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Safer West Sussex Partnership

Domestic Homicide Review:

Adult A

(who died in December 2019)

Independent Chair & report author: Kevin Ball

Date: November 2022

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Personal statement from Adult A's mother

" 'A' was a beautiful, kind, loving, hardworking individual who brought joy and laughter to her family, friends and work colleagues. As a child and in adolescence, she worked hard at school and further education, getting part time work in retail with unsociable shifts to earn a little bit of money. She graduated to work within a profession that educated young children, a career path she always wanted to achieve and of which we were all so proud. She was at the pinnacle of her career when she tragically passed away.

"Her smile lit up the room and her laugh was infectious. Whenever she bid farewell to us whether it be out the front door, in the street, at the end of a telephone call, she would always say 'bye…love you!' I can still hear her say it, we all miss that and it breaks our hearts.

"She was very well known within her community and had lots of friends, she had such an aura of warmth and friendliness about her that you could not forget her. She loved everyone and everyone loved her, what was there NOT to love about 'A'

" 'A' took every chance to enjoy herself and get the most out of life, always wanted to get married and have the opportunity to have children of her own. She was committed to her profession and always quoted the phrase 'the more you put in, the more you get out' it was a phrase her secondary school head teacher always quoted and she never forgot it, she was a very much respected and inspirational member of staff. 'A' has been devastatingly missed by colleagues, children and parents alike.

"Nothing ever prepares you for the loss of a child, whatever the age and is something our family will never overcome, especially in such brutal circumstances.

"After working closely with the Independent Chair for Safer West Sussex Partnership for this DHR, who has been tactfully respectful throughout towards us, in generating this report, I feel there is nothing more that could have been done to prevent this tragedy but welcome the recommendations that have been made that could, in future, prevent a family from going through the same awful atrocity."

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1. Introduction to the case under review

1.1. This Domestic Homicide Review examines the contact and involvement of local professionals and organisations with Adult A, who died in December 2019. Adult A, aged 32 years old, died as a direct result of injuries suffered outside her home having been assaulted by her husband, Adult B. Another adult, who will be known as Adult C, who was passing by at the time of the incident and who tried to intervene was also assaulted by Adult B and tragically died as a result of being attacked and injuries suffered. Adult A and Adult B had been in a relationship for 10 years and had been married for 12 months; both were of white British origin and ethnicity. Following the assault, the Police conducted an investigation and the matter went to criminal court. Adult B accepted responsibility for the murder of Adult A and also the individual that tried to intervene. The outcome of the trial was that Adult B was found guilty of double murder and was subsequently sentenced to 26½ years in prison.

1.2. The Domestic Violence, Crime & Victims Act 2004 sets out the circumstances when a Domestic Homicide Review should be considered referring to the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by a) a person to whom he/she was related or with whom he/she had been in an intimate personal relationship, or b) a member of the same household as himself/herself. Using these criteria, the Safer West Sussex Partnership determined in July 2020, that a review should be completed. Based on statutory guidance (pdf), the purpose of any Domestic Homicide Review 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 inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

1.3. Domestic Homicide Reviews are not inquiries into how a person died or who was responsible for the death; those are matters for Coroners and criminal Courts respectively to determine. This review will solely examine issues relating to Adult A and Adult B, but not the circumstances of the individual that was passing by and tried to intervene.

1.4. The Safer West Sussex Partnership and the Independent Chair would like to offer their formal condolences to Adult A's family, as well as the family of Adult C who was also tragically murdered.

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2. Methodology for conducting this review, including terms of reference & contributors to the review

2.1. Following the decision in June 2020 to commence a Domestic Homicide Review the following steps were taken;

a) *Requests for information about any contact or involvement with Adult A and Adult B were made to the following agencies;*

- Surrey & Sussex NHS Healthcare Trust
- Brighton & Sussex University Hospitals NHS Trust (Princess Royal Hospital)
- Integrated Care 24 (out of Hours GP Services)
- Western Sussex Hospitals NHS Foundation Trust
- Sussex Community NHS Trust
- Sussex Partnership NHS Foundation Trust
- South East Coast Ambulance NHS Service Foundation Trust
- Sussex NHS Commissioners
- West Sussex County Council: Adult Services, Children's Services, Fire & Rescue services
- Change Grow Live – Substance Misuse Services
- Mid Sussex District Council
- Kent, Surrey & Sussex Probation Services
- Sussex Police
- National Probation Service
- Services for those experiencing domestic abuse in Sussex: Safe in Sussex and My Sister's House

