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Safer West Sussex Partnership

Domestic Homicide Review

Executive summary

Under section 9 of the Domestic Violence, Crime & Victims Act 2004 into the death of:

Laura (who died in April 2011)

Given the inextricable links to the death of Laura, this report also considers the death of Rachel (who died in March 2006), conducted as a discretionary review prior to the requirement to conduct Domestic Homicide Reviews.

(All names used in this report are pseudonyms in order to protect the identity of the victims & their families)

Independent Chair & report author: Kevin Ball

Date: Final version of executive summary – May 2022

1. The Review process:

1.1. This summary outlines the process undertaken by the Safer West Sussex Partnership Domestic Homicide Review Panel in reviewing the homicide of Laura in April 2011, who was a resident in their area, and aged 52 years. This review was conducted under section 9 of the Domestic Violence, Crime & Victims Act 2004. Given the inextricable links, a discretionary review has also been conducted into the death of Rachel, who died in March 2006 aged 35 years, prior to the requirement under section 9 of the Act, to conduct such reviews.

1.2. In order to protect the identity of their families, the following pseudonyms have been in used in this review for the victim – Laura, who died in April 2011, and Rachel who died in March 2006. For the purposes of this review, the perpetrator will be known as David. Both victims, and the perpetrator were of white, British ethnicity.

1.3. The findings of a post mortem concluded that Laura's death was consistent with smothering, the toxic effects of alcohol, ischaemic heart disease and emphysema. A Sussex Police investigation and an Inquest (November 2011) found, and ruled, that she had died from accidental causes, and there was no prosecution. However, following a lengthy campaign by Laura's family, a re-investigation by Sussex Police was relaunched in 2016 and a further independent pathology review completed, both of which ultimately led to a conviction. David, aged 43 years, was convicted of Laura's murder in April 2017. David was also convicted of manslaughter at the same trial, having also been found guilty of killing another former partner five years prior to Laura's death, in March 2006. The findings of the post mortem conducted on Rachel at the time in 2006, concluded that she too had died of natural causes whilst asleep when with David; at the time, this conclusion was also accepted.

1.4. In light of these re-investigations and convictions, in 2018 HM Coroner for West Sussex applied to the High Court in 2020 for an Order under section 13 of the Coroners Act 1988 to quash the original Inquest verdict of accidental death for Laura and substitute a fresh conclusion of unlawful killing. The Coroner intended for a short Hearing in order to achieve this, however this was opposed by Laura's family, who sought a wider Inquest into the circumstances of Laura's death, especially an investigation into whether the circumstances involved breaches by Sussex Police of duties imposed by Article 2 of the European Convention on Human Rights (ECHR). These breaches were claimed to have arisen in relation to events just before Laura's death, but also an investigation by Sussex Police into Rachel's death, five years earlier in March 2006, which was also treated as non-suspicious at the time. Following further legal arguments and then judicial review in October 2020 about whether an Article 2[1] compliant Inquest should take place, Laura's family's request for a full Inquest was granted. This Inquest subsequently took place in July 2021 resulting in a verdict of the unlawful killing of Laura. An earlier Inquest held in February 2018 into the death of Rachel in 2006 also resulted in a verdict of unlawful killing.

1.5. Laura died five days after multi-agency statutory guidance for the conduct of Domestic Homicide Reviews (pdf) came into force in April 2011, requiring a Domestic Homicide Review to be conducted under the Domestic Violence, Crime & Victims Act 2004. Rachel's death

[1] Crown Prosecution Service: 'Article 2 inquests are enhanced inquests held in cases where the State or 'its agents' have 'failed to protect the deceased against a human threat or other risk' or where there has been a death in custody. Cases where the deceased has been under the care or responsibility of social services or healthcare professionals are also often included in this category of inquest'.

occurred in 2006 and therefore happened before the requirement to conduct such a review. At the point that David was found guilty of Laura's murder and Rachel's manslaughter in April 2017, the Safer West Sussex Partnership determined that a Domestic Homicide Review should be conducted in respect of Laura under the new statutory guidance that has just come into force. Given David's involvement with both women, a decision was also made that a discretionary review into agency contact with Rachel should also be undertaken. Given the inextricable links of both women being victims of crimes committed by David and losing their lives, this decision made complete sense.

2. Contributors to the review:

2.1. All agencies that potentially had contact with both victims and the perpetrator prior to the point of death were contacted in August 2017, and asked to confirm whether they had involvement with them. A total of 15 agencies or services were contacted, with nine being asked to secure their records, and make further contributions to the review.

2.2. In respect of Laura, the following agencies were asked to submit Individual Management Reports (IMRs):

- NHS Coastal West Sussex Clinical Commissioning Group: Which reviewed the contact Laura and David had with GPs'. In Laura's case, this was only between January and April 2011 as earlier notes were not available.
- Sussex Partnership NHS Foundation Trust: Which was responsible for assessing David's mental health on a number of occasions between April 2009 and November 2016.
- Sussex Police: Which investigated the deaths of Laura and Rachel and responded to a number of incidents involving David and a number of women with whom he was friends or in a relationship, including Laura.
- Turning Tides (previously Worthing Churches Homeless Project): Which provided accommodation and support for both Laura (in 2010) and David 2009 and 2016.
- Adur & Worthing Councils: Whose housing department had contact with David (from 2004 to 2017) and whose benefits department had contact with Laura (one contact in 2011).
- University Hospitals Sussex NHS Foundation Trust: Responsible for providing Hospital services which Laura attended.

2.3. In respect of Rachel, the following agencies were asked to submit Individual Management Reports:

- NHS Coastal West Sussex Clinical Commissioning Group: Which reviewed the contact Rachel had had with GPs' during the period under review. In David's case, it has not been possible to access notes for this period.
- Sussex Police: Which investigated the deaths of Rachel and Laura and responded to a number of incidents involving David and a number of women with whom he was friends or in a relationship, including Rachel.
- Adur & Worthing Councils: Whose housing department had contact with David (from 2004 to 2017) and whose benefits department had contact with Rachel (one contact in 2002).

2.4. Authors that contributed to these IMRs were independent of having any direct case management role or responsibility.

2.5. Members of both Laura and Rachel's families have contributed to this review at various times since it began. More recently, both families have been offered the opportunity to

contribute and see the final report. The Chair reminded Laura's family of the pseudonym that was to be used, Laura; they expressed a clear view that they did not wish for this name to be used and did not recall it being agreed originally in 2017 – instead they wished for their daughter's real name to be used. The Chair, at the time of the meeting, advised that this was not in accordance with statutory guidance and the need for anonymisation. The family representative for Rachel's family was satisfied with the pseudonym being used.

3. The Review Panel members:

3.1. The Review Panel was established in October 2017. Membership is set out below in Table 1. The Review Panel was established to support the requirements as set out in statutory guidance in respect of the duty to conduct a DHR which examined Laura's death, but also the discretionary review into Rachel's death.

Table 1: Membership of the original Review Panel established in October 2017

Agency	Name	Role
Independent Chair	Arthur Wing	Original Independent Chair
Coastal West Sussex Clinical Commissioning Group	Alex Morris	Designated Nurse, Safeguarding Adults
National Probation Service	Mark Burden	Senior Operations Support Manager SEE Division – Sussex Local Delivery Unit
Safe in Sussex (previously Worthing Women's Aid)	Sharon Howard	Chief Executive Officer
Sussex Partnership NHS Foundation Trust	Marian Trendell	Deputy Director Social Work - Principal Social Worker
Sussex Police	Jane Wooderson	Detective Sergeant, Safeguarding Reviews, Strategic Safeguarding Team, Public Protection
West Sussex County Council	Philippa Gibson	Senior Commissioning Manager, Substance Misuse
West Sussex County Council	Emily King	Principal Manager: Community Safety & Wellbeing

3.2. Members of the Review Panel were independent of having any direct case management role or responsibility.

3.3. Due to the process of seeking a judicial review, and then the actual judicial review in October 2020, plus the scheduling of a new Inquest in July 2021, the DHR was paused pending the outcome of both parallel processes. This pause lasted until October 2021. At this point the Review Panel reconvened, after some considerable pause; invariably, membership had changed, and the revised membership is set out below in Table 2.

