Fenland Community Safety Partnership

Domestic Homicide Review

Overview Report

A report into the death of Laraine in April 2016

Independent Author: Dr Russell Wate QPM

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1.0 Introduction

1.1 This Domestic Homicide Review concerns the tragic death of 52 year old Laraine, whose family wanted the review author to use her real name and not a pseudonym.

1.2 The death of Laraine (who will also be referred to as the 'victim') occurred sometime before April 24th 2016, which is the date that her body was discovered. The offender was a 43 year old male and for the purpose of this review he will be identified as the perpetrator. The victim and the perpetrator were in a relationship, although there is no clear information as to the extent of what that relationship was and is explored further within the following sections.

1.3 The perpetrator was convicted of the victim's murder in November 2016 and is serving a life sentence. The review author is not aware of any further proceedings or any appeal against conviction or sentence by the perpetrator.

1.4 HM Coroner has opened and adjourned an Inquest and is likely to close the proceedings and rely on the murder conviction as his final judgement.

1.5 There is no indication that the family of the victim will seek to further any Inquest proceedings under Article 2 Human Rights Act (Right to Life)

1.6 A Domestic Homicide Review (DHR) is a statutory process in accordance with Section 9 Domestic Violence, Crime and Victims Act 2004, which was enacted from April 2011.

1.7 The Act states that a DHR should 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 or she was related with or with whom he or she was or had been in an intimate relationship, or*
b) *a member of the same household as him or herself, and, is held with a view to identifying lessons to be learnt from the death.*

1.8 The Home Office definition of Domestic Abuse is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

1.9 Controlling behaviour is further defined as: *a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

1.10 This review has been undertaken with due regard to the revised Statutory Guidance for conducting Domestic Homicide Reviews (December 2016)

2.0 Establishing the Domestic Homicide Review (DHR)

2.1 The Fenland Community Safety Partnership, notified the Home Office in accordance with statutory responsibility on the 20th June 2016 that the death of Laraine met the criteria for a domestic homicide review as defined by the then in place Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (August 2013). The guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and states that it should be completed within a further six months.[1]

2.2 The Fenland Community Safety Partnership have appointed Dr Russell Wate as the Independent Chair for panel meetings and the combined function as author of the final report. This is in accordance with both the 2013 and the 2016 revised DHR guidance. The review is supplied by RJW Associates.

2.3 Russell Wate is an independent practitioner who has chaired and independently authored a number of DHR's, Child Serious Case Reviews and Safeguarding Adult Reviews. He is independent of any agency within the Fenland area. He is a retired senior police detective, who is also particularly experienced in the investigation of homicide and child deaths. Panel meetings have been held where attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via email consultation and telephone.

2.4 Panel Composition (The panel members are all independent of any case work in relation to this DHR):

- Dr Russell Wate, Independent Chair and report author.
- Detective Superintendent Chris Mead, Previous Head of Public Protection, Cambridgeshire Police.
- Detective Superintendent Lorraine Parker, Current Head of Public Protection Cambridgeshire Police. (took over from Chris Mead)
- Jo Curphey, Deputy Director, Bench CRC
- Matthew Ryder, Head of Cambridgeshire Local Delivery Unit, National Probation Service
- Paul Collin, Head of Safeguarding, Cambridgeshire and Peterborough NHS Foundation Trust
- Carol Davies, Designated Nurse Adult Safeguarding, Clinical Commissioning Group
- Tom Jefford, Head of Youth Support, representing Cambridgeshire County Council
- Rob Mitchell, Fenland Community Safety Partnership

2.5 Agencies that had relevant information to assist the review, submitted Individual Management Reviews

[1] The Independent Author notes that the 2013 guidance has been revised and publication of the new guidance from December 6th 2016 will take effect for the purpose of this review as it has been prepared from December 2016 and will be submitted to the Quality Assurance Panel on that understanding.

- Cambridgeshire Constabulary
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)[2]
- National Probation Service (NPS)
- Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust (QEH)
- GP Practice- Trinity Surgery
- GP Practice- Clarkson Surgery

2.6 Agencies with little or no relevant information submitted reports

- Cambridgeshire County Council
- North Cambs Hospital minor injuries Unit
- Local Alcohol services (Drinksense and Inclusion) were contacted but no information to add

2.7 Family Involvement: The Independent author has approached the family of the victim through the Police Family Liaison Officers. The family of the victim consists of her two sons (a further child a daughter died aged just 2 years of age) her elderly parents who reside in the same area as the victim. The victim also has a sister and brother who live outside of the area. They have all declined to engage directly with the review author, but to engage with the review through the family liaison officers. The author is grateful for them allowing inclusion of facts from their witness testimony. They have also included their victim impact statements, which were prepared and read on behalf of the family. The family liaison officers have remained in close contact with members of the family, in particular the victim's parents. They have been great assistance to this review.

2.8 Friends and neighbours: The independent author considers that the perspectives of friends and neighbours are important and as such has made efforts to seek the perspective of these individuals. In this case it appears that the victim led a relatively isolated lifestyle that in part appears to be linked to her disabilities and as such had very little social interaction.

2.9 Offender Involvement: There has been engagement with the perpetrator within this review process through him agreeing consent for his information to be shared. However the review author has requested that any contribution from him in the interim period following conviction and the submission of the review, that may be of relevance to this DHR process will be notified to the Police IMR author by the investigating officers. The perpetrator did plead not guilty to murder. He has at the date of publication not expressed a view to contribute to this review.

2.10 The author has ensured that lines of communication are maintained with relevant persons irrespective of whether or not they have chosen to engage with this DHR process, through their agency contact.

3.0 Terms of reference

3.1 The purpose of this DHR is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

[2] Submitted in the format of a serious Incident Investigation report which had been commissioned by the CPFT

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work both individually and together to safeguard and support victims of domestic abuse including their dependent children.
- 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; and
- Prevent domestic violence homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

3.2 The offence date is to be treated as being the 24th April 2016. This is the date on which the victim's body was discovered. However it is not the same date as the date the offence is understood to have taken place. It is possible that the victim remained undiscovered for up to two weeks.