b) The Chair of the Safer West Sussex Partnership appointed Kevin Ball as the Independent Chair and report author for this Domestic Homicide Review. He is an experienced Chair and report author, notably of cases involving the harm or death of children, but also more recently Domestic Homicide Reviews. He has a background in social work, and over 30 years of experience working across children's services ranging from statutory social work and management (operational & strategic) to inspection, Government Adviser, NSPCC Consultant and independent consultant; having worked for a local authority, regulatory body, central Government and the NSPCC. Over his career, he has acquired a body of knowledge about domestic abuse through direct case work, case reviews and audit, and research and training, which supports his work as a Chair and reviewer of Domestic Homicide Reviews. During his career, he has worked in a multi-agency and partnership context and has a thorough understanding about the expectations, challenges and strengths of working across complex multi-agency systems in the field of public protection. In the last 10 years he has specifically focused on supporting statutory partnerships identify learning from critical or serious incidents and consider improvement action. He has contributed to the production of Quality Markers for Serious Case Reviews, developed by the Social Care Institute for Excellence & the NSPCC – which are directly transferable and applicable to the conduct of Domestic Homicide Reviews. He has completed the Home Office on-line training for Domestic Homicide Reviews and the Chair training course provided by Advocacy after Fatal Domestic Abuse (AAFDA). He has no association with any agencies involved and is not a member of the Safer West Sussex Partnership. He held the role of interim Head of Safeguarding for West Sussex County Council Children's Services until November 2018 before becoming a fully independent Consultant. There is no conflict of interest.

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c) In August 2020 an initial scoping discussion was held involving the Chair, the Violence Reduction Unit Lead for West Sussex County Council, the Police Senior Investigating Officer and the Family Liaison Officer to assist the Chair gain a better understanding about the situation relating to the Police investigation.

d) Also, in August 2020 an initial Review Panel meeting was convened in order to provide oversight and scrutiny to the process, agree the Terms of Reference, offer relevant expertise and ensure the smooth and timely conclusion of the review. Further meetings were scheduled as necessary, however given the findings from the initial information requests being extremely limited, the timing of the criminal trial and sentencing hearing, a second Review Panel meeting did not take place until March 2021.

e) Following the initial Review Panel meeting in August 2020 the Chair contacted Adult A's family to explain the purpose of the review and what it hoped to achieve, as well as seek their contributions. Contact with Adult B's parents was intentionally delayed given the ongoing criminal investigation and Court process. Contact with Adult B was also delayed, initially given the Police investigation and the need for his mental health to stabilise, but then waiting for the Court process to fully conclude. Face to face contact was not possible due to the Covid-19 restrictions in place and throughout the whole of the time that the Court process was underway.

f) Statements taken by the Police and used in their investigation have been reviewed by the Chair. Expert reports commissioned as part of the Police investigation and trial have also been reviewed.

g) The final report was presented to the Safer West Sussex Partnership in June 2021. As such, the review process took 11 months to complete from the point a decision was made to complete a review. Factors that contributed to the review taking this time to complete included the need to wait for the conclusion of the Police investigation and court process, and then the Chair making more meaningful contact with members of Adult A's family and Adult B's family – all of which took place during the Covid-19 pandemic and associated restrictions.

h) The content of the overview report and executive summary have been anonymised in order to protect the identity of the victims, perpetrator, relevant family members, and others, and in order to comply with the Data Protection Act 1998. In order to secure agreement, pre-publication drafts of this overview report were seen by the membership of the review panel, and the Safer West Sussex Partnership Executive Board.

i) The report was shared with the Home Office Quality Assurance Group in September 2021. Comments back from the Home Office were received in March 2022, and which were responded to, with a revised draft being submitted back to the Home Office in May 2022. Further correspondence from the Home Office was received in October 2022 highlighting new issues they wished to be covered, not previously highlighted in their earlier correspondence. This resulted in a further revised draft being submitted to the Home Office by their deadline of January 2023. Approval for publication was granted by the Home Office on the 1 February 2022. The Executive Summary and Overview Report will be disseminated to the following:

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- Victims' relatives
- Domestic Homicide Review Panel
- Safer West Sussex Partnership Board
- Children and Adult Safeguarding Boards
- Health and Wellbeing Board
- Domestic Abuse Commissioner
- Sussex Office of the Police and Crime Commissioner Head of Commissioning

j) Adult A's family received support from a Family Liaison Officer, and also independent support from the Victim Support Homicide Service (an independent charity that provides support to anyone affected by a crime) during the Police investigation and subsequent trial; they did not have an advocate however have gone on to receive specialist counselling. Adult B's family received support from a Family Liaison Officer. Adult A's family were kept apprised of comments received from the Home Office and the process up to the point of publication.

