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

Safer West Sussex Partnership

Domestic Homicide Review

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 MAY 2022

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1. Introduction & purpose of the review

1.1. Laura died in April 2011; she was 52 years old. The findings of a post mortem conducted at the time 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. The perpetrator, who for the purpose of this review will be known as David, aged 43 years, was convicted of Laura's murder in April 2017 having formed a relationship with her in December 2010, some five months prior to her death. 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. For the purpose of this review, the former partner will be known as Rachel, who was 35 years old when she died. As part of the re-investigation by Sussex Police in 2016, Rachel's death was also examined given the inextricable links both Laura and Rachel had with David. 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.

1.2. 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 21 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.

1.3. Laura died five days after Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews 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 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

[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'.

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.

1.4. 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. Based on the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, 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.

1.5. 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. In this case, those matters have been extensively examined thanks to the significant and persistent efforts of Laura's family.

1.6. The passage of time, and complicating factors, have considerably impacted on the conduct of this review; these factors cannot be ignored nor must they be used to minimise the value gained by conducting this review irrespective of the time it has taken to draw it to a conclusion. As such, this review and final report have sought to bring together learning identified by examining the contact and involvement of agencies with both victims. It is fully recognised that Laura's death occurred over a decade ago, and Rachel's death over 15 years ago – but by linking together their stories, their respective contact with agencies or services, and placing this in the current context of partnership working in West Sussex, it is hoped that it will provide strengthened insight and learning about how agencies and professionals can work together to safeguard victims of domestic abuse, and reduce the likelihood of recurrence.

2. Methodology & scope of the review

2.1. Following David's conviction in April 2017, the Chair of the Safer West Sussex Partnership agreed that a Domestic Homicide Review should commence. The following steps, set out in chronological order, were then taken:

2.2. 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.

2.3. 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. Terms of Reference/lines of inquiry were agreed at this meeting (see Section 3). It was known that there had been complaints about the Police investigation into the death of Laura and that these had been referred to the Independent Office for Police Conduct, formerly the Independent Police Complaints Commission. It was agreed that, in accordance with Home Office Guidance, the Review would not seek to address questions about the Police investigations into the deaths of Laura and Rachel as this was, and remains, a separate parallel process.

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

2.4. Further Review Panel meetings were held as and when needed. Records indicate these took place in March, September and October 2018, January, February and June 2019.

2.5. 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.

2.6. 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.

2.7. The list below provides details of the key agencies in West Sussex, that were contacted in 2017 to identify if they had any contact with either Laura, Rachel or David.

Agencies contacted for information in October 2017 regarding Laura, Rachel or David

- Kent, Surrey and Sussex Community Rehabilitation Service
- Turning Tides (previously Worthing Churches Homeless Projects)
- National Probation Service
- West Sussex Domestic Abuse Services (previously WORTH)
- NHS Coastal West Sussex Clinical Commissioning Group
- West Sussex Drug and Alcohol Wellbeing Network (incorporating Change, Grow, Live or CGL, previously Crime Reduction Initiatives or CRI)
- Safe in Sussex (previously Worthing Women's Aid)
- Western Sussex Hospitals NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- Adur & Worthing Councils[2]
- Sussex Police
- West Sussex County Council
- Adult Social Care Services
- Children's Social Care and Safeguarding Services
- Education Services
- Sussex Police and Crime Commissioner

2.8. The majority of the agencies or services in the list above had no contact or no relevant contact. Those which had had relevant contact were asked to provide Individual Management Reviews and chronologies. It was recognised at an early stage that given the time that had elapsed some older information may not have been retained. Table 3 below, sets out those agencies or services that were requested to submit an Individual Management Review.