3.3 Timescales for review: The review panel agreed to start the initial information trawl from organisations dating back to 01/01/2014 moving forward to the incident date of the 24/4/2016. As a result of the information received there was a requirement to move further back in time[3]. The review author has included historical matters which are relevant for contextual purposes and these are identified accordingly.

3.4 In addition to the generic terms of reference the review panel specifically sought the individual management reviews to address the following specified issues:

- Alcoholism, both victim and perpetrator
- His continued violent nature (the perpetrator)
- Mental health issues, of both victim and perpetrator

3.5 The author has answered these key questions within the narrative of this report as these are the key themes which the panel considered to be important areas to examine arising from the preliminary reports and agency chronologies.

4.0 The victim

4.1 The victim Laraine was a 52 year old woman of white British background who has suffered from a number of medically diagnosed conditions and ailments. These have also been examined historically in order to contextualise the family background, which helps in gaining a greater understanding about the victim herself. Laraine had mobility problems which appear to have impacted on her day to day life, and as such she relied partly on others for care and support. The perpetrator appears to have been someone that played a significant part in her life.

4.2 Laraine is a divorcee and had moved to the local area some 15 years ago following separation from her husband. Laraine took her mother's maiden name following the divorce.

4.3 When married she and her spouse had three children, two sons and a daughter. The daughter sadly died of a rare illness aged just 2 years and this appears to have had an enduring impact on Laraine's life. Although it was something that she was willing to discuss, clearly her emotions and

[3] Agencies have provided relevant historical information in order to assist in informing the review process.

memories ran deep and there were triggers, such as significant anniversaries, which seem to have brought those events to bear heavily on her wellbeing.

4.4 Having divorced from her husband, Laraine moved to Cambridgeshire and bought her own accommodation. This was a ground floor flat in a block of six similar residential premises. Her two sons, who were both teenagers at that time, remained living with their father. Their relationship with their mother remained sporadic for a number of years and although they remained in contact with her, those relationships do not appear to have been strongly bonded.

4.5 Laraine's parents live in the area and this, combined with the availability of affordable housing was partly behind her reasons for the decision to move to Cambridgeshire. This meant that she left behind her friends as well as her immediate family and although her parents and a sibling lived in the area, she did not have a wide social circle.

4.6 There is information that Laraine had previously abused alcohol and this is linked back to the time following the tragic death of her daughter. This perspective does not appear to have changed when she moved to Cambridgeshire, although there are indications that she sought support for her use of alcohol in the early years. The information provided by CPFT about her as a service user indicates that she had "*Mental and behavioural disorder due to alcohol and cannabinoids, emotionally unstable personality disorder borderline type traits, history of anxiety and depressive symptoms".*

4.7 Although not employed at the time of her death, she was in receipt of benefits comprising of disability and living allowances. Her finances were 'managed' by her parents[4] including her bank accounts. This was not due to any financial impropriety by Laraine, but was principally due to her having been the victim of financial abuse at the hands of a former partner in 2010 and this arrangement had continued since that time. Although not fully financially secure, she was able to live adequately on her income and able to pay her outgoings without being in debt. In essence her parents would collect her benefits, complete her banking and provide her with cash as she required it which they handed to her on their visits to her home.

4.8 The reason that Laraine was not employed was due to her chronic illnesses which included left sided weakness, arthritis and chronic back pain which she had suffered from in excess of 20 years. There is also evidence from her medical records and hospital attendance that indicates that she may have suffered from a bipolar affective disorder. She also had suffered facial droop and appears to have informed members of her family that she had a brain tumour; however there is no medical evidence that supports that assertion by her. There was also no evidence of this disease found at the post mortem. She was able to walk but used a crutch in order to assist her mobility.

4.9 There is evidence that Laraine suffered with pseudo-seizures[5] and in June 2014 she appears to have had serious concerns for her own health following significant head pains. She made a visit to her GP and to the Ambulatory care at the QEH for which she received priority treatment, MRI scans and post attendance support, which is seen by the review as exemplary treatment. There was no clinical concern for her and the MRI study showed as a 'normal study'. It does perhaps re-inforce the background symptoms of pseudo-illness that her earlier medical records suggest.

[4] Both her parents survive her and are both aged in their late 80's.
[5] A psychiatric *disorder* characterized by the repeated fabrication of *disease* signs and symptoms for the purpose of gaining medical attention.

4.10 Laraine is reported as rarely leaving her home but would tend to remain there and consume alcohol. These facts are reported by neighbours and other residents of the flats whom indicate that she would often smell strongly of alcohol. The pathology toxicology report indicates that the victim was *"Significantly intoxicated with alcohol in combination with drug substances at the time of her death, but this did not play any part in the cause of her death"*.

4.11 The relationship with the perpetrator leading up to her death had evidence of apparent abuse and violence. The victim had also been in a number of abusive relationships before this relationship with the perpetrator. Although those other relationships are outside of the reviews timeframe, it is nevertheless important to identify that her vulnerability appears to have followed a common pattern. In that she suffered from poor health, had significant reliance on alcohol and perhaps more latterly cannabis and was the victim of physical, financial and coercive abuse. Those relationships were with three different men over a period of some several years. When considering not just domestic abuse, its causes and affects but coupled with adult vulnerability and alcohol abuse; this combination of effect is significantly magnified, and was for this victim.

4.12 In summary, the victim was both vulnerable by her own frailties and also to external influences and the information provided suggests that she was a repeat victim of abuse. This is supported from a financial point of view as the victim was in receipt of Employment and Support Allowance (ESA) - this where the claimant's ability to work is limited by ill health or disability. The victim was also in receipt of Disability Living Allowance (DLA). This is made up of two components based on care needs and mobility.

4.13 The perpetrator

4.14 The perpetrator is a single man. He has never married and there is little obvious history of any tangible relationships until his relationship with the victim which is believed to have commenced in late 2011.

4.15 The perpetrator is 10 years younger than the victim. His birthplace is outside of the area although he has been in Cambridgeshire from his late teenage years. Little is known of his family background other than he admits to abusing alcohol since he was 12.

