When completing their IMR, the Education department sought to examine events thematically as the education records reflected that many of the events and experiences are connected to understand how the schools understood, worked with, and responded to working with the children in this family and the adults in their roles as parents and carers.

3.6.2 **Understanding relationships within the family, blended families, and complex parental relationships**

3.6.3 The records and conversations with staff indicated that both PS1 and PS2 understood the relationships within the household and what the lived experiences were for the children. The PS1 Headteacher reflected that the perpetrator's relationships prior to Lynne appeared to be of convenience. He noted that the women the perpetrator had previous relationships with were vulnerable with 'emotional well-being difficulties' and those relationships were troubled by the negative influence of alcohol and the perpetrator's misogynistic attitude towards them. The Headteacher of PS1 perceived that the relationship between the perpetrator and Lynne was different. He described Lynne as being unlike the perpetrator's previous partners in that she was not vulnerable, and he was aware of Lynne's family's disapproval of the relationship from the outset. PS1 Headteacher also reflected that the relationship was positive for Child 2 and Child 3 who had experienced so many changes in the perpetrator's relationships, house moves and school transfers that resulted from these frequent and sudden changes in partner. Child 2 experienced a period of consistency from a female care giver that they had not experienced since their biological mother and Child 3 had not previously experienced. Conversely, the relationship between Lynne and the perpetrator did not appear to be so positive for Child 4 who expressed to PS1 school staff her struggles with the perpetrator's behaviours and the resultant arguments. An absence of any safeguarding records for Child 4 prior to Lynne and the perpetrator's relationship suggests she had not been exposed to a significant level of conflict or risk within her family home.

3.6.4 PS1 had regular telephone communication with Child 2 and Child 3's biological mother but did not fully understand why the children were residing with the perpetrator. Through this contact, PS1 had some awareness of the history of control and coercion from the perpetrator towards Child 2 and 3's biological mother.

However, PS1 appears not to have recognised that Child 2 and Child 4 talking about the perpetrator's manipulative behaviours such as feeding their breakfast to the dog or shouting and swearing at them during arguments lasting until 1am were indications of escalating events involving alcohol and arguments between the perpetrator and Lynne.

These incidents mirrored the perpetrator's previous relationships PS1 was aware of and were possibly indicative of changing dynamics within the family home. If recognised in this way, school staff may have been able to offer support to Lynne.

Since Lynne's death the understanding of domestic abuse has improved within education settings. This is due, in part, to the implementation of Operation Encompass and the training of 446 Domestic Abuse Champions across education settings since 2015.

3.6.5 PS2 understood Child 3 to accept Lynne as their mother and having limited contact with their biological mother. Child 3's biological mother made contact once to request a school report and she did not make contact again.

PS2 reflected that they had not prioritised her as an absent parent and this resulted in a one-sided picture of Child 3's network and past experiences.

3.6.6 The high school (HS1) did have some contact with Child 2's biological mother during the period in March 2016 when they went to live with her for a very short period. HS1 DSL met with both biological parents and this episode at HS1 was memorable and developed his understanding that the perpetrator could become angry when he was not able to control the decisions being made.

3.6.7 Child 2's biological mother did contact HS1's DSL to talk about what life was like for Child 2 and he supported Child 2 through regular opportunities for them to talk. Child 2 did talk about how scary the perpetrator could be when he was drinking showing that they felt safe to talk in school to a trusted adult, but that they were worried about the implications if the perpetrator was made aware of what they were talking about.

The IMR author noted that the schools that participated in this review demonstrated a clear understanding of family dynamics and what life was like for children, highlighting the crucial role schools can play in supporting children and the victims of domestic abuse.

3.6.8 **Working with aggressive parents who may have a history of violence and a shared understanding of risk across multi-agency working**

3.6.9 All three schools were aware of the perpetrator's aggressive attitude. PS1 experienced his aggressive behaviours towards female school staff and had received information from Child 2 and 3's biological mother about his control and coercion during their relationship. PS2 and HS1 received Operation Encompass notifications regarding Lynne's disclosure in January 2020 of the perpetrator's controlling and coercive behaviour over a three-year period including threats of violence and threats to prevent her from seeing the children. PS2 contacted Children's Advice and Duty Service (CADS) following Lynne informing the school of the events, Child 3's disclosures in school and the receipt of the Operation Encompass notification providing the full detail of Lynne's disclosure. ***It is a positive example of the impact of sharing information about domestic abuse with schools, the support they can offer to children and their families and the wider context and information that they can share as a result.***

3.6.10 NSPCC's Domestic Abuse: learning from case reviews briefing (June 2020) identifies that '*families who have experienced domestic abuse do not always engage with services, such as domestic abuse support programmes or mental health services. They may participate in a service and gradually stop, suddenly stop attending support sessions or not engage with support at all. If practitioners are not aware of this, they may believe children and families are being supported when they are not*'.

For this family, neither HS1 or PS2 were aware of the other agencies offering support through the MARAC plan or Lynne's gradual withdrawal of engagement with services. Whilst Operation Encompass provides schools with details of incidents, in this case neither setting was involved in the subsequent planning for Lynne and the children, and this would have been beneficial. Neither PS2 or HS1 were invited to attend the MARAC meeting held in January 2020 nor had the subsequent safety plan shared with them. PS2 and HS1 were aware of Lynne's continued contact with the perpetrator, her return of Child 5 and Child 6 to the perpetrator's care and the increasingly difficult living arrangements for Lynne and Child 4 through Child 4's disclosure to a teacher at HS1 but did not understand that these events escalated the risk level within the family.

As neither school were part of the multi-agency response to Lynne's report to police in January 2020, they were not aware of which professionals to talk to about increasing risks. The absence of PS2 in the multi-agency response also prevented other agencies from drawing on the role of schools as a place of safety where they can be an enabler for other agencies where engagement is poor, such as when Lynne disengaged with Leeway in March 2020.

In addition, PS2's DSL reflected that they had not understood the extent of the perpetrator's violent history and the level of risk that he posed to Lynne and the children until it was disclosed to them during the strategy meeting in June following Lynne's murder. The involvement of education settings in MARAC is a learning point from the case.

Recommendation

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

3.6.11 PS2 and HS1's DSLs reflected on the positive benefits of the Operation Encompass scheme in enabling them to support pupils at their schools who have been involved in an incident. Prior to January 2021, Operation Encompass notifications were shared with DSLs via a telephone call. The combination of a greater number of education settings participating in the scheme, staff absence and increasing volume of notifications due to the creation of new control and coercion offence from 2015 resulted in delays in DSLs receiving daily notifications. From January 2021, Operation Encompass notifications have been shared with schools and colleges electronically to ensure swifter delivery of key information before the start of the school day.

As a result of Lynne's murder, daily management oversight of incidents has been introduced to ensure that the most serious incidents, including murder, are provided to education settings via telephone contact.

Recommendation

Both HS1 and PS2 suggested that the information contained within the police reports can be confusing or limited and it is recommended that a single point of contact for Operation Encompass would be a beneficial further improvement.

Recommendation

It is recommended 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

3.6.12 Sadly, the immediate response to Lynne's murder did not include any consideration of the schools the children attended. PS2 reflected on the difficult period from learning of Lynne's murder through local newspaper articles and rumours within the local community, where many members of school staff lived, to the strategy meeting held on 22nd June 2020. PS2's Headteacher described the complications in trying to ascertain official information from the police and CSC over the weekend period resulting in uncertainty and distress and the inability to initiate support for pupils, staff and the wider community until official confirmation was received through the strategy meeting.

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.

Recommendation

It is recommended 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.

3.6.13 **The challenges of managing concerns when they are deemed not to meet CSC threshold**

3.6.14 All three schools understood, to varying extent, that there was domestic abuse occurring within the family home through disclosures made by Child 2, Child 3 and Child 4 at different times throughout the period and from sharing of police information through the Operation Encompass in January 2020. All three schools described the perpetrator's aggressive manner and PS1 and PS2 were keenly aware of the negative impact of his behaviours towards female school staff and parents within the community in addition to his partner relationships and for the children within the family.

3.6.15 PS1 and PS2 provided safe and secure spaces with trusted adult relationships enabling Child 2, Child 3 and Child 4 to talk about their lived experiences at home. HS1's DSL sought advice from Children's Advice and Duty Service (CADS) when Child 2 disclosed the perpetrator's aggressive behaviour and language towards them. HS1's DSL was advised to discuss Child 2's worries with the perpetrator and offer support as threshold for social work intervention had not been met. HS1's DSL, in consultation with HS1 Headteacher, did not feel it would be in Child 2's best interests to talk to the perpetrator about their feelings and continued to support them through providing a safe space to talk in school.

3.6.16 PS2's DSL spent time with Child 3 following Lynne's police report in January 2020 enabling them to explore their wishes and feelings about the events and sought advice from Children's Advice and Duty Service (CADS) in response. Children's Advice and Duty Service

did not offer social work intervention for the children as Lynne's actions to remove herself and Child 4, Child 5 and Child 6 from the family home were deemed protective.

This decision did not appear to consider that Child 2 and 3 remained in the family home with the perpetrator and the different risks posed to them by being left being cared for by the perpetrator of the abuse.

3.6.17 HS1 and PS2 both described the difficulties for schools where thresholds for statutory intervention thresholds 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. The schools did demonstrate some tenacity in these difficult circumstances. PS1 and PS2 did offer the perpetrator early help support despite his aggressive attitude towards school staff, but he did not accept the offers. Without parental consent for outside agency intervention and concerns not meeting CSC's statutory thresholds for intervention, PS2 worked hard to manage the perpetrator's behaviours, provide opportunities to engage Lynne away from his influence and support Child 3 to develop healthy relationships and behaviours. PS2 identified Child 3 was mirroring the perpetrator's behaviours and they introduced discreet support to build their confidence, creating opportunities for them to shine. This in turn enabled positive interactions with the perpetrator leading to the development of a better relationship with the school. As Child 3 was learning self-regulation and building his self-esteem, they talked more about their home life and their conflicting feelings about dad's behaviours.

3.6.18 **The impact of COVID-19 lockdown**

3.6.19 The safety and support offered by school was undoubtedly impacted by the partial school closures in response to Covid-19 in March 2020. During the period of partial school closures, PS2 offered school places for both Child 3 and Child 5 which neither the perpetrator nor Lynne accepted. They persisted in offering support through regular contact with the family ensuring they had opportunities to talk with the perpetrator, Lynne, and the children.

3.6.20 PS2 Designated Safeguarding Lead was concerned for Lynne and used the collection of free school meal vouchers and home learning packs to provide opportunities for Lynne to meet with her away from the perpetrator. PS2 Designated Safeguarding Lead considered how difficult it is to support families during relationship breakdowns where frequent reconciliation can be a feature of the partner relationships demonstrating the complex nature of abuse and domestic violence.

3.7 GP FOR LYNNE AND THE PERPETRATOR

3.7.1 It is clear from the chronology that the health visitor (and the social worker) was aware of concerns about ongoing domestic abuse.

3.7.2 Presently the GP surgery would expect a health visitor or midwife who has concerns to communicate with the practice in one of three ways:

(1) If the concern is urgent, it would be passed to the General Practitioner on call for emergencies at the surgery the patient normally attends. The discussion can be face to face although other options include emails, tasks, and phone calls.

(2) If there were concerns of a less urgent nature especially if the health visitor or midwife wanted to speak to a clinician with personal knowledge of the patient, it would be

passed to the GP best placed to reply however it might not be possible to deal with it on the day, depending upon workload and whether the GP was available - all contacts now are by telephone appointment however pre-pandemic telephone consultation slots could be used for this type of concern, which were in addition to the normal face to face surgeries.

(3) Non urgent concerns would be passed to the liaison health visitor, to raise at the monthly liaison meetings

3.7.3 A monthly health visitor liaison meeting has been held at the Practice since approximately 2016. There is always at least one GP in attendance to discuss concerns about child protection. Minutes are not taken, however a list of patients discussed is retained and entries made in the clinical notes when discussion occurs that it is felt important to document regarding clinical care - a process which was approved at the practice last CQC inspection. Patients to be discussed are identified through concerns raised by the health visitor, practice staff or following receipt of a MARAC report.

It is apparent that the issues of domestic abuse in this case, were discussed at a meeting held with the liaison health visitor three days after the face-to-face consultation with a GP in March 2020 where concerns were raised. The safety of the children was discussed although the timing of information sharing was coincidental. There is no record of discussion of the case at these meetings before March 2020.

Recommendation

It is recommended that the ICB supports a primary care system wide review of health visitor/social worker escalation processes and establish effective protocols, as necessary

3.7.4 Following a MARAC meeting, the GP surgery will receive notifications electronically and health visitors will document the discussion and its outcome within the Systm One records. Where concerns are raised that need to be shared, the expectation is that these are brought to the weekly GP meeting attended by GPs, GP trainees and nurse practitioners and information is cascaded through the practice team when appropriate.

Recommendation

It is recommended that the ICB supports a primary care system wide review of responses to notifications of domestic abuse and high-risk concerns and establish effective protocols as necessary

Practice staff including receptionists, health care assistants, nurse, managers, and doctors received domestic abuse training provided by Leeway (local specialist domestic abuse charity) in approximately 2013. Existing staff within the Practice have not accessed any further dedicated domestic abuse training since this time, despite it being a requirement for all staff to have awareness (or higher-level training, dependent on role) every three years, as outlined in the Adult Safeguarding: Roles and Competencies for Health Care Staff 2018 intercollegiate document[28].

[28] https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/august/pdf-007069.pdf

Recommendation

It is recommended that the ICB works in partnership with specialist services to ensure the availability of domestic abuse training

Recommendation

It is recommended that the ICB includes domestic abuse (identification/response etc) in the primary care adult safeguarding exemplar policy

3.7.5 New staff induction training includes Child and Adult Protection guidance, and receptionists in particular, are trained on how to identify and deal with possible abuse towards children or other adults.

The GP practice does not currently have a Domestic Abuse Champion

Recommendation

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

3.7.6 **The perpetrator's mental health**

3.7.7 A GP in Birmingham, in 2011, added a note to the perpetrator's records indicating that he was diagnosed with schizophrenia. It appears that he was diagnosed by a psychiatrist in 1993 after a prison sentence for a stabbing. When registering he made no declaration of mental health issues and was taking no medication.

3.7.8 In 2013 it was noted that he was seen by a mental health team and missed several appointments. The surgery was then advised that two clinicians should see him at every appointment. Mental health follow-up seems to have ended in July 2012 and the reason for this is unclear.

3.7.9 He was not on a regular prescription from his GP in Norwich. At the appointments he had in Norwich, the perpetrator reported being under stress and having poor sleep and was prescribed medications to assist with his sleep.

3.7.10 At the appointment in November 2018, he was noted to be 'short fused/irritable?' On examination he was noted to be tense/anxious, but his demeanour does not appear to have been explored further.