[2] Adur & Worthing Councils refers to two local government bodies, Adur District Council and Worthing Borough Council, in West Sussex, England, who have operated under a joint management structure, with a single Chief Executive, since 1 April 2008

Table 2: Agencies or services that were requested to submit an Individual Management Review in October 2017

In respect of Laura and the statutory DHR:	**In respect of Rachel and the discretionary review:**
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.	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 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 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.
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.	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).
Turning Tides (formerly Worthing Churches Homeless Project): Which provided accommodation and support for both Laura (in 2010) and David (between 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.	-

2.9. The Western Sussex Hospitals NHS Foundation Trust provided information about Laura and David's attendances at Worthing Hospital. Assessments and plans in relation to Laura's contacts with substance misuse services in 2010 – Addaction, Change – Grow - Live, then known as Crime Reduction Initiatives (CR)I, and Worthing Churches Homeless Projects (now known as Turning Tides) - were reviewed. Similarly, assessments and plans in relation to David's contacts with substance misuse services between 2008 and 2016 – Addaction, Change – Grow - Live and Worthing Churches Homeless Project - were reviewed.

2.10. In collaboration with the Review Panel, the original Independent Chair, identified learning and draft recommendations from the statutory review into Laura's death as well as the discretionary review into Rachel's death. These were expressed in a full draft overview report which was brought to as near a conclusion as possible under the circumstances of a further Inquest needing to be held.

2.11. The original Independent Chair met with Laura's parents to explain the review process, to establish what questions they had, and to obtain information from them. They were provided with copies of the relevant Home Office leaflet. Records examined suggest that two meetings took place in November and December 2018. No further information can be found which indicates they were contacted again until the DHR was resumed in October 2021. At this point, Laura's parents were advised by letter of the review recommencing. The Chair then met with them in April 2022 with an aim of sharing the draft report; see section 4.

2.12. The original Independent Chair also met with one of Rachel's sons. Again, no information can be found which confirms ongoing contact up until the DHR being resumed in October 2021; see section 4.

2.13. David declined the opportunity provided to him by the original Independent Chair, to contribute to the Review.

2.14. 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. Records indicate that the family were not formally advised of this pause despite this being agreed by the Review Panel at the time.

2.15. At the point the DHR could recommence in October 2021, 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 is no conflict of interest.

2.16. In October 2021 an initial scoping discussion was held involving the Independent Chair, the Violence Reduction Unit Lead for West Sussex County Council, the original Sussex Police Review Panel representative and the Director of Communities (formerly the Principal Manager for Community Safety & Wellbeing and also an original Review Panel member) to consider the original terms of reference and how best to draw the reviews to a conclusion. This final report reflects the basis of those discussions and the revised terms of reference (see section 3).

2.17. No further efforts were made by the newly appointed Independent Chair to resume contact with David given he had declined the offer originally made to contribute to the review.

2.18. Review Panels were held in January and May 2022 to consider the draft report written by the Independent Chair. Membership of this reformed Review Panel is set out below in Table 4, and where possible, consistency with the membership of the original Review Panel was sought.

Table 3: 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

2.19. The final report was presented to the Safer West Sussex Partnership in May 2022. As such, the review process has taken just over 5 years to complete from the point a decision was made to conduct a review in 2017. Factors that contributed to the review taking this length of time included the need to wait for the conclusion of a judicial review and a new Inquest, and then the new Independent Chair making meaningful contact with members of Laura and Rachel's family - some of which was impacted by Covid-19.

2.20. The report was shared with the Home Office Quality Assurance Group in June 2022. Comments back from the Home Office were received in November 2022, and which were responded to, resulting in a further draft being re-submitted to the Home Office in January 2023. The Home Office approved publication of the reports on the 7 March 2023. The Executive Summary and Overview Report will be disseminated to the following:

- 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

2.21. The review has kept in mind the 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). The characteristics of disability (including physical disability and mental ill health), and sex are considered relevant to this review and have been considered in section 6.6. The other characteristics have been discounted as not being relevant to the circumstances of the individuals concerned.

3. Original lines of enquiry for the review agreed in 2017 & revised terms of reference agreed in 2021

3.1. 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?

3.2. 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 …'3 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.