4.16 He has a history of violence dating back to his late teenage years and this is believed to be linked to his abuse of alcohol. In 1993 he was convicted of manslaughter following a robbery he committed on an elderly woman. The victim in that case died of heart failure brought on by the trauma of the robbery. In 2010, he committed a serious assault on another woman, with whom he was in a short term relationship and was drinking with at the time of the assault. Both he and that victim were alcoholics and their relationship was founded on a mutual addiction to both alcohol and drugs. This was of course also domestic abuse as they were in a relationship and she was reported as being his partner.

4.17 In respect of the 2010 incident both the Police and National Probation Service IMR's indicate that he was not sentenced or convicted as a dangerous offender[6]. His pre-sentence report by a probation officer detailed that alcohol abuse was a major factor in the offence and offending history of the perpetrator. It noted that his established pattern of behaviour was one that he was acutely

[6] The Criminal Justice Act 2003 introduced the concept of a "dangerous offender". The provisions introduced indeterminate sentences of imprisonment for public protection and extended (determinate) sentences of imprisonment for dangerous sexual or violent offender. These provisions came into effect on 4 April 2005.

aware of and that he should moderate his behaviour to minimise the risks he poses to the public and others. It was noted that as the assault was on his 'partner', he could be a risk to those close to him.

4.18 A Probation Officer assessed the perpetrator as posing a *'Medium Risk of Causing Serious Harm to Known Adults and Members of the Public'*. The definition of an assessment of medium risk is that there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances. Those circumstances are suggested as being, failure to take medication, loss of accommodation, relationship breakdown, drugs or alcohol misuse.

4.19 It followed that on his release on licence from his sentence in respect of the 2010 assault he was managed by the Probation Service, with a non-contact clause to the victim of the assault that lead to his imprisonment. It is noted that his assessment included concern surrounding the potential risks associated to domestic abuse. His licence was withdrawn by the Probation Service following his failure to comply with his conditions, principally concerning the suitability of his address but moreover his failure to address his alcoholism. This led to a recall to prison where he completed his sentence and was then released without any management or reporting requirements.

4.20 The perpetrator had a history of alcohol abuse and this appears in a number of agencies IMR's as a clear indicator of his known behaviour. Admissions to hospital, although unspecified in respect of circumstances or treatment, identify alcoholism as do the 11 separate attendances to Accident and Emergency since 2000.

4.21 It is not clear as to when (or how) the victim and perpetrator met, although there is an indication that they commenced their relationship during late 2011, but that by the latter part of 2015, that relationship had deteriorated.

4.22 Laraine as already stated owned and lived in her own accommodation. She does not appear to have visited the perpetrators address and in the main this may be due to the fact that his accommodation was a third floor flat accessible only by a series of staircases, reducing her ease of accessibility.

4.23 The perpetrator had his accommodation provided by the local authority. He lived between his and the victim's home. It is not clear as to how much time was spent at each location by him. Although indications are that a greater proportion of his time was spent with the victim at her home than his, whilst there he acted as her carer (Carer is not an officially sanctioned role- a carer is simply someone who provides care.[7]) He provided emotional support to Laraine, did her shopping, took her shopping, helped her in the shower (due to physical issues), and made sure she went out with him once a week (otherwise she would choose to stay at home). The Support, Time and Recovery (STR) worker was confident he was undertaking these activities and the family had no reason to think he was not fit to be a carer, and found him to be supportive of her.

5.0 The facts as reported by the agencies

5.1 On April 24th 2016, Laraine's parents visited their daughter's home as they had not heard from her for a number of days and were concerned for her welfare. They went to her home but were unable to get a response from her and consequently contacted the police.

[7] Section 10.3 of the Care Act 2014 gives the definition as "Carer" means an adult who provides or intends to provide care for another adult (an "adult needing care")

5.2 Officers attended the victim's home, met with her parents and forced entry to the flat. They almost immediately found the perpetrator. He was found to be incoherent, naked and had a number of what appeared to be minor and self-inflicted injuries to his groin and other parts of his body. Following a short search the officers found the victim deceased in the bedroom. She appeared to have been dead for several days. The perpetrator was arrested but admitted to hospital straightaway for treatment to his injuries and for a mental health assessment. He was later taken into custody and charged with the victim's murder as he was deemed as fit to be detained by the health professionals who had assessed him.

5.3 It is apparent that following her death, (which possibly occurred up to two weeks earlier) after the perpetrator had attacked her that he then left her flat and returned later removed some of her clothing and placed her into her bed. He then created a 'shrine' of cards and 'mementoes' from their relationship. He then continued to access the victim's flat up until the time he was discovered by the police. Although he had self-inflicted injuries which were relatively minor, these would not have led to his death or an expectation of death, although he claimed to have attempted suicide.

5.4 The victim died as a consequence of a single knife wound to her neck, which had cut an artery, although she had a number of other wounds to her face and neck as attributed to the attack on her. Those other injuries were superficial. These were likely (according to the pathologist) to have been inflicted at the same time and were not historical although she had other superficial bruising.

5.5 The perpetrator, having admitted to her manslaughter, pleaded not guilty to Laraine's murder on the basis of self-defence, claiming that he had been attacked by her with a knife. He was convicted of Laraine's murder following a trial in October 2016 and was sentenced to life imprisonment. He has not made any indication of making an appeal against his conviction or sentence.

5.6 The review panel have received a number of Individual Management Reviews (IMR) from a range of statutory agencies who had engaged the victim, perpetrator or both of them. The detail within these reports has varied considerably in respect of the information made available for the panel.

5.7 What is apparent is that both the victim and perpetrator, although having reasonably comprehensive background information as individuals, appear to have little information concerning them as a couple. The previous history of the victim as a victim at the hands of other men was comprehensively recorded and documented by the police, records of which were accessible to the partnership. Laraine was identified as being a vulnerable person by the police as early as 2010, information which at that time was shared with the local authorities Vulnerable Adults Team. Earlier occurrences of abuse against her in 2007 and 2008 were referred to the Independent Domestic Violence Advisor (IDVA) service. The police records indicate that her engagement with services appeared to have been minimal at that time.

5.8 The victim presented at the QEH Outpatients clinic in February 2014 with chronic lumbar pain. This chronic condition was noted to have been subject of previous history. She was referred to a pain clinic for advice. It was noted that she used a crutch to aid her mobility. There is no indication of any person having accompanied her to the appointment.

5.9 On the 12th June 2014, she was referred by her GP to the Neurology Department at QEH as an outpatient to August 2014. It appears that the victim was so concerned about her head pains that she requested to be seen as a priority and she was referred to the Ambulatory Emergency Care at the QEH for 15th June. She attended on that date reporting symptoms of left sided weakness,

headaches and blurred vision. It is indicated that she had attended her opticians a week earlier and had informed the optician that she had a brain tumour. The optician immediately referred her to her GP.

5.10 She was discharged the same day from the Ambulatory Emergency Care with plans for an outpatients MRI scan and consultation with a neurology specialist. The discharge letter indicated that she had *"longstanding headaches, blurred vision, associated with left sided jerky movements. Now has an increased symptom. Clinically stable. For neurological review as an outpatient".*

5.11 On the 28th June 2014, an MRI scan showed a normal study and referred the patient back to the GP if needed. Laraine did not attend any further outpatient appointments at QEH in this respect.

5.12 Laraine was last seen at her surgery on 30 December 2015 for a blood pressure check. She was last seen by her GP on the 27 August 2015. Laraine was not seen often as she might have been as her care was mainly provided by the psychiatric teams. This is not seen as unusual or inappropriate. She attended appropriately, collected medication when due. No concerns were ever documented. There were no references either in letters or within her GP notes regarding possible domestic abuse. There were no indicators that appear to have been missed regarding this in the notes.

5.13 The GP records in respect of the perpetrator indicate that on the 10th September 2015 he attended his GP in respect of alcohol dependence. The notes indicate that he was *"feeling low as had housing issues, advice given on alcohol and depressive mood handling"*. There is no detail as to what the housing issues were or the nature and extent of his depressive mood.

5.14 CPFT reference that the perpetrator had visited unannounced to the victim's, Support, Time and Recovery Worker (STR) on the 20th January 2016 and had informed the worker that he was very concerned for Laraine's welfare. The perpetrator is reported as having several cuts to his face and head and when challenged about those, he had responded that Laraine had attacked him *"for no reason".* He stated that he had not retaliated.

5.15 The STR worker made contact with Laraine the following day and was informed by her that she was leaving to stay with her brother out of the County. There is no other information concerning this and no indication of what questions, if any, were sought of the victim's perspective. Although the indications are that this 'move' was intended to distance her away from the perpetrator, this understanding was not clarified by the professional involved.

5.16 The brother of Laraine was seen by the police homicide investigation team as part of the background enquiries concerning the victim. He confirmed that in late January 2016, Laraine contacted him by telephone and asked him if she could stay with him. Although she would occasionally contact him by phone, this request to stay with him was completely out of character. When he collected her a few days later she did not tell him the reason behind her request to stay with him at that time, but she appeared to have prepared herself for an extended stay due to the amount of belongings that she had gathered to take with her.

5.17 In the coming weeks (Laraine stayed with her brother for approximately four weeks) she gradually gave him an 'indication' of what had occurred between her and the perpetrator. She intimated that she and the perpetrator had been at a local public house one evening and that she had only gone along with him in order to appease him as she hadn't wanted to go. Having spent some time drinking she suggested to him that they went home, the suggestion being that he had had too much to drink. When they returned to her home they argued and she was assaulted by him.

She fought back, injuring his cheek, but did not indicate how this injury was caused. He had then gone on to assault her further. There was no indication of the extent of any injury caused to her by the perpetrator and her injuries were not seen by her brother.

5.18 Although Laraine made reference to the fact that she had recorded images of her injuries on her mobile phone, she never showed her brother a photograph of this. However, she did show a photograph of the perpetrator's injury to his cheek. Which she suggested was *"far worse"* than she had recalled, suggesting that the injury was or had been embellished or made worse by him. How or why she had this image on her phone is not clear but it would suggest that the perpetrator had sent this to her.

5.19 The perpetrator made repeated phone calls to Laraine during her stay. After four weeks, her brother returned her home at her request. He was aware that her relationship with the perpetrator continued although there is no suggestion that the perpetrator was at her home upon her return. It transpired that the perpetrator did not have a key to her home so he relied on her being at home in order to give him access to her flat.

5.20 The STR worker from CPFT contacted Laraine on the 1st and 8th of February whilst at her brothers. The worker then engaged with Laraine, on her return from her brothers, which happened late in February 2016. The worker had been in contact by telephone and this home visit was arranged by letter. The worker was informed by Laraine that she and the perpetrator had decided to get back together. She was told that Laraine had set rules to the perpetrator concerning his use of alcohol, and that he was not to bring alcohol to the flat or she would not allow him to stay overnight. If he did not agree to those rules, Laraine stated that she would end the relationship.

5.21 The STR worker emphasised that Laraine should notify the police if she felt threatened in any way, however the response from Laraine was that she would return to her brothers should anything happen again. There is no clear indication as to the level of any domestic abuse information actually obtained by the STR Worker.

5.22 The police have no record of any self-referral either by the victim, a third party or neighbours in respect of any domestic abuse occurrence either in January or February 2016. There were, however, opportunities for the victim to report the events that existed both before, during her absence from her address and on her return, which extended to later contact with the STR worker.

5.23 The Police IMR is clear that other than the tragic events of April 24th 2016, they had no calls to the victim's address. There is no record of any domestic abuse reports emanating from the victim, other agencies or any third party concerning the perpetrator. The previous history of abuse known to them about the victim, all pre-date the relationship with the perpetrator.