There is no information available that can assist us as to why his mental health appears not to have been explored.

When the surgery received the alert advising against lone visiting due to documented entries of previous violence, this could have provided an opportunity to consider a review of the perpetrator and his mental health, there is no information available to assist us as to whether this took place or not.

3.7.11 **The impact of COVID-19 lockdown**

3.7.12 Clinical contact moved to being by video or over the phone which made it more difficult to identify causes for concern.

3.8 **LEEWAY**

3.8.1 Leeway is Norfolk's largest specialist provider of domestic abuse support and provides the Independent Domestic Violence Advocate (IVDA) service for high-risk victims.

3.8.2 **16th – 28th January 2016**

3.8.3 The IDVA High risk service received a referral for Lynne who was 5 months' pregnant and staying at her mother's address with her two children. Lynne's mum was looking after the perpetrator's children whilst he was in custody awaiting an interview as he did not have any family who can look after his children.

3.8.4 Lynne said that she and the perpetrator had been together for about 18 months. Lynne said that he was very controlling, and she felt like he is her shadow; he would follow her everywhere, had drink problems and emotional/mental abuse was always taking place in their family. He would call the children names and Lynne said he that he had once kicked a child but other than that he had not touched them.

3.8.5 A DASH was not completed as Lynne was getting on with so many things and said that she did not know what was normal in a relationship anymore. She said after the incident that day she would leave him as she knew where it could lead, as her mother had been in an abusive relationship too and she did not want to repeat it in her life. She said that the perpetrator had threatened her with a knife once, but she had not taken any action. She said that he had stabbed his previous girlfriend, and once in the park wanted to hurt her with a knife but as she was there with her baby, he could not do anything. Lynne said he had experienced mental health issues previously after his mother had died by suicide. He was, once, admitted to hospital after having taken an overdose. Lynne said she did not know if he had a criminal history.

3.8.6 No refuge space was available, and Lynne was offered temporary accommodation, but she decided to stay at her mother's house for the weekend.

3.8.7 Following this conversation, Lynne was telephoned on several occasions and a male always answered the phone. On 27th January Lynne spoke to Leeway and said everything was OK and she was back with the perpetrator and no longer needed support. She thanked Leeway for being there and the worker believed that the perpetrator was present. Leeway reported their concerns to the police and CSC. No further contact was established, and the case file closed on 22nd March.

Leeway noted that Lynne was vulnerable as she had a young baby and was pregnant. They were concerned that she felt that, as the police had been involved, he would now change. It was noted that Lynne felt that as he had custody of his children, and that he presented himself to society as a 'good person' he was able to change.

It is noted that there is a sense that Lynne felt that as the police had been involved, other agencies would also automatically become involved, and he would be helped by mental health services.

3.8.8 **New referral on 20th January 2020**

3.8.9 Leeway received a referral for Lynne on 22nd January. It was noted in the referral that over the previous three years, the perpetrator had been threatening violence towards Lynne to control her. He had a tracker on her phone and never let her do anything on her own. He had threatened to take the children away and never let her see them again. The perpetrator would make Lynne feel bad to make her stay with him. Child 5 had been hurt in the latest incident.

3.8.10 Leeway telephoned Lynne on 24th January and she engaged with support and stated that she wanted accommodation locally as she had heard that refuges were not nice. Leeway reassured her that they were OK and were safe. They discussed the housing situation with Lynne as she was with her mother and the house was overcrowded, and the tenancy was about to end. Leeway suggested applying to transfer the tenancy into her name, but Lynne said this would not be possible as she had an Individual Voluntary Agreement[29]. She said that she had also been in business with the perpetrator so was now out of work. Temporary accommodation was discussed and the IDVA arranged to meet with Lynne. Lynne said that the perpetrator was abiding by his bail conditions, and she had not heard from him.

3.8.11 The IDVA met with Lynne on 28th January. Lynne was grateful for the opportunity to meet and talk things through. It was noted that Lynne had an appointment with Broadland District Council on 21st February to discuss her housing situation. The IDVA agreed to contact the council to see if she could be seen earlier.

3.8.12 Lynne was concerned about taking action against the perpetrator due to the impact that it would have on the children. She was aware that he knew his rights and, once the bail conditions ended, he could just collect them from school. Lynne was provided with details of a solicitor, and she said she would call them as soon as possible to discuss child contact arrangements. Lynne was determined that the relationship was over, and a DASH was completed from which she was identified as HIGH risk, along with safety planning. She said she had received no contact from the perpetrator but that he did speak to the children on the phone. Lynne continued to engage with the IDVA.

3.8.13 The perpetrator's bail conditions were lifted on 20th February, and Lynne told the IDVA that she met with him after he contacted her to sort everything out. The children were playing up and she could not hear him on the phone so had picked him up and they went to a public place to talk. She had allowed the youngest two children to stay with him for two nights. She said that her mother was very angry about this and had said that she was not welcome to stay any longer. Lynne said she was jobless and homeless and was having suicidal thoughts and

[29] https://www.iva.org/what-is-an-iva

had been reported as a missing person, although she had assured everyone that the thoughts were flippant, and she has her children to look after.

3.8.14 The Leeway Anchor Project sourced emergency accommodation for a few nights, and she then moved into a local motel provided by Broadland Council.

3.8.15 On 2nd March Lynne spoke to the IDVA and said she was very happy in the motel, and she seemed more settled. She had been in contact with the perpetrator, and this had been fine and she and her mother were now talking again. Lynne then started to disengage from support and no longer answered phone calls or text messages.

3.8.16 The case was closed on 19th April as there was no further contact.

Lynne was reluctant to access a refuge as she wished to stay in the area, and she had negative views of refuge. Her engagement with the IDVA meant that she was able to stay in their temporary accommodation and support her to make an application to Broadland District Council. *This is an example of good practice.*

The review notes that the perpetrator used the children as a form of control. Lynne, to her credit, was very independent and believed that she could manage the perpetrator and keep her and the children safe. In talking with the IDVA, Lynne was able to use the 'power and control' wheel to understand the patterns of the perpetrator's coercive behaviour.

3.9 **NORFOLK CONSTABULARY**

3.9.1 **15th January 2016**

3.9.2 The police were called to the home address following an incident between Lynne and the perpetrator and all five children were present. Lynne had attempted to leave with Child 5 (8 months). She had put the baby in the car seat and walked out towards the car parked on the driveway. The perpetrator had followed her, and a tug of war has occurred over the car seat, with him trying to prevent her from leaving with Child 5. Lynne said that he had elbowed her in the neck with force. During her statement Lynne said that he mouthed to her 'you are going to die'. Lynne was seen with reddening to her chest and neck area upon police arrival however this had disappeared by the time that photographs could be taken.

3.9.3 A DASH was undertaken and assessed at HIGH risk. Lynne said, as part of the assessment, that she was fearful of further injury or violence and that he would kill her. She said that the physical assaults had increased, she was frightened of the perpetrator and that he policed her in her own home. Lynne also said that the perpetrator had been in possession of a knife, and he had explained to Lynne that he had previously wanted to kill his ex-partner. She also gave details of the debts that the perpetrator had accumulated through gambling. Lynne said that she would like to leave the relationship but would ultimately need a huge amount of support as she had five children and a sixth on the way.

3.9.4 A referral was made to the Multi-Agency Safeguarding Hub (MASH) where research showed that there was no domestic abuse history between Lynne and the perpetrator but there were three reports against the perpetrator in relation to other partners. This information was added to the investigation for the attention of officers.

3.9.5 The DASH underwent a secondary review the following day and the risk was reduced to MEDIUM on the basis that the perpetrator was in custody, and, in a telephone call, Lynne confirmed that she had moved in with her mother. The MEDIUM risk accepted that there was still potential for the perpetrator to cause serious harm, but it was unlikely unless the circumstances changed.

The review agrees with the IMR author that this may have proved an opportunity to consider conditional bail rather than NFA.

3.9.6 A strategy discussion took place with CSC following a referral from the police.

3.9.7 The attending officers' statements documented their concerns about the perpetrator's behaviour and demeanour at the scene particularly towards the children. There had been two reports of assaults on Lynne – one prior to leaving the house and the other on the driveway.

Both Child 3 and Child 4 had witnessed the incident and their accounts were noted in the officers' pocket note books and a request was made for consideration of ABE (Achieving Best Evidence) interviews to capture their accounts due to their age and vulnerability. These interviews did not occur.

3.9.8 The officer made a closing report setting out the rationale for no further action being taken. This report said, 'I have reviewed the evidence and discussed this case with the OIC. The victim has made a statement in relation to common assault alleging the perpetrator has assaulted by elbowing to the chest area. She makes no reference to consuming alcohol throughout the afternoon, the perpetrator agreed during interview that the version of events given in the statement was correct however he was trying to remove the baby out of the car as he didn't want Lynne to drive with the baby in the car. The pub was spoken to and confirmed that Lynne had drank three glasses of wine while in the pub. Lynne was spoken to and agreed she had been drinking as stated. The FCT[30] was not met. Legitimate defence as he was trying to stop an offence take place. NFA.'

The review agrees with the IMR author that bail should have been considered for any outstanding enquiries and to safeguard the victim ensuring her ongoing engagement with the investigation and support services.

3.9.9 When interviewed the officer could not recall reading the attending officers statements or watching body worn footage to provide additional evidence to support Lynne's account[31]. The CAD linked to the investigation could also have provided key evidence to corroborate Lynne's account. During the call she referred to the perpetrator having previously pulled a knife on her and was 'hysterical'.

[30] The Full Code Test is the test that must be satisfied for a prosecutor to make the decision to charge a suspect and bring a prosecution. Stage one of the test requires prosecutors to assess the evidence in each case and decide whether there is a reasonable prospect of conviction

[31] His lack of recollection can be attributed to the volume of evidential reviews in that role and the time that has elapsed since the incident.

> The perpetrator's ex-partner rang the police as Child 2 had witnessed the incident and was described as 'petrified'. She was not contacted to support Lynne's account and provide critical insight into the perpetrator's domestic abuse history.

The review believes that more action could have been taken as part of the investigation before deciding that No Further Action was the appropriate disposal.

3.9.10 **18th January 2016**

3.9.11 Child 3's school subsequently reported on 18th January, that Child 3 had confirmed the events of the reported domestic as having occurred. Child 3 disclosed that when their father returned home on his release, and prior to his arrest, he had shouted at Child 3 to come downstairs, and that when they did not do this, the perpetrator dragged them downstairs by the hair (or by the hand) and made them have a drink. Child 3 said that he drank half and threw away the other half, then ran back upstairs. Child 3 said that all the children had been hiding having overheard all the shouting and altercation between Lynne and the perpetrator.

3.9.12 This information came to the police via a referral from CSC and a strategy took place on the same day. The outcome of the strategy discussion was that this would be a MASH single agency investigation.

3.9.13 **1st March 2016**

3.9.14 The perpetrator's ex-partner attended HS1 to collect Child 2 having made arrangements for her to move to live with her without the perpetrator's knowledge.

3.9.15 Police were initially called by the perpetrator's ex-partner as she was concerned that the perpetrator would turn up at school and cause problems. The police were then called by HS1 as he did, as expected, arrive at the school and they were concerned that he was going to become aggressive.

3.9.16 This incident was referred to the MASH for further review, but the report does not document any background checks or the perpetrator's ex-partner's reasons for removing Child 2 from the perpetrator's care despite disclosures of domestic abuse during her relationship with the perpetrator. The referral was risk assessed, based on the information known, as MEDIUM and the MASH police referred the case to CSC. The report referred to CSC already being involved with the family as Child 3 was subject to a S47 single agency investigation.

The review agrees with the IMR author that, although the police investigation lists the children in the family, there is little information to suggest that it explicitly recognised the emotional impact on the other children in the family.

3.9.17 **23rd March 2016**

3.9.18 The police recorded an intelligence item on 23rd March that indicated that the perpetrator and Lynne would go out drinking (alcohol) and leave Child 1 (aged 13), Child 3 and Child 4 at home with Child 5. It was noted that Lynne was pregnant. This intelligence was disseminated on 22nd March with the MASH and CSC as medium priority.

3.9.19 The intelligence report is information collected by the police on a routine basis. It is subject to evaluation and risk assessment before it is then used to assist police decision making regarding crime, criminality, vulnerability, and other patterns of offending. It protects the source and contributes to an audit trail of the intelligence. Standardisation of reporting provides a shared confidence between law enforcement communities and partner agencies. All information is graded and shared under strict handling conditions.

3.9.20 In this instance the information was graded as from a reliable source (1) and not known (D). This scoring matrix indicates the level of confidence that can be taken in the intelligence dissemination, informs the decision-making process and supports the exchange and use of the information between agencies. The Source of the information can be either the name and address of the person providing the information or an Intelligence Source Reference number. This grading is used when the source is believed to be both competent and information received is generally reliable. Intelligence evaluation as D - not known applies where there is no means of assessing the information. In relation to this intelligence report, the source of the information was reliable, however the actual information they gave could not be tested, presumably because it was third hand information, hence the D1 grading.

3.9.21 **21st January 2020**

3.9.22 Lynne's mother reported to the police that her daughter was a victim of coercive and controlling behaviour. Over a period of 3 years, the perpetrator had threatened violence towards Lynne to control her. He placed a tracker on her phone, and he never let her do anything on her own. He had threatened to take the children away from Lynne and never let her see them again. The perpetrator would make Lynne feel bad to make sure that she stayed with him. They had, at that time, five children living at the house.

3.9.23 Following attendance at the address on the date of the report, Lynne was spoken to, and the outcome was that the perpetrator was arrested. In line with the police protocol a DASH Risk Assessment (DASH) was completed and was graded as HIGH risk. Whilst completing the assessment Lynne talked about being scared of the perpetrator and that if she left, he would take revenge. She stated that he would alienate and stalk her. Notably, she also stated, 'he could murder me'. Within the DASH an incident of assault was disclosed against Child 5, which is subsequently recorded as a crime.

The review notes that safeguarding was undertaken, and the perpetrator was arrested at the earliest opportunity.

3.9.24 The DASH was secondary reviewed within the MASH the following day (22nd January) and the risk remained at high. The IMR author has explored why this was done the following day rather than the same day and has established that MASH would not have received the full Athena investigation until approximately 18:30hrs on 21st October. MASH business hours are until 19:00hrs so this would have been picked up the following morning.

The review agrees that this is not a concern and would not warrant a review of business hours within the MASH as initial safeguarding actions are taken by attending officers on the day.

3.9.25 The following day the MASH correctly identified that there were indicators of serious harm and that the risk assessment should remain at high risk. MASH policy states that cases remaining at high risk are reviewed weekly by the allocated safeguarding officer.