4. Family contributions to the review

4.1. Seeking the contributions of family members has been an important consideration for the statutory review into Laura's death, but also the discretionary review into Rachel's death. Having reviewed information submitted over the course of the reviews it is apparent that good efforts were made to engage respective family members, seek their contributions, and keep them informed of progress. Records indicate that this included them being provided with copies of the Home Office leaflets regarding DHRs, and being briefed by the original Chair of the review findings, and being given the opportunity to comment on them prior to when it had been hoped to draw the review to a conclusion. These efforts do however appear to have faltered at the point a decision was taken to pause the review in 2019 with no records of this decision being conveyed to family members. Understandably, family members efforts and energy have been invested in other parallel processes which were more concerned about seeking justice; although it has been clear that the contributions from family members across the timeframe has also been informed by them wanting to ensure that other similar situations are avoided and the likelihood of recurrence is reduced.

4.2. Additional efforts were made by the new Independent Chair to meet with family members, and offer them any further opportunity to contribute to the review, read the draft report and offer any comments. These took place in April 2022. The Chair met with Laura's parents with an aim of sharing the draft report. They expressed a clear view that they did not want to see the report and remained adamant about the Police failings in the run up to, and following, Laura's death. The Chair reminded them 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.

4.3. The Chair also met with Rachel's adult son. He read the report, was satisfied with it and was content with the findings and recommendation – understanding that the passage of

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016, Home Office.

time has been a significant contributory factor and that a considerable amount has changed in terms of professional practice around domestic abuse. He expressed a wish, on behalf of his family, that it was time to move on and find some closure. He too was reminded about the pseudonym of Rachel being used; he was satisfied with this name and happy for it be used.

Contributions gained from Laura's family:

4.4. At the time of the review beginning, Laura's parents explained to the original Chair that their daughter had had a successful career in the City of London before coming to live in Worthing. She had two sons prior to her divorce. One of her sons joined the first meeting with Laura's parents. After her divorce, Laura bought and moved into a flat which she had to give up as she was not keeping up with the payments. They supported her in her efforts to find a new home and particularly encouraged her to make and maintain her contact with substance misuse services, her mother even accompanying her to an appointment.

4.5. They were in regular contact with Laura and knew that she had begun her relationship with David in December 2010. She had moved into her own one bedroomed flat that month. They recalled meeting David at the charity shop where Laura worked – he was intoxicated. They knew that he was a friend and that he and Laura were in a relationship. They did not think that she was aware of Rachel's death.

4.6. Laura's family explained to the original Chair when the review first began, that a neighbour of Laura had heard various incidents of domestic violence and made reports to the Police. This neighbour was originally invited to contribute to the review by the first Chair however there is no record that the neighbour chose to accept this invitation. Laura's family did not know of any other friends or relatives having contacted the Police or other agencies about any concerns before Laura died.

Contributions gained from Rachel's family:

4.7. At the time of the review beginning, Rachel's son explained to the original Chair that he was one of four children. They, and their mother, had moved to Worthing about five years before she died. He would have been about five years old. They had left his father following domestic abuse and initially stayed in London, where they had a relative. They then moved to Worthing where his mother's cousin was already living. He recalled that, at first, they lived in temporary accommodation. He thought this was a refuge. He could remember his mother's relationship with David building up. He thought they had met in a night club and had been together for about six months. He recalled that whenever he had seen David, he had had a drink in his hand. He did not have any memories of violence between them, although he could remember David smacking him for misbehaviour when his mother was out. He had not told his mother. He has heard from other relatives that there had been some violence – she had apparently said "I'm not going to be here for my 40th birthday". He did not think that any of these relatives had contacted the Police or other agencies about their concerns before his mother died.

4.8. At the time of the review beginning, Rachel's son had questions about why the Police did not investigate his mother's death more thoroughly, particularly as he had learned that David had previously assaulted two women. He was told at that time, that the review would be pleased to hear from any other relatives, particularly those who had been in contact with his mother after she came to live in Worthing. Rachel's son, who originally contributed to the

review, agreed to act as the family representative at the time of this review resuming in October 2021.