5.24 On the 2nd February 2016, the perpetrator attended his GP. He was reported as being *"completely drunk"* and stated that his partner was *"beating him"*. There is no evidence within the GP Practice IMR that any injury to him was noted or examined, however the GP advised the perpetrator that he should inform the police, which he declined but wished for details to be recorded within his record. This was a single appointment with no follow-up appointment or other consultation.

5.25 A neighbour, who resided in the same residential block of flats, was aware that Laraine had vacated her home for a period of *"several weeks*" from the latter part of January 2016. The neighbour had 'assumed' that Laraine had gone away on holiday and in fact shortly after her return

had spoken to her in what was an infrequent exchange with her and had asked her if she had enjoyed her holiday. Laraine simply affirmed that she had.

5.26 The same neighbour gave information to the police as part of the homicide investigation that he had heard the unmistakable sounds of raised voices emanating from Laraine's flat and the perpetrator begging not to be thrown out. This was in turn followed by several days of activity where the perpetrator would appear at the flats, at various times of day, asking for Laraine to let him in. The neighbour suggests that this was possibly some two to three weeks before the tragic discovery of the body. These events support the fact that the perpetrator did not have keys to access Laraine's flat. There is no clarity surrounding what actions that the neighbour felt he could have done, however the police IMR does confirm that there was no record of calls to service to the location that would have triggered any additional action.

5.27 The National Probation Service IMR gives added context and refers within the original assessments made of the perpetrator in 2010 and 2011, that he had an underlying issue linked to his offending behaviour as being associated with the misuse of alcohol. The risks to future partners were deemed as being high if he did not address his alcoholism.

5.28 The Police IMR identifies that the perpetrator has a criminal record of some 23 offences and his associated risks[8] or 'warnings' were those of '*violence, self-harm, epilepsy and the use of alcohol'.*

5.29 Laraine had no police record of criminality.

5.30 The perpetrator appears to have acted as the primary carer for Laraine. It is implied, that he was due to attend training for this function on a voluntary basis. It is unclear as to whether or not he received a carer's allowance or that Laraine received an attendance allowance. There is however through the evidence of the family and the STR worker reason to believe that the perpetrator did in fact act as Laraine's carer and this is certainly how he presented himself to Laraine's family.

5.31 The perpetrator had met the wider family of Laraine on several occasions and had attended 'family' functions out of the area with her. He had not raised any obvious concern from her sons, in fact to the contrary, he gave the impression that he cared for her and that he *"was good for her".* What is clear is that the family knew little of him, as Laraine did not regularly spend time with members of her family.

5.32 Although Laraine had regular contact with her parents in that they would bring her money and do some occasional shopping for her in that regard, they did not access her flat, but would exchange the items on her doorstep or outside of the flat. Laraine was actually quite a private person. Many of those behavioural traits are mentioned by her family.

5.33 Although having little physical contact with her two sons, she did see them occasionally and would keep in touch with them by telephone. The bond between her and her sons was clearly low level at times and they nevertheless respected their mother's wish for privacy.

5.34 Laraine appears to have had few close friends, certainly none who came forward following her tragic death, and her lack of engagement with her neighbours perhaps emphasises her reluctance to maintain a wider social outlook. She was a smoker and would often be seen outside of her flat smoking along with the perpetrator. She was described as being house-proud, although few people appear to have been inside her home on a regular basis.

[8] These are recorded on the Police National Computer record of the perpetrator.

5.35 Laraine's use of cannabis was well known to the family and neighbours reported the *"unmistakable smell of skunk"* [9]emanating from her flat on occasions. Primarily it is believed that she started her use of cannabis as a pain suppressant.

5.36 In summarising the facts as known, other than the occurrence reported in January 2016, there was relatively little known to agencies or shared between agencies that signposted any apparent concerns for Laraine in respect of signs or symptoms of domestic abuse between herself and the perpetrator.

6.0 Analysis of Significant Safeguarding Events

6.1 What is apparent from the submissions made to the panel by the relevant agencies is that there has been no obvious 'joined up activity' or scrutiny of events when there was an undertone of domestic abuse in respect of the victim and perpetrator, that took place in January 2016.

6.2 The report from the National Probation Service, although relating to an earlier time than the period set for the review, makes a particularly informed assessment of the perpetrator. It states that in 2010 he posed a high risk of alcohol fuelled violence against a partner. This position did not diminish on his release in late 2011. However in view of the fact that he was released on completion of his sentence; he did not require any supervision or management under statute or terms of any licence. The previous breach had led to his early recall and completion of his original term of imprisonment. Whilst this is a legislative and procedural matter, there is no doubt that the assessment was an incisive and accurately made insight into the perpetrator's make-up and future concerns for him. It would have been useful if this information could have been shared with agencies.

6.3 The incident of January 2016 appears to have been a significant pre-cursor episode to the tragic events of April 2016. This background was apparent to two of the agencies reporting in this DHR process. Firstly CPFT who in their IMR (which used the Serious Incident Investigation methodology) report that the Perpetrator had made direct contact with the STR worker to advise her of about his concern for Laraine's welfare that appears to have happened soon after the actual occurrence. Whether this was in fact a manipulation by the Perpetrator by making this initial contact could be at the core of this notification by him.

6.4 It is also indicated that he had a 'number' of facial injuries, which may be at odds with the alleged single facial injury referenced by Laraine to her brother, and which she had a photographic image of on her telephone. The fact that the perpetrator left the reporting to his GP until February meant his injuries, which appear to have been made worse by self-infliction, had possibly healed and would have brought little challenge that they were self-inflicted.

6.5 The STR worker did make immediate contact with Laraine as a consequence of the report made by the perpetrator, which is seen by the review as good practice. This was by telephone and an immediate face to face appointment was made.

6.6 The perpetrator also attended his GP in an apparent heavily intoxicated state within a similar timeframe in what appears to be several days after his report to the STR worker and was in early February 2016. He asked for his GP to record the fact that he was being 'beaten by his partner'. Again a similar reflection could be put on this that it is more than likely that this action served as a smokescreen to his control within the relationship.

[9] Skunk is a form of potent cannabis.