2.2. The following Terms of Reference were agreed by the Review Panel. Given the initial requests to agencies and organisations provided very limited information the Terms of Reference inevitably reflected this, and as such were limited to the following issues;

1. Any agency's involvement with the Adult A and Adult B from December 2014 to December 2019.

2. Any concerns or issues regarding the ethnic, cultural, linguistic and religious identity and whether any special needs were explored, shared appropriately and recorded.

3. Any concerns amongst family / friends / colleagues or within the community and if so, how such concerns might have been harnessed to enable intervention and support.

2.3. The review has kept in mind the nine protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). With the exception of sex, and gender, each of these has been considered and discounted as not being relevant to the case under review. The characteristic of sex has not been discounted given the researched evidence of women being the greater victims of violent crime caused by men[1], and being the greater victims of homicide.

2.4. Given the extremely limited information that was returned from the request to the above agencies, conducting a proportionate review was an important consideration for the Safer West Sussex Partnership. As such, no Individual Management Reports were requested. The following agencies came together to form a Review Panel in order to assist the Chair as well as bring relevant expertise to the process;

[1] Thiara, R., & Radford, L., Working with domestic violence and abuse across the lifecourse: Understanding good practice, 2021, Jessica Kingsley.

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Membership of the Review Panel

Name	Agency	Role
Kevin Ball	Independent Consultant	Independent Chair & report author
Emma Fawell	West Sussex County Council, Communities Directorate	Violence Reduction Unit Lead & representing Safer West Sussex Partnership
Jane Wooderson	Sussex Police,	Detective Sergeant, Strategic Safeguarding Team
Gill Field	Clinical Commissioning Group	Designated Nurse Safeguarding Adults
Mandy Cunningham	Mid Sussex District Council	Community Safety & Safeguarding Manager
Bryan Lynch	Sussex Partnership NHS Foundation Trust	Director of Social Work
Philippa Gibson	West Sussex County Council Public Health	Senior Commissioning Manager: Substance Misuse Services
Rachel Tandy	West Sussex County Council	Service Manager for Early Help for Integrated Front Door and Domestic abuse and Sexual Violence

3. Family contribution to the review

3.1. Seeking the contributions of family members has been an important consideration for this review. As noted above, Adult A's mother, as the agreed and designated family representative, was informed of the review and reasonable efforts were made by the Chair to keep her informed about the progress of the review but also seek her contributions. The impact of Adult A's murder on the family has been catastrophic and devastating. Their contributions to the review have been at a time when they have had to deal with their grief alongside the investigations and Court process – all during periods of a national lockdown due to Covid-19 which has brought its own unique pressures and challenges; the Chair is extremely grateful for their thoughts during a difficult period of time. Adult A's family wished for the term Adult A to be used to describe the deceased. Having reviewed this report and agreed with its contents, Adult A's mother is in total agreement with the recommendations.

3.2. Information from the Police investigation was used to assist the Chair assess whether friends and other non-professional contacts, might be able to assist the review. Based on the extensive information gathered by the Police from friends and work colleagues during the course of their investigations, (which were reviewed by the Chair via witness statements) the Independent Chair did not consider it necessary to explore these networks further.

3.3. Efforts were made by the Chair to engage Adult B and seek his contributions once the Court process had concluded. Adult B, via his Probation Officer, actively declined the offer to contribute to the review citing continued stress and emotion about what had happened. Adult B did however provide consent for his parents to be approached by the Independent Chair to hear of any contributions they may have. The Chair spoke with Adult B's parents, who also expressed a deep sadness and loss about what had happened. They were aware that Adult B was experiencing some degree of stress but were unaware about the extent of it, and certainly did not think it would result in him fatally assaulting other people. Having reviewed this report and agreed with its contents, they have expressed complete support for the recommendation made, knowing that Adult B had not sought any help or support and that had he done so, it may have prevented events.