3.9.26 A referral to Health & Children's Social Care was made on 21st January and appropriate action was taken in a referral to partners from the MASH. This crime was then reflected in the Operation Encompass workloads the following day meaning that school should have been appropriately notified by Children's Social Care (CSC). ***This is an example of good practice.***

A further review within the MASH took place on 29th January and the risk was reduced to MEDIUM as the suspect had bail conditions, Lynne had moved in with her mother and had the support of services such as an Independent Domestic Violence Advisor (IDVA).

The IMR author notes that the justification for this reduction in risk is further detailed stating that there had been a period without further incident. However, the review notes that only a week had passed and that there was still potential for the suspect to cause serious harm.

The review does not accept that this could be described as unlikely unless there was a change in circumstances as it is well researched that risk increases after separation. This is discussed later in the report.

3.9.27 Early review of the investigation was undertaken on 21st January and the outstanding actions listed on the same day involved taking statements from both of Lynne's sisters, speaking to school and the children to see if they had witnessed any incidents. A statement was taken from Lynne's mother on 22nd January. This further detailed the controlling behaviour of the perpetrator and Lynne's mother stated that Child 2 and Child 4 had met her in secret asking to be taken away from the perpetrator and reference was made to Child 4 wanting to kill herself. The investigation listed three exhibits provided alongside the statement from Lynne's mother. The first is a diary entry from Child 4. The second and third are screen shots of conversation between Lynne, her mother and Child 4. All provide corroboration for Lynne's account.

Child 2 and Child 4 were not spoken to about this report.

A second, child protection investigation (CPI) was not submitted to update the information that Child 4 wanted to kill themself. This would have provided an opportunity for the police to provide a fuller assessment of risk to CSC.

In terms of process, the MASH would not have revisited this investigation unless they had been notified by the officer taking the statement or the officer in the case that there was additional information that should be disseminated to partner agencies.

3.9.28 The perpetrator was released on conditional bail, which would be in place for 28 days and ended on 22nd February.

3.9.29 The MASH made contact again with Lynne on 24th January to check on her welfare and Lynne confirmed that she had moved in with her mother and asked if she could have contact with Child 2 and Child 3 who had remained with the perpetrator. Police advised that she could if she did not have contact with the perpetrator.

> There was then a three-week gap with no contact between police and Lynne. As the risk assessment was reduced to medium risk, MASH police no longer made weekly contact and it would have been for the Officer in the Case (OIC) to maintain contact with Lynne.
>
> The officer in the case went on a driving course and was abstracted from normal duty for three weeks. The investigation was not passed on or overseen by a supervisor during this time and whilst bail conditions remained in place the outstanding enquiries were not progressed.

3.9.30 On 15th February officer (PC1) contacted Lynne who stated that she wished to retract her statement due to feeling guilty about what would happen to the perpetrator's children if he were to be found guilty. Lynne stated she also wanted her younger children to be able to see their father. The officer advised Lynne to give the matter some thought and to speak to her family and Child 4, who was described as also potentially being a victim of the perpetrator's behaviour.

The review believes that, if more regular contact had been made with Lynne, she may have not decided to retract her statement or, at the very least, the police officer would have been aware of her concerns and could have ensured that she was supported. The fact that the children were not spoken to independently was an opportunity missed to corroborate Lynne's account and gain a deeper understanding of what was going on in the house.

The review also considers that there was an opportunity for the IDVA to have been informed of the conversation with Lynne so that they could have discussed with this her and supported her to continue with the statement.

3.9.31 On 7th March the officer in the case received an email from Lynne that said:

Hi PC xxx,
I have myself been struggling to contact you, apologies!
When you have previously called me, my young daughter has been playing games on my phone and she likes to delete my calls to carry on her game!
I would like to retract my statement mainly because of the reasons I put in my last email. But also, now the bail conditions have been lifted (name) and I are getting on OK.
He didn't react as badly as I thought he would to me leaving the home and he has maintained a good relationship with our children.
I appreciate I may have wasted a lot of your precious time, but I was genuinely in need of help to leave the home and I was worried about the repercussions of this.
Thank you so much for everyone's help and support!

3.9.32 The officer then closed the case with the following explanation. 'The victim has withdrawn her support from the investigation. She has stated that her and the perpetrator are on better terms following the lifting of his bail conditions. Multiple agencies have been involved in this investigation and have performed the necessary safeguarding measures to protect the victim. There have been no further incidents between the couple. It has been downgraded from a HIGH risk to MEDIUM risk. A letter is to be sent to the suspect informing him of the decision. Further entry at 0435hrs confirming letter sent confirming NFA.

The review notes that Lynne's withdrawal of her statement took place *after* the bail conditions had been lifted. She then met up with the perpetrator and had an argument with her mother. Lynne began to disengage from the IDVA and then withdrew her statement.

The review is aware that changes have been made to the process when a victim makes a withdrawal statement. It is now necessary for any withdrawal statement to be taken from the victim in person. In this case, we cannot be certain that Lynne wrote the withdrawal email herself and, if she did, she may have been coerced by the perpetrator to do so. The review welcomes this change but suggests that further support could be offered to a victim if an IDVA were present at the time of withdrawal statement.

Recommendation
It is recommended 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.

3.9.33 **Evidential review undertaken when the case was closed**

3.9.34 An evidential review was undertaken, and this noted the following information:

- Financial control as the perpetrator is alleged to have spent her savings.
- Lynne described having loans taken out in her name.
- Her step child monitoring her movements and reporting back to the perpetrator.
- He has spoken about stabbing his ex-wife and that he has a history of football violence.
- She did not feel as if she could visit her sister.
- She felt that she had to earn his trust.
- Her phone was regularly checked, and he monitored when she is online.

No enquiries were made into the financial control that Lynne had disclosed. Whilst this was covered in his suspect interview, the matter was closed before any further checks were made, by the OIC, into his bank details etc.

The officer stated that Lynne had withdrawn her support for the case and that she and the perpetrator are separated, and she now lives with her mother. She has said that their relationship has improved, and she is no longer supporting the case. The Reviewing Officer said, 'I am satisfied she is safeguarded'.

The review believes that this statement demonstrates a lack of understanding of the risks to a victim at the point of separation and a lack of further investigation and ownership of the investigation

after he was released from custody. Norfolk Constabulary has advised the review that training is ongoing into investigation standards for all first responder officers. All will receive a domestic abuse focussed input in the early part of 2022 as part of the rolling CPD training days which now form part of the response shift pattern.

3.9.35 Lynne's mother had also given a statement and in this she described:

- That she felt that she was kept from her daughter and grandchildren
- How the perpetrator checked Lynne's phone and had to communicate with her family in secret
- How she felt he was controlling

The review is aware that a 7 Point Plan (7PP) has been introduced to ensure a full supervisor's review of all available evidence is completed prior to sign off and closure. This provides a secondary review tool to ensure no investigative opportunities have been missed.

The review is aware that the policy has also been changed so that not only are HIGH risk cases reviewed by a Detective Sergeant[32] before they are closed as No Further Action, but all cases that have, *at any point been HIGH risk,* are reviewed by a Detective Sergeant. The review notes this is a positive change.

3.9.36 **Evidence-led (Victimless) prosecution**

3.9.37 The perpetrator had stated in interview that he mended furniture and Lynne did the books. He denied controlling and coercive behaviour and fraud.

3.9.38 The officer considered an evidence-led (victimless) prosecution and believed that there was no realistic prospect of conviction without a supportive victim. It was noted that the situation appeared to have changed and that Lynne was no longer in a relationship with the perpetrator.

The review is advised that Norfolk Constabulary has now adopted the 8 Point Plan (8PP) for investigations. The 8PP is a tool used to support officers at the start and during the investigation. This is set by the officer in the case and reviewed by all supervisors at the start of any investigation, and supports, particularly in domestic abuse cases, the need for considering an evidence led prosecution. Training is ongoing for investigation standards for all first responder officers, all of whom will receive a domestic abuse focussed input in the early part of 2022 as part of the rolling CPD training days which now form part of the response shift pattern.

3.9.39 **The report of assault by perpetrator on Child 5**

3.9.40 When Lynne reported, as part of her statement on 20th January, that the perpetrator had hit Child 5 on the leg with a tennis racquet on 1st August 2019. A child risk assessment was undertaken and appropriately graded at MEDIUM risk. Lynne said that the perpetrator would involve the children in their arguments. She did say that the children were not at risk of physical harm from the perpetrator but said that he would try and alienate her from the

[32] The additional review must be undertaken by a *Detective* Sergeant as they are trained and experienced in investigative police work at a higher level

children. The child protection investigation was subject to secondary review by the MASH on 22nd January and a referral was forwarded to CSC.

3.9.41 The statement provided by Lynne (as part of her full statement on 21st January) stated that she had heard Child 5 crying and one of the other children, Child 3 shouting that the perpetrator was hitting them with a tennis racquet.

Child 3 was not spoken to by the police.

3.9.42 There was therefore no supporting evidence obtained in relation to his allegation. When the perpetrator was interviewed about the coercive and controlling behaviour he was also arrested and interviewed about this assault, he denied the offence and no further action was taken and the case was finalised as NFA due to a lack of corroborating evidence.

The review believes that, had Child 3 been spoken to, there may have been corroborating evidence in this case. The review is advised that children, following agreement by the National Athena User Group, continue to be listed as 'involved parties' however the following additional information will now also be added:

Within the person/child
Victim information
Victim type = CHILD
Reason vulnerable = DOMESTIC ABUSE

3.9.43 **MARAC (MULTI-AGENCY RISK ASSESSMENT CONFERENCE)**

3.9.44 A MARAC is defined by SafeLives[33] as a meeting where 'domestic abuse victims who have been identified as at high risk of serious harm or homicide are referred to.'

3.9.45 **28th April 2020**

3.9.46 After Lynne's mother had contacted the police on 20th April a DASH risk assessment was completed that identified the risk as HIGH. All domestic abuse incidents assessed as either MEDIUM or HIGH risk are subject to a secondary safeguarding review within the MASH. As this was assessed at HIGH risk this was then reviewed within the MASH the following day. In line with correct procedures the secondary safeguarding involved a referral made by police to MARAC.

[33] A UK-wide charity dedicated to ending domestic abuse. It works with organisations to transform the response to domestic abuse.

3.9.47 The MARAC meeting was held on 28th January. Lynne was aware of the meeting and consented to this referral to MARAC. The MARAC meeting was chaired by a professional from Early Help and was attended by the police, Leeway, and the health representative in the MASH. Apologies were received from James Paget Hospital, North Norfolk County Council (previously known as Broadland District Council), Clarion Housing and Probation.

3.9.48 Research commissioned by Norfolk and Suffolk Police and undertaken in 2020 by Adisa [34] cited the work of Steele et al (2011)[35] that, for a most effective MARAC, a minimum of six core agencies should engage within the MARAC – police, probation, IDVAs, health, housing, and CSC. The IMR author notes that whilst all did not attend the meeting, updates were provided to the meeting.

The safeguarding lead from both children's schools were not invited and could have provided additional information about the children's lived experience and any disclosures that had been made in school.

The MARAC meeting did not identify any additional actions that could further enhance Lynne's safety from those that were in place. This comment is made as an observation and not a criticism.

3.9.49 Adisa's research identified that one of the principles of a good MARAC is the attendance of a wide variety of services.

Whilst the review accepts that all the key agencies were represented on the membership of MARAC only three attended the meeting. Although they provided updates to the meeting, the strength of multi-agency problem-solving is that all agencies contribute to a discussion thereby providing a depth and breadth of solutions.

The review is aware that Norfolk has recently launched a new integrated domestic abuse service. This is discussed later in the review.

3.9.50 **Addressing additional safeguarding risk and sharing with partners**

3.9.51 The MASH acts as the hub for receiving and reviewing all police investigations or incidents that contain certain elements of vulnerability. It was established in September 2011 and there are 21 agencies signed up to the Information Sharing Agreement. There are staff from five agencies physically based within the hub – police, CSC, Adult Social Care, Leeway, and health with other agencies working remotely from the hub site.

[34] Adisa O, Professionals' perceptions of MARACs and barriers to attendance, 2020

[35] Steel, N., Blakeborough, L. & Nicholas, S. (2011). *Supporting high-risk victims of domestic violence: a review of multi-agency risk assessment conferences (MARACs).* London: Home Office. Available at: https://www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non- secure/s/u/p/supporting-highrisk-victims-of-domestic-violence-a-review-of-multiagency-risk-assessment-conferences-maracs.pdf (Accessed: 27 July 2020) cited in Professionals' perceptions of MARACS and barriers to attendance, University of Suffolk, 2020

3.9.52 The MASH reviews all medium risk cases of domestic abuse reported to the police and reviews all incidents (crime and non-crime) that involve a child or vulnerable adult. The aim is to assess vulnerability and share information with relevant partners where necessary.

> The IMR author has noted that the MASH process of sharing information with partners is efficient at the single point in time when the referral is first reviewed. However, it has been recognised that, if after that point of referral more information or evidence is added to the investigation by the OIC, the MASH would not be sighted on this. Due to the large volumes of investigations that have an element of vulnerability it is not practicable for MASH staff to revisit investigations.

3.9.53 High risk cases that are held by domestic abuse staff in the MASH have a weekly review until such time they have been reduced to medium. This is to ensure ongoing safeguarding of the victims and any children. The MASH member of staff is not expected to review all the case information (which can be held in different places within policing systems) for additional concerns.

Recommendation

It is recommended that officers across Norfolk Constabulary are reminded of the need to inform partner agencies when additional information is obtained.

Section 4 – Further analysis of Lynne and the abuse she faced

4.1 What did Lynne's family and friends tell us about her?

4.1.1 Lynne was an intelligent woman who had trained as an accountant. Her work friends said that she was very motivated by her career, and that nothing fazed her.

4.1.2 She was very easy going and never argued with anyone.

4.1.3 Lynne's close friend described her as being very sociable before she met the perpetrator. They were always messaging and meeting up. She was great fun. Lynne liked to go to the cinema and to go on holiday.

4.1.4 Lynne's work friends said that she was kind, calm, patient and friendly. She was very loyal. She was beautiful – inside and out and had the most infectious smile and laugh. She was great fun to be with and liked to party.

4.1.5 Lynne cared about other people. She was concerned about poverty, homelessness, and children in care. Her kindness completely shone through her.

4.1.6 Lynne's friend said that, before meeting the perpetrator, she was always very particular about her appearance, particularly her hair and make-up but when she was with him it went downhill, and she looked 'tired and worn down' and 'rougher'.

4.1.7 Before she met the perpetrator, Lynne was full of energy and life, but he took her spark.

4.2 Evidence of domestic abuse

4.2.1 A Domestic Homicide Review is charged with exploring the trail of domestic abuse. The review has begun looking at the perpetrator's history as a domestic abuser before discussing the abuse that Lynne experienced.

4.2.2 **THE PERPETRATOR'S PREVIOUS HISTORY**

4.2.2.1 The perpetrator has a number of previous criminal convictions beginning when he was a child. His offending history began with offences of theft and burglary but quickly escalated to offences where the use or threat of violence was present [36]: He received a significant custodial sentence in 1994 for various offences including robbery and his history thereafter is listed below.

Date	Offence	Disposal
1994	Attempt robbery Wounding Theft ABH ABH Criminal damage	Custody – 42 months Custody - 2 years concurrent Custody - 3 months concurrent Custody - 6 months concurrent Custody - 6 months consecutive Custody - 1 month concurrent

[36] Due to the historical nature of these offences – not all are linked to a specific offence on PNC

1994	Theft ABH x 2 Criminal damage	Custody – 3 months Custody - 6 months concurrent x 2 Custody - 6 months concurrent
1995 (whilst in prison)	Threats to kill (partner)	Lie on file (not to be proceeded with without leave of Court or Court of Appeal £250 concurrent
1995	Common assault on adult (partner)	Lie on file (not to be proceeded with without leave of Court or Court of Appeal £250 concurrent
1996	Fail to surrender (bail)	Imprisonment 1 day
1996	Wanted on breach of parole and FTA at Oxford on threats to kill matter	No other information available
1996	ABH (partner)	Detected, no linked disposal on PNC
1999	Possession of offensive weapon in a public place	Conditional discharge for 12 months
2016	Harassment (ex-partner)	No Further Action as evidential difficulties and victim could not support prosecution

The following incidents are also recorded:

2014	Domestic abuse incident Police were called by neighbours as smashing and banging could be heard and had been going on for 30 minutes. The police attended and the perpetrator's partner had left. Both parties were spoken to. During this conversation she said that he 'spies on her phone for text messages'. She said the abuse was getting worse and happening more often. He had made threats to kill, had made attempts to strangle/choke her and reported rough sex. She said that he had threatened to take his own life.

4.2.3 **EVIDENCE FROM PREVIOUS PARTNERS**

4.2.3.1 The murder enquiry identified 17 previous female partners and two male partners of the perpetrator from 1988, with six having had children. Information is known about abuse experienced by eight partners. The pattern of behaviour was very similar against all women.

4.2.3.2 The perpetrator's ex-partner as well as giving evidence in the murder trial, also spoke to the Review Chair and Report Author on more than one occasion. The perpetrator's ex-partner is the mother of Child 1, Child 2 and Child 3. Time will be spent discussing her relationship with the perpetrator as this has many similar traits as his relationship with Lynne and demonstrates the far-reaching hold that he exerted on his ex-partners. As the behaviour is similar for all women the review has concentrated on the evidence from the perpetrator's ex-partner, the mother of his children who lived with Lynne and the perpetrator.

4.2.3.3 The perpetrator's ex-partner met the perpetrator when she was a child, 14 years old and he was 27 years old. She met the perpetrator through friends. She used to 'hang out' at the Salvation Army and the perpetrator was living there. She said that things moved very quickly, and she realised that they were in a relationship. She had a troubled upbringing and, at the time, believed that no-one cared about her. She was anorexic. She did not eat as she had to travel to meet him. The perpetrator paid her a lot of attention, and she became dependent upon him. She was always running away from home so she could be with him, and he encouraged her. The perpetrator's ex-partner was then placed in a care home because of this. She was young, impressionable and he made her feel wanted so she continued to run away to be with him. When she would ask him about the age difference he would say, 'age is just a number'. He gave her the attention that she craved.

4.2.3.4 The perpetrator's ex-partner became pregnant when she was 15 years old. The perpetrator was abusive from the early stages of the relationship, and he would often accuse her of cheating on him. He was living in Blackpool at the time, and she would travel to see him. He refused to travel to see her. When she arrived, he would make her remove her underwear so he could examine her to see if she had had sex.

4.2.3.5 On one occasion he got so angry with her that he grabbed her by her hair pulling out a large chunk and setting fire to it. The perpetrator kept saying that he was sorry, and she forgave him. Eight days after this she was placed in a secure unit after the police had found her in his bedsit.

4.2.3.6 From the beginning of the relationship the perpetrator was controlling, and his ex-partner would wait in a phone box for hours because she was required to call him at certain times. She would learn to speak when she was spoken to and when she went shopping, she was given the exact money. The perpetrator would go out clubbing and lock her in the house whilst he was out. She said that he was drinking and gambling and, when he had been paid, he would spend all day in the pub.

4.2.3.7 The perpetrator's ex-partner said that for twelve years she was not allowed to speak to any family and friends that she had known before meeting him. She was only allowed to speak to those people who they met when he was around. He did not like her talking to anyone and was paranoid that she would be 'bad mouthing' him. She said that she was stuck in the house, wasn't allowed out and would have done anything to keep the peace. She said that when she became pregnant with Child 2 the control and intimidation continued. She did not dare to stand up to him because she was scared of him. She tried to always keep him happy as she feared what he would do.

4.2.3.8 The perpetrator's ex-partner described the perpetrator as very racist and said that he had tattoos of a swastika with KKK in the middle. He was a white supremist and a huge fan of Hitler. He would vote BNP and his passwords were always a combination of Hitler or 666. He did not hide his views in front of the children.

4.2.3.9 The perpetrator's ex-partner said that, in 12 years, he hit her only three times because he did not need to as his look was enough. The perpetrator would tell her that no-one would ever want her as she had baggage (the children). The perpetrator's ex-partner described two specific occasions when he was physically abusive to her. The first was when she was pregnant with Child 2. A neighbour accidentally kicked a ball over the fence, and it hit her in the stomach. The perpetrator found this funny and was laughing about it. She was not happy,

so she threw the dregs of her coffee in his direction. He turned on her, dragged her into the house and shoved her onto the sofa. She said that she knew not to answer back as he needed to be in control. The second time occurred When she was eight months pregnant with Child 3, he came home drunk at 5 am and wanted sex. When she refused, he became angry and punched her on the side of her head causing a bruise. He also grabbed her arm causing an abrasion and told her to hide the bruises when she took the children to school.

4.2.3.10 In 2010 the perpetrator's ex-partner had medical problems and decided to be sterilised. The perpetrator was angry as he said that she had removed his right to be a father. She remembers him saying to her, 'if you leave me, I will kill you'. The perpetrator was always forcing himself on her.

4.2.3.11 When the children started school, he would time her from when she left the house to when she returned. If she was not back within 15 minutes, he would be calling her asking where she was and who she had been talking to. He would keep Child 3 at home so that he had a hold on her, to make her return home.

4.2.3.12 The perpetrator's ex-partner described how the perpetrator would spend hours on the internet and would meet women in chatrooms and have sexual conversations with them. It became common practice for him to send these women pictures and for them to send him gifts and money. He said it was just fun and he had no intention of meeting them.

4.2.3.13 The perpetrator had taken out debts in his ex-partner's name and in 2010 she had to declare bankruptcy due to the debts of £33,000.

4.2.3.14 As the years went by, and the children came along, the family moved 17 times in 12 years. The perpetrator's ex-partner never had a key to the properties that they lived in.

4.2.3.15 Whenever she left the house for shopping, the perpetrator would keep at least one of the children with him so that she had to go back. This was particularly stressful for her when they lived in a rural location as she had to walk two miles to the shops.

4.2.3.16 In April 2011 shortly after the perpetrator's ex-partner had left the perpetrator, she agreed to meet up with him to see the children. They met in a pub, and everything was fine until she received a text from a girlfriend. He launched out of his seat, across the table, to try and grab her phone. He grabbed her by her hair and dragged her out of the pub towards some fields. He then smashed her phone. He grabbed her throat and she felt like he was crushing it. He accused her of cheating on him and totally 'lost it'. He scared her, she believed by the look in his eye and the tone of his voice that he was really going to hurt her. As people started to look and the children started to cry, he came to his senses and apologised. He then started begging her to come back to him. The only way she knew to get away was to promise him that she would come back because if she had not, he would not have let her leave. He then took the two of the children back with him on the bus.

4.2.3.17 She agreed to see him again two days later. He arrived just with Child 3 and did not have Child 1 and Child 2 with him. Child 3 was asleep in the buggy. The perpetrator wanted to go to the fields where there was a wooden bench. She felt unnerved as something was very wrong, and something was about to happen. It felt completely different and there was no negotiating with him. Usually, she said, he would listen to a bit of reasoning but not on this day, he just stood over her. He was wearing a bomber jacket and had his hand in his pocket.

He kept fidgeting and would not sit down, was just towering over her. He then said, 'after today you are doing nothing' and she saw that he had a knife in his pocket. She pinched Child 3's leg to make him cry, then she picked him up and walked away. She said she felt bad doing this, but it was the only thing she could think of to distract him and get herself and Child 3 out of there alive. She was scared and believed he was going to stab her. That was the last time she ever saw him alone.

4.2.3.18 After she left the perpetrator the next six months were absolute hell. He would bombard her with texts and calls 24 hours a day. She had to leave her children with him, or she would not have been able to get away. She was scared that if he found her, he would kill her. He would tell her that the children hated her, that she was selfish and that if he could not have her, then nobody could. She tried unsuccessfully to secure custody of her children.

4.2.3.19 She obtained a contact order that said that she could see the children every two months. The perpetrator told the court that he would take the children to her at weekends and in the school holidays, but he never did this. Parental responsibility was shared between them, and it was agreed that she would see the children every two weeks and in the holidays. The perpetrator then disappeared with the children. Even when they had telephone contact, he had her number in his phone as 'cunt' so this is what the children saw when they spoke to her.

4.2.3.20 The perpetrator's ex-partner described herself as a slave for 12 years. She said that he made her feel like a worthless object. She said that there are only three things that the perpetrator is interested in: sex, money, and himself.

4.2.3.21 The perpetrator's ex-partner said that she was the first person to ever leave the perpetrator, he had ended all is other relationships and she does not think that he forgave her for that.

4.2.4 EVIDENCE OF ABUSE AGAINST LYNNE

4.2.4.1 Lynne said in her statement to the police in January 2016 that it was hard to explain the abuse she experienced as 'he is nice to me at times….'

4.2.4.2 Lynne wrote several dated notes when she was living with her mother in April 2020. Lynne's mother has shared these notes with the review. The photograph of these notes is not included as they identify the children. The content is referenced in the next section. It is clear that the abuse had escalated from January 2016 as Lynne says, in the last sentence of her note 'All day misery!'

4.2.4.3 Coercive and controlling behaviour

4.2.4.4 The perpetrator made it very clear to Lynne what he was capable of. In January 2016, he told her had planned to kill one of his ex-partners. She said that she did not know if this was true, but that he said it to scare her. He also told her that he had been involved in football violence.

4.2.4.5 Lynne told the police, in January 2016, about an incident when she had been suffering hours of mental and emotional abuse. He sent the children to bed and Lynne told him that she wanted to leave him and did not want to live with him anymore. He went to the kitchen and came back with a knife and made it clear to Lynne that he had it. She says that he did not take the knife out of his trousers but that she was terrified throughout. She said that she had

to talk him down and say that she had not meant it and was just being silly. She had to beg him, cuddle him, and promise him that she would not leave. This went on for ages, then he got up, put the knife back in the kitchen and they went to bed.

4.2.4.6 Lynne said, on her wedding day that she was hoping that marrying him would calm him down and that he would not be so insecure if she married him.

4.2.4.7 Lynne's phone was regularly checked, and he monitored when she was online, and she felt as though she had to earn his trust (January 2020 to police). In her note on 5th April 2020 Lynne said that the perpetrator had asked her why she had called Child 4 at 7.50 pm the previous night. She had to show him her phone to prove that it had been at 6.50 pm. Lynne recorded in her note that if she did not reply instantly to him, he would constantly stress. She said, 'wants to know everything!!!' and 'always rude'.

4.2.4.8 To ensure that Lynne remained with him, the perpetrator threatened that he would take away her children and not allow her to see them. This was not an idle threat as Lynne knew that he had done with Child 1, Child 2, and Child 3.

4.2.4.9 In her statement in January 2020 Lynne said that for years she had felt conditioned to respond in a certain way, or to act in a certain way. For example, she said that if she did not touch his genitalia first thing in the morning, he would get stroppy with her and make her feel as if she had done something wrong. Lynne said, 'I do it out of habit now'. Early in their relationship he would grab her hand and put it there and she said she had seen what if it was like if she didn't do it. She said that if she did not tell him she loved him, he would look at her strangely and she would get the 'cold shoulder'. She said, 'it's habitual, I'm saying it for the sake of it, because its expected'.

4.2.4.10 Lynne told the police in January 2020 about the control that the perpetrator had over her. Following an incident when the children had said that (whilst Lynne was out of the room) the perpetrator had hit Child 5 with a tennis racquet. She said, 'I don't dare question [the perpetrator] about it, he's made me feel like he's the boss and I have no power or opinion on anything. He undermines everything that I say, if I try to discipline the children he'll overrule me, either making it better or worse punishment, just so he has the last say.' She went on to describe feeling trapped in the relationship, that they were always together, they worked together so there was no escape. She said, 'I don't think he wants to get a job as he wants to be at home keeping an eye on me all the time'.

4.2.4.11 There is information to suggest that the perpetrator also controlled his children.

4.2.4.12 In September 2017 Lynne told the nurse practitioner at the GP surgery that the perpetrator was not willing to have a vasectomy.

4.2.4.13 In her note., Lynne said that on 5th April 2020 the perpetrator had called her nine times whilst she was on the phone to her mother and sister.

4.2.4.14 Lynne's family were aware that the perpetrator would use Lynne's phone to send them messages purporting to be her. They got into the habit of sending generic messages in case they were not speaking to Lynne. Lynne's best friend also said that she was never sure that she was messaging with Lynne and so was careful what she said. She said that Lynne messaged when they got back together and said that she had gone back because it was hard

dealing with the children on her own. Her friend knew that this was not true and so she wondered if it was the perpetrator messaging.

4.2.4.15 **Physical abuse**

4.2.4.16 On one occasion when Lynne had not been with the perpetrator very long, her sister saw them out in the city. He was drunk and feeding money into fruit machines. Her sister was worried about Lynne going home with him. As they walked to the car, he wanted Lynne to hold his hand, which she did not want to do. He said, 'you have to hold my fucking hand' and her sister said that she did not have to. He then slammed the car door back into Lynne's sister's face.

4.2.4.17 Lynne's sister saw him, on another occasion, punch the dog in the face. Child 4 said that he would kick the dog although it was old and ill. He would put the dog outside in all weathers.

4.2.4.18 The police attended in January 2016 after the perpetrator had elbowed Lynne in the neck with force during an altercation when she was trying to leave with Child 5.

4.2.4.19 In January 2020 Lynne told the police that over the previous three years, the perpetrator had been threatening her with violence to control her.

4.2.4.20 Lynne's friend asked her if the perpetrator had ever hurt her and she said that it had been when he was drinking, as if that were a reason.

4.2.4.21 **Verbal and emotional abuse**

4.2.4.22 Lynne told the police about how she was treated by the perpetrator when she was in labour with Child 4. It was a long and difficult labour; Lynne was scared and exhausted and focussing on what the staff were doing. She said she remembered the perpetrator saying, 'are you not going to talk to me, should I just leave now then?' He gave Lynne no support and was only concerned for himself and was upset about the lack of attention that he was receiving. She said, 'he made me feel worthless, at the lowest point of my life'.

4.2.4.23 One of the children reported that in July 2015 had been shouting and swearing after having been to the pub and this continued until 1 am.

4.2.4.24 In January 2016 Lynne described how the perpetrator would not allow her to sleep. He would talk to her all night saying horrible things to her, trying to scare her.

4.2.4.25 **Isolation**

4.2.4.26 Lynne's mother said that initially she thought they were 'behaving like a loved-up couple' and they did not want their family around, so she gave them space. As time went on, she began to realise that the family were being ostracised. If her mother tried to see her an excuse would come back in a text, but it did not sound like Lynne had written this. If they called at the house, the perpetrator would say that Lynne was in the shower, or she was out.

4.2.4.27 Lynne was very strong-willed and knew where she was going in life. Very quickly it seemed as though she had been brainwashed. She was a partner in a successful company, but the perpetrator would not allow her to continue working.

4.2.4.28 Lynne had to go wherever the perpetrator wanted and would always agree with him in an attempt to avoid an argument. As early as January 2016 Lynne said that numbers were blocked from her phone to prevent and limit who she could speak to. She was not allowed to see members of her family, particularly her sisters. Any time she spent out of the house, would lead to her being questioned about who she was with and where she was. Her mother described her as becoming a prisoner in the home, being monitored 24-7.

4.2.4.29 Lynne's work friends would meet up socially every month or so and when she had met the perpetrator she would forget when the get togethers were, it seemed that text messages were going missing, and she lost their contact numbers.

4.2.4.30 Lynne's friend said that, once she was with the perpetrator, Lynne was not allowed to do things. They did not meet up very often and she would have to check with him before she could agree to anything. She said that he seemed happy for her to go to their home but not for Lynne to go out. She did this a few times, but it was very uncomfortable. He would sit in the room on his phone whilst she was there.

4.2.4.31 Lynne's work friends had a similar experience. When they went to visit to meet the baby when Child 5 had been born, she had to go out and get milk for drinks. They thought that this was odd as she had known they were coming, and the perpetrator was there. The perpetrator did not make them welcome; he would not let them hold the baby and asked them to sit on the floor so that he could sit on the sofa with the baby.

4.2.4.32 Lynne's friend said that a couple of times a year the perpetrator would allow the friends to meet up at Costa but when they did meet Lynne was constantly messaging him and she had to buy something he would like to take home to him. Lynne said that she had to take him something to prove that she had been there and was not lying to him. On one occasion, they wanted to go over the way to B&M and Lynne had to check with him that it was OK.

4.2.4.33 Lynne's work friends also talked about meeting for coffee and noticing that Lynne was clock and phone watching the whole time, as well as always wanting to take a treat for the perpetrator albeit a cake or a sausage roll. Lynne said, in her police statement, that she had taken a photo of them all together and sent it to the perpetrator. He had not asked her for it, but she had sent it because she felt that she had to prove who she was with to avoid questioning when she got home.

4.2.4.34 After she had married, Lynne withdrew once again from her work friends and her text messages became less frequent.

4.2.4.35 In January 2016 Lynne was referred to Leeway. She spoke to them on one occasion but, after that, when they called several times, her phone was answered by a male. When Lynne spoke to Leeway a few days later to say that she no longer needed their support, the IDVA believed that the perpetrator was present.

4.2.4.36 In August 2018 the perpetrator was engaged with Unpaid Work when he did grounds work and charity shop work. When he was out of the house, Lynne felt free, like a huge weight had been lifted from her shoulders. She could go out without being questioned or feeling anxious. However, she very soon realised that Child 1 was telling the perpetrator about her movements. It got to the point that she would jokingly say, 'I'm going to the shops, let your

dad know' but she said, in her police statement in 2020, that she was not joking. She said that she felt like a mug, like her life was being dictated by a teenager. At that time, Lynne did not see her family as it was not worth the interrogation that he would subject her to. Lynne said that she would pop to the shops and nothing more.

4.2.4.37 Lynne said that he would not let her do things on her own (in January 2020). She did not feel able to visit her sister (January 2020 to police). Lynne's mother described to police that she was kept from seeing Lynne and her children. She had to devise a means of communicating with them secretly.

4.2.4.38 In her note on 6th April Lynne recorded that the perpetrator had been really unhappy because she had not backed him up when her mother had a go at him. She said that he 'wouldn't have minded me going out with my family if I had backed him up'.

4.2.4.39 In the Social Work Assessment undertaken in January 2016 noted that the family appeared to be very insular and spent a lot of time together as a family unit. There was little mention of family friends or social events with people outside the family unit.

4.2.4.40 Lynne's mother stayed with the family for three months when she saw the coercion and control first hand. She said the only time she could speak to Lynne alone was when they whispered on the front door step. Even though they were living in the same house, Lynne would message her mother from the toilet.

4.2.4.41 The perpetrator insisted on going with Lynne to places. Even when her sister needed to be taken to hospital in an emergency, he would not allow Lynne to go alone. His excuse was that he might need to carry her sister.

4.2.4.42 In October 2019 Child 4 had been invited to a party and it was arranged that Lynne would go alone to take him which she thought was odd. Just as they were about to leave, he flew out of front door and asked who would be at the party. When Lynne said that she did not know he said that he was going too. Lynne was bothered that he had come to check up on her.

4.2.4.43 When Lynne was living in the temporary accommodation, he took her laptop from her as 'he needed it'.

4.2.4.44 **Economic abuse**

4.2.4.45 When Lynne met the perpetrator, she had £17,000 in savings and he spent this within six months. The perpetrator had taken out loans in Lynne's name. In January 2016 Lynne disclosed that their debts were accumulated through the perpetrator's gambling.

4.2.4.46 Within a short time, the perpetrator gave up his council property and moved, with his children, into Lynne's privately rented property. This made no financial sense.

4.2.4.47 At the beginning of the relationship, he was gambling £300 per night on the fruit machines. He was getting the money from her credit card and sending Child 2 to the cashpoint at the local shop to withdraw cash. She did not realise until four months later when she read one of her statements – then it all made sense.

4.2.4.48 Lynne said that she did not give him permission to take her money but, by this time, she was already scared of him, so she did not ask about it.

4.2.4.49 Lynne had kept her wedding ring from her first marriage to give to Child 4 when they were older. The perpetrator pawned this and when she asked him about it, it said, 'yeah, I didn't think you needed it anymore'.

4.2.4.50 Lynne described to the police in January 2020 how she had would have loved to get a job so that they were not working together. She said that he put her off doing this as they received money from tax credits, and he did not want to lose this.

4.2.4.51 Lynne had access to two bank accounts – one a joint account and one her own account – which both allowed instant notifications of spending. This joint account had only been opened recently and Lynne believed it was so that she would 'share' his debt on that account that was £500 overdrawn. The perpetrator would give her money for petrol or food but, other than that, they did everything together, so she did not 'need' money. All the money from their business was paid into the perpetrator's account – Lynne did not know what the business was earning. He had taken out payday loans in Lynne's name. As a result of the perpetrator's spending, in January 2020 Lynne had a £24,000 Individual Voluntary Agreement[37].

4.2.4.52 Lynne said that she would not be able to escape the perpetrator with the debt that was hanging round her neck. He also told her mother that, if she ever left him, she would have to pay maintenance to him'.

4.2.4.53 The perpetrator had used Lynne to extract money from her mother. He told Lynne's mother that they did not have the money for rent and, because he said Lynne would be upset, she gave him the money. On another occasion, he booked a holiday for the family knowing that he would not be able to pay for it. He then asked Lynne's mother to pay for the holiday so that the children were not disappointed. He had £30,000 from Lynne's mother.

4.2.4.54 In December 2019 Lynne said in a text that she was not able to move out and rent a new place as she had a bad credit history.

4.2.4.55 Between the time when Lynne left in January and her death, the perpetrator took out several credit cards in her name. When she died Lynne was £40,000 in debt.

4.2.4.56 After Lynne left the perpetrator in February 2020 she was living in hotels, relying on foodbanks, and had run out of money.

4.2.4.57 The perpetrator used economic abuse against the children. He told the children that he would pay them £30 if they told the social worker that everything was fine. His economic abuse of the children continued after Lynne's death continued to control their belongings.

4.2.4.58 **Stalking and technology facilitated abuse**

[37] An Individual Voluntary Arrangement (IVA) is **an agreement with your creditors to pay all or part of your debts**. You agree to make regular payments to an insolvency practitioner, who will divide this money between your creditors. An IVA can give you more control of your assets than bankruptcy.
https://www.gov.uk/options-for-paying-off-your-debts/individual-voluntary-arrangements#:~:text=An%20Individual%20Voluntary%20Arrangement%20(%20IVA,of%20your%20assets%20than%20bankruptcy.

4.2.4.59 Stalking has been identified as a dangerous behaviour. Campbell et al (2007) said that it could be even more indicative of homicide than prior abuse[38]. Stark (2013) reported that stalking often occurs *within* a relationship and women could have their movements constantly watched[39]. The evidence of this behaviour is set out below.

4.2.4.60 As recorded in Lynne's note, the perpetrator added her to Life360[40]. This allowed him, according to their website, to see her whereabouts in real time throughout the day, get notified as she would come and go from her most frequented spots and navigate directly to her by tapping on her photo, with no address needed.

4.2.4.61 She also recorded on that on 5th April the perpetrator was annoyed that she had sat on the beach and had not video called him as required. She told her he would be watching her more closely now. She had to promise him, multiple times, that she only had one Facebook account and was not talking to any other men.

4.2.4.62 The perpetrator would, as recorded in Lynne's note, check her activity on Facebook. On 6th April Lynne recorded in her note that he had insisted on going through her phone 'disguised as he was making space on my phone' but she knew that he had been through everything because he referred to something in a text.

4.2.4.63 Lynne said that she would take her phone upstairs when she put Child 4 to bed. The perpetrator will go on his phone and if he sees that she is online he will send her a message saying, 'hello' or an 'eyeball' emoji to let her know that he is watching her.

4.2.4.64 In April 2020 Lynne spent a few hours talking to her sister on the phone and, during that time, he called her approximately 150 times. She told him she was on the phone to the bank and to stop calling her.

4.2.4.65 The perpetrator used Child 1 and 2 to monitor Lynne's movements, forcing them to report back to him.

4.2.4.66 **Threats to kill**

4.2.4.67 In January 2016 when Lynne tried to leave the house with Child 5, as well as assaulting her, he had mouthed to her 'you are going to die'. She told police that she was fearful of further injury or that the perpetrator would kill her.

4.2.4.68 Lynne said that on many occasions he would tell her about how he had planned to kill his ex-partner. She believed he did this as a threat to her. In January 2020 the perpetrator and Child 3 were having a bit of banter and Child 3 was taking the mickey out his dad for being in a prison cell. The perpetrator looked directly at Lynne and said, 'The next time I am in a prison cell it'll be for murder.

4.2.5 HOMICIDE TIMELINE

[38] Monckton Smith et al, Domestic Homicide, Homicide and Gender, Palgrave Macmillan, 2014

[39] Cited in Ibid

[40] https://www.life360.com/intl/

4.2.5.1 The analysis here draws on the research of Professor Jane Monckton-Smith of University of Gloucestershire into Intimate Partner Femicide Timeline[41]. This research has identified eight stages through which a relationship that ends in homicide is likely to go. It is important to remember, as we consider this timeline, that at any point the timeline could have been stopped as it had been by the perpetrator in the past. Lynne's murder was not inevitable.

4.2.5.2 **Stage One – Pre-relationship history**

4.2.5.3 Monckton Smith identifies a criminal record or allegations from previous partners of control, domestic abuse, and stalking. The review has already set out the extensive pre-relationship history of the perpetrator. The timeline notes that victims are often aware but do not always believe the reports. Lynne was not aware of the perpetrator's history when the relationship began, and he then controlled what he wanted her to know.

4.2.5.4 **Early relationship**

4.2.5.5 The research found that the relationship would speed up with early declarations of love, possessiveness, and jealousy. This was very clear in Lynne's relationship and, from her police statement in January 2016 we can hear Lynne's words.

4.2.5.6 Lynne described how their relationship, and the abuse, had begun. She said that she had met him in 2014 when their children were best friends at school. They became friends and he (and his three children) quickly moved in with her within a few weeks of the relationship starting. Before they began a relationship, he said to his children 'that woman is going to be my wife'. He had set his sights on her.

4.2.5.7 When they first met, he swept her off her feet and lavished her with lots of presents. she was desperate for another baby. He promised her children and a business. They would buy cheap furniture and then sell it on.

4.2.5.8 Lynne's friend said that she was attracted by the attention that he gave her. He would say, 'you are the most beautiful woman'. In comparison to her previous relationship, she said this was so exciting.

4.2.5.9 Lynne's family were concerned with the speed of the relationship. When they sat, he would have his hands all over her. Lynne was convinced that she was in love.

4.2.5.10 **Relationship**

4.2.5.11 Lynne said that the relationship got off to a rocky start because the perpetrator wanted them to go to the pub every night, taking the children with them, so that he could go drinking and gambling. She said that she thought he was loading money into the fruit machines whilst she was at the bar and then he would make out that he had won a lot of money. At the time Lynne was uncomfortable with this lifestyle as she did not want the children to be in the pub every night. When she raised it with him, he would compare her to his ex-wife and say, 'you're just like my fucking ex, you're a cunt'. Back home he would take out his gambling losses on Lynne, shouting at her and waking the children up.

[41] Monckton-Smith, Jane (2019), Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide. Violence Against Women, University of Gloucestershire

4.2.5.12 Lynne described in her police statement in January 2020 that she felt like she had to earn the perpetrator's trust, but she had never given him a reason not to trust her. She said that on the rare occasions that they were apart, she had to prove where she was.

4.2.5.13 Monckton Smith's third stage is a relationship dominated by coercive control, usually with some of the high-risk markers. Monckton Smith has identified fourteen characteristics[42] that can be used to predict dangerousness or risk of homicide or serious assault. Referring to the evidence set out in the previous section of this report we can identify the majority of risk factors in this relationship:

√ Previous domestic abuse
√ The woman is frightened that she is in serious danger
√ Separation or the threat of separation
√ Sexual assault
√ Threats to kill, or use of, weapon
√ Threats to kill her or her children
√ Threats to commit suicide
√ Violence, especially escalation in seriousness or frequency
x Pregnancy (especially violence)
√ Stepchildren in the home
√ Stalking or harassment
? Strangulation, simulated or real
? Threats to kill loved ones or pets -evidence of cruelty to pet
x Arguments over child contact

4.2.5.14 **Triggers**

4.2.5.15 The Homicide Timeline has identified that an event occurs that threatens the control of the perpetrator. Usually, it is separation or its potential.

4.2.5.16 The review believes that the trigger was the incident in January 2016 when Lynne was attempting to leave and called the police after he had assaulted her and threatened to kill her. Although Lynne did not leave at that point, she had decided that she needed to leave and start a new life.

4.2.5.17 The review has noted that on the two occasions when Lynne had made a complaint against the perpetrator and had sought to separate from him, or had indicated that she wanted to separate that the heightened risk that separation can bring was not acknowledged.

4.2.5.18 In January 2016 when Lynne had indicated that she wanted to leave the relationship and the police were called, a DASH risk assessment was undertaken and graded as high. However, it was then reduced to medium. The rationale for this was that the perpetrator was in custody and Lynne had gone to her mother's. The rationale said that, whilst there was the potential for him to cause serious harm, it was unlikely *unless circumstances changed.* The complaint was closed with No Further Action. The circumstances *had therefore changed,* and the DASH was not revisited. Lynne had indicated to the perpetrator that she wished to leave the relationship therefore the risk to her was increased.

[42] Domestic Abuse, Homicide and Gender, Monckton-Smith et al, Palgrave Macmillan, 2014

4.2.5.19 Again, in January 2020 Lynne's mother reported to the police that Lynne was experiencing coercive and controlling behaviour and the DASH was graded as high risk. The perpetrator was arrested, and the DASH remained as high when it was reviewed. However, when the perpetrator was released from custody with conditional bail, it was then reduced to medium because there were bail conditions, Lynne was with her mother, and she was being supported by the IDVA.

4.2.5.20 Research is very clear that the biggest trigger for fatal violence is separation or the threat of violence. Both Stark (2007) and Polk (1994) routinely found a strong correlation[43]. In her study of homicides in London, Richards (2003) found that 76% of domestic homicides involved separation[44].

There is a need for the dangerousness of separation to be more recognised in risk assessments undertaken particularly when a victim has left the relationship or has indicated a wish to leave the relationship.

Recommendation

it is recommended 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 if necessary.

4.2.5.21 **Escalation**

4.2.5.22 This is the stage when the perpetrator tries to reinstate control. This can be seen through an increase in the frequency or severity of control tactics like suicide threats, begging, violence and stalking.

4.2.5.23 The control then escalated with the perpetrator isolating her and stalking her movements.

4.2.5.24 This continued until Lynne left the perpetrator in April 2020. Although she had threatened previously to leave him, or had gone to her mother for a few days, this time was different. On 18th April 2020 Lynne told her sister that she was never going back, and she had it under control. There was a change in Lynne. Her family recall that she was now able to stand up to him in ways she had not been able to do before. For example, she was talking to her sister, and he made about 150 calls to her. Lynne told him to stop calling her and her family say that she would not have had the courage earlier to say this to him.

4.2.5.25 On 15th May Lynne was told by Broadland and South Norfolk Council that she had been allocated a property owned by Clarion Housing. Although the house was not yet ready for her to move into, she had the prospect of a new start.

4.2.5.26 **Change in thinking**

4.2.5.27 At this stage feelings of revenge, injustice or humiliation may drive a decision to resolve issues, through either moving on, revenge, or potentially homicide.

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[43] Monckton Smith et al, Domestic Homicide, Homicide and Gender, Palgrave Macmillan, 2014

[44] Richards L, Findings from the Multi-Agency Domestic Violence Murder Reviews in London, 2003 cited Horley S, Power and Control, Why charming men can make dangerous lovers, Vermillion, 2017

4.2.5.28 Although we do not have direct evidence from this time, the judge in his sentencing remarks made it very clear that Lynne had challenged his control by leaving him and 'you could not stand that'. Clearly, he had to find a way to resolve this in a way that he felt was resolved. This would have been what was right for him, and him alone.

4.2.5.29 **Planning**

4.2.5.30 This stage may include buying weapons, seeking opportunities to get the victim alone, stalking and threats. This is possibly the most chilling stage of Lynne's death. The perpetrator arranged to meet Lynne at a relatively deserted area that was known to them. A place where they would go to meet and, on occasion, to have sex. This was a location that would not rouse Lynne's suspicions.

4.2.5.31 The perpetrator had placed messages on his Facebook saying, 'the day has come', eulogies and funeral poems. In response to this, Lynne had put ?? as she did not understand. A couple of days before Lynne's murder, the perpetrator had changed all Lynne's passwords and her photo ID to a photo of them both.

4.2.5.32 The night before going to meet Lynne, the perpetrator had packed the children's clothes into the car. He went to meet Lynne carrying a knife.

4.2.5.33 **Homicide**

4.2.5.34 The research indicates that this stage may involve extreme violence, suspicious death, missing person, or multiple victims. The judge in sentencing referred to this being an attack of 'great brutality'. She screamed for some time. She fought for her life. She died from multiple stab wounds, including many directed to her neck and chest. Some were driven home with severe force. The judge said that the perpetrator was 'merciless'.

4.2.5.35 As was set out above, the perpetrator could have decided to stop this timeline of events. He did not have to murder Lynne; this was his choice.

4.2.5.36 She was vulnerable because she had left her previous partner. She had been with him but they separated because she desperately wanted another baby and he could not have children. Lynne's work friends said that more than anything Lynne wanted to be a good mother, and she yearned to have more babies. Family life was the most important purpose for Lynne.

4.2.6 WHAT BARRIERS DID LYNNE FACE WHEN TRYING TO LEAVE THE PERPETRATOR?

4.2.6.1 To learn from Lynne's murder the review has sought to explore the barriers that Lynne faced and has drawn on the thoughts of Lynne's family and friends as well as her own thoughts.

4.2.6.2 The review is aware of three different times when Lynne specifically spoke of leaving the perpetrator. Firstly, in the Autumn of 2015 when she was pregnant with Child 6, secondly in January 2016 and finally in January 2020 when she did actually leave. In December 2019 she had told Child 4 that she was making plans to leave and hoped that they would be out of there soon.

4.2.6.3 **Committed to marriage and family life**

4.2.6.4 For Lynne marriage and family life was important. She said that she wanted to save her marriage because she had been very upset when her parents had divorced. She had also experienced marriage breakdown already and had been devastated by this. Lynne's work friends said that more than anything Lynne wanted to be a good mother, and she yearned to have more babies. Family life was the most important purpose for Lynne.

4.2.6.5 **She had not experienced domestic abuse previously**

4.2.6.6 Lynne had never been in an abusive relationship before and therefore it was not straightforward for her to identify this. She believed the lies that the perpetrator told her when he blamed the abuse on anxiety and alcohol.

4.2.6.7 Horley[45] point out that, as paradoxical as it may seem, women in an abusive relationship often feel less frightened staying with their abusers than if they were to leave them. They have, they say, some idea of where they are. One victim told Horley that it was almost a relief when he tracked her down. The subsequent abuse that she suffered was less terrifying than never knowing what he was doing.

4.2.6.8 Lynne had told her work friends that she wanted to leave the perpetrator, but next time they saw her she said that things were better, and he was good with the babies. There was a sense of denial and resignation. She seemed to have convinced herself that things were not that bad. This may well have been her way of coping with helplessness that she felt at being able to leave.

4.2.6.9 **Financial worries and constraints**

4.2.6.10 In the Autumn of 2015 Lynne was pregnant with Child 6 and she told her work friends that she wanted to leave him. She said that he had taken her nest egg and cleared her out implying that this made it more difficult for her to leave.

4.2.6.11 The perpetrator had taken all her money and built-up debts in her name, which also affected her credit rating.

4.2.6.12 In their examination of the housing experiences of domestic abuse survivors[46], Women's Aid found that more than half of the respondents cited concerns about future housing were a barrier to leaving. The challenges they identified were a lack of access to money to cover the costs of setting up a new home, fear of homelessness and being forced to live in unsuitable accommodation, being denied help from their local housing team and difficulties in finding a landlord who would accept rent paid by benefits.

4.2.6.13 Lynne was well supported by her local council who accepted a duty to house her. Just before her murder she had been allocated a new home for her and her children. However, she had, understandably been in temporary accommodation before this was available and she had expressed concerns about this. In fact, she had returned to her mother's home as she was

[45] Horley S, Power and Control, Why charming men can make dangerous lovers, Vermillion, 2017
[46]The Hidden Housing Crisis, Women's Aid, 2020

unhappy with it. We cannot know, if this had not been an option, if she would have considered returning to the perpetrator to provide a 'suitable' home for her children.

4.2.6.14 **Fear that he would take the children from her**

4.2.6.15 Many women are terrified of going to the police or to take legal action against their partners for fear that their children will be taken away[47].

4.2.6.16 Lynne's children were everything to her and she feared that the perpetrator would not only fight her for custody but that he would be successful. After all, he had successfully taken Child 1, Child 2, and Child 3 from their mother.

4.2.6.17 Lynne told Child 4 to report to the pastoral team at school what the perpetrator was doing to them so that it was logged. She feared what he would do.

4.2.6.18 **Fear that he would not let her leave**

4.2.6.19 Lynne's friend said that she had said that he had control and would not let her leave. She said that he would beg her not to leave.

4.2.6.20 **Fear of starting again**

4.2.6.21 Lynne's friend said that Lynne had been fearful of starting again with the children on her own.

4.2.6.22 In January 2016 the coercion and control had ground Lynne down and she said in her statement that 'I felt cheated and upset, I started giving up then, I thought I'd made my bed and had to lie on it.'

4.2.6.23 **The perpetrator's threats to kill her**

4.2.6.24 In January 2016 when the police were called, the perpetrator had mouthed to her 'you are going to die'.

4.2.6.25 Lynne was fearful of leaving the perpetrator because, if she did, he would take revenge. She said that he would alienate and stalk her. She also said, 'he could murder me'.

4.2.6.26 It is important that, having considered the barriers to Lynne leaving, that we remember that she *did* leave him. She had been offered a house by the council; she was getting her life back on track. It may have been difficult for her to see the picture as a whole, as Horley[48] says, the idea of leaving the perpetrator was as nerve-racking and dangerous as jumping from a train but Lynne was not a passive victim, she was a resourceful and coping survivor who had left the perpetrator and was making her way alone.

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[47] Horley S, Power and Control, Why charming men can make dangerous lovers, Vermillion, 2017
[48] Horley S, Power and Control, Why charming men can make dangerous lovers, Vermillion, 2017

Section 5 – The perpetrator

5.1 Alcohol

5.1.1 The perpetrator has not engaged with this review and thus information about him is from agency records and what Lynne's family, friends and others are able to tell us.

5.1.2 It has been documented throughout this review that the perpetrator was a man who like to drink to excess. There were numerous times when Lynne 'excused' his abuse by suggesting that it only occurred when he had been drinking.

5.1.3 Lynne was not happy about the impact that the perpetrator's drinking and gambling had on the family. She was not happy for the children to spend hours in the pub whilst he was drinking. We know that in January 2016 when Lynne had called the police, this was because of her challenging him keeping the children in the pub and she had taken them home.

5.1.4 The perpetrator's involvement with probation began after he had been found guilty of failing to provide a specimen of breath. He had driven the car whilst intoxicated. This incident occurred after a night out in town. Lynne had planned to leave the car in town and get a taxi home. When she was ready to leave, the perpetrator would not accompany her and so she went home alone. He then drove the car whilst intoxicated.

5.1.5 Research from the US finds that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of the assault[49] and that cases involving severe violence are twice as likely to include alcohol[50]. It has also been found that in an intimate relationship where one partner has a problem with alcohol or other drugs, domestic abuse is more likely to occur[51]. However, the impact of alcohol on domestic abuse is complicated.

5.1.6 It is important that we remember that domestic abuse is about power and control by one partner over another. Not all alcoholics are abusive and not everyone who abuses their partner is alcoholic. Whilst we can say that alcohol may be a compounding factor in a person being abusive to their partner, we must avoid suggesting that it *causes* it. Alcohol is *not* the cause of abuse or the violence, the desire for power and control is. Alcohol can be offered as a reason, or an excuse, for the abuse but this should not be accepted and the responsibility for his actions should not be removed from the perpetrator by blaming the fact that he was drunk.

5.1.7 In this case the perpetrator was controlling of Lynne and his coercive and controlling behaviour extended way beyond when he was drunk. He was constantly stalking her and monitoring her, this cannot be explained away as being because he was drunk.

5.1.8 Whilst the review fully understands that Lynne may have been told by the perpetrator that his behaviour was due to alcohol and, due to the abuse she was experiencing she may have believed him, the review does not accept this.

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[49] Bennett L and Bland P, Substance Abuse and Intimate Partner Violence, National online recourse centre on violence against women, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

[50] McKinney C et al (2008), Alcohol Availability and Intimate Partner Violence Among US Couples, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

[51] Galvani S, (May 2010), Supporting families affected by substance misuse and domestic violence, The Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire, ADFAM, p5 cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

5.2 The manipulation of processes and professionals by the perpetrator

5.2.1 The evidence in the report of the abuse that the perpetrator's ex-partner and Lynne experienced has painted a picture of the perpetrator as a very manipulative man. It has also become clear that it was not only women in an intimate relationship that the perpetrator manipulated but, in fact, anyone who he encountered and was able to impact on him and his life.

5.2.2 Going back over many years it is possible to see evidence of the perpetrator manipulating processes and professionals. There is evidence that the perpetrator would seek to use intimidation to control the processes, opinions, and actions of professionals.

5.2.3 The records that were forwarded to the schools in Norfolk reflected concerns about the perpetrator being aggressive towards school staff and refusing to allow the children to be spoken to about concerns raised by school staff.

5.2.4 The psychiatrist report prepared as part of the murder trial, references a visit by the health visitor in 2012 where she noted that he was aggressive and hostile towards her. The health visitor had raised concerns about Child 3's speech and the perpetrator had made it very clear that he did not want anyone to look into this or do anything about it.

5.2.5 The school records of the children at this time also reflect concerns about the perpetrator's aggression to school staff and his refusal to allow the children to be spoken to in response to concerns raised by school staff.

5.2.6 It was decided in a professionals' meeting at this time, that the perpetrator would only be seen with two people present and would not be seen on his own.

5.2.7 Lynne and the perpetrator were seen together by professionals in April 2015, and it was noted that he was reluctant to disclose the reason for the families' impending move and this was interpreted by the health visitor as defensive.