6.7 Although clearly advised to self-refer the alleged violence to the police by the GP, the perpetrator was unhesitatingly clear that he had *no intention* of doing so. Although this perspective from an alleged 'victim' is not unique or unusual, the question arises as to what motives the Perpetrator had. Was he covering his tracks and why had he waited to report this to his GP in comparison to his approach to the STR worker? There is a possibility that his choosing to report this was fuelled by his apparent intoxication. There does not appear to have been a more in depth examination of the facts at the time and the review author feels that this is an area of safeguarding risk that was overlooked. The NICE [10] guidance for domestic violence and abuse (2016) has issued some clear quality statements for frontline health practitioners in relation to asking about and referring DA. This includes perpetrators of DA and referrals about them. If these quality statements had been followed in this case, this could have helped in relation to safeguarding.

6.8 The significance of Laraine's need to move away from her home should not be underestimated and that this would, by all accounts, be the first time that she has left her home for any significant period of time. She appears to have felt safe with her brother and more comfortable to have shared some of the facts, albeit with apparently relatively limited detail. It is apparent that this was completely out of character and that in itself could have raised alarms to her family.

6.9 Overall Laraine in fact gave little in the way of details of what happened. Although evidence from the homicide investigation does indicate that the perpetrator had some minor injuries 'possibly' associated with an assault against him. This does not exclude that Laraine may have caused these injuries, bearing in mind the alternative perspective that she may have been defending herself as opposed to being the aggressor.

6.10 In summary there were these two key safeguarding events where safeguarding opportunities could have been considered at the time, although these do not appear to have contributed to the actual homicide given the gap in the timeline of events.

6.11 What life was like for the victim seems to have been heavily influenced by the perpetrator given that he acted as her sole carer. There was considerable reliance on her part on him and as such he was in a position of some control and influence over her. With his support, she turned to no one else, even refusing access to her home by her elderly parents. There was clearly some compatibility within the relationship with the perpetrator that seems to have formed. There are indications that they also had a sexual relationship and the evidence tends to suggest that the early part of their relationship appeared, on the face of it, to have been mutually agreeable. By all accounts Laraine was at that time leading a lonely lifestyle after having had a number of abusive and failed relationships. The family and the STR worker at the time felt that the perpetrator was a positive influence on the life of Laraine.

6.12 There became a time, possibly up to several months leading up to the tragedy that Laraine wished to cease their relationship but was unable to do so. She seems to have retained some 'control' in respect of restricting the perpetrator's freedom of access to her home, and about his drinking yet he still spent some considerable time at her home.

6.13 Within their relationship the perpetrator did provide care for Laraine. She regarded him as her main carer and when he did not drink, she felt he provided her with good care and that they enjoyed each other's company. As already stated the informal care he provided was not an officially sanctioned, and as such no agency had a responsibility to do any vetting of him.

[10] NICE, Domestic violence and abuse Quality standard [QS116] Published date: February 2016

6.14 The review author when considering equality and diversity fully accepts that in the main domestic homicide is a gender crime as by far the most victims of these homicides are women. It is also particularly relevant in this case given the victim's disabilities and apparent lack of access to services as a disabled woman.

7.0 Family Perspective

7.1 The family of Laraine have been approached both individually and as a family unit in order to gain their understanding and support to this review process. As already stated they feel too upset to engage with the author. However they have expressed support to the actual review process and support the function of the DHR. The author is grateful for the additional background provided by the police and the interaction of the homicide investigations family liaison officers and the Senior Investigating Officer with the family. The family liaison officers will remain as the contact point for the author and panel. The author understands the trauma suffered by the family and respects their wishes accordingly. (The family impact statements indicate considerable trauma by each family member.)

7.2 In bringing matters into perspective, one of her sons in particular had made efforts to stabilise the relationship with his mother and would make regular contact with her by phone or messaging. Both sons seemed to have been making efforts to improve the relationship with their mother and both had recognised what they considered to be the help and assistance that the perpetrator appeared to have provided to their mother. There does however appear to be some conjecture in the emphasis of the relationship between Laraine and the perpetrator. One of the sons understood that he fulfilled the role of her primary carer, the other that he was both her carer and her fiancé. Indeed there appear to be a number of family members that considered the perpetrator to be her carer and that that relationship had brought about their engagement. Whether or not they were actually formally engaged is unclear.

7.3 One of her sons understood that his mother had a brain tumour and the hospital attendance in June 2014 by Laraine may further emphasise her pseudo illness. It is not clear what she actually told her family concerning this supposed tumour however her pressing of medical professionals including her GP into some immediate treatment may not only have convinced others that she was ill, but also have contributed to her own beliefs.

7.4 There is no doubt that the image portrayed by Laraine concerning her relationship with the perpetrator was not entirely clear, but the family seem to have been convinced that the perpetrator was regarded as her carer. How this may have been influenced by him cannot be qualified. Prior to early 2016, there is no evidence or suggestion of violence on either the part of the victim or perpetrator with each other. What is apparent is that between late January 2016 and mid-April 2016, their relationship had significantly deteriorated.

7.5 The impact of Laraine's death has had a profound effect on the family. The sons respected her privacy and her determination to live her life and clearly are devastated by the impact of her murder.

8.0 Conclusions

8.1 It is fair to describe Laraine as a private individual, who had a number of physical and mental health disabilities. These would make her in the review author's opinion a vulnerable person. Her move to the area following her divorce saw her enter into relationships where she became a victim

of abuse and violence on a number of occasions. It was one such relationship that led to her parents taking over her finances to protect her and this support remained in place at the time of her death. This perspective, whilst indicating an effective and supportive response from her family where they were able to do so, also perhaps emphasises her overall vulnerabilities. As such these were identified as early as 2010 by agencies that include the STR worker service, Police, Local Authority and health professionals, but do not appear to have been given further thought or communication between agencies since that initial assessment of her as being vulnerable. It must be highlighted that Laraine did have mental capacity and as a result, was free to make, her own decisions.

8.2 In trying to understand why this tragedy occurred, there appears to be a number of influencing factors, which individually may not be regarded as significant risks, but combined their toxicity was amplified. Those risks are identified as being:

Risk Factors and Learning Themes in this case:

- Alcohol misuse and abuse by both the victim and perpetrator.
- Drug misuse by both the victim and perpetrator
- Victim isolation, lack of regular contact on her behalf with family and friends
- Carer reliance by the victim on the perpetrator
- Victim disabilities including her mental health and pseudo illnesses
- Victim vulnerability in respect of her background as a historical survivor of domestic abuse
- Lack of professional curiosity as to potential knowledge of who was in the household
- The perpetrators history of violence

8.3 Drugs and alcohol featured to a large extent within Laraine's relationship with the perpetrator. There is an indication that the drugs were used as an effective pain killer for her chronic back pains, however the use of cannabis, in particular skunk, has been known to be associated with episodes of psychosis.

8.4 Relatively little information was known about Laraine and the perpetrator as a 'couple'. More was known about their individual circumstances but none of this was 'joined up' by agencies like health services and the police, because there had been no reported pre-cursor events leading up to the incident of January 2016 reported by any of the agencies.

8.5 In an academic study[11] into 'Intimate Partner Homicide', of particular note was the number of homicides that did not feature pre cursor violence or antecedent offending by the perpetrator. It was found that almost 40% of all recorded cases had no external indications of abuse rendering the traditional/current risk assessment methods somewhat redundant in the identification of imminent lethal violence. Substance abuse, mental health and suicide ideation for offenders may carry greater significance than has been previously considered. Although in this case there was an inference of abuse, it was not considered as a risk, and should be in the future.

8.6 There was an opportunity by the STR worker to have broadened the partnership picture of the events of January 2016. Contact was made with Laraine, and a clear discussion took place between them in relation to the events that had occurred. Laraine was very clear on protecting herself and was going to stay with her brother. The opportunity to have shared partnership information sharing if consent was asked for and agreed was missed.

8.7 When the STR worker visited in March 2016, which was on her return from her extended stay at her brothers, Laraine did not make any more significant disclosure. The victim was of course now again in regular contact with the perpetrator. The information that was obtained could have been

[11] A descriptive analysis of Intimate Partner Homicide in England and Wales 2011-2013

shared and had Laraine been identified in practice as being 'vulnerable', such information sharing could have taken place. This may not have prevented the later tragic events however this is an area of risk that needs to be taken forward to close any potential future gaps in practice.

8.8 The engagement with Laraine and the STR worker that took place in February and March 2016 was however a good response in a follow-up to the original contact made in January 2016. The STR worker was satisfied that Laraine had a clear 'safety plan' and that there was no history of violence in the relationship and that the care provided by the perpetrator to her in the past had been good. Interestingly the STR Worker was informed by Laraine that the perpetrator had been in prison for burglary and not violence (It is unlikely, based on the available information, that Laraine was fully aware of the perpetrators violent past.) A further appointment and review with her psychiatrist was scheduled for 21st April. However by this time the homicide is likely to have been committed. Her last contact with the service was the meeting with the STR worker on 31st March 2016.

8.9 The Domestic Violence Disclosure Scheme[12] introduces recognised and consistent procedures for disclosing information that enables a partner who is or was in an intimate relationship with a previously violent or abusive individual to make informed choices about continuing in that relationship or about their personal safety if no longer in that relationship. Laraine was in such a position, as was her brother in seeking such information concerning the perpetrator. It appears that Laraine was aware of the perpetrators criminal past, but not for violence or manslaughter, both of which may have been disclosable to them under the scheme. This scheme requires to be further considered and opportunities to explore endorsed by both statutory and voluntary organisations. Recent further guidance effective from December 2016 has been introduced. This is a training opportunity for all agencies.

8.10 The report to his GP practice by the perpetrator in February 2016 concerning the alleged assault on him by Laraine appears fuelled by his intoxication. His motivation for reporting this with the gap between his reporting to the STR worker is unclear. Interestingly this GP surgery and CPFT operating locations are in very close proximity. The professional responsibility of the GP accorded with recognised practice in that a record was made in the patient's notes, but the information was not shared. Although the action taken by the GP is identified within the surgery IMR as being 'usual practice', this leaves a gap in practice in that the record 'stands alone' and is not shared with other agencies, for example the police or the STR worker.

8.11 Research from key findings within domestic homicide reviews conducted between 2013 and 2016 identified that in a number of cases the perpetrators of domestic abuse will often use statutory services to make false or exaggerated allegations about victims or will make counter allegations in order to dismiss the victim's accounts of the facts[13]. It is possible that this was a ploy by the perpetrator to deflect the interest away from him in anticipating that Laraine would report the assault to professionals.

8.12 Alcohol misuse is a learning theme in this DHR. The support of the voluntary sector should not be underestimated and clear pathways to support need to be identified by professionals to service users. What is not apparent in respect of drugs and alcohol misuse by Laraine is what considerations or safeguards were put in place by agency professionals that were actively pursued or subject of further discussion and appointments. There is an indication that Laraine may have taken steps to receive some rehabilitation for her addiction, but this cannot be established.

[12] Frequently referred to as Clare's Law

[13] Domestic Homicide Reviews, Key findings and recommendations from Home Office and Standing Together reviews, 2016.

8.13 In respect of the perpetrator during his hospitalisation immediately following the homicide, he admitted to health professionals that he consumed some 10 to 15 large cans of high strength (9%) lager as well as unknown quantities of vodka and brandy daily. He also claimed that he smoked up to £20 of cannabis a day. It is unlikely that he would be able to support those volumes on his limited benefit income and it is believed that this was partly funded and supported by the victim.

8.14 Reflecting on the learning from this case, there may have been an opportunity to make a third party referral to services but may not be aware of how to do so and did not do so. This case, as many others in England and Wales, highlights how the many families and friends of victims *could* help victims. Although domestic abuse is well publicised in the media, information aimed specifically at families, friends and neighbours still requires impetus.

8.15 In respect of mental health services, in March 2016, Cambridgeshire Constabulary and the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) implemented an Integrated Mental Health Team Joint Procedure. Although in place at the time of the tragic events, neither Laraine nor the perpetrator had been 'signposted' by referral or incident. Initiatives such as this show how both statutory and voluntary services are able to broaden support and identify pathways to expertise, quickly and effectively.

8.16 What was life was like for Laraine? She was somewhat reclusive and appears to have relied to a considerable extent on the perpetrator to assist her everyday needs. This possibly extends to his obtaining alcohol and cannabis for her as it is unlikely that she conducted such transactions herself. Her relationship with her family was inconsistent and she had low level contact with her two grown up sons. As such she was quite isolated and the perpetrator appears to have been able to initially provide companionship and support to her needs. They both used alcohol and cannabis, but this did not raise any concerns to neighbours that caused any referral to other agencies including the police. Although Laraine was no doubt the victim of abuse in January 2016, there does not appear to have been any obvious occurrence prior to that time. Laraine did appear to be able to control access to her home both to the exclusion of her family and the perpetrator when she wanted to do so. She maintained a very tidy and clean home given her disabilities and was able to support herself financially, albeit with the support of her parents.

9.0 Recommendations

9.1 This review makes a number of recommendations as highlighted below and when implemented will assist the partnership to improve its response to DA. These recommendations also take into account the NICE Guidelines on Domestic violence and abuse: multi-agency working Public health guideline published in February 2014.

Recommendation 1

The Fenland Community Safety Partnership (FCSP) should encourage all six Community Safety Partnerships within the Cambridgeshire and Peterborough area:

i. To produce and implement a single set of guidance to ensure statutory requirements are complied with in respect of Domestic Homicide reviews commissioned. This will also help to ensure the learning from these reviews is embedded, in a systematic and auditable fashion.

ii. To produce and implement an information sharing protocol for tackling domestic abuse. It is proposed that this could take place in the Multi-agency safeguarding hub.

This will help to improve inter-agency communication and proactive information sharing. This is in response to the way that information sharing in this case seemed not to take place due to individuals not spotting the signs and referring. The arrangements should include voluntary sector organisations where possible in particular those agencies supporting persons with alcohol and drug addictions.

Recommendation 2

The FCSP proposes to the Home Office the commissioning of a toolbox for professionals on how best to increase awareness in those close to people affected by Domestic Abuse. The aim of this toolbox would be to seek opportunities for educating family, friends and neighbours of the effects of domestic abuse and how they can safely and confidentially report their concerns. This should be combined with publicity as to guidance concerning the Domestic Violence Disclosure Scheme. The FCSP do currently deliver this community awareness once a year, but should consider looking for opportunities to broaden its promotion.

Recommendation 3

The FCSP contacts critical partners engaged in tackling Domestic Abuse to point out the benefits of building in some of the key elements of this case into their risk assessment processes. The partnership should request that Cambridgeshire Constabulary systems and partners processes take into account any identified disabilities, both physical and mental health of victim, perpetrator and relevant children. This would ensure that all risks are considered as part of the dynamic risk assessment process vital to the safe management of such abuse cases.

Recommendation 4

The FCSP seeks assurance from the MASH Governance board that awareness-building programmes are being provided in relation to the MASH and referral processes. This awareness programme should highlight how referrals are made to the MASH from organisations in their area and in particular General Practitioners in relation to Domestic Abuse.

Recommendation 5

The FCSP should contact the Safeguarding board to satisfy itself on the level of checking carried out on paid carers. It is important to stress that the perpetrator in this case was in a relationship with Laraine and was not in receipt of funding for the care he provided for her. The learning from this case, however, should prompt the FCSP to request assurance from the Safeguarding Adult Board about carer recruitment. It is vital that those agencies which commission paid carers carry out safer recruitment practices. These practices should include necessary safeguarding checks in relation to the recruitment of carers. Advice should be made available on how to carry out the necessary checks, whenever a carer is engaged via a direct payment or by a person who is self-funding their care.

Glossary

CPFT	Cambridgeshire and Peterborough (NHS) Foundation Trust
DHR	Domestic Homicide Review
FCSP	Fenland Community Safety Partnership
IMR	Independent Management Review
IDVA	Independent Domestic Violence Advisor
MRI	Magnetic Resonance Imaging
QEH	Queen Elizabeth Hospital
QPM	Queens Police Medal
STR	Support, Time and Recovery (Worker)

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6 December 2017

Dear Mr Locks,

Thank you for submitting the Domestic Homicide Review (DHR) report for Fenland to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 October 2017. I very much regret the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a thoughtful review which has identified some useful recommendations. The Panel noted the family's participation in the review and particularly commended the chair for also seeking input from friends and neighbours.

There were, however, some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The Panel noted that the family engaged in the review through the Family Liaison Officer and reiterated the importance of offering specialist advocacy services to families when inviting them to participate in reviews;

- Reviews should include the full terms of reference and not assume that readers will be aware of the suggestions set out in the statutory guidance;

- There was no voluntary sector representation on the review panel. The Panel felt a representative from mental health services may have been beneficial to the review given the circumstances of the case;

INVESTORS IN PEOPLE

- You may wish to more clearly articulate paragraph 8.5 as the Panel found the narrative confusing;

- The Panel noted that the sister is missing from the statement given in paragraph 7.5 and queried whether a full list of contributors was necessary?

- You may wish to reframe paragraph 8.14 as the Panel was concerned that it identifies a family member when talking about a missed opportunity to make a third party referral;

- There is no consideration of equality and diversity which the Panel felt were particularly relevant given the issues around isolation and access to services by a disabled woman;

- Please proof read the report for typing errors before publication.

The Panel noted that the family of the victim want the review to use her real name and not a pseudonym. The statutory guidance is clear that reports should be anonymised in order to protect the identities of those involved, in particular the victim. If the family wish to maintain this position, you will wish to ensure that they are made aware of the implications of using the real name of the victim and the risks associated with this and potentially the long term consequences. Ultimately this is a matter for the Community Safety Partnership who may wish to consult their legal team on this issue.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Hannah Buckley
Acting Chair of the Home Office DHR Quality Assurance Panel