5. Summary chronology of relevant history

5.1. A considerable amount of information has been generated through the criminal trial held in 2017, the initial commissioning of this DHR in 2017 (post the trial) and then the Article 2 Inquest held in July 2021. This has highlighted a history of highly relevant and significant information which helps us – with the benefit of hindsight – develop a whole and rounded picture of history. The following proportionate 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.

5.2. Rachel came to live in Sussex in 2000, bringing her children. She had fled from an abusive relationship with her husband in Scotland and had initially spent some time in London. 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. It has not been possible to trace any more information about this period and what support she may have received in resettling in the area. In July 2002 Rachel had contact with the local authority housing department for assistance with her rent.

5.3. 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.

5.4. 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. Also in 2004, David was considered to have an alcohol dependence and it is understood that he engaged with the local Substance Misuse Service for support and counselling.

5.5. 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.

5.6. In 2006 Rachel and David formed an intimate relationship and they lived together with Rachel's children. In March 2006, on Mother's Day, 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; she was 35 years of age, and of white British heritage. She had died during the night; she and David having slept together. Her four children had been in the home at the time and they had been preparing breakfast for her downstairs when it became apparent that something had happened. 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. Prior to this incident, there

had been no previous calls to the Police or reports involved the couple. Rachel's family were aware of some previous violence and they were always suspicious, particularly in hindsight, having learned of Laura's death. Although Rachel's family expressed concerns about the circumstances of her death, the post mortem concluded that she had died from natural causes and there was therefore no further official review of this until the case was re-opened in 2016.

5.7. In 2006 and 2007, there were two further incidents involving David to which the Police were called to incidents involving two former partners. The first was criminal damage with a former known previous female partner; the Police were called out twice during the same month and one call out resulted in David being Cautioned. The second was when David was said to have been verbally abusive to another former female partner when they had been drinking. Police were called out twice on the same day and both incidents were categorised as domestic related incidents.

5.8. Primary care records show that David was considered to have an alcohol dependence syndrome and that he had been assessed by the Substance Misuse Service in 2008. In 2009, he had also been assessed by the Mental Health Liaison Service at the local Hospital and, in 2010, he had had a number of attendances at the local Hospital Accident & Emergency Department for a variety of reasons, often due to mental health or alcohol related issues, one of which included he had disclosed he was having suicidal thoughts and wanted to rape someone. This information was known to the Police.

5.9. 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. In July 2009 this relationship ended; however, the partner asked Police to disclose if David had a criminal record as she had heard that he could be violent when drunk. No information was disclosed by the Police.

5.10. 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 Domestic Abuse, Stalking & Harassment (DASH) risk assessment form 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.

5.11. 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.

5.12. 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 which had an impact on all areas of her life. 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 committed offences, all of which involved excessive consumption of alcohol, such as driving with excess alcohol, drunk and incapable, and drunk and disorderly, and assaulting a Police Officer during an arrest – these all date back to 2002. 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 Hostel. She progressed to the Recovery Project in the same organisation, in May 2010, where she received support in relation to her use of alcohol.

5.13. 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. The rules of that service prohibited relationships between residents and it has been confirmed that the staff were not aware of a relationship between Laura and David while they were living there. David had previous contacts with agencies (including the Police, his G.P., various substance misuse services, the Housing Department) over the preceding years.

5.14. There is no known record of any domestic abuse while Laura was resident at Worthing Churches Homeless Project Hostel in 2010, or that staff there were aware that David had a history of being a perpetrator of abuse. 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 (NB – David was not convicted of Rachel's manslaughter until 2017 and therefore any knowledge of her death would not be suggestive of a crime being committed at that time). There is no information to suggest that Laura was aware of Rachel's death. There is though, no suggestion that David was secretive about it.

5.15. Laura secured her own accommodation in October 2010, although, before she moved out of the Worