Permission has been granted by the Home Office to publish this final report.

REPORT INTO THE DEATH OF MISS P

Executive Summary

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1. Introduction

1.1 This report of a Domestic Homicide Review examines agency responses and support given to Miss P a resident of Chichester, West Sussex prior to her being found dead on 28th January 2013. Miss P was found deceased at home around 7.45 am on Monday 28th January 2013 by her colleague and manager who was due to take her to a work commitment in London. On 30th January 2014, following a trial Adult B was convicted of the murder of Miss P and, the following week, sentenced to life imprisonment with a recommendation that he serve a minimum of 15 years.

2. The Review Process

2.1 This review was commissioned at a meeting of the West Sussex County Council Domestic Homicide Review Panel on the 21st June 2013 in line with the Multi Agency Guidance for the Conduct of Domestic Homicide Reviews 2011.

2.2 The initial time scale for the review was set for the Interim report to be submitted by 8th November 2013 and the overview report to be completed by 20th December 2013. However, due to complexities with the criminal investigation and prosecution this time scale was delayed with the interim report to be submitted by the 13th March 2014 for consideration by the Domestic Homicide Review panel on 20th March 2014.

2.3 The review was asked to look at the period between 1st January 2007 and 28th January 2013.

2.4 The case specific Terms of Reference were set as being:

1. Whilst Miss P had no known contact with any specialist domestic abuse agencies or services, the review will consider whether there was any history of domestic abuse involving Miss P and/or Adult B and therefore whether there were any warning signs.

2. Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide and what they did or did not do as a consequence.

3. Whether there were any barriers or disincentives experienced or perceived by Miss P or her family/ friends/colleagues in reporting any abuse including whether they knew how to report domestic abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.

4. Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.

5. Whether Miss P had experienced abuse in previous relationships during the time period under review, and whether this experience impacted on her likelihood of seeking support in the months before she died.

6. Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse or sexual violence experienced by the victim that were missed.

7. Whether there were opportunities for professionals to refer any reports of domestic abuse or sexual violence experienced by the victim or committed by the alleged perpetrator (towards Miss P or any other partner) to other agencies and whether those opportunities were taken.

8. Whether there were opportunities for agency intervention in relation to domestic abuse regarding Miss P, the alleged perpetrator or the dependent children that were missed or could have been improved.

9. Whether the homicide could have been accurately predicted and prevented.

In addition:

- The review will give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- The review will identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.

- While it is not the purpose of this review to consider the handling of child safeguarding concerns related to the case there may be issues that arise from the review that relate to the safeguarding of children who may be affected by domestic abuse. If this is the case these issues will be raised with the West Sussex Safeguarding Children Board.

2.5 The chair of West Sussex Strategic Community Safety Partnership (WSSCSP) wrote to Chief Executives/Chief Officers of the following agencies requesting they return Summaries of Involvement in advance of the first panel meeting.

- Chichester District Council
- Sussex Police
- Surrey and Sussex Probation Trust
- Sussex Partnership Foundation NHS Trust
- West Sussex Hospitals NHS Trust
- West Sussex County Council Adult Services
- NHS West Sussex
- Arun Community and Voluntary Sector
- West Sussex Fire and Rescue Service
- South East Coast Ambulance Service

2.6 The panel considered these and consequently requested Individual Management Reviews (IMRs) from:

- NHS Coastal West Sussex Clinical Commissioning Group (to include all NHS involvement)
- Sussex Police
- Chichester District Council
- West Sussex Fire and Rescue Service

2.7 The objective of the IMRs which form the basis for the DHR is to give as accurate as possible an account of what originally transpired in an agency's response, to evaluate it fairly, and if necessary to identify any improvements for future practice. IMRs also propose specific solutions which are likely to provide a more effective response to a similar situation in the future. The IMRs have assessed the changes that have taken place in service provision during the timescale of the review and considered if further changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

2.8 This report is based upon these IMRs and the content of 22 witness statements, three Records of Video Interview and interviews held with:

- Miss P's Daughter
- Miss P's Sister
- Miss P's Ex Husband (father of Child A)

3. Findings of the Review

3.1 The review has found no evidence that Miss P had made any direct contact with any specialist domestic abuse agency. Whilst she had undoubtably been suffering from considerable torment from Adult B's extreme controlling and psychologically abusive behaviour, there is no evidence that prior to him killing her he subjected her to physical or sexual abuse. Adult B did deliberately 'mark' her with love bites when she was about to go on a spa break with her friends. This appears to have been in an effort to make her unattractive to other men and is evidence of his extreme jealousy of which she was well aware and growing increasingly concerned about.

3.2 Miss P was a popular and outgoing person with a large network of friends. She often confided in them of the suffering she was undergoing and, in some cases, surmised that the abuse may escalate to an extent where it would become physical and she would be harmed. Whilst there was no evidence of this happening prior to the murder, she and her friends did appear to recognise what she was suffering was domestic violence.

3.3 The warning signs that Adult B was a controlling and abusive person were evident almost from the start of Miss P's relationship with him. She shared this but certainly there was nothing that had happened that this review has uncovered that indicated the abuse was becoming physically violent albeit, as stated, Miss P suggested this may happen in the future. It is unknown whether this was as a result of any act or threat she did not disclose or that she presumed this to be a natural escalation given her previous experiences.

3.4 Miss P kept no secrets from her friends regarding the abuse she was suffering. She was less open with her family albeit her daughter knew her mother was not happy in her relationship with Adult B but she seemed to project this to her of being 'tired' of his ways rather than suffering from abuse. She did not reveal to her parents that she was suffering and neither did she to her sister.

3.5 Her friends, on the other hand, were clear that Adult B was abusive. She had been very honest about the nature of Adult B's jealous, controlling and abusive behaviour. She had confided in how frightened she was becoming. Many of her friends had been very clear to her that she should end the relationship which, on more than one occasion, she did. However, as is often the case, that seems to have just caused Adult B to intensify his campaign of harassment so she acquiesced and the relationship and cycle of abuse resumed.

3.6 On several occasions she was advised by her friends and particularly her employer that she should report the abuse to the police or to her employer's occupational health service. She did not do either but, when pressed, she assured those who asked that she had reported Adult B to the police or that her sister was helping her draw up an injunction. Inevitably, this reassured her friends that she was accessing services which would help protect her. The effect of this was that they stopped insisting that she seek help. This may have been the outcome Miss P was trying to reach.

3.7 Whilst not everyone who knew of the abuse advised Miss P to report many did and this was commendable. It is with no criticism that the review reflects that none made a third party referral on Miss P's behalf. Few people do and this will be discussed further.

3.8 Miss P had been encouraged to report her abuse to the police. Her employer had encouraged her to seek support from their occupational health service and she seemed to know about civil justice remedies she could take. However, for whatever reason, she did not take these options. She had had experience of the police responding to her calls for help when she had suffered domestic abuse in previous relationships. There is nothing to indicate that the service she received was negative in any way but nothing too to indicate that those reports had triggered support from specialist services. Had the police done this, there may have been an agency or network that Miss P could have naturally accessed when she started to suffer the abuse she eventually did.

3.9 The knowledge of services available amongst Miss P's friends and colleagues, through no fault of their own, appear to be superficial. Other than the occupational health service, there is no mention of anyone suggesting a referral to an agency other than the police. Similarly, there is no suggestion that anyone has considered making a third party report to the police, Crimestoppers or a specialist domestic abuse agency on behalf of Miss P.

3.10 Therefore, it is difficult to say whether there were any barriers or disincentives experienced or perceived but it is reasonable to hypothesise that Miss P, her family, friends and colleagues may have been unaware of the existence of specialist support available or the myriad routes there now exist of accessing their services.

3.11 West Sussex County Council publishes a wide network of domestic abuse services. Some of these have conditional access (e.g. Multi Agency Risk Assessment Conferences discuss high risk domestic abuse cases) and some have geographical restrictions (e.g. Rise UK is accessible only in Adur and the north of West Sussex).

3.12 In Chichester District the primary providers of Domestic Abuse Specialist Services are Worth Services or (prior to re-commissioning) Chichester Outreach provided by Chichester Shared House. These services were available through a helpline and referrals can be made either by somebody suffering from domestic abuse or someone reporting on their behalf. Both publish their contact details on line and Worth Services provide a great deal of helpful advice on their website to supplement the direct support they provide.

3.13 The only service for perpetrators is through the Integrated Domestic Abuse Programme (IDAP) provided by Surrey and Sussex Probation Trust. This is only accessible to people convicted of domestic abuse offences. This dearth of offender programmes is not isolated to the Chichester area. It is unlikely, given Adult B's response to the police investigating Miss P's murder, that he would have engaged with an open access perpetrator programme should it have existed.

3.14 Crimestoppers is a national charity which in February 2012 launched a campaign in Sussex to encourage people to 'Third Party Report' domestic abuse.

3.15 Sussex Police encourages people to report domestic abuse either on their own or on others' behalf and provides guidance to people on what to do if they or someone they know is suffering.

3.16 There is, therefore, a huge range of services and a great deal of information available to people if they, or someone they know, is a victim of domestic abuse. However, in this case the knowledge held by the not inconsiderable network of friends, family and colleagues regarding this seems to be limited to knowing that the victim herself can call the police. That is not a criticism of then but an observation of the profile of those services. It is probably over ambitious to suggest that everyone should be expected to have a detailed knowledge of the services available but it is a matter of grave concern that the people who would have been able to ensure that Miss P received the services she needed were oblivious to them.

3.17 More should be done to improve the reach of any current communications strategy around this so that ordinary people in communities understand the services that are available to them and recognise them as the experts they are in supporting people who are suffering in the way Miss P was.

3.18 It is evident that Miss P had suffered significant physical and sexual abuse in previous relationships. It seems that, of her long term relationships, only her first marriage was non abusive. She had reported this to her friends, to the police and to her GP. Whilst, when she did report abuse, the police and the GP provided a reasonable service of the nature expected from their profession what did not happen was any onward referral to specialist services which would have provided support and an ongoing relationship to whom Miss P could turn should she experience abuse again from that or another partner.

3.19 It is of course a matter of conjecture whether, had Miss P been referred to specialist services, she would have engaged with them or sustained contact over the ensuing months and years. However, she was not given that opportunity by those professionals to whom she presented. This was regrettable and represents missed opportunities. It is possible, albeit of course not certain, that the absence of onward referral may have led her to believe there was no point in reporting psychological abuse as no one would be able to do anything about it. Also, had she been referred before she would have a greater knowledge of the range of services available and may have sought help and support from them.

3.20 Miss P did not make any direct calls for the services of the police or anyone else while she was in a relationship with Adult B regarding the abuse she was suffering. The only agency relevant to this review that she had contact with was the National Health Service through both her GP and St Richard's Hospital. None of those contacts were directly for the purpose of reporting domestic abuse. Miss P had had significant contact with her GP over the years but for her mental health and, more recently, gynaecological problems. Therefore, opportunities to provide a direct service to a direct request were slim.

3.21 However, as previously discussed, there were opportunities for professionals to be more curious as to what was happening in Miss P's life and many of these were missed.

3.22 The police, when attending two calls of domestic abuse of which Miss P was a victim did not take the opportunity to refer her on to other specialist support services. They dealt with the incidents reasonably competently but in a very police-centric way not seeing the bigger picture and seemingly failing to appreciate the nature of domestic violence by assuming their response would prevent recurrences. They did not appreciate that others were better placed to help Miss P live a safer life. They neither gave Miss P the choice nor took the initiative to engage outside their own organisation.

3.23 Miss P's GPs did not know about support services (albeit their practice manager knew about some). They therefore did not consider any specialist support outside of the in-house Time To Talk counselling for Miss P for the historic domestic abuse, the rape or the sexual assault that she reported. Neither did they consider the impact living with domestic abuse may have on Child A. Further they did not report or, seemingly suggest to Miss P, that she report the rape that was disclosed to them to the police.

3.24 St Richard's Hospital were selective with which type of admission would be screened for Worth Services and, even when it was of the type that such screening was available, whether that took place was a matter for professional judgement the application of which appears varied. This denied staff the opportunity to identify domestic abuse victims in all but the obvious cases. This in turn would therefore deny a victim the opportunity of help.

3.25 The principle of 'no wrong door' should be applied in whichever agency a victim happens to present. That agency should regard itself and present as a gateway to a wider system of medical, psychological, practical and emotional support as well as to the criminal justice system if appropriate. No agency here adopted that principle and none appeared to speak to another. Agencies dealt with what presented to them in accordance with their core professional responsibilities without considering the bigger picture.

3.26 Greater professional curiosity beyond what was being presented in the here and now could have presented to Miss P a range of professional support that she could have accessed then or in the future. It would be churlish to predict that this may have made any difference to the tragic events that ended Miss P's life but she may have felt that there were greater options available to her than suffering the significant abuse that was the hallmark of most of her adult life.

3.27 Agencies could have been more collaborative, more curious and looked to the root of the problems Miss P presented with. Broadly, awareness of specialist services was not as great as it could have been with most of her friends being oblivious to the range of services available and professionals equally lacking knowledge. Opportunities were missed to help Miss P get the support that may have helped.

3.28 However, it is clear that whilst Adult B was a controlling, manipulative and abusive person in many of his relationships, there is no evidence to support a hypothesis that, other than the day he killed Miss P, he had been physically or sexually abusive to her. There appeared to be an escalation in his psychological abuse of her but never to the point of violence.

3.29 It may have been that had Miss P had access to specialist support services either by her own contact or referral by professionals she may have escaped the relationship before it took her life. However, it cannot be said that the homicide could have been predicted as a natural consequence of the abuse she suffered. No agency knew the whole picture of what life was like for Miss P so no agency failed to take action against Adult B or in support of Miss P which would have prevented her death either.

4. Lessons to be Learned

4.1 GP notes are not fit for the purpose of Domestic Homicide Reviews. Whilst that is of course not their primary purpose, it does suggest that practitioners may struggle in rationalising the decisions they or the patient took regarding suggested safety measures to protect them from harm.

4.2 The routine onward referral to specialist services of people disclosing domestic or sexual violence to medical practitioners does not seem to occur. This denies victims the opportunity to engage with specialist services who are commissioned and established to support them.

4.3 There is no clear guidance for GPs as to what, when, whether and to whom they should refer disclosures of crimes especially of serious sexual assaults, with the exception of the GMC rules of confidentiality (ibid). Referrals and actions taken therefore vary between surgeries. This is not a satisfactory situation for patients, the wider public and doctors alike.

4.4 GPs should clearly record what action they take when faced with information revealing that a child may be suffering distress having been living in a household where domestic violence is taking place.

4.5 The mechanisms within Western Sussex Hospitals Trust to screen people for suitability for support from Worth Services are not sufficient to be able to promote referral other than from people who self-disclose or present in 'majors.' Even then that relies on individual staff discretion which does not seem to be underpinned by training.

4.6 The Health sector, in certain settings, has not fully grasped the statutory nature of Domestic Homicide Reviews and therefore do not provide information to them in same manner as with other statutory reviews.

4.7 The knowledge of some police officers regarding the nature and purpose of questions asked on the DASH forms is lacking. This can result in the true nature of repeat victimisation to be missed in subsequent risk assessments. This, in turn, could lead to both an inappropriate risk level being assigned and response provided.

4.8 This review indicated that the police do not routinely refer victims of domestic violence to specialist services. This prevents the victim having the option of support from those very agencies commissioned and equipped to deliver it. This could negatively impact on further safety of that victim or denial of a 'lifeline' should s/he become a victim in the future.

4.9 The arrangements of the supervision of rape cases in 2001 by Sussex Police were not sufficient to guarantee that effective investigations and victim care were the norm. Whilst this review has been informed such failings could not happen again, this should be verified.

4.10 Despite the best efforts of agencies, the knowledge about the nature of specialist domestic violence service provision in West Sussex is not as widespread as many assume. Whilst this is not unique to West Sussex it means that those who need support for themselves or others have a narrow view of which agencies are available to them and the services they offer.

4.11 Agencies examined in this review do not, routinely, regard those presenting to them as in need of wider services than their own. They do not consider who else could be engaged to meet the needs of domestic abuse victims rather restricting the offer to that within the gift of their own agency. This denies victims anything other than very restricted support from the service they happened to engage with on that occasion.

5. Recommendations of the Review

5.1 That the Domestic and Sexual Violence Strategic Board works with NHS England, Coastal West Sussex, Crawley and Horsham & Mid Sussex Clinical Commissioning Groups to ensure that the services they commission are delivered in accordance with the National Institute for Health and Care Excellence Guidelines - Domestic Violence and Abuse: How Health Services, Social Care and the Organisations They Work with Can Respond Effectively (The NICE Guidelines) particularly Recommendation 6 so that frontline staff in all services are trained to both recognise the indicators of domestic violence and abuse and to ask service users whether they have experienced domestic violence and abuse. Further to ensure staff know, or have access to, information about the services, policies and procedures of all relevant local agencies and that all services have formal referral pathways in place for domestic violence and abuse.

5.2 That in support of Recommendation 1, the Domestic and Sexual Violence Strategic Board ensures that all health providers, particularly GPs and Acute Hospitals, are reminded of:

- Recommendation 8 of the NICE Guidelines (ibid) specifically that they prioritise people's safety and that they refer people from general services to domestic violence and abuse specialist services, and

- the contents of the GMC Confidentiality Guidance (ibid) including Paragraph 51 which refers specifically to those need the support of specialist support services.

5.3 That the Home Office requires the GMC to issue specific guidance to all GPs of the circumstances when they should disclose serious sexual offences to the police that have been revealed to them by patients accepting that sometimes this might be restricted to a referral where the name of the patient is not revealed.

5.4 That, to enable Western Sussex Hospital Trust to ensure its patients are fully safeguarded, they develop their policies, training and practices in accordance with the NICE Guidelines to that ensure that all patients presenting are considered as potential domestic abuse victims and that staff feel competent and enabled to make informed decisions to treat them as such and provide them with the opportunity for onward referral to specialist agencies.

5.5 That the Home Office requires the Department of Health to issue clear guidance to health commissioners and providers, of the statutory nature of Domestic Homicide Reviews and their duty to co-operate with them except in exceptional circumstances.

5.6 That Sussex Police explore ways to make it clear to officers and staff completing Domestic Abuse Stalking and Harassment Risk Assessments that any previous victimisation of a domestic nature must be recorded and form part of the risk assessment.

5.7 That Sussex Police ensure they have effective processes in place which ensure that domestic abuse victims are provided with information about specialist support services available to them and that they themselves refer victims to suitable services following domestic abuse incidents.

5.8 That Sussex Police assure the Domestic and Sexual Violence Strategy Board that there are robust measures in place that the prevent reports of rape or serious sexual offences being discontinued without an effective investigation and senior officer or CPS authority.

5.9 That the Domestic and Sexual Violence Strategy Board develop a far reaching communications strategy which has the ambition of ensuring that the reach and accessibility of both statutory and specialist support services for domestic violence is such that people in every community are clear on where to seek help for themselves and others in a way which meets their needs.

5.10 The Domestic and Sexual Violence Strategy Board should develop a similar communications strategy to that proposed in Recommendation 9 but this time focusing on statutory and specialist support services so that all become routinely aware of other services to whom they can refer domestic abuse or sexual violence victims and that they operate a 'no wrong door' philosophy when presented with such cases.