5.2.8 When Lynne was in hospital for the birth of her child in May 2015 the midwives recorded that the perpetrator had been very rude both to them and the doctor. He was reluctant to accept the medical advice that Lynne should stay in hospital and said, 'I think that should be up to the parents. We have raised five children we know what we're doing'. When it was suggested, after he had fallen asleep in the chair, that he went home for a rest and returned later, he was very aggressive and said, 'I am not leaving them here'. When he was later advised that they could transfer to the post-natal ward he said, 'I feel you are not listening, we are going home'. Lynne was recorded as pleading with him to calm down. The midwife recorded in summary that they found his behaviour 'dominant and controlling towards Lynne and rude and aggressive towards staff'.

5.2.9 On 18th January 2016 the MARAC meeting agreed that professionals would not attend the family alone.

5.2.10 On 27th January 2016 the health visitor and social worker attended together. ***This was good practice considering the recent decision.***

It is noted that from 27th January numerous lone visits were made by health visitors to the family

5.2.11 This was then noted on the GP records on 22nd February.

5.2.12 When the health visitor visited the couple on 14th March for a planned antenatal visit, the perpetrator was defensive when it was suggested that the meeting should be rescheduled as Lynne had to go out to take Child 3 to the GP, saying, 'can't we just get this over with'. Had the perpetrator taken Child 3 there would have been the opportunity to see Lynne alone. If the health visitor had not been alone, they may have felt more able to challenge.

5.2.13 In April the perpetrator had refused to allow CSC to speak to the children without him as part of their review. The social worker noted that the perpetrator was controlling and that they would have to make a further visit to see the children.

5.2.14 CSC completed their review in May, but the information obtained was described as restricted as the perpetrator would not allow the children to be spoken to alone and full details of his violent history were not obtained as he would not give his consent to them being accessed.

5.2.15 The relationship that the perpetrator had with the children's schools was described as difficult when CSC suggested that the school spoke to one of the children about a disclosure made. The school felt that to do this would deter the children from feeling safe to disclose information at school.

5.2.16 When the two-year development check for Child 5 was undertaken in December 2017, the perpetrator was controlling of the meeting, saying he did not have time to engage with the questionnaire as he had to get back to work. The perpetrator said that it was a waste of time, and he would post the questionnaire back. The health visitor referred to the perpetrator's voice as being 'intimidating'.

5.2.17 This may be because of their conscious thought for their own and other's safety and a need to maintain the status quo in the presence of the person displaying the abusive behaviour, albeit in the form of intimidation and control.

5.2.18 CSC were involved with the family after the incident in January 2016 and earlier in the report it is noted that the focus of this involvement was on working with the perpetrator who was controlling in his attitude. There appears to have been more emphasis placed on gaining his consent to an assessment than on addressing the domestic abuse. There was a reluctance to move towards Section 47 that would have negated the need for the perpetrator's consent.

5.2.19 In 2018 the perpetrator was sentenced to Unpaid Work and was allocated to a work group. However, he then requested a change to his work placement so that he could have an individual work placement.

5.2.20 Following the report of coercive and controlling behaviour to the police in January 2020, CSC closed their involvement with the family as they did not believe that the perpetrator would consent to a social work assessment and the evidence available did not meet the threshold for a Section 47 investigation.

The CSC IMR author noted that it would have been helpful for a full chronology of the incidents of abuse and violence to have been collated by CSC. This would have provided better ability and more place to challenge the perpetrator about the concerns about his ongoing care of the children. This would also have allowed social workers to clearly think about Section 47 and the need to have a clear plan to look at the impact of domestic abuse on the children.

This review is aware that the practice of social building chronologies of events from files and applying this to thresholds and on-going decision making is now regularly monitored and reported upon on a weekly basis as part of good casework. This is welcomed.

5.2.21 All three schools were aware of the perpetrator's aggressive attitude. The first primary school (PS1) experienced his aggressive behaviours towards female school staff.

The review is aware that the challenges of working with such complex cases has been recognised by the Norfolk Safeguarding Children Partnership (NSCP). In response to learning from previous Serious Case Reviews, the NSCP has developed the NSCP Joint Agency Group Supervision Protocol. This supports a safe place for professionals to allow 'slow thinking' about complex, difficult or drifting cases. Moving forwards a case such as this would consider in this multi-agency environment.

5.3 Taking action against high-risk perpetrators

5.3.1 There is clear evidence with the MARAC meeting notes from January 2020 that the perpetrator had issues around alcohol abuse and there is police intelligence referring to the couple drinking. The perpetrator had also demonstrated mental health issues previously with the threat to commit suicide. There are also concerns around previous domestic abuse in relation to other victims however without any convictions. Whilst there is support in Norfolk for victims of domestic abuse both through statutory and non-statutory partners provision for domestic abuse high risk perpetrators outside of the criminal justice at the time of the murder were limited.

5.3.2 It has been recognised by Norfolk Constabulary that victims of domestic abuse cannot be supported successfully without a whole system approach including perpetrator prevention, provision of service, partnership working with the potential to disrupt, if necessary, through police tactical means.

5.3.3 Norfolk Domestic and Sexual Violence Group (DASVG) partners through the DASVG Perpetrator Partnership subgroup have developed an appropriate response to the domestic abuse perpetrator intervention agenda. The development of the Domestic Abuse Perpetrator Partnership Approach (DAPPA) of intervention, disruption, education, and interruption model including the evidence base and business case to support the model. This follows the same approach as the Northumbria Multi Agency Tasking and Coordination (MATAC) approach which has been subjected to evaluation.

5.3.4 This approach, will support the partnership strategic vision to:

- Develop a cohesive multi-agency operational delivery group to manage:
- Perpetrators, who are serious or repeated risk to harm, regardless of post conviction, gender or geographical location
- Focus and develop a dedicated referral team/partnership management process/focused pathway to support enabling:

- Reduced reoffending
- Impacting positively on offender's behaviour
- Improvement of victim safety, criminal justice outcomes and partnership working
- Provide access to intensive, targeted perpetrator intervention programmes (inclusive of all protected characteristics or geographical location) which are not reliant on criminal justice outcomes

5.3.5 The model of perpetrator support has now been reviewed since initial implementation and a new model of service has been implemented.

5.3.6 This is a jointly funded partnership between the Office of the Police and Crime Commission and Norfolk Constabulary. The OPCCN manages the commissioned service and Norfolk Constabulary manages the DAPPA team who manage, respond and bring the partnership together to manage perpetrator intervention whether they be disruption or engagement.

The review recognises that DAPPA is in its infancy in terms of embedding a team within the MASH but welcomes this approach by Norfolk. Numerous DHRs identify that the multi-agency processes concentrate on the victim – protecting them and supporting them to make changes to improve their safety. A concentration on perpetrators is welcomed but the review would encourage Norfolk to ensure that the two processes 'talk to each other' and a victim and perpetrator are not dealt with in two different silos.

Recommendation
It is recommended that Norfolk Constabulary continues with the development of the Domestic Abuse Perpetrator Partnership Approach (DAPPA) that has now been established in the county.

5.4 Should agencies have known about his history?

5.4.1 One of the areas that Lynne's family struggle to understand is how the extensive history of abuse by the perpetrator set out in this report was not known to agencies when they interacted with the perpetrator and Lynne.

5.4.2 There is no doubt that the evidence presented in the murder trial, and repeated in this report, painted a picture of the perpetrator as a repeat abuser, but the review has sought to examine what information was known *at the time* of interactions with the perpetrator and Lynne.

5.4.3 Firstly, any check on the perpetrator's history would have identified the following in relation to domestic abuse:

1995	Threats to kill (partner)	Lie on file
1995	Common assault (partner)	Lie on file
1996	ABH on partner	

There are no further convictions since 1996. The review does not consider that the perpetrator was not abusing women during this time, in fact the evidence from his previous partners to the murder trial, clearly states that he was abusing them, but they were too fearful to report to the police.

5.4.4 In January and March 2013 Child 2's school raised concerns with CSC about bruising on Child 2 and an incident with the perpetrator's partner at the time. Initial assessments were undertaken, and no further action was deemed necessary.

During these assessments, the children were spoken to, and they spoke about their mother. This was not followed up and no attempts were made to speak to her.

The review believes that had the perpetrator's ex-partner been spoken to at this point – the first time that the perpetrator and his children came to their notice – there would have been a better understanding of the perpetrator and his abusive history that would have impacted on all the interactions that followed. This has been addressed with a recommendation earlier in the report.

5.4.5 The next time that the perpetrator and his children came to the notice of CSC was 30th March 2014 when the school raised concerns about the number of school placements and an anonymous call was made to CSC about the children looking unkempt and them just having returned from Liverpool. A further anonymous call was made to NSPCC at the end of July 2014.

5.4.6 These reports were all considered by CSC and no further action was taken.

The review accepts that, with the information available to CSC, this was appropriate at the time.

5.4.7 On 29th September 2014 the perpetrator's ex-partner telephoned CSC because she was having difficulty in getting access to her children as this was being prevented by the perpetrator.

The perpetrator's ex-partner was advised that she needed to seek legal advice. It is always possible to reflect and consider whether if more professional curiosity or understanding been shown, there was an opportunity for her to disclose the abuse she had experience from the perpetrator and improve the understanding of professionals of the situation. The nature of the telephone call will never be fully known after the event and thus it would be unwise to place too heavy an emphasis on this aspect.

5.4.8 In December 2014 and February 2015 Child 2 spoke to the school. In March 2015 both Child 2 and Child 4 spoke to the school about an argument that had occurred between Lynne and the perpetrator.

Whilst these reports did not warrant action by CSC, had they known about the history of abuse against the perpetrator's ex-partner these reports may well have been dealt with differently.

5.4.9 On 17th March 2015 the perpetrator's ex-partner called CSC again as she was still having difficulty with access.

The perpetrator's ex-partner was advised to seek legal advice. Given the reports from the children just a matter of days and weeks before this, the review believes that there should have been more professional curiosity and the opportunity taken to speak to her about the problems she had in the past, and was experiencing at the time, with the perpetrator. This could have given greater context to the reports of the children.

5.4.10 On 17th April the health visitor met with the perpetrator and Lynne, and it was noted that the perpetrator was reluctant to give reasons for their impending move and was seen as defensive.

This was significant enough for the health visitor to make a note of it. Had the health visitor have known about his history of abuse towards the perpetrator's ex-partner then this interaction may have been more probing.

5.4.11 January 2016 is significant in helping us to answer this question. Lynne called the police following an assault by the perpetrator. The DASH assessed Lynne as high risk, so she was now on the radar of Norfolk agencies. The search by the MASH found no history of domestic abuse history with Lynne as this was the first time that she had called the police.

On 16th January the perpetrator's ex-partner called the police as Child 1 was on the phone to her expressing how terrified the children were that the perpetrator was being released from custody and was on the way home.

This was the first contact that the police had with the perpetrator's ex-partner but, the records do not help us understand the level of professional curiosity evident in their interaction with her. There is no evidence that she was asked about her relationship with the perpetrator, if she was and if relevant information was disclosed there is no evidence that this information was shared with CSC.

5.4.12 On 18th January Child 3 disclosed at school the incident when the police were called and their feelings about this. This was shared with CSC and the police. The review has seen no evidence that the police and CSC would have held a strategy meeting without the proactive intervention of the school.

5.4.13 If we move to January 2017 the perpetrator's ex-partner called CSC as her children had told her that they were scared.

Whilst an initial assessment was undertaken, the perpetrator's ex-partner was not spoken to about her experiences.

5.4.14 At the end of January, it is noted that the social worker had spoken to the perpetrator's ex-partner, and she had spoken of the abuse she had experienced. **This did provide evidence of his previous abusive behaviour.** There is no evidence to assist this review as to whether it was shared with other agencies.

5.4.15 In March 2017 there is an incident at the school where, the perpetrator, his ex-partner and Lynne were all present. The perpetrator's ex-partner talked to the police and the school about her experiences of abuse by the perpetrator.

5.4.16 **The police, CSC and the school are now all aware of what his ex-partner had told them of his history.**

The review concludes that when the perpetrator moved to Norfolk there was little that they would or could have known about his abusive past. However, if the perpetrator's ex-partner had been spoken to, on any of the opportunities available, it is possible that she would have disclosed some of her experiences and what she knew about his history not only with her but with other partners too.

5.5 Post-Conviction Control

5.5.1 As this review has progressed one of the major issues affecting the family is the continued manipulation and control of the perpetrator from prison. This control has come through his influence on what happens to the children and Lynne's belongings.

5.5.2 The review is aware that Lynne's family plan to take this further in her memory.

Section 6 – Safeguarding Lynne

This section will consider the mechanisms used to safeguard Lynne.

6.1 Norfolk Integrated Domestic Abuse Service (NIDAS)[52]

6.1.1 NIDAS was launched at the beginning of 2022 to provide joined-up support for those experiencing domestic abuse and help their journey to freedom. The service is led by the Office of the Police and Crime Commissioner for Norfolk, Norfolk County Council, Norwich City Council, South Norfolk and Broadland District Councils. Funding has been confirmed for the next five years, giving this new approach long term funding.

6.1.2 NIDAS is delivered by Leeway, Daisy Programme and Safe Partnership. The service offers:

- A strengths-based personalised support/safety plan
- High quality, integrated and consistent support from a named IDVA working with high and medium risk clients
- Step down and recovery support including group work and programmes
- Support for children if their parent/care giver is, or has been, supported by an IDVA
- Support in accessing community networks and multi-agency partnership working linked to Help Hubs
- Contact with trauma-informed, person-centred, trained, and skilled staff
- Sanctuary support for a rapid response to target hardening, offered to those as high risk to keep them safe in their home
- The Community Recovery Support workers will support clients, enabling them to form support networks and move on with increased confidence and well-being

6.1.3 The review notes that the interaction between NIDAS and MARAC will develop in the coming months.

The review welcomes this new integrated model that will offer a consistent, risk and needs led service across the County to support victims from early identification to long term positive outcomes.

Recommendation
It is recommended that, as NIDAS develops, the comments made about MARAC within this report are part of the future planning of service delivery.

6.2 Domestic Violence Disclosure Scheme (DVDS)

6.2.1 The perpetrator was well known to Police and there is clear evidence provided both within the chronology, in the information which falls outside of the agreed scope of the review, that he had been in other abusive relationships as the perpetrator. This review has considered whether there were opportunities for disclosure under the Domestic Violence Disclosure Scheme (DVDS).

[52] https://nidasnorfolk.co.uk/

6.2.2 Under the Domestic Violence Disclosure Scheme (also known as Clare's Law) the police have common law powers to disclose information about a person's known history of violence and abuse. Disclosure is made normally relating to convictions or charges and where there is a need to disclose this information to prevent further crime and to safeguard any individuals. The scheme recognises two procedures for disclosing information:

- **Right to ask** – this is triggered by a member of the public applying to the police for a disclosure
- **Right to Know** – this is triggered by the police making a proactive decision to disclose information to protect a potential victim.

6.2.3 When a case is being considered for disclosure a Police Staff Investigator (PSI) will carry out the necessary research of all police systems. If this establishes that there is a history of domestic incidents the full research package is presented to a panel who will determine if a disclosure should be made.

6.2.4 Within this case there was no request from any member of the public for disclosure so the Right to ask was not applicable.

6.2.5 The MASH made the decision not to disclose information to Lynne under the Right to Know section of the DVDS. A review of this decision by the police concluded that there was not a strong case for putting this case through the DVDS when it was secondary risk assessed in April 2020 as the essential criteria is for the person to have a conviction for a domestic-related offence and the perpetrator does not have this. The Police Staff Investigator (PSI) could have made a request for DVDS if they felt there was sufficient history of violent behaviour of concern and multiple domestic reports which did not gain a conviction. Although the perpetrator does have a number of domestic incidents reported there are no convictions and PNC does not show numerous NFA for domestic incidents.

6.2.6 Had the PSI made a request task supported by reasons for their great concerns then they would have put it through for process and the decision about disclosure would have been made at panel.

6.2.7 A check was carried out of the Police National Database (PND) which brings together intelligence from forces across England and Wales. The PND check did not show a pattern of numerous reports of domestic from out of county and from the police national computer (PNC) which show arrest or conviction data there was nothing at court between 2008 and 2016.

6.2.8 The DASH completed with Lynne in April 2020 indicated that she was aware of him having been previously involved in football violence. She also said that, as well as him assaulting her in 2016, she was also aware that he harmed other people.

The IMR author notes that the decision was proportionate and justifiable given the lack of a conviction for a domestic related offence or a concerning history of violent behaviour.

Section 7 – Lessons Identified

7.1 **BROADLAND AND SOUTH NORFOLK COUNCIL**

7.1.1 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.

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

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

7.2.2 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.

7.2.3 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.

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

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

7.2.6 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.

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

7.3.1 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.

7.3.2 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.

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

7.4.1 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.

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

7.5 **DEPARTMENT OF WORK AND PENSIONS**

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

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

7.6 **NORFOLK COUNTY COUNCIL – EDUCATION DEPARTMENT**

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

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

7.6.3 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.

7.6.4 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.

7.7 **NORFOLK CONSTABULARY**

7.7.1 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.

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

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

Section 8 – Recommendations

8.1 **PROFESSIONAL CURIOSITY**

8.1.1 **Cambridgeshire Community Services**

8.1.1.1 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.

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

8.1.1.3 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.

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

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

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

8.1.2.3 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.

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

8.1.3.1 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.

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

8.2 **INFORMATION SHARING AND FORA FOR DISCUSSION**

8.2.1 **Norfolk County Council – Education Department**

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

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

8.2.1.3 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.

8.2.1.4 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.

8.3 COLLABORATIVE WORKING, DECISION-MAKING, AND PLANNING

8.3.1 All agencies

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

8.3.2 Cambridgeshire Community Services

8.3.2.1 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.

8.3.3 Norfolk and Waveney Integrated Care System

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

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

8.3.4 Norfolk Constabulary

8.3.4.1 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.

8.4 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 if necessary.

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.

Section 9 – Conclusions

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

9.2 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.

9.3 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.

9.4 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.

9.5 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.

9.6 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.

9.7 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.

9.8 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.

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

Appendix One – Terms of Reference

Terms of Reference for the Domestic Homicide Review into the death of Lynne

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Norfolk Community Safety Partnership in response to the death of Lynne which occurred in June 2020.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Overview Author for the purposes of this review. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the incident in June 2020 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Lynne.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

2.4 Additionally, establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

2.5 Contribute to a better understanding of the nature of domestic violence and abuse.

3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with the criminal investigation into the death of Lynne and process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 Draw up a chronology of the involvement of all agencies involved in the life of Lynne to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of The Act.

4.2 Produce IMRs for a time period commencing from 1st January 2014 (start of the relationship) to the date of the homicide.

4.3 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.4 To consider in particular the factors affecting offenders who perpetrate acts of abuse on multiple partners.

4.5 To review how much information was known by agencies of the perpetrator's past.

4.6 To consider in particular any additional pressures placed upon relationships by the creation of a blended family.

4.7 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.8 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.

4.9 To consider the impact of the Covid 19 lockdown on the relationship.

4.10 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Norfolk Community Safety Partnership will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel, escalating to the CSP Chair as necessary.

Gary Goose and Christine Graham
Independent Chair and Overview Author

Appendix Two –
Ongoing professional development of Chair and Report Author

2.1 Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
- Ensuring the Family Remains Integral to Your Reviews - Review Consulting (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
- Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
- Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
- Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
- Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
- Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
- Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
- Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
- Suspicious Deaths and Stalking, Professor Jane Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
- Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
- Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)
- Giving children a voice in DHRs – AAFDA (November 2021)
- Cross Cultural Training Webinar – Incels and Online Hate – HOPE Training (November 2021)

2.2 Christine has completed that Homicide Timeline Online Training (Five Modules) led by Professor Jane Monckton-Smith of University of Gloucester.

2.3 Gary and Christine have:

- Attended training on the statutory guidance update (May 2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford (September 2018)
- Attended AAFDA Annual Conference (March 2017,2018 and 2019)
- Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)
- Attended AAFDA DHR Chair Refresher Training (August 2021)

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15th February 2024

Dear Amanda,

Thank you for submitting the Domestic Homicide Review (DHR) report (Lynne) for Norfolk Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21st December 2023. I apologise for the delay in responding to you.

The QA Panel felt that the report has been written compassionately and respectfully. It draws out the learning across agencies. There were agencies involved and all seemed to realise that Lynne was in an abusive relationship. The report is detailed and provides the readers with a history of the relationship, evidence of escalation and detailed agency involvement.

Condolences were provided by the chair and CSP to the family of Lynne. A pseudonym was used for Lynne, which was chosen by her family. There was positive engagement with Lynne's family, friends, and employers to contribute to DHR process who were supported by AAFDA. This brought her voice to the review more strongly. Despite there not being a specific tribute to Lynne within the report, there is a sense of her throughout the report and the attempts she made to be protective to her children and stepchildren. It was decided by the panel that the offender would be known as 'the perpetrator' and the six children numerically which protected their gender and identity.

This is a sensitive report which captures the range of abuse Lynne experienced from the perpetrator and shows a good understanding of coercive control. The report provides an overview of the perpetrator's previous abusive behaviours with his ex-partners. The report has a detailed action plan that allows for ownership and tracking of actions.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- When Children's Services grade a case as High Risk, it should not be downgraded and closed when there is domestic abuse involved.

- It should be noted in the report that domestic abuse training will be attended on a yearly basis.

- There should be a requirement for GP practices/Primary Care to improve their understanding and response to families and victims where domestic violence and abuse is identified.

- There were missed opportunities for Health Visiting Services and Children Social Care (CSC) to provide a more joined up approach to the safeguarding/protection of children as part of the statutory processes.

- There was a lack of professional curiosity and routine enquiry by all agencies.

- Though financial abuse is recognised, this should be classed as economic abuse to capture more fully the range of abusive behaviours used by the perpetrator, including coerced debt and preventing Lynne from working. In addition, the direct links between his abuse (e.g., running up debts in her name) and the impact on Lynne (needing an IVA, being unable to rent because of the damage to her credit score) could be more explicitly recognised, drawing on research to demonstrate how powerful this can be. In addition to coerced debt, he used the threat of her having to pay him maintenance for the child to prevent her leaving, as well as using the children by offering them £30 if they told CSC everything was fine. That he continues to control her and the children's belongings after her death is also a form of economic abuse. There could also be a recommendation around the police not investigating the savings he spent or having taken out loans in her name (3.5.34). Surviving Economic Abuse has published research (2017, 2023) on prosecutions of coercive control and economic abuse, which may be helpful.

- There is identifying information for the children included throughout which should be removed, such as their date of births (2.2.19, 2.2.52). Pronouns or other gendered terms are also included.

- The report references technology-facilitated abuse throughout, from tracking her location via the Life 360 App, to monitoring her calls and messages, checking her accounts, and making Lynne send photos to prove her location. Yet the report does not recognise the abuse as technology-facilitated abuse and fails to list any actions for agencies to help support other victims.

- The review does not follow the Home Office template, so some sections feel repetitive, and information is revealed in section 4 (from family and friends) which could have been incorporated earlier. In addition, appendix 3 includes a

full chronology, but this is marked as being only for the Home Office – it is unclear why this is.

- The Equality and Diversity was too brief and only considers sex. Was pregnancy/maternity not considered to be relevant?

- The use of the term 'Stockholm Syndrome' at 3.2.57-9 and in a recommendation is not appropriate given the recent criticism of this – the review is talking here about how the perpetrator was able to manipulate services, and this would be more suitable language.

- For the entries in the chronology in 2012-early 2014, 'the children' are referred to – presumably these are the perpetrator's children, but this could be clearer.

- 1.12.2 uses 'Ex-Partner 1' (which is how the perpetrator's former partner is referred to throughout), but this should be changed to 'ex-partner'.

- A glossary would be helpful, as some terms are not explained (e.g. PS1, PS2, HS1)

- Some in text-references do not have a full reference, e.g., Stanley and Goddard, 2002; Adisa, 2020. In addition, some of the research cited at 5.1.5 is from a US context, so either UK research should be used, or this should be contextualised as such (e.g. 'Research from the US finds that…').

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

Office of the Police and Crime Commissioner for Norfolk
Jubilee House
Falconers Chase
Wymondham
NR18 0WW

03 May 2024

Domestic Abuse Policy Team
Home Office
2 Marsham Street
London SW1P 4DF

Sent via email: DHREnquiries@homeoffice.gov.uk

Dear Sir/Madam,

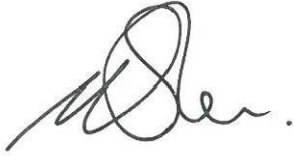
Thank you for the advice and comments contained in the letter received from the Home Office DHR Quality Assurance Panel (QA panel), on the 15th of February 2024 regarding the DHR of Lynne.

As Chair of the Norfolk Community Safeguarding Partnership, I am satisfied full consideration has been given to the points raised by the QA panel and addressed by the Norfolk panel members together with the independent chair and author of the review.

I am aware your office will not be able to amend the QA panel letter to reflect the changes that have been made to the final review without further submission to the QA panel. This QA panel would not review this report until September 2024. To stop any further delay in the publishing of this report, we will attach the QA panel letter and this NCSP response to yourselves to demonstrate the changes made to that review. The changes made to the report are included in this letter.

Every DHR undertaken by our partnership champions the voice of the victim. This independent review process has ensured that Norfolk partners understood the circumstances that led to Lynne's death, how agencies work individually and together and established the lessons to be learned. As a partnership we will continue to apply these lessons learned to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

Yours faithfully,



Mark Stokes
Chair of the Norfolk Community Safety Partnership
Chief Executive of the Office of the Police and Crime Commissioner for Norfolk

DHR Lynne report changes following Home Office Quality Assurance feedback.

Area of Development from Home Office QA Panel	Evidence of DHR Lynn panel development taken
There was a lack of professional curiosity and routine enquiry by all agencies.	The authors have identified this is clearly covered and referred to throughout the report, notably in paragraph 3.3.4 and references this within the recommendations. The Education panel member identified schools were professionally curious especially with regards to PS2 within the review, requesting clarification from the Home Office QA panel to understand what it is about school practice that lacked curiosity and routine. Note: The Home Office QA panel cannot respond to this request as the report will not be submitted for further QA process.
Though financial abuse is recognised, this should be classed as economic abuse to capture more fully the range of abusive behaviours used by the perpetrator, including coerced debt and preventing Lynne from working. In addition, the direct links between his abuse (e.g., running up debts in her name) and the impact on Lynne (needing an IVA, being unable to rent because of the damage to her credit score) could be more explicitly recognised, drawing on research to demonstrate how powerful this can be. In addition to coerced debt, he used the threat of her having to pay him maintenance for the child to prevent her leaving, as well as using the children by offering them £30 if they told CSC everything was fine. That he continues to control her and the children's belongings after her death is also a form of economic abuse. There could also be a recommendation around the police not investigating the savings he spent or having taken out loans in her name (3.5.34). Surviving Economic Abuse has	The heading of paragraph 4.2.4.44 has been amended to economic abuse. Last sentence of 4.2.4.8 moved to 4.2.4.52 New paragraph added at 4.2.4.57 It was agreed by the author and Police panel member that a further recommendation was not required. Since this incident there is greater awareness around Coercive and Controlling behaviour within policing. Training remains ongoing.

published research (2017, 2023) on prosecutions of coercive control and economic abuse, which may be helpful.	
There is identifying information for the children included throughout which should be removed, such as their date of births (2.2.19, 2.2.52). Pronouns or other gendered terms are also included.	The report has been amended by the authors
The report references technology-facilitated abuse throughout, from tracking her location via the Life 360 App, to monitoring her calls and messages, checking her accounts, and making Lynne send photos to prove her location. Yet the report does not recognise the abuse as technology-facilitated abuse and fails to list any actions for agencies to help support other victims.	The heading at 4.2.4.58 has been changed
The review does not follow the Home Office template, so some sections feel repetitive, and information is revealed in section 4 (from family and friends) which could have been incorporated earlier. In addition, appendix 3 includes a full chronology, but this is marked as being only for the Home Office – it is unclear why this is	Appendix three has been removed by the authors.
The Equality and Diversity was too brief and only considers sex. Was pregnancy/maternity not considered to be relevant?	New paragraphs on pregnancy have been added to the report by the authors.
The use of the term 'Stockholm Syndrome' at 3.2.57-9 and in a recommendation is not appropriate given the recent criticism of this – the review is talking here about how the perpetrator was able to manipulate services, and this would be more suitable language.	Wording in this section has been changed and the agency panel member is aware of the QA panels feedback.
For the entries in the chronology in 2012-early 2014, 'the children' are referred to – presumably these are the perpetrator's children, but this could be clearer.	The authors believed this was clear in the report. However, a footnote has been added
1.12.2 uses 'Ex-Partner 1' (which is how the perpetrator's former partner is referred to throughout), but this should be changed to 'ex-partner'.	References to Ex-Partner 1 have been changed to the perpetrator's ex-partner.
A glossary would be helpful, as some terms are not explained (e.g. PS1, PS2, HS1)	The authors have added explanation to the terms and do not think a full glossary is needed in the report as all other terminologies are explained.
Some in text-references do not have a full reference, e.g., Stanley and Goddard, 2002; Adisa, 2020. In addition, some of the research cited at 5.1.5 is from a US	A reference was included in the report. However, an extra reference has been added at 3.5.48.

context, so either UK research should be used, or this should be contextualised as such (e.g., 'Research from the US finds that…').	Contextualisation of the further reference has been added as requested.