3.4. The family members of the other adult murdered, Adult C, were informed of the review taking place. As the focus of the review does not relate to this additional murder because there was no intimate personal relationship and were not related, and they were not living together, they have not been invited to contribute, although the relevant sections of the report were shared with the family prior to publication. However, it is acknowledged that their murder has been an equally tragic and senseless loss to the family, and the devastation caused by their murder should not go unrecognised.

4. Summary of relevant case history

4.1. Given the lack of involvement by both Adult A and Adult B with statutory services there was an absence of information to form a chronology as might be expected; as such, no Individual Management Reports were requested, and no chronology has been provided given there was no information to build on.

4.2. Initial information gathered as part of the Police investigation indicated that there were no known, or knowable, factors which might have precipitated Adult B's behaviour resulting in him carrying out any assault. Adult B was experiencing some recent work-related stress managing his own business with a business partner, which appears to have resulted in some very recent reflective discussions between one another, however these were not viewed to be at a level that was impairing his thought, judgement or behaviour.

4.3. The evening before the assault, Adult B went out with some friends and his behaviour on returning home caused Adult A such concern that she contacted Adult B's father, who travelled to the family home to see if he could assist. Adult B went to bed after a long discussion with his father, and his father then returned to his own home. The following morning Adult B's parents remained concerned about him having spoken to him on the phone that morning; they decided to travel over to the family home to see him. Prior to their arrival neighbours reported shouting and seeing both Adult A and Adult B in the road. By the time Adult B's parents arrived Adult B had assaulted Adult A and she had died. A member of the public, who tried to assist Adult A during the assault also tragically died as a result of an attack by Adult B.

4.4. Accounts provided by family, friends and colleagues were that Adult A and Adult B were a happy, loving couple having been in a long-term relationship and recently married. Both were white British. They had known each other as children and their respective families had known one another for many years. Adult A was a 32-year-old professional woman, described as very popular and well-liked by all her work colleagues. She had never disclosed any worries about her relationship with Adult B. Adult B, at 37 years old, has been described as a well-liked and a successful self-employed businessman who was devoted to Adult A; he has also been described as a private person that liked to be in control of decisions. Neither Adult A or Adult B had any children.

4.5. As a result of further investigations by the Police it was ascertained that Adult B had traces of new psychoactive substance in his system. This was a complicating factor in the trial, in that there was a possibility that the traces originated from prescribed drugs used after the incident whilst receiving treatment and care; it is therefore not possible to confirm conclusively that they were a contributory factor to Adult B's behaviour, especially as Adult B consistently denied using any substances other than using magic mushrooms in 2002 when abroad.

5. Findings & analysis

Information known to agencies and professionals

5.1. Information returned from agencies has highlighted a total lack of contact with services, other than routine contact with GP services. This is not an unusual situation and the lack of contact with agencies should not necessarily be viewed as problematic. Review of information provided by the GP service for both Adult A and Adult B, going back to childhood, does not highlight any factors or health issues which would raise concerns or which would be of interest to this review, for example there is no history of mental health difficulties, drug or alcohol misuse, family or relationship worries. The lack of any identified contact by Adult A or Adult B with any agency led to the decision not to request the production of Individual Management Reviews. Whilst it has been important to adopt an evidence led approach in this case, the review has remained open and curious about the possibility of abuse and Adult A being in an abusive and controlling relationship, given the known statistics about females being the greater victims of homicides.

5.2. Psychiatric assessment reports undertaken during the Police investigation have been reviewed by the Chair. There is no information whatsoever to suggest any previous harm or abuse between Adult A or Adult B. Information gathered by experts confirms some work-related stress, but no other stress or complicating factors. Information gathered points to Adult B experiencing an acute episode of mental illness at the time of the incident.

Any concerns or issues regarding the ethnic, cultural, linguistic and religious identity and whether any special needs were explored, shared appropriately and recorded.

5.3. No information has been provided as a result of contact with agencies, family, friends and work colleagues to suggest any relationship disharmony or dysfunction; in fact, the opposite view has been consistently provided and this has been confirmed via the statements taken by the Police during their investigations. No issues relating to ethnic, cultural, linguistic or religious identity of Adult A or Adult B, nor any special needs have been identified as contributory factors or which would have needed to be considered by agencies and professionals.

Any concerns amongst family / friends / colleagues or within the community and if so, how such concerns might have been harnessed to enable intervention and support.

5.4. There is no evidence or information that there were any relationship difficulties or domestic abuse between Adult A and Adult B.

5.5. Police statements taken during the investigation have been reviewed by the Chair. These included statements from friends and work colleagues to both Adult A and Adult B. Many of the statements taken were from very long-standing friends, who maintained regular contact with both Adult A and Adult B. Without exception, all conveyed a positive description of each, a very positive image of their relationship and provided no information that would indicate any marital difficulty or relationship problems.

5.6. Adult A's workplace did not have a specific policy or support mechanism in place should she have wished to access advice or support had she been experiencing domestic abuse. They did however (and still do) have access to Worth Services (specialist domestic abuse service in West Sussex), who provide support and advice to employees. Other services are also available such as Safe in Sussex, My Sister's House, and Victim Support[2]. In addition to this Adult A's workplace had/have free access to a confidential counselling support service, which anyone at the workplace could access, and the management of the workplace did operate an 'open door' policy, meaning that any staff could share any concerns (personal or professional) if they wished to. The particular circumstances of Adult A's workplace also meant that they were/are very well placed to understand the dynamics and difficulties for victims of abuse to disclose abuse and seek support. It has highlighted the importance for all colleagues, irrespective of work setting, to remain open and curious about the likelihood of relationship difficulties which may become abusive and mindful about the need for support. Specific training on the matter has been provided by Adult A's workplace. Had any evidence of domestic abuse been found, it would be reasonable for this review to consider making a specific recommendation to support the implementation of such a policy/mechanism in the workplace. Also, had Adult A made an approach to anyone at her work place seeking support, again, this would add more weight justifying a recommendation. However, neither situation was the case, and therefore making a recommendation about this issue might seem disproportionate and would have no evidential basis. As a result of this event, and the shock it caused, Adult A's workplace have now implemented a Wellbeing Policy, which provides wider personal support to staff, if needed in addition to the existing offer. These steps taken reflect the expectations set out in paragraphs 402-412 of recently issued statutory guidance about the duty of care employers have towards their workforce. In remaining open to the possibility of abuse, this review is minded to make recommendations on a wider basis for the Home Office, the Domestic Abuse Commissioner's Office and the Safer West Sussex Partnership on this matter.

5.7. Both Adult A and Adult B's phones and digital media/computers were downloaded and reviewed in detail by the Police. There was no evidence of any problems between the couple, searches for help or support or suspicious incidents. All of the contact between the couple was extremely loving.

5.8. Adult B had been experiencing some stress though work related issues, mostly related to the constant pressures of running his own business with a business partner. Review of the Police statement taken indicates no greater outward expression of stress than might be considered normal when responsible for running a small business and working in partnership with another person. Whilst individually, we all have different thresholds at which stress may impair our thinking or functioning our responses are usually not extreme; it is therefore difficult to consider work related stress as a contributory factor to Adult B's actions.

[2] Other specialist domestic abuse services are available in West Sussex in addition to the three named above, and include: Paragon Sussex (The You Trust), Hourglass, Hersana, Age Counselling Services and Veritas Stalking Advocacy Service.

5.9. In this case the finding of traces of a new psychoactive substance in Adult B's system was a complicating factor. As noted, there was a high possibility that these traces originate from prescribed and legitimately used drugs on Adult B whilst receiving care and treatment after the murders took place. Adult B consistently denied using any substances prior to events in December 2019, admitting to having tried magic mushrooms once when younger in 2002. Whilst not impacting on his relationship with Adult A, or his more recent behaviours, it does serve as a reminder about the risks and unpredictable effects of misusing drugs. Prior to this, Adult B had no recorded history of emotional or mental health problems to the extent that they were seen to impair his thinking, behaviour or judgement. It is evident that Adult B did not seek any professional support for the work-related stress he reported to be experiencing.

5.10. Societal expectations and gender stereotyping has influenced the way in which the emotional and mental health of men has been viewed, often resulting in issues and difficulties being undiagnosed, remaining hidden and support not being sought. (These issues can be explored on Mind's website and the Mental Health Foundation website). In situations where emotional and mental stress may be affecting any individual (regardless of gender) it is important that all individuals are encouraged to seek support. In practical terms, and in this case, support is most likely to have been sourced via a GP or local counselling service (most likely privately funded given the reported level of stress being experienced).

5.11. Domestic Homicide Reviews pre-suppose the presence of some degree of domestic abuse within an intimate relationship; there is no evidence or information to support a view that domestic abuse, in any form, was present in the relationship between Adult A and Adult B. Inevitably, this limits the learning that can be gained from conducting a review. The view of expert opinion in the trial concluded that Adult B had experienced some form of abnormal and acute mental state, in the form of a hypomanic episode, which as a consequence resulted in him killing two people.

6. Lessons to be learnt

6.1. Based on the circumstances of this case, the complete absence of evidenced contact or involvement with agencies by either Adult A or Adult B, and the outcome of the Court process it can only be concluded that Adult B's extreme behaviour and the assault of Adult A could not have been predicted. Whilst stress may have been a contributing factor to Adult B's emotional state, the Court has determined that Adult B was under the influence of a new psychoactive substance at the time of the murders. Although not the purpose of a Domestic Homicide Review to comment on preventability, given that there was no previous history of emotional or mental health difficulties with either adult, no previous history of taking Class A drugs nor any drug use in the family home, it is reasonable to conclude that no steps could have been taken any earlier, by anyone individually or by an agency, to act preventatively; whether those preventative steps be from an early intervention perspective with Adult B seeking, for example counselling support or more interventionist such as Adult B seeking support from a GP.

6.2. As such, using an evidence led approach, there are no lessons for this review to highlight which relate to the actions taken by any individual agency or professional. As a consequence of this, no recommendations have been made for any single agency.

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6.3. There are however three general public health messages to promote via all agencies, all professionals as well as the general public. These are:

a) *Emotional and mental health and everyday living: encouraging anyone who may be feeling or experiencing some level of emotional or mental stress, to talk about their worries, consider diet and exercise, and seek specialist support if needed. The national charity MIND has useful webpages as a starting point.*

b) *Drug use and mental health: raising awareness about the unpredictable impact on mood or behaviour of misusing drugs and/or alcohol, or using drugs on a recreational basis, and discouraging anyone who may be experiencing any form of emotional or mental health stress from misusing such substances. The national charity MIND has useful webpages as a starting point.*

c) *All employers, work colleagues, friends and family need to remain open and curious about the possibility of domestic abuse and controlling relationships.*

7. Conclusion

7.1. Adult A was murdered in 2019 having been assaulted by her husband outside the family home. A second unrelated passer-by was also murdered following attempts to come to Adult A's aid. Both murders have shattered the lives of each family involved. This Domestic Homicide Review was commissioned in order to establish what lessons might be learnt in the way which local professionals and agencies work individually and together to safeguard victims, as well as consider any learning regarding preventability.

7.2. Despite a thorough and systematic process of trying to gain information, access to material generated by the Police and Court process, this review has not been provided with any information which has highlighted any lessons to be learnt by local agencies, or any steps that could have been taken to prevent Adult A's murder (and by implication, the murder of a local passer-by). There was no evidence of a domestically abusive relationship between Adult A and Adult B. Adult B accepted responsibility for Adult A's murder; the outcome of a criminal trial concluded that Adult B was found guilty of double murder.

7.3. The Chair would like to thank members of both Adult A and Adult B's family for their contributions to this review and once again, re-emphasises his condolences to family members.

8. Recommendations

8.1. The following recommendations are made for the Home Office and Domestic Abuse Commissioner's Office as well as the Safer West Sussex Partnership:

1. The Home Office & the Domestic Abuse Commissioner's Office should ensure that all employers are made aware of the Domestic Abuse Act 2021 guidance and employers responsibilities laid out within this. Employers should be directed to the Employers' Initiative for Domestic Abuse (EIDA), a business network which empowers employers to take action against domestic abuse, for their staff, and their sector.

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2. The Home Office & the Domestic Abuse Commissioner's Office should ensure that all employers should be referred to the Public Health England & Business In The Community Domestic Abuse Employer Toolkit. This toolkit helps employers of all sizes and sectors make a commitment to respond to the risk of domestic abuse and build an approach that ensures all employees feel supported and empowered by their workplace to deal with domestic abuse.

3. The Safer West Sussex Partnership should work with relevant agencies and other strategic partnerships to examine methods for reaching into local communities and that encourage adults (particularly adult males) to seek support about emotional or mental health worries.

4. The Safer West Sussex Partnership should ensure that West Sussex local businesses are in receipt of information regarding their responsibilities as employers as laid out within the Domestic Abuse Statutory Guidance 2021 and referred to the Public Health England & Business In The Community Domestic Abuse Employer Toolkit.

5. The Safer West Sussex Partnership will ensure all that its Board Member organisations review whether they have domestic abuse policies in place and ensure employees are made aware of these policies and are aware of domestic abuse resources and pathways of support.