Table 2: Membership of the Review Panel established in 2021/2022

Agency	Name	Role
Independent Chair	Kevin Ball	Independent Chair & author
West Sussex County Council	Emma Fawell	Violence Reduction Unit Lead
Sussex Police	Jane Wooderson	Detective Inspector, Safeguarding Reviews, Strategic Safeguarding Team, Public Protection
West Sussex County Council	Philippa Gibson	Senior Commissioning Manager, Substance Misuse
Sussex Partnership NHS Foundation Trust	Bryan Lynch	Director Social Work
NHS West Sussex CCG	Alex Morris	Assistant Head of Safeguarding: Designated Nurse
West Sussex County Council	Russell Hite	Adult Safeguarding Service Manager
Safe in Sussex (domestic abuse support charity)	Sharon Howard	Chief Executive Officer
The Probation Service	Lee Whitmore	Head of West Sussex Probation Service
Turning Tides	Niall Read	Head of Operations
University Hospitals Sussex NHS Foundation Trust	Monique Devlin/ Frank Ungani	Safeguarding Adults Nurse Specialist/ Trust Senior Lead for Adult Safeguarding Worthing, St Richard's and Southlands Hospitals

4. Author of the overview report:

4.1. An Independent Chair was appointed in September 2017. This Independent Chair, Arthur Wing, had worked for the Probation Service until 2011 but had not worked for the agencies involved during the periods of their involvement. He had experience of partnership working in relation to community safety and domestic abuse and had chaired Serious Case Reviews under the Multi-Agency Public Protection Arrangements. He had also completed the Home Office on-line training for Independent Chairs of Domestic Homicide Reviews.

4.2. Due to the considerable pause in the review process, the original Independent Chair had retired and the Safer West Sussex Partnership decided that a fresh look at information submitted, as well as a review of the process to date, would be beneficial; this would also include a revised approach to reporting. As such, 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 has been no conflict of interest.

5. Terms of Reference for the review:

5.1. In relation to Laura's death in 2011, it was recognised that as a significant amount of time had elapsed, there could be difficulties in obtaining all the relevant information and also that many single agency and multi-agency processes had changed over the intervening years. The review considered work carried out between February 2010, when Laura was first known to have had a relevant contact with agencies and April 2011 when she died.

5.2. Similarly, in relation to Rachel's death in 2006, it was also recognised that an even greater amount of time had passed and which would likely cause difficulties obtaining information. The review considered work carried out between 2005, when Rachel is understood to have first met David, and March 2006 when she died.

5.3. The original Terms of Reference set by the Review Panel in 2017 established some key lines of inquiry. As a result, agencies providing Individual Management Reviews at that time were asked to consider the following:

1. Whether an improvement in communication between services might have led to a different outcome.
2. Whether the work undertaken by services was consistent with each organisation's professional standards, domestic violence policy, procedures and protocols, and in light of the features of these cases, whether the organisation's policy, procedures and protocols adequately address stalking and harassment.
3. The response of the relevant agencies to any referrals concerning domestic violence, stalking and harassment or other significant harm; to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:
    a. Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.
    b. Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
    c. Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
    d. The quality of the risk assessments undertaken by each agency.
    e. The assessment and management of any risk that David posed to children.

4. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.
5. Whether thresholds for intervention were appropriately calibrated, and applied correctly.
6. Whether practices by all agencies were sensitive to the sex, disability, ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either adult were explored, shared appropriately and recorded.
7. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.
8. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
9. Were there any concerns amongst family / friends / colleagues or within the community and if so, how could such concerns have been harnessed to enable intervention and support?

5.4. In 2021 refreshed terms of reference were agreed, given the emergence of revised information and evidence presented at the Article 2 Inquest. These revised terms of reference have, in no way undermined or replaced those originally set, but were agreed as a way to move the review forward, and to a conclusion. These consist of:

1. To produce one overview DHR that combines learning in relation to the two identified victims, but which considers other information pertaining to other victims of domestic abuse by the perpetrator. The primary victim will be Laura, given the requirement to conduct a DHR only became a statutory function after her death.
2. To outline the journey and history of the case review process to date, reasons for delays and steps taken.
3. To produce a concise and proportionate timeline of professional contact and involvement with Laura and Rachel that can be used to set any learning identified in context.
4. To examine information already submitted and verify that the learning that has been identified by each agency is appropriate under the circumstances of the case, as was known at the time.
5. To use the findings and learning from this particular case to '… illuminate the past to make the future safer …' (HM Government, 2016) particularly in relation to the key areas of information sharing, record keeping, agency assessment, and risk management. This to be achieved by reflecting on changes in practice since events occurred and linking them to learning from other local and more recent reviews from across the Partnership e.g., SCRs/CSPRs, Adult Safeguarding Reviews, and other recent DHRs. This would mean that the whole exercise has some currency and may be seen as a worthwhile exercise, rather than a forensic legacy review.

6. Summary chronology:

6.1. The following chronological summary makes specific reference to Laura and Rachel as separate victims of domestic abuse whilst in a relationship with David, but additionally includes reference to other women, whom had formed a relationship with David. In order to protect their identities, no names have been assigned.

6.2. Rachel came to live in Sussex in 2000, bringing her children, having fled from an abusive relationship. Rachel and her children lived at the local Women's Aid Refuge from August 2000 until February 2001. It is recorded that they then moved into their own accommodation provided through Adur & Worthing Councils.

6.3. In November 2003, the Police were called to a woman's flat. They found both the woman and David under the influence of alcohol. She had several injuries and David was Cautioned for the offence of Common Assault.

6.4. In February 2004, the same woman reported having received threats from David, describing him as her ex-partner. She requested that her calls were logged but did not want the Police to take any further action at that stage.

6.5. In October 2005, the same woman, whom David had assaulted in 2003, called the Police to say that she was being kicked by a drunken male – it is recorded that he was believed to be David. Police were unable to locate her as she had left the house where she had been and with no evidence of a crime, the case was closed.

6.6. In 2006 Rachel and David formed an intimate relationship and they lived together with Rachel's children. In March 2006, the Police were called to a house by a neighbour who had been called for assistance by one of Rachel's children. Rachel had died, aged 35 years, during the night; she and David having slept together. The circumstances of her death were described as 'puzzling' by the attending Forensic Medical Examiner, but not considered suspicious and a decision not to commence a homicide investigation was taken; however, a post mortem was carried out. This concluded that she had died as a result of a subarachnoid haemorrhage. As the medical findings were that the death was as a result of natural causes and, in the absence of any evidence to the contrary, the police investigation was concluded.

6.7. In 2006 and 2007, there were two further incidents involving David to which the police were called to incidents involving two former partners. David was considered to have an alcohol dependence syndrome and some mental health difficulties.

6.8. In 2009, the Police recorded 19 incidents involving yet another female partner of David's in a one-month period, including harassment and assault by David. On investigation by the Police, David denied these matters and the incidents were closed.

6.9. In May 2010 David was Cautioned for Common Assault. This was as a result of a verbal altercation with another female partner, him slapping her face and kicking her in the groin. A DASH risk assessment (Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool) was completed by the attending Police Officer, at standard risk, but then upgraded to medium risk by a Police Supervisor, given information about David's mental health. In the first part of 2010 David was living in his own accommodation. He gave up his tenancy and was admitted to a Recovery Project in July 2010, which is where he met Laura.

6.10. Laura was 52 years of age when she died, and of white British heritage. She had been a successful business woman, married and had two children. Laura then experienced divorce

after 25 years of marriage, and also increasingly abused alcohol. She moved jobs frequently, struggled to make her mortgage payments resulting in repossession, was evicted from a unit for the homeless and came to the attention of Sussex Police on a number of occasions. Laura had twelve attendances at the local Hospital's Accident & Emergency Department between 2007 and 2010 for injuries to her arms and through falls; all related to excess alcohol use. Her first known contact with other services was in early 2010 when she was living in temporary accommodation. Laura went to live at the Worthing Churches Homeless Project Short Term Assessment Hostel.

6.11. David was accommodated at the same Hostel in July 2010, at a similar time that Laura was living there – which is how they met. They were both living at the Hostel between July and October 2010. Staff were aware of the circumstances relating to the death of one of David's former partners, Rachel, in 2006, but felt they were not in a position to share David's history with Laura. There is no information to suggest that Laura was aware of Rachel's death. Laura secured her own accommodation in October 2010, although, before she moved out of the Worthing Churches Homeless Hostel, was asked to leave because she had lapsed into alcohol use several times. David left shortly afterwards reverting to his street drinking lifestyle and spending time staying with Laura.

6.12. The first recorded incidents of domestic abuse against Laura arose in early 2011. Police were called three times. This was initially to an argument and then, some weeks later, to two incidents in three days. After the second of these two incidents, the Officers called were sufficiently concerned to Caution David for Assault. He had admitted the assault and the Police attending noted that they felt Laura was with-holding information. They made repeated efforts to engage with Laura without success. When the Caution was reviewed it was withdrawn due to insufficient evidence.

6.13. Three weeks later, in April 2011, Laura died; she and David were sleeping together on the sofa in her flat. A Home Office post mortem was carried out and recorded that Laura's death was consistent with smothering (overlaying), toxic effects of alcohol ischaemic heart disease and emphysema. The Coroner's Inquest concluded that her death was accidental.

6.14. Laura's family insisted that they never accepted this explanation and made two consecutive complaints against Sussex Police which were each reviewed, but not upheld. This decision was appealed and considered by the then Independent Police Complaints Commission and subsequently by the Independent Office for Police Conduct; again, the outcome was not upheld and did not find in the complainant's favour. Laura's family subsequently commissioned a further independent pathologist's report which led to a further Police investigation. These actions also led to a judicial review of the verdicts from the original Inquest being challenged in October 2020. This resulted in a new Article 2 compliant Inquest being conducted in July 2021. The revised determination of the Coroner, was that Laura was unlawfully killed.

6.15. David was charged and convicted in 2017 of Laura's murder and Rachel's manslaughter; he was sentenced to life imprisonment.

6.16. In summary, information provided confirms five former female partners, in addition to Laura and Rachel, were victims of domestic abuse between 2003 and 2011. As well as David misusing alcohol and having mental health difficulties, all female partners were known to misuse alcohol, two were known to have suffered with serious mental health difficulties, and one to have had a physical disability; two had dependent children at the time of David having a relationship with them.

7. Key issues arising from the review:

7.1. Those agencies that submitted IMRs were asked to do so, some 11 and 6 years respectively, after their involvement with the individuals concerned. Inevitably, this created challenges about whether records were retained, staff turnover and the need to be mindful of avoid hindsight bias.

7.2. Intentionally, the DHR did not examine the quality and effectiveness of either the original Police investigation into Rachel's death in 2006 or Laura's death in 2011. These matters had been extensively interrogated and conclusions reached, via the different processes of Police re-investigation in 2016, criminal trial in 2017, judicial review in 2020 and the Article 2 Inquest held in July 2021. In 2017, following the criminal trial and conviction, Sussex Police offered an apology for the failings of the Force into the deaths of both Laura and Rachel. This apology was further reiterated in July 2021 following the above verdict of the Article 2 Inquest.

7.3. Key issues include:

- Before he met Laura, David had been involved in a number of incidents to which the police were called. These dated back to 2003 (and included his relationship with Rachel) and were almost invariably in the context of drinking alcohol – usually by both David and the victims. Although assessed several times, David was never diagnosed as mentally ill nor did he receive formal treatment, although he was sometimes considered to be depressed. He did receive support in relation to his alcohol dependence.

- David did not have a conviction in relation to domestic abuse although he had been Cautioned in November 2003 for common assault. In August 2006 David was charged for criminal damage and in May 2010 for Battery. Each of these offences was committed in the context of domestic abuse.

- Staff at Worthing Churches Homeless Project were not aware of previous Cautions or offences. Even if they had been, as a matter of policy, they would not have told other residents or clients about them. They would only deviate from this policy if there was considered to be a significant risk to another resident or client.

- The only known opportunities to intervene in relation to domestic abuse regarding Laura were when Police were called in early 2011. Police were called to incidents between David and Laura three times in the months before she died. They attended and dealt with each situation. On the third occasion, the Police officers attending saw injuries but despite repeated efforts to engage with Laura, she did not support any further Police action. The information available to the Police including David's criminal record of three Cautions and previous abusive relationships did not reach the threshold for referral for discussion at a Multi-Agency Risk Assessment Conference. One of the main findings from the Article 2 Inquest was the failure by Sussex Police to access and use information that was held about David and previous attendances at domestic abuse related incidents. The re-investigation by Sussex Police, and subsequent Article 2 Inquest concluded that further, and different actions could have been taken by the Police in regard to information that was available to them at the time.

- Information provided from other agencies indicates that very little would have been done differently, in terms of their response to Rachel, Laura or David, and that appropriate steps were taken under the circumstances to manage the presenting issues. In part, this was due to non-engagement, notably by either Laura or David.

8. Conclusions:

8.1. The passage of time since the tragic deaths of both Rachel and Laura has been considerable. Through the persistent efforts of Laura's family, justice has been achieved in holding David to account for his actions. Additionally, through the Article 2 Inquest, Sussex Police have also been held to account for the way in which they managed their original investigations into the deaths of both Laura and Rachel.

8.2. Given the passage of time, it has been important for this review to not only chart and understand the actions of each agency that had contact with Laura, and Rachel, but also place the findings from the review in context of current practice, acknowledging the considerable developments made across all agencies about how they recognise and respond to domestic abuse. The review has attempted to achieve this, and hope that it goes some way in using the learning identified as a means of focusing future professional efforts to support those who are victims of domestic abuse.

8.3. The review acknowledges the contributions from both Laura and Rachel's family over the timeframe of this review.

9. Lessons to be learned:

9.1. Key learning points captured as a result of this review into the tragic deaths of both Laura and Rachel include;

- Research[2] highlights that mental ill health, substance misuse and the perpetrator having a history of violence are common features in other domestic homicide reviews and violence against women. These factors most likely therefore, increase the risk of domestic abuse occurring. Domestic Abuse statutory guidance (2022) (pdf) – helpfully refers to this (p.76) '…Mental health problems are not a cause of domestic abuse; however, it can be a risk factor for perpetration and victimisation …' and (p.46) '… Factors such as alcohol and drugs misuse can increase the likelihood and severity of domestic abuse. However, there is not a causal relationship between substance misuse and domestic abuse. Substances can act to disinhibit, rather than act as a cause of violence and abuse. Many people believe that alcohol and/or drugs increase aggression and physical violence and therefore perpetrators are likely to use this as an excuse for their abusive behaviour…'. The guidance also helpfully sets out

[2] a) Domestic Homicide Reviews, Key findings from analysis of domestic homicide reviews, December 2016, Home Office, b) London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process, Bear Montique – Standing Together, October 2019, c) Domestic Homicide Review (DHR) Case Analysis, Report for Standing Together, Nicola Sharp-Jeffs and Liz Kelly, June 2016, d) Intimate Partner Violence and Alcohol, World Health Organisation, 2006, e) Violent Crime and Sexual Offences - Alcohol-Related Violence: Findings from the 2013/14 Crime Survey for England and Wales and police recorded crime over the same period on violent crime and sexual offences.

information about perpetrator tactics which will be useful for all services and agencies to be aware of.

- It is not uncommon for victims of domestic abuse to decline to cooperate in prosecutions and also to decline support. This is a common finding in other homicide reviews, supported by research[3], and highlights a potential barrier for victims of domestic abuse. Therefore, the learning that should be taken forward from this review is that criminal justice agencies and domestic abuse support services should ensure that pathways and mechanisms exist which better empower victims to proceed with prosecutions and seek support without fear or blame. Domestic Abuse Statutory guidance (pdf) refers to this (p.104) '… A significant share of domestic abuse cases are withdrawn, with the victim not supporting police action. It is vital to work with victims in a trauma-informed way to support them through an investigation process and to prevent re-traumatisation. Victims may withdraw their support for prosecution if they experience a lack of communication, empathy and support …'. It may be that the new provisions set out in the Domestic Abuse Act 2021, specifically relating to Domestic Abuse Protection Notices and Orders will help victims feel safer when being faced with decisions relating to prosecutions, especially when taking place alongside a coordinated package of support for victims.

- It is important to be mindful that the presence of a partner when someone attends hospital with a poorly explained injury, can be a tactic by the partner to exercise control and deter disclosure[4].

- There is a need for continued awareness about the vulnerability of men and women who appear to have a transient lifestyle, and are not settled in permanent accommodation, to domestic abuse. This is especially so for individuals that misuse substances and/or those who experience mental health difficulties. The connectivity between housing needs and domestic abuse[5] has gained a greater profile in recent years in line with other legislative and policy changes. Professionals still need to remain alert to this dynamic when conducting assessments, especially focusing on risk assessing placements for victims. For those services that provide support to individuals who have more unsettled accommodation or who lead more transient

[3] a) Domestic abuse and the criminal justice system, England and Wales: November 2021, Responses to and outcomes of domestic abuse-related cases in the criminal justice system, Office for National Statistics, b) London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process, Bear Montique – Standing Together, October 2019, c) Domestic Homicide Review (DHR) Case Analysis, Report for Standing Together, Nicola Sharp-Jeffs and Liz Kelly, June 2016, d) Home Office, Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews, September 2021.

[4] Controlling or Coercive Behaviour in an Intimate or Family Relationship: Statutory Guidance Framework, December 2015, HM Government.

[5] a) Homelessness code of guidance for local authorities, February 2018, Chapter 21: Domestic abuse: Guidance on providing homelessness services to people who have experienced or are at risk of domestic violence or abuse. HM Government, b) Safe at home: the case for a response to domestic abuse by housing providers, no date, Safe Lives, c) Domestic Abuse and Housing: Connections and Disconnections in the pre-Covid-19 policy world, Interim Report, Annette Hastings, Mhairi Mackenzie and Alice Earley, 10 February 2021, UK Collaborative Centre for Housing Evidence.

lifestyles, there will be merit in considering if, or how, perpetrators of domestic abuse may target individuals, and exploit their vulnerabilities; being prepared for this possibility, could form part of an early intervention strategy. As highlighted above, many of these issues are helpfully detailed in the recently published statutory guidance – Domestic Abuse (July 2022).

- Although the Multi Agency Risk Assessment Conference (MARAC) arrangements can address the risks and coordination needed in cases reaching the relevant threshold, there is also a need for single-agency working in cases that fall below that threshold but where there is a justification to exchange information. This should take place as a matter of good professional practice and where appropriate with the service user's consent. This approach should be underscored by good communication and information exchange and by the continuation of both single and multi-agency training. Where consent to share information is not provided, professional curiosity and some healthy scepticism should be exercised in a sensitive manner as to the reasons for this; it may conceal continuing risk in which case, practice wisdom formed from extensive experience and supported by research should be the justification for sharing information. Whilst there appear to be a plethora of agreed Information Sharing Agreements currently in place in the county (many of which clearly relate to risks related to whether there are children in the household and considered to be at risk) there are fewer which specifically and solely target adults who may be living in an abusive relationship. There may be scope to refresh these, specifically providing guidance about when consent to share information may not be provided by the victim and where concerns fall below the MARAC threshold for multi-agency consideration.

10.Recommendations from the review:

10.1. Considerable changes and improvements have taken place in the intervening years since events occurred. However, the specific lessons learnt identified were relevant at the time of the victims' deaths, but also continue to have currency. Every opportunity must be taken to make it easy for victims of domestic abuse to seek the right help at the right time, and for their relatives or members of the public to alert agencies to the need for support or intervention. Discussion with original members of the Review Panel, who remained involved up until this review concluded, recall considerable discussion when the review began, about policy, practice and attitudinal change since these incidents occurred; in turn, this made it challenging to think what recommendations might be needed. The case remains, that more work is needed to tackle the issues identified.

10.2. As a forward-looking activity, it is recognised that a Pan Sussex Domestic and Sexual Violence and Abuse Strategic Framework 2020-2024 has been created, which in turn, provides for a local West Sussex Strategic Framework Action Plan and Safe Accommodation Action Plan 2020-2024. In developing this strategy and action plan it has allowed the Partnership the opportunity to identify gaps around prevention and early identification, service provision, pursuing perpetrators, and accommodation. The action plan that accompanies the strategy offers confidence that the issues identified in section are known about, and plans are in place to tackle them.

10.3. It is therefore recommended that progress on tackling the issues identified as in need, is reviewed and published on an annual basis by the Partnership, so as to promote transparency, scrutiny and accountability.

10.4. In addition, given the recent publication of statutory guidance – Domestic Abuse (July 2022) – by the Home Office, this review makes a recommendation that the guidance is promoted across all relevant agencies and services in West Sussex as a way of highlighting many of the learning points captured in this review.

10.5. A final recommendation is made in relation to existing Information Sharing Agreements. These should be reviewed to improve consistency by developing a best practice model which provides clarity regarding consent/non-consent based information sharing across local statutory and specialist domestic abuse providers in West Sussex. Work to align any revisions with Information Sharing Agreements should also take place so as to ensure a collective consistency regarding the issue of consent/non-consent and information sharing.