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

Safer West Sussex Partnership

Domestic Homicide Review Overview Report

FINAL REPORT INTO THE DEATH OF ADULT MISS P IN 2013

Report produced by Graham Bartlett

Date: 13 March 2014

SECTION 1 - INTRODUCTION AND BACKGROUND

1.2 Introduction

1.2.1 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. The review will consider agencies contact and involvement with Miss P and Adult B, the perpetrator, from 1st January 2007 to the 28th January 2013.

1.2.2 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. She was found slumped on a two-seater armchair in her front room. She had no obvious injuries except a love bite on her neck and some bruising on her left arm and right calf. The cause of her death at that stage was unclear.

1.2.3 She had been in a relationship with Adult B which, to all intents and purposes, had been curtailed by Miss P. He, however, had made several attempts to re contact her including on the night before she was found dead. Following her being found he was invited to Chichester Police Station where, after an initial interview, he was arrested on suspicion of her murder. However, given that the post-mortem did not reveal a cause of death, his account and the lack, at that stage, of sufficient evidence he was bailed by the police. The investigation continued and following the exclusion of natural causes and the results of forensic evidence a decision was taken on 28th May 2013 to re - arrest him. He was subsequently charged with Miss P's murder and remanded in custody. He stood trial on 6th January 2014 and was convicted of murder on 30th January 2014. On the 3rd February 2014, he was sentenced to life imprisonment with a recommendation that he serve a minimum of 15 years.

1.3 Reasons for Conducting the Review

1.3.1 Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). 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 was related or with whom he was or had been in an intimate personal relationship, or*
>
> *b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.*

1.3.2 The purpose of a DHR is to:

> *a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;*
>
> *b) 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;*
>
> *c) apply these lessons to service responses including changes to policies and procedures as appropriate; and*

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.4 Process Of The Review

1.4.1 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 (pdf). The chair and author was appointed shortly afterwards and the review started immediately. Whilst the review was commissioned under the previous guidance, given its timing it has been carried out in accordance with the revised guidance which took effect from 1st August 2013.

1.4.2 The WSCC Domestic Homicide Review Panel who sat on the 21st June 2013 comprised:

Agency	Name	Post
West Sussex County Council	David Simmons	Councillor (Chair)
West Sussex County Council	Sue Cart	Head of Safeguarding
West Sussex County Council	Trish Harrison	Domestic and Sexual Violence Manager
West Sussex County Council	Sonia Knight	Multi Agency Risk Assessment Conference Co-ordinator
Sussex Police	Stuart Hale	Detective Inspector, Protecting Vulnerable People Branch
Surrey and Sussex Probation Trust	Amanda Radley	West Sussex Local Delivery Unit Director
West Sussex NHS Clinical Commissioning Group	Emma Luhr	Head of Quality
Chichester District Council	Pam Bushby	Senior Community Safety Officer
Sussex Community NHS Trust	Sue Giddings	Deputy Chief Nurse
West Sussex Fire and Rescue Service	Kathy Burke	Community Risk Manager

1.4.3 Mr Graham Bartlett was appointed to chair the review and write the overview report. He is the Director of South Downs Leadership and Management Services Ltd and Independent Chair of Brighton and Hove Local Safeguarding Children Board. He has completed the Home Office on-line training for independent chairs of Domestic Homicide Reviews and has completed the Social Care Institute for Excellence Learning Together Foundation Course which is the methodology now widely used for Children Safeguarding Serious Case Reviews. He is a recently retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for the city of Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the policing of Child Protection, Domestic Abuse, Multi Agency Public Protection Arrangements (MAPPA), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for the issues under review here whilst in the police.

1.5 Time Scales

1.5.1 Whilst it was known that Miss P and Adult B had only been in a relationship for a year, given information held by the police regarding calls to them relating to Miss P and domestic abuse from previous partners, the timescales for the review were set for the period from 1st January 2007 to the date of the Miss P's death, that being the 28th January 2013.

1.5.2 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, for reasons discussed later 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.

1.6 Terms of Reference

1.6.1 The specific terms of reference for this Review to consider were:

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 Chichester district

- 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.

1.7 Agency Involvement

1.7.1 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

1.7.2 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

1.7.3 The authors of the IMRs are independent in accordance with the guidance. They submitted their reports within the timescales set and were in the format required. The agencies were also diligent in responding to requests for clarification or further information from the chair.

1.7.4 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.

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

1.7.6 An integrated chronology has been prepared which shows agency involvement and significant events during the time period considered by this review. Where relevant, events outside the time period have been included. This is contained in Appendix A.

1.7.7 The report's conclusions and recommendations are the collective views of the DHR panel which has the responsibility, through its constituent agencies, for implementing the recommendations.

1.8 Confidentiality

1.8.1 The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers. However, a redacted Overview Report and executive summary has been prepared and will be published in accordance with the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (ibid).

1.9 Dissemination

1.9.1 Whilst key issues have been shared with organisations the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of the report were seen by the membership of the Review Panel and the IMR authors.

1.9.2 The IMRs will not be published but the redacted overview DHR report and Executive Summary will be made public and the recommendations will be acted upon by all agencies in order to ensure that the lessons of the review are learned.

1.9.3 The content of the Overview Report and Executive Summary is anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998.

1.9.4 Miss P's family have been shown a draft copy of this report and will be provided a final copy the day before publication

1.10 Impact of Criminal Proceedings

1.10.1 The complexity surrounding the criminal investigation and trial meant there was a delay in seeing certain key witnesses. This meant that some could not be interviewed until after the trial. The trial itself was then delayed and did not conclude until the end of January 2014. These factors were reported to the panel and were accepted as causing unavoidable delay in the completion of this review.

1.10.2 It is worthy of note that the police Senior Investigating Officer, recognising the importance of identifying and sharing any learning, allowed the independent chair to review key witness statements prior to the conclusion of the criminal proceedings. This was particularly valuable as, from the Individual Management Reviews, it seemed that Miss P had little contact with statutory or specialist support services and had certainly had not been identified as a person who was suffering domestic violence at the hands of Adult B. Therefore, it was important to understand Miss P's state of mind in terms of her decisions around whether to seek help and whether she had raised her suffering with close friends or relatives.

1.10.3 The police witness statements were very helpful in this regard. Had the police not have been so accommodating it would have been necessary to interview far more witnesses which would have delayed the review further and, crucially, would have prolonged the suffering for those who knew and loved Miss P and had already had to relive their experiences in court.

1.11 Subjects of the Review[1]

Deceased	**Miss P**
Children	**Child A**
Perpetrator	**Adult B**

1.12 Involvement of Family

1.12.1 Sussex Police have, through their Family Liaison Officers, facilitated contact with the family members of Miss P. Miss P was adopted as a baby and, whilst the criminal investigation had occasion to involve her natural parents, given that she was not in contact with them save for on one occasion, a decision was taken that contact would be through her adoptive family whom Miss P would have considered and, indeed were, her next of kin. Because of the ill health of Miss P's father and difficulties in communicating with her mother due to her being deaf the detailed liaison was with her sister, who

[1] These are pseudonyms chosen by Child A who is now an adult

undertook to ensure her parents were kept fully apprised, and her first husband as he is the father of Child A with whom she is now living.

1.12.2 Meetings were held with her parents nonetheless, who were grateful for the review taking place and keen to receive the final report, and with Child A who is a very mature 17 year old who, too, understood the process and wished to remain engaged with it.

1.12.3 This review concluded on 10th February 2014.

SECTION 2 - DOMESTIC HOMICIDE REVIEW PANEL CONCLUDING REPORT

2.1 Introduction

2.1.1 This review report is drawn from information and facts provided by and concerning:

- Langley House Surgery, Chichester,
- Selsey Medical Practice, Selsey,
- Western Sussex Hospital Trust,
- Sussex Police,
- Chichester District Council and
- West Sussex Fire and Rescue Service.

2.1.2 It also contains information drawn from reviewing witness statements and records of video interview and from interviews with selected witnesses.

2.1.3 From a review of Summaries of Involvement submitted at the beginning of this review it was established that Miss P and Adult B only had relevant contact within the time period under review with those agencies referred to in para 2.1.1. Relevancy was determined by reference to the terms of reference agreed.

2.2 Summary of the Case

2.2.1 Miss P was a 44 year old woman who lived in Chichester District with her then 16 year old daughter from her first marriage, Child A. She had been previously married twice and, following the breakdown of her second marriage, had another long-term relationship. Miss P was adopted at a very early age and was brought up as a full member of her adoptive family together with her sister, who was the natural daughter of her parents. She met her natural parents once but, given this was not a comfortable experience, she did not do so again. Some of her friends said that she had told them she had attachment difficulties due to her confusion of why she was adopted. This, some said, manifested itself in her 'needing to be loved' and hence they regarded that she made some poor decisions in her choice of some partners.

2.2.2 Her first marriage broke down shortly after the birth of Child A and, unlike her second marriage, her further relationship and the relationship with Adult B, this one was not characterised by domestic violence.

2.2.3 Child A had a good relationship with her father and spent various evenings and every other weekend with him, her step-mother and their young son. Miss P's relationship with him was limited to facilitating shared contact with their daughter and they lived very separate lives.

2.2.4 Her relationships with her second husband and common law husband were volatile while they were current with Miss P being victim of significant domestic violence leading to, in one case, her reporting to friends that she had been raped. Since each relationship ended there is no evidence that she had any contact with either other than in 2012 her reporting a rape and/or what appears to be a sexual touching by one of her former partners to her GP.

2.2.5 She suffered in the past from stress, anxiety and had panic attacks. In the time period under review, she had in excess of 20 General Practitioner consultations relating to these conditions and was prescribed a range of medications and therapeutic programmes. Alongside these conditions and possibly related to them she reported that she was drinking heavily, sometimes up to two bottles of wine a night.

2.2.6 Latterly she suffered from various gynaecological disorders. These added to her stress and anxiety and culminated in her having a hysterectomy ten weeks before her death.

2.2.7 In January 2012 Miss P met Adult B through work. She was a schemes manager at a care home and he a bus driver for a residential home and part time private hire driver.

2.2.8 Her relationship with Adult B was described by her friends as 'rocky'. There is little doubt that Adult B was a jealous and possessive individual wishing to take complete control of Miss P's life. Examples of this included making it clear, very soon after the relationship started, that he wanted to marry her and have children. Over the period of the relationship he was verbally aggressive and abusive to her accusing her of infidelity, deliberately marking her with love bites to prevent her being attractive to other men, sending her images of him self-harming and texting her with comments which indicated he was following her. He often threatened to self-harm when she tried to break the relationship off, he accessed her mobile phone and read and replied to her texts and left tearful messages for her on her voicemail.

2.2.9 There were two significant acts that Adult B carried out which had a profound effect on Miss P. The first was when, on her request, he pawned some of her jewellery and retained £10 without her permission. The second was when he used a pseudonym to email her employers to make fictitious allegations that she had neglected a dying patient and that she had breached patient confidentiality. This was particularly insensitive given that it was sent while Miss P was recovering from her hysterectomy.

2.2.10 During the course of the relationship, they split up a number of times however they always seemed to get back together. Friends and family of Miss P have said that this was because she had an all-consuming desire to be loved and needed.

2.2.11 Miss P had a large circle of friends and acquaintances who, without exception, were very fond of her. They expressed a desire to look out for her and, to a certain extent, try to protect her from herself. Many, including her employer, knew of the domestic abuse she was suffering and some encouraged her to seek help. Often, she would assure her friends that she would or indeed that she had reported what was happening to her. Unfortunately, she had not done so and probably had no intention of either. It is unlikely that she did not recognise what was happening to her as being domestic abuse it is just that, for reasons only known to herself, she did not want any interventions.

2.2.12 On the 27th January 2013, Adult B killed Miss P in her home probably by smothering her while she was seated on the settee in her lounge. Her body was discovered the following day by her employer and Adult B was subsequently arrested on suspicion of her murder.

2.2.13 He denied any involvement in her death but, 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.

2.3 Domestic Abuse Service in West Sussex

2.3.1 West Sussex County (WSCC) commission a range of services to support victims of domestic violence who present in the county. This is overseen by the Domestic and Sexual Violence Strategic Board which comprises senior members of NHS Clinical Commissioning Group, Police, Probation, Crown Prosecution Service and Public Health as well as WSCC Domestic Violence commissioners. It is jointly chaired at a senior level by the Head of Safeguarding for WSCC and the Designated Nurse: Safeguarding Adults for Coastal West Sussex, Crawley and Horsham & Mid Sussex Clinical Commissioning Groups (CCGs).

2.3.2 Amongst the services commissioned which would have been available to Miss P during the period covered by this review are:

- **The Saturn Centre** – a Sexual Assault Referral Centre based at Crawley Hospital but which covers the counties of West Sussex, East Sussex and the City of Brighton and Hove. This is a one stop shop for victims of serious sexual assault which provides support at the point of crisis through to recovery. It combines the services of Police, 24/7 crisis support workers, support workers, Independent Sexual Violence Advisors (ISVAs) and counselling services. The centre opened in January 2009.

- **WORTH Services** - an Independent Domestic Violence Advice (IDVA) Service supporting people affected by domestic abuse in West Sussex. They are available 7 days a week between 0900-1700hrs and contactable by published telephone numbers. They also provide online information and help (pdf) through their website. They are based in three hospitals across the county and take referrals from all agencies, victims as well as third party reports of abuse. They work to identify, assess and assist medium-high risk victims of abuse.

- **Chichester Outreach** - an outreach service providing support and advice to anyone who is experiencing domestic abuse/violence in the Chichester District. This was available Monday to Friday 0900-1700 and was accessible to third parties as well as victims themselves. This service has now been recommissioned and is now provided by Stonham Outreach Service.

- **Life Centre** - specialists in counselling survivors of rape and sexual violation, whether this has been a recent incident or historical. They provide helpline support, an email and text helpline service for all age groups, run by trained volunteers. They offer face to face counselling, with professionally trained counsellors, to survivors, and to their supporters - close family members or friends - or partners of survivors affected relationally by sexual violation. They also provide information through their website.

2.4 Analyses of Individual Management Reviews

2.4.1 The aim of this section is to analyse the response of services involved with Miss P and Adult B in the time period under review. It will look at the nature of the engagement reported, the recognition of the root cause of the issues presenting and the quality of the response or service provided.

2.4.2 There is always a risk in providing such analysis that the passage of time, the events that have ensued and the level of information now available that hindsight bias will become a factor. Clearly this is not helpful especially when it incorrectly presupposes that those providing a service would or should have had access to information that was

not or could not have been reasonably available to them at the time. However, by examining the sequence of events from the perspective of all the agencies with whom Miss P and Adult B had contact it can be useful to predict what information agencies could have known had information sharing arrangements been different. Where that is the case comment will be made and any lessons learned identified.

2.4.3 The IMR authors are all independent of the matters under review and have all provided as full an account and as detailed analysis as possible, triangulating sources where possible and using their significant knowledge of their respective agency's policies, procedures and practices to draw inferences regarding the service provided and make judgements and recommendations regarding that. Neither Miss P nor Adult B sought targeted support specific to their experiences as either a victim or perpetrator of domestic abuse. As previously outlined, in fact, Miss P seemed to make a conscious effort to avoid such support. Both only therefore presented to universal services. By far and away the agency which had most contact with Miss P was her GP and, latterly, the local hospital for both planned and unplanned admissions.

2.5 Information from Family and Friends

2.5.1 As previously explained in para 1.9.2, the nature and timescale of the criminal investigation and the eventual trial required that access to those who were or who may be witnesses was difficult. A request was made to the police Senior Investigating Officer that the DHR chair be permitted to interview a number of named witnesses in the period leading up to the trial. Quite reasonably he declined this request as it could not be predicted with any certainty which of Miss P's family and friends would be required to give evidence. This was a genuine concern as the prosecution case was complex given the absence of a definitive cause of death.

2.5.2 However, understanding the importance of Domestic Homicide Reviews, he allowed the chair to read and take notes from 22 witness statements and three Records of Video Interview on police premises and under police supervision. It was agreed that such access was necessary for a number of reasons.

2.5.3 Firstly, it had already been established that Miss P had not formally reported the abuse she was suffering to the police or any support service only that she had mentioned elements of it whilst engaging with her GP. It was therefore important to understand whether she had kept this part of her life secret from everyone or whether she just avoided formal agency intervention. If the latter was the case, then it was necessary to establish why, what efforts her closest friends and family had made to encourage her to access support and what her response to that was.

2.5.4 Secondly, given the nature of the police investigation and the police IMR, it seemed likely that such issues had already been covered by the police in their evidence gathering for the homicide investigation. Assuming that to be the case, access to that material would obviate the need to require those grieving Miss P's death to once again have to repeat what would no doubt be very upsetting accounts possibly for the third time.

2.5.5 Finally, had it not have been possible to review the accounts of those who knew Miss P best until after the trial, the delay to this DHR would have been much greater than it has been. That would have had the effect of delaying the analysis provided and therefore the implementation of recommendations.

2.5.6 In the event, the process of reviewing the statements meant that the need to interview those 25 witnesses was all but eliminated. As predicted, the police had been diligent in covering most if not all of the issues the DHR would have sought to cover in interviews. This was beneficial to both the review and, more importantly, to those witnesses.

Good Practice Point 1

That where legal processes are prolonged, to avoid delay to the Domestic Homicide Review, further upset to witnesses and to expedite learning, the police allow the Independent Chair supervised access to witness accounts already secured and notes to be taken from them.

2.5.7 The view from all of the witnesses was that Miss P was a popular and sociable woman who had many friends but who suffered from depression, anxiety and low moods. She was an excellent mother to Child A and ensured that she wanted for nothing. However, some witnesses say that she seemed to have issues with self-esteem which she had sometimes related to the fact that she was adopted. Some say that she had an overwhelming desire to be loved and needed and that this had resulted in her making poor choices in some of her relationships.

2.5.8 Reflecting the closeness and the trust that she shared with her friends few were completely ignorant of the abuse she had suffered in her various relationships since the breakdown of her first marriage. On the contrary in fact, Miss P often confided in friends telling them of her experiences, the violence of her previous relationships, the psychological abuse she was suffering from Adult B and her worries that it may escalate.

2.5.9 Many too knew of her mental illness and her occasional excessive drinking. Understandably these were attributed by some to the many years of abuse and broken relationships she had suffered. It was striking that, rather than being passive bystanders, her close friends and family, including her employer, often made great efforts to encourage her to report her suffering to the police, to support services or to take other preventive action. For example:

- When she said she had been raped by a previous partner, she implored the friend she reported it to not to contact the police despite her being both physically injured and incredibly distressed.
- She mentioned to her GP that she had been 'touched' by her ex-partner but had no intention of reporting it to the police.
- She had twice been encouraged to contact a counselling and advice service available through her employers. She prevaricated on both occasions and made no contact.
- She was advised to report Adult B's stalking behaviour to the police by many people. She assured them that she had done so and they had offered him 'advice.' There is no record of her making such a report and the presumption can only be that she did not and that she said she had just to pacify her worried friends.
- She told her friends that her sister, a solicitor, was helping her draw up an injunction to prevent further harassment and abuse. She had never mentioned to her sister that she was suffering any abuse and certainly had not asked her help with any legal processes.
- She told relatives of Adult B that she loved him and intended to get back with him when she was telling others the opposite.

2.5.10 It is important to stress that such responses are not in the least atypical of people suffering domestic abuse. The reasons why this is the case are myriad but what is clear is that people who avoid services or support in this way do so for a reason. Nothing in this review apportions or implies blame to Miss P for avoiding services in this way but seeks to establish the reasons why and what can be done about it.

2.5.11 It is the responsibility of all agencies charged with responding to or providing support for victims of domestic abuse to truly understand how they can make their services more available and accessible even to the most reluctant. This is not an easy challenge and this review does not pretend that is. What this case suggests, however, is that statutory agencies and specialist support services must constantly reassess their reach and accessibility so that those that need them are not, through ignorance, deprived of the excellent support they provide.

2.6 National Health Service IMR

2.6.1 The author of the NHS IMR is employed as Designated Nurse: Safeguarding Adults by the Coastal West Sussex, Crawley and Horsham & Mid Sussex Clinical Commissioning Groups (CCG). None are directly responsible for providing any of the services accessed by Miss P or Adult B during the period of this review. She is therefore both suitably experienced and qualified to undertake such a review and holds the necessary independence.

2.6.2 The Sussex Primary Care Support Service (PCSS) was contacted to obtain details of any General Practitioners which Miss P or Adult B may have been registered with. Both the GPs were contacted and ask to supply their medical records.

2.6.3 In addition, both the local Acute Hospital Trust – Western Sussex Hospital Trust, and the neighbouring Trust – Portsmouth Hospitals Trust were contacted to determine if they had any contact with either party within the timeframe set down by the review.

2.6.4 Both hospitals interrogated their patient administration system to reveal any attendances at the Accident and Emergency departments, or any inpatient and outpatient episodes.

2.6.5 As a result of these enquiries, it was discovered that Portsmouth Hospitals Trust had no attendances recorded. The NHS IMR, therefore, refers to the services provided to Miss P and Adult B by Langley House Surgery, Selsey Medical Practice and Western Sussex Hospital Trust.

General Practitioner Services – Miss P

2.6.6 Miss P attended her GP surgery over 40 times – 33 for appointments with GP's, as well as for the Well Woman Clinic, Smoking Cessation Clinic, mental health appointments, blood tests and cervical smears. In addition, she had one home visit, and one encounter recorded with the Out of Hours services.

2.6.7 Of the 33 medical appointments, she saw 8 different GP's. There were recurrent visits concerning her low mood and, where anti-depressants were prescribed, these were regularly followed up by the GPs. During one such appointment, where she talks about historic domestic abuse, Miss P referred to Child A being distressed. There is nothing to suggest this was followed up. Mental health patient questionnaires were completed at several appointments, and referrals made both to the mental health team, in-house counselling, and Time To Talk.

2.6.8 Around the time that she started her relationship with Adult B she was receiving treatment for gynaecological problems. During the course of her consultations, she revealed that she had been raped by an ex-partner, raped at work and/or that she had been touched by an ex-partner. The notes are really unclear whether these are the same incident or perhaps three. They do appear to be conflated in a letter of referral to the hospital as this refers to Miss P being raped by an ex-partner. There is no reference elsewhere in the review of a rape at work and, whilst Miss P had reported to a friend a rape from her then current partner in July 2011 this does not, from the dates, appear to be the matter the GP notes are referring to in early 2012. Despite the best efforts of the IMR and Overview Report author, these issues still remain confused and this could cause potential issues for patient care and certainly for these reviews.

2.6.9 During these appointments where she revealed she had been raped, notes indicate that further discussions took place with Miss P regarding the circumstances, and her methods of coping. A referral to in house counselling was offered and accepted. There was also a discussion regarding reporting a 'touching' by her ex-partner to the police, which Miss P declined.

General Practitioner Services – Adult B

2.6.10 Adult B did not visit the GP for a 3-year period up to 2008. Following this there were only three visits recorded on his records. One following a car accident, and two, close together, regarding an ear infection. There are no recorded indications of any violence issues or any concerns noted regarding his mental health during the timeframe for the DHR.

Western Sussex Hospitals Trust

2.6.11 The attendances of both subjects at the A&E department were not at the same time and there was nothing in the records to indicate that Miss P and Adult B were in a relationship on any of these occasions. During Miss P's inpatient stay in November 2012, the emergency contact name was given as "B". This was crossed out and Miss P's parents were listed. There is nothing to indicate why this change was made. It is known, however, that somehow Adult B discovered the date of Miss P's rescheduled procedure and attended the hospital but was asked to leave by staff.

2.6.12 References were made to a "partner" when Adult B attended A&E on 16th August 2012, but no name for this partner was recorded.

2.6.13 There are domestic violence related questions on the A&E paperwork relating to one attendance (there are 3 templates used, dependent on reason for attendance), 'Do you feel safe at home' and 'Refer to Worth Services' – however these were not completed.

2.6.14 It seems that these questions are not asked of everyone, they are asked depending upon factors such as patient presentation, history, injury, behaviour, condition, verbal communication, non-verbal communication – and on Miss P's admission for chest pain, these were not deemed appropriate. Her other 2 attendances were for a 'stubbed toe', and different paperwork was used which did not contain these questions on the template.

Analysis of Practice

2.6.15 Miss P did discuss her low mood and anxiety during appointments, and medication was prescribed, enabling the GP to manage and monitor her mental health. The pharmaceutical and therapeutic treatments prescribed appear appropriate and were

reviewed regularly.

2.6.16 Several of the appointments with the GP surgery, and subsequently the hospital were regarding vaginal bleeding, both inter-menstrual (between periods) and post-coital (after intercourse). On further investigation with both the GP and Hospital, Miss P had a long history of gynaecological problems, including inter-menstrual bleeding, which commenced prior to the timeframe of this review. Therefore, although the rape was disclosed alongside reports of this bleeding, when further bleeding occurred, there would have been no reason to attribute this to a possible further rape.

2.6.17 One of the GPs has confirmed that her usual practice when a patient discloses sexual assault would be to enquire further with a patient but would assume that there were no responses from the patient to make her think she was at risk of further harm. It is disappointing that this was not reflected in the notes as it is impossible to judge whether that conversation happened in this case, what the nature of it was and its outcome. This was a theme with the GP notes in that they were scant on detail, sometimes appeared muddled (e.g. regarding the rape/ touching disclosures) and did not always set out follow up arrangements (e.g. Child A's distress and PV examination not carried out)

Lessons Learned 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.

2.6.18 The Practice manager stated that generally speaking, if a patient says they have been raped during a consultation, the response would vary according to the patient's wishes, giving examples that they would advise them they can report it to the police, obtain help from the Life Centre or refer them for in-house counselling via Time to Talk. If the rape was recent, the surgery would also consider STI referral (tests for sexually transmitted diseases).

2.6.19 Miss P did disclose to her GP that she had been raped. She also disclosed she had been 'touched' which is presumed to have meant sexually assaulted. Further she revealed she had been in an abusive relationship. There is no evidence that, despite the assurances provided by the practice manager of what should happen when rape is reported, that any referral was discussed or made to any services outside of the practice. She did accept an offer of counselling with Time to Talk which is a first level talking therapy. The service isn't specific to Domestic Violence, nor is it for diagnosed complex mental health issues. It is more for low level anxiety, or depression.

2.6.20 This omission in discussing or referring Miss P to other services who are commissioned to deliver just the support that she needed or to the police who could have instigated a criminal investigation is concerning. Whilst these offences are not believed to relate to Adult B, by providing Miss P with the information and connections that could have provided her with help not only may this have enabled the rape to be investigated but she could have received specialist support and may have been inclined later to seek that same or similar support for the abuse Adult B subjected her to.

2.6.21 The General Medical Council has issued comprehensive guidance on how practitioners should deal with confidentiality. Specifically it provides advice on how the medical profession should work with patients who, in their view, need support in protecting themselves. This makes a direct reference to victims of domestic violence.

Lessons Learned 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.

Recommendation 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.

Recommendation 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.**

2.6.22 This case demonstrated a disconnect between services who a victim would be most likely to present to following a serious sexual assault. Here, Miss P informed her GP that she had been raped and/ or sexually assaulted. The question of referral to the police appears to have been asked once regarding the sexual assault but there is no evidence it was discussed further especially regarding the rape(s). The interpretation of the GMC Guidelines could be a factor in this in that, whilst the relevant GP may have perceived that, at that moment, Miss P was safe, a deeper understanding of the nature of sexual or domestic violence may have led them to realise that she, and possibly other women could be at risk from the perpetrator.

Lessons Learned 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.

Recommendation 3

That the Home Office requires the GMC to issue specific guidance to all GPs of the circumstances when the 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.

2.6.23 There is nothing in the notes to indicate that anything further was done to offer support to Child A when Miss P revealed, in the context of a discussion with her GP of her leaving an abusive marriage, that she was distressed too. This omission could have left a child vulnerable to emotional abuse and therefore needs to be prevented in the future.

Lessons Learned 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.

2.6.24 The admissions to A & E for the chest pains and stubbed toes could all have been the result of domestic violence. The chest pain was muscular skeletal, the toe injuries were said to have been caused by a Guinea pig run and a falling soft drinks bottle. Within the A&E department, there are referral cards, self-help information, and information regarding Worth Services clearly displayed both in the waiting room and on the information rack. However, the routine enquiries made of people presenting with injuries which could be the result of domestic violence appears sporadic. The screening is not on the 'minors' paperwork on which the 'stubbed toe' admissions were recorded. Whilst staff believe they are targeting such questioning to those they believe most likely to provide a positive response, further training and a review of the policy of reserving enquires thus would be beneficial.

Lessons Learned 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.

Recommendation 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.

2.6.25 Neither the GP surgery nor the staff in A&E currently use the DASH risk assessment tool. Additionally, Miss P's GP surgery are not aware of Worth services and therefore will not have referred or recommended self-referral to any patient to the service. This is a real gap in knowledge which surprised the panel and has been addressed already by the Designated Nurse: Safeguarding Adults. She was in contact with Worth and asked for some material to send out to GP surgeries. She has also sent out posters, stickers, leaflets and other materials to all GP surgeries across West Sussex. Additionally, she has sent them information about the training courses offered, and suggested staff from practices attend.

Good Practice Point 2

That the Designated Nurse: Safeguarding Adults has recognised a significant gap in knowledge within primary care and has been proactive in addressing this immediately it became apparent.

2.6.26 There was some difficulty in obtaining some of the necessary medical records, due to issues surrounding confidentiality and consent. This frustrated the early stages of the review and it was only through the significant efforts of the NHS IMR author that this was overcome. Recognition that Domestic Homicide Reviews are statutory does not seem to be complete across primary care providers. Guidance should be made clearer to fill this gap so that a complete information picture can be obtained within reasonable timescales to allow essential learning to be identified and therefore vulnerable people protected.

2.6.27 The Review did contact the Department of Health through the Home Office on this point and the position they gave was;

> *'It is the Department's view that GPs and NHS organisations should cooperate with domestic homicide reviews and disclose all relevant information about the victims and, where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or Human Rights considerations), the following steps should be taken:*
>
> *a) The review team should be informed about the existence of information relevant to an inquiry in all cases; and*
>
> *b) The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.*
>
> *However, where there is evidence to suggest that a person is responsible for the death of the victim, their confidentiality should be set aside in the greater public interest of investigating a serious crime.*
>
> *However, if the review team is seeking information about a previous violent partner whose actions are not the cause of the victim's death then there can be no public interest in disclosing his data without his explicit consent.'*

2.6.28 They also referred to the GMC guidance on confidentiality (ibid)

Lessons Learned 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.

Recommendation 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.

2.7 Sussex Police IMR

2.7.1 Sussex Police provides policing services for the counties of West Sussex, East Sussex and the city of Brighton and Hove. Operational policing is delivered by Divisions which are configured to those areas. With the exception of Brighton and Hove each division is then sub divided into districts which are co-terminus with local government boundaries. During the majority of the time covered by this review, the services referred to were delivered by Chichester District within West Sussex Division.

2.7.2 Sussex Police has a number of departments which are responsible for policing functions which, necessarily, transcend divisional boundaries. They have no line management of or responsibility for the Divisional or District staff.

2.7.3 One such department is the Specialist Crime Directorate. A branch of that directorate is the Protecting Vulnerable People Branch which has a review function enabling Sussex Police to independently audit and assess operational activity. The police Individual Management Review was undertaken by a former police officer attached to that branch. He is independent of the matters under review and, as a recently retired Detective Chief Inspector, has the necessary skills and experience to undertake such reviews.

2.7.4 Sussex Police have provided a great deal of information and evidence to this review as a consequence of their investigating the murder of Miss P. Much of this is included at various stages of this overview report and is reflected within the chronology (Appendix A)

2.7.5 This section will, however, focus on the Individual Management Review which relates to the terms of reference and timescales of this Domestic Homicide Review.

Police Contact Regarding Miss P

2.7.6 The police have no record of any reports to them relating to any domestic abuse, or any other matter, between Miss P and Adult B. This reflects the theme of most of the witness testimony in that, save for an assurance that Miss P gave to others that she had spoken to the police about Adult B's harassment of her, nobody was directly aware of any police contact or involvement with the abuse she was suffering. Many had advised her to report to the police but, for reasons only known to her, she did not.

2.7.7 This was not always the case. Miss P had reported other matters to the police in the past. She had reported three previous incidents two of which related to domestic abuse by previous partners. One of these resulted in the perpetrator receiving a caution for common assault and the other was found not to be a crime.

2.7.8 The first of these incidents was in October 2007 and involved an assault on Miss P in front of her daughter. It resulted in a caution being administered to the perpetrator and the matter being notified to Children's Services in respect of Miss P's daughter witnessing domestic abuse. There is no indication whether, as a consequence of this, Miss P was referred to any specialist services.

2.7.9 The second was a verbal dispute between Miss P and another partner in March 2010. There were no arrests but a DASH risk assessment was undertaken and it was determined that the situation was of standard risk, that being the lowest of three risk categories. There was no further police action in respect of this. Similarly, there is no indication of any referral to specialist services.

Police Contact Regarding Adult B

2.7.10 There are two significant offences which Adult B is alleged to have committed prior to the time frames of this review. However, as both are offences of rapes against partners and, in one case, the manner in which agencies responded to those reports reveal learning opportunities, they are referred to here.

2.7.11 Adult B was in a relationship with another woman from 1989 and they lived together in Chichester District, West Sussex. During the course of the homicide investigation she disclosed to the investigating officers two previously unreported rapes carried out by Adult B on her.

2.7.12 The woman concerned is unable to furnish specific dates other than the rapes occurred during the course of their relationship. She was alone in the flat when Adult B returned home under the influence of alcohol. She said that he appeared aggressive and that he pushed her down onto the kitchen floor, pushed her head into the open drum of the washing machine and raped her. On another occasion she awoke to find Adult B engaging in full sexual intercourse with her but says she closed her eyes and went back to sleep. The relationship ended soon after the birth of their daughter in May 1990. She was adamant that she would not support any police action in respect of these.

2.7.13 The second matter was more recently. A separate woman commenced a relationship with Adult B in 1997 when he was in another relationship. That ended, the couple married, lived together in Chichester District and they had a child in 1999. In March 2001 Adult B had been drinking alcohol and his wife left him in the front room and went to bed. Adult B came to bed and although they started kissing, she refused to take it any further. Adult B forced her down and attempted to rape her. She resisted and Adult B placed his hands around her neck and began to apply pressure. At this point the baby awoke and Adult B immediately released her

2.7.14 She went to her parents' house the following morning, told them of the assault and attempted rape and her father took photographs of the marks on her neck. She also visited her GP on 28th March 2001. The GP has no recollection of the visit but medical notes state '<Name> was attacked by her husband last night. Bruising in shape of necklace chain around neck at front. Aching all over this morning. He tried to force her to have sex, but she refused and had to fight him off. She has told him that he must leave.' She recalls the doctor telling her that she was 'bound to be bruised' and that he gave her Citizens Advice Bureau and Women's Refuge number. She did not take up either option of support as the relationship ended soon after.

2.7.15 She also went to a West Sussex police station where an initial report was taken and the photographs were handed to police. She later withdrew her allegation and no further action was taken by police. The original paperwork has now been destroyed but

despite this the woman is now supporting the police and Adult B has been charged with the attempted rape. She has said, during this re-investigation, that she was told by the police at the time that they 'needed her permission to arrest for attempted rape and attempted murder.' Given this and underpinned by the fact that she was terrified of Adult B she declined to give them 'permission' and no further action was taken.

2.7.16 A further non-domestic violence related report was reported to the police in January 2008. Adult B was alleged to have stolen a coat belonging to a fellow private hire driver from his car. The matter was reported two days after the offence was alleged to have taken place and Adult B arrested a further five days later. He was subsequently charged in March of that year but acquitted at Chichester Crown Court in December 2009.

Analysis of Practice

2.7.17 The first domestic abuse report Miss P made was prior to the introduction of the risk assessment tools but nevertheless was dealt with positively, in investigation terms, with the offender being cautioned for the matter.

2.7.18 The Domestic Abuse, Stalking and Harassment and Honour Based Violence (2008) Risk Model (DASH) was not in place at that time. There was no further action taken in relation to the notification to Children's Services. These notifications are a standard procedure when children are present during domestic abuse incidents but do not, on their own, lead to formal interventions or support as a Child in Need or Child Protection case. There is sometimes confusion in the language used by police regarding these notifications as some term them 'referrals.' They are not referrals as defined within Pan Sussex Child Protection and Safeguarding Procedures and therefore do not trigger automatically such action.

2.7.19 The second matter was also recorded appropriately and a risk assessment was completed in accordance with policy and procedure. A DASH form was submitted and the risk assessment was 'standard.' Whilst this was appropriate, it was identified through this review that the form indicated that there was no history of domestic abuse with any partner. This was clearly not the case given the assault in 2007. Whilst this may not have changed the risk assessment or the response of the police or other agencies it could have. The fact that a person has previously suffered domestic abuse can increase their vulnerability with that or future partners and can influence how they engage with and respond to services.

Lessons Learned 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.

Recommendation 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.

2.7.20 Neither report to the police appears to have resulted in a referral to a specialist support service. This is a worrying omission as victims who report to any service may not know of others available or may be disinclined to proactively approach them. A police referral to a specialist service can provide an excellent opportunity for that service to make contact and engage with a victim and develop a supportive relationship that can enhance safety.

Lessons Learned 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.

Recommendation 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.

2.7.21 The report made by Adult B's ex-wife was not responded to effectively by the police. She went to a police station and took with her evidence of the attempted rape she was reporting with the clear intention of affording the police the opportunity of protecting her. She had available the corroboratory information contained within her GP records as well as the GP himself. However, rather than taking a positive approach to this, the officers transferred the burden of responsibility to her by inferring that she had to give them permission to arrest him for specific serious offences. She, naturally, became overwhelmed by this and, effectively, withdrew her support for further action. All of the papers relating to that report have since been destroyed in accordance with Sussex Police policy which, of course, removes the opportunity to consider the rationale for the inaction of the police. Whatever that rationale, Adult B should have at least been arrested and interviewed and the evidence considered by senior officers or CPS.

2.7.22 It should be noted that this matter was reported in 2001 and, whilst the response should have been as it would be today, the IMR author asserts that there are now robust checks and balances in place that would require senior officer or Crown Prosecution Service approval of the cessation of any rape or serious sexual assault investigation.

2.7.23 Adult B was finally arraigned for this matter concurrently with his murder arraignment. Following his conviction for murder the rape matter was ordered to 'lie on file.'[2] It is regrettable, however, that this victim of crime has had to wait 13 years for justice and support.

[2] Lie on File is explained as 'An offence not admitted to by a defendant may be allowed to lie on file if the judge agrees that there is sufficient evidence, but it is not in the public interest to have a trial, as the defendant has admitted other offences, and a further conviction would make no difference to the sentence imposed. If an offence is left on file, it can in theory, be reinstated at a future date, but only with leave of the trial judge or Court of Appeal.'

Lessons Learned 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.

Recommendation 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.

2.8 Chichester District Council IMR

2.8.1 Chichester District Council (CDC) provide, in common with other similar Authorities, a full range of services for its residents, businesses and visitors. The town of Selsey and the village of East Ashling fall within Chichester District. The author of the CDC IMR is the Assistant Director of Communities for CDC and therefore a senior officer with sufficiently qualifications, experience and independence of the matters under review to discharge this responsibility.

2.8.2 Both Miss P and Adult B had occasional contact with CDC for, in the main, universal services relating to housing and council tax benefits. They indicate the normal range of activity and interaction with a council by one of its residents. The nature of those records or interaction do not by themselves give any adverse indications. The level of personal contact with those services was minimal and there appears to have been no disclosures made during those limited interactions.

2.8.3 Records in relation to the licensing of private hire drivers show that Adult B was a licensed private hire driver. He was first licensed by CDC in December 2006 and this was renewed annually up until 30th November 2012 when no further application for renewal was made.

2.8.4 The application process is made by written application form, which includes an employment history, two references, the result of a medical examination and a criminal records check. There is no automatic interview unless something appears untoward in the application papers. There is, in law, a presumption towards the grant of such a licence unless the local authority is satisfied that the applicant is NOT a fit and proper person. If refused there is then a right of appeal by the applicant to a Magistrates Court. Adult B held a licence continuously from 2006 to 2012 which was not at any point suspended or revoked by CDC.

2.8.5 The file records do show that in January and October 2008 respectively, two complaints were received about the conduct of Adult B , one of which was subject of a police investigation (para 2.7.16) and one subject of an investigation by Chichester District Council.

2.8.6 The second matter relates to an incident in October 2008 whereby a complaint was received about the conduct of Adult B from a member of the public. It was alleged that he had acted improperly towards a female customer when she had been a passenger in the private hire vehicle he was driving.

2.8.7 The complainant was interviewed and she said that previously she had been the recipient of 'perceived flattery' from Adult B whilst in his capacity as a Private Hire driver.

This then developed into a short-term physical relationship between the two during the summer of 2008.

2.8.8 Given this relationship it was unclear why the complainant had reported the matter and Council records do not shed light on this. Adult B was interviewed and denied the allegation.

2.8.9 The matter was considered by Chichester District Council's Legal Services Department in November 2008 with the potential of presenting the case to a Sub Committee of the Council for consideration as to whether Adult B remained a 'fit and proper' person to hold a Licence. After careful consideration it was decided not to present the case to a Sub-Committee and no further action was taken. Both parties received written confirmation on 29th January 2009 that the matter would not be pursued.

2.8.10 Regarding the matter referred to in 2.7.16, the Council decided to track the case through the criminal courts reserving any decision around suspension or disqualification until after his trial. Given his acquittal this was not pursued further.

Analysis of Involvement

2.8.11 Given the generic and unremarkable universal services provided by CDC to Adult B and Miss P there are not any matters of concern which should have generated a response other than that which was given from those contacts.

2.8.12 Both allegations regarding Adult B's conduct were considered and investigated by CDC. In both cases, for different reasons, a decision was taken not to suspend or disqualify Adult B from holding a private hire licence. It appears that this process is fit for purpose and CDC take the safety of the public seriously when considering such matters.

2.9 West Sussex Fire and Rescue Service IMR

2.9.1 West Sussex Fire and Rescue Service (WSFRS) provide the fire and rescue service to the Chichester District given that it is within West Sussex. The author of their IMR has a service wide role as the Community Risk Manager & Safeguarding Lead. She is therefore independent of those providing services to Miss P or Adult B.

2.9.2 The only involvement that WSFRS has had with either Miss P, Adult B or their addresses was on 8th June 2011 when they were called to the smell of burning behind a wall void at Miss P's address. It was found to be a small fire caused by radiated heat from a chimney fire. No record was made of the individual/s that may have been present at that time. It is therefore not possible to provide any further information in relation to this call. However, it seems very unlikely given the information that is available that this matter was anything other than a routine non-suspicious fire.

2.9.3 The Incident Recording System (IRS) enables WSFRS to record incident details, such as incident number, address, reason for the call/attendance etc. Details of the individuals dealt with at an incident are not recorded as a matter of course on this system except in cases of serious injury or fatality.

2.9.4 The Terian database which records information relating to Technical Fire Safety and Home Fire Safety Checks does record details of individuals that have been visited, along with information regarding action taken, specialist equipment fitted and onward referrals made to relevant agencies. There is no record of such a check relating to Miss P, Adult B or their addresses on the Terian database.

Analysis of Involvement

2.9.5 It is evident that WSFRS is working to ensure that repeat calls to one specific address are flagged in order to trigger a review and appropriate response in terms of service delivery. Alongside this, they are also becoming increasingly involved in referrals for Home Fire Safety Checks, relating to domestic violence.

2.9.6 As personal information is not recorded as a matter of course on the IRS, it is difficult for them to provide a clear picture in terms of incidents attended and the behaviour of individuals at such incidents. If WSFRS attend on a number of occasions, without a record of the individuals spoken to, vital information can be lost and with it, opportunities to contribute to the partnership knowledge from which effective safety plans can be developed.

2.9.7 It is reassuring to note that WSFRS acknowledges that, in order to fully participate in processes such as the Domestic Homicide and Serious Case Reviews, there is a need to undertake a review of how they record information relating to incidents, individuals present, for what reason they attended and for how long whilst taking into consideration the requirements of the Data Protection Act.

2.9.8 As a result of this DHR, WSFRS has undertaken to review its current procedures.

Good Practice Point 3

That West Sussex Fire and Rescue Service have committed to reviewing their databases to ascertain if it is possible to contribute to the partnership knowledge around domestic abuse victims by including details of persons present at fire calls on IRIS

SECTION 3 - CONCLUSIONS

3.1 Conclusion

3.1.1 The content of this section will address the terms of reference in the statutory guidance and will be organised to reflect the case specific terms of reference identified as part of the review.

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.**

3.1.2 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.

3.1.3 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.

3.1.4 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

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.**

3.1.5 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.

3.1.6 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.

3.1.7 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.

3.1.8 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. 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.

3.1.9 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.

3.1.10 The knowledge of services available amongst Miss P's friends and colleagues 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.

3.1.11 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.

3.1.12 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).

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.

3.1.13 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 (ibid) to supplement the direct support they provide.

3.1.14 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.

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

3.1.16 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.

3.1.17 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. 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.

3.1.18 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.

Lessons Learned 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.

Recommendation 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. 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.

3.1.19 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.

3.1.20 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.

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.

3.1.21 Given the logical sequence of points 6,7, and 8 of the Terms of Reference they will be dealt with together here.

3.1.22 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.

3.1.23 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.

3.1.24 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.

3.1.25 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.

3.1.26 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.

3.1.27 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.

3.1.28 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.

Lessons Learned 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.

Recommendation 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.

3.1.29 There has been a great deal of commentary on how agencies could have been more collaborative, more curious and looked to the root of the problems Miss P presented with. It has also been mentioned that the 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.

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

3.1.30 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.

3.1.31 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.

SECTION 4 - SECTION FOUR: LESSONS LEARNED

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.**

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.**

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. **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.**

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.**

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.**

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.**

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.**

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.**

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.

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.

SECTION 5 - SECTION FIVE: RECOMMENDATIONS

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.**

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.**

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.**

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. **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.**

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.**

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.

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.**

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.**

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.**

SECTION 6 - GOOD PRACTICE POINTS

1. **That where legal processes are prolonged, to avoid delay to the Domestic Homicide Review, further upset to witnesses and to expedite learning, the police allow the Independent Chair supervised access to witness accounts already secured and notes to be taken from them.**

2. **That the Designated Nurse: Safeguarding Adults has recognised a significant gap in knowledge within primary care and has been proactive in addressing this immediately it became apparent.**

That West Sussex Fire and Rescue Service have committed to reviewing their databases to ascertain if it is possible to contribute to the partnership knowledge around domestic abuse victims by including details of persons present at fire calls on IRIS.

APPENDIX A - INTEGRATED CHRONOLOGY

Date	Event	Sub.	Agency	Details	Outcome
01/12/1989	Adult B allegedly rapes a previous partner - Date approx.	Adult B	Sussex Police	A previous victim, not Miss P alone in the flat when Adult B returned home. Recalls that he was under the influence of alcohol and appeared aggressive. Says that he pushed her down onto the kitchen floor and pushed her head into the open drum of the washing machine and raped her. She recalls another occasion where she awoke to find Adult B engaging in full sexual intercourse but says she closed her eyes and went back to sleep	Not reported to police. Only became apparent during homicide investigation
28/03/2001	Adult B rapes a previous wife	Adult B	Sussex Police	Adult B had been drinking alcohol and victim left him in the front room and went to bed. Adult B came to bed and although they started kissing, she refused to take it any further. Adult B forced her down on to the bed and attempted to penetrate her but she resisted. He placed his hands around her neck and began to apply pressure. At this point the baby awoke and he immediately released her	Victim told parents of the assault and attempted rape the next day. Her father took photographs of the marks on her neck. Previous victim also visited her GP, that day. Medical notes reflect the report also made to a West Sussex police station where photographs were handed to police. She later withdrew her allegation and no further action was taken by police. Adult B was not arrested or interviewed as the victim did not want his told of the allegation Unfortunately all of the original paperwork and photographs have not been located thus the quality of the police response and support cannot be analysed. The victim subsequently supported a prosecution on Adult B's arrest for murder and he was charged with attempted rape.

01/12/2006	Adult B registers as a private hire driver	Adult B	CDC	Annually renewed until 30/11/2012 when no application was received for further renewal	
01/01/2007	Miss P and her then husband on Housing List	Miss P	CDC	Indicates Miss P and her then husband wishing to be provided with social housing	They made no bids and Miss P was removed from the register in 2010
30/03/2007	GP Appointment	Miss P	NHS	Seen by GP – complaining of low mood, remains on Fluoxetine (Anti- Depressant) and requestsrepeat prescription.	GP comment – review in 3 months.
14/05/2007	GP Appointment	Miss P	NHS	Seen by GP – continual low mood. Drinking to excess "2 bottles last night",	Support offered but declined, "will see how she goes". Medication review with Miss P, continues on Minocycline, Fluoxetine dose increased.
27/07/2007	GP Appointment	Miss P	NHS	Continues to complain of Depression but feels better since increased dose.	GP to review in 1-2 months' time
01/10/2007	Council tax records show Miss P's then husband leaving the victim's home address	Miss P	CDC	Update to council tax records indicate the end of the relationship between Miss P and her then husband	
11/10/2007	GP Appointment	Miss P	NHS	Discussed depression, Miss P happy on current dose, not keen to reduce yet.	GP comment – to review in 2-3 months.
28/10/2007	Police called as Miss P suffers an assault by her then husband	Miss P	Sussex Police	Miss P is assaulted by her then husband in front of daughter	Husband receives a caution; a notification is made to children's social care.

01/11/2007	GP Appointment	Miss P	NHS	Complaining of high levels of stress, and difficulty sleeping. Stated was assaulted by husband at the weekend.	Sleeping tablets prescribed, side effects discussed.
12/12/2007	Telephone Call with GP	Miss P	NHS	Discussed medication. Miss P requests to remain on Fluoxetine, as low mood continues, and "has just come out of violent relationship"	None recorded
01/01/2008	Complaint made in relation to Adult B re his conduct as a private hire driver	Adult B	CDC	Inference may be drawn from the facts that the application process is subject to scrutiny; is subject of an annual renewal; and the fact that Adult B held a licence continuously from 2006 to 2012 which was not at any point suspended or revoked by this council.	TBC
04/01/2008	GP Appointment	Miss P	NHS	Complaining of pain across top of foot. No trauma. Mild Tenderness and Redness on examination	Painkillers prescribed.
23/01/2008	Adult B arrested for theft of coat from mini cab	Adult B	Sussex Police	At 21.00hrs on 23rd January 2008 a jacket was stolen from a minicab in Market Road car park, Chichester, Adult B was identified by a witness as the offender.	Arrested, charged but acquitted in December 2009
28/01/2008	GP Appointment	Miss P	NHS	Continued pain in foot, as previous. Stated settled then flared up again	X-Ray and Review arranged
25/02/2008	GP Appointment	Miss P	NHS	Complaining of Acne (long standing problem) Already on Minocycline. Noted bruise on thigh, and some itching.	Blood tests requested

11/06/2008	GP Appointment	Miss P	NHS	Complained of increased anxiety. Stated "left an abusive 7 year marriage to an alcoholic 6 months ago. Daughter who lives with her also distressed" Poor self-esteem. Stated "has been on anti-depressants for all 7 years of her marriage, no previous mood problems". "Adopted and 2x marriages, is Evaluating her life." Additionally complaining of Bacterial Vaginosis – swab taken	Suggested her reading Mind over Mood and offered Cognitive Behavioural Therapy. Infection confirmed and Antibiotics prescribed
16/06/2008	GP Appointment	Miss P	NHS	Complained of increased anxiety, poor sleeping pattern and low appetite. Tearful, and stated is drinking "1 bottle wine per night	Restart SSRI (Anti-depressant) and review on 3 weeks
10/07/2008	GP Appointment	Miss P	NHS	Review re Anxiety. Miss P states "doing Alright" wants to continue with Anti-Depressants.	Discussed Counselling and Miss P agreed. Referral made
12/08/2008	GP Appointment	Miss P	NHS	Review re Anxiety. Miss P states "doing well", no suicidal ideation, has heard from Counsellor, on waiting list. Wants to try to reduce tablets, once supported.	
10/09/2008	GP Appointment	Miss P	NHS	Seen at surgery for Guided Self-Help assessment whilst on waiting list for Counsellor.	
24/09/2008	Self Help Assessment	Miss P	NHS	Did not attend.	
30/10/2008	GP Appointment	Miss P	NHS	Discussed Anti- depressants, states "mood better" so requests continue on SSRI.	

01/11/2008	Council tax records show Miss Ps former partner, Adult Z, also living at address retracted	Miss P	CDC	Update to council tax records indicate the co-habitation between Miss P and Adult Z	
14/11/2008	GP Appointment	Adult B	NHS	Complaining of Cervicalgia (pain in neck). Reported being involved in a car accident in September, and had developed neck and thoracic back, shoulder and left arm pain.	GP recommended exercises for possible whiplash.
08/06/2009	Hospital Visit	Miss P	NHS	Attended A&E at St. Richards Hospital, in Chichester with foot injury. Seen in A&E at 07.55 with her partner (no name recorded but address recorded as same as the patient- History given was that Miss P had stubbed her toe on a guinea pig run the previous night	An examination revealed a small bruise over the proximal phalanx 2nd toe on the left foot. There was no wound swelling, a slight valgus deformity and tenderness of the 2nd toe of the left foot. An x- ray confirmed an undisplaced fracture of the middle phalanx 2nd toe left foot and a fracture clinic appointment was made for 15/6/2009.
15/06/2009	Hospital Visit	Miss P	NHS	Attended Fracture Clinic for strapping to injured toe	
08/12/2009	Enhanced CRB Check	Adult B	Sussex Police	Enhanced CRB check by Area 24/7 Chichester Borough Council	Nothing Disclosed
25/03/2010	Verbal argument between Miss P and her then partner Adult Z reported to police	Miss P	Sussex Police	As no offences committed no further police action taken	Domestic violence forms submitted. Of note on the DASH form it is indicated that there is no history of domestic abuse

24/05/2010	Hospital Visit	Miss P	NHS	Attended A&E at St Richards Hospital, Chichester with a small toe, left foot injury	Seen and discharged with no follow up treatment
14/09/2010	GP Appointment	Miss P	NHS	Complaining of feeling depressed. Miss P stated "feeling in low mood and very negative. Trouble sleeping." Health questionnaire completed – score 20.	Health questionnaire completed – score 20.GP comment - Catastrophising, similar problem in 2008. Recommence Anti- depressants and to consider Cognitive Behavioural Therapy.
04/10/2010	GP Appointment	Miss P	NHS	Feeling depressed, felt dizzy at work, has been working 70 hours per week.	Observations (pulse, breathing rate, blood pressure) normal. No oedema. Diagnosis: Anxiety Attack. Anti-depressants reduced and encouraged to have few days out.
19/10/2010	GP Appointment	Miss P	NHS	Miss P states feeling much better, sleep improved and feeling positive	Health questionnaire completed – score 4
14/02/2011	Enhanced CRB Check	Adult B	Sussex Police	Enhanced CRB check by Manpower UK 926	Nothing Disclosed. Senior Officer considered the allegation made by rape victim but did not disclose it due to it being historic, of a domestic nature and the victim not supporting the allegation.
08/06/2011	Fire and Rescue Service called to smell of burning at Miss P's home	Miss P	WSFRS	Fire service called to smell of burning.	Small fire caused by radiated heat from a chimney fire. No details of people present recorded.
22/06/2011	GP Appointment	Miss P	NHS	Presented tearful and low in mood. Complaining of being in low mood in the two weeks prior to her period. Keen to restart antidepressant citalopram. Continued post-coital and inter-menstrual bleeding.	Started 20mg citalopram. Referred to gynaecology department for their review.

22/07/2011	Miss P alleges rape by partner	Miss P	Statement	Miss P alleges to friend that she has been raped by her partner. Described as crying uncontrollably and has bruising on inner thighs. Insists that friend does not tell the police	Police not informed and no other agency alerted at this time.
14/11/2011	GP Appointment	Miss P	NHS	Complained of low mood and panic attacks, especially last 7-9 days. Stated had relationship problems. Had Breakdown of marriage 4 years ago. Had Counselling - beneficial. In another relationship which ended 12 months ago (partner drank); managed to stay in touch and saw him 9d ago when was unpleasant and touched her (discussed but Miss P no intention of reporting this). Since then, has been waking in the night and having panic attacks. Had argument with daughter which has made it worse. No hallucinations, no thoughts of suicide or self-harm.	Health questionnaire completed. Prescription for Citalopram continues. Referral made to Time to Talk.
21/11/2011	GP Appointment	Miss P	NHS	Accompanied by her former manager at workplace, Miss P still feeling low in mood, and having panic attacks. Has appointment with Time to Talk tomorrow. Requested sick note	Sick note issued for 1 week. To review in 2 weeks
02/12/2011	Out of Hours Doctor	Miss P	NHS	Complained of blood in vomit.	Discontinued Citalopram and commenced Diazepam.
03/12/2011	Time to Talk Service	Miss P	NHS	Attended Time to Talk appointment. Mental health service.	
05/12/2011	GP Appointment	Miss P	NHS	Reporting waking herself up with anxiety. Feels Diazepam is helping	Advised re high addictiveness of Diazepam, advised to only use as last resort.

01/01/2012	Miss P and Adult B start relationship	Miss P/ Adult B	Sussex Police	Miss P and Adult B start a relationship. Within a week of this he asks her to marry him	
12/01/2012	GP Appointment	Miss P	NHS	Complaining inter- menstrual bleeding for 3 months. Disclosed that she had been raped at work (previously discussed at appointment in Nov 2011). Already seeing Time 2 Talk and is awaiting additional counselling.	Prescribed the antidepressant sertraline and booked her into the well woman clinic.
20/01/2012	Miss P reports a rape by Adult Z to GP in Oct 2012	Miss P	Sussex Police	Not reported to police	
20/01/2012	GP Appointment	Miss P	NHS	Attended the Well woman clinic – Raped by Adult Z in Oct - intermittent brown discharge since. No pain; still has regular cycles. Thrush last week - improved with over the counter treatment. Normal smear in May 11.	Miss P was examined and swabs taken (subsequently found to be normal). A trans- vaginal Ultrasound was ordered to further investigate bleeding.
09/02/2012	Enhanced CRB Check	Adult B	Sussex Police	Enhanced CRB check by Transport Bureau	Nothing Disclosed. Senior Officer considered the allegation made by rape victim but did not disclose it due to the credibility of the victim, she did not support the allegation.
25/04/2012	GP Appointment	Miss P	NHS	Complaining of post- coital (after intercourse) bleeding. Also bleeding gums and weight loss. Miss P was worried she may have leukaemia.	Prescribed antibiotics for a dental infection and ordered blood tests (which were normal).
08/05/2012	Hospital Visit	Miss P	NHS	Attended A&E at St Richards Hospital, Chichester. Complaining of chest pain.	No abnormalities found, discharged same day, with GP follow up.

27/06/2012	Hospital referral	Miss P	NHS	GP referral received by Gynae team. Referral to team for inter-menstrual bleeding for last year. The letter also stated that Miss P had been raped by Adult Z in October 2011. Miss P had been screened for sexually transmitted infection following this.	
19/07/2012	Council tax records show Miss P becoming eligible for single occupancy discount	Miss P	CDC	Update to council tax records indicate the end of the relationship between Miss P and Adult Z	
20/07/2012	GP Appointment	Miss P	NHS	Miss P complaining of left rib pain	Examination undertaken and thought to be musculoskeletal in nature, due to coughing.
06/08/2012	GP Appointment	Miss P	NHS	Review of Anti-Depressants	Further citalopram (Anti- Depressants) prescribed following review and discussion

16/08/2012	Hospital Visit	Adult B	NHS	Adult B was brought into A&E at 03.16 by ambulance via a 999 call. It was reported that he had an episode of a loss of consciousness. The records indicate that Adult B had felt unwell but had no pain, went outside to get some air and then went to bed. His partner (who was not named) found him unresponsive and called an ambulance. When the crew attended, they found him face down on the bed, his partner reported that he was unresponsive but he responded to their voices. He sat himself up, but then kept laying himself back and holding his breath. The ambulance crew recorded that Adult B said he had a headache and shoulder pain. The ambulance crew commented on Adult B's "unusual behaviour".	Following attendance at A&E, observations (pulse, blood pressure, temperature) were recorded as within normal limits, and the plan was for blood tests to be taken. However Adult B left the department before he was seen by a Doctor.
23/08/2012	Hospital Visit	Miss P	NHS	Attended Gynaecological outpatient's clinic. Found to have multiple fibroids.	Booked for a hysterectomy on 5/11/2012 (Consequently, this procedure was cancelled and rebooked for the 19.11.2012)
31/10/2012	Miss P and Adult B relationship ends	Miss P/ Adult B	Sussex Police	Following a dispute over some jewellery belonging to Miss P, they split up. Adult B was supposed to pawn some jewellery for Miss P. He received £130 for it, he only gave her £120 keeping £10 back for him.	Relationship ends
06/11/2012	Alleged last sexual contact between Adult B and Miss P	Miss P/ Adult B	Sussex Police	Adult B states he last had sex with Miss P on 5th or 6th Nov after the cancelled hysterectomy	
09/11/2012	Adult B and Miss P split up	Miss P/ Adult B	Sussex Police	Adult B said that he and Miss P last had sexual contact in November 2012 and they split up on 07-09/11/2012.	

09/11/2012	GP Appointment	Miss P	NHS	Complaining of anxiety and low mood since relationship break-up.	Restarted citalopram and prescribed antibiotic (amoxicillin) for a chest infection.
19/11/2012	Hospital Visit	Miss P	NHS	Laparoscopic vaginal hysterectomy performed. Adult B arrived at the hospital despite not being told by Miss P of the date for the operation.	No complications. During this admission the nursing paperwork recorded the next of kin as her parents. A reference was also made to an initial of a name (redacted) as the contact to ring in an emergency and who was to collect her on discharge. This was then crossed out and her parents were down as the people who would collect her on discharge.
21/11/2012	Hospital Visit	Miss P	NHS	Discharged from hospital	
30/11/2012	Adults B's registration as a private hire driver lapses.	Adult B	CDC	Lapses due to no further application.	
27/12/2012	Adult B makes false allegations to Miss P employer re negligence and confidentially	Adult B	Sussex Police	Adult B made false allegations to Miss P employers alleging she had failed to answer a care call after a lady had had a heart attack as Miss P was drunk. He also claimed she was breaching confidentiality and data protection, by revealing information about patients.	Found to be malicious a fact that Adult B admitted to Miss P
27/12/2012	Adult B sends abusive texts to Miss P while she is away at her sisters	Adult B	Sussex Police	During the period from 27/12/2012 to 4/1/2013 Adult B sent abusive and threatening texts to Miss P. These do not appear to have been reported to police.	

21/01/2013	Miss P Returned to work after hysterectomy	Miss P	Statement	Miss P Returned to work after hysterectomy. Miss P told of emails from Adult B	Miss P asked to have time to think about them
22/01/2013	Miss P emails employer telling them of the harassment she has been experiencing by Adult B	Miss P	Sussex Police	Miss P sent an email to employer explaining the harassment she had been suffering and that she was going to seek an injunction against him with the help of her sister who was a lawyer	She did not mention the harassment or obtaining an injunction to her sister at all
24/01/2013	Adult B alleges that he last saw Miss P	Miss P/ Adult B	Sussex Police	Adult B said they met and he had last seen Miss P on 24/01/2013, Miss P had asked to see him about the email he had sent. After confirming he had sent it, he said he was hurt that they weren't together; he apologised and said he would send a retraction email which he states he did that night. He said they had a long cuddle and he left.	
27/01/2013	Adult B says he phoned Miss P	Miss P/ Adult B	Sussex Police	Adult B says that he spoke to Miss P on the phone and had a conversation about him emailing her work. They spoke about the fact that Miss P was alone, and they agreed to keep their relationship going secretly. Miss P invited Adult B round to see her allegedly but he says when he got there she was not in or wouldn't answer the door	
27/01/2013	Telephone calls by Miss P	Miss P	Sussex Police	Miss P makes many phone calls and sends texts regarding her concern about Adult B and the meeting she had the following day in London	

28/01/2013	Miss P found deceased by colleague	Miss P	Sussex Police		
26/04/2013	**Claim for Housing and Council Tax Benefit on Address retracted**	**Adult B**	**CDC**	**Unsuccessful due to him not responding to requests for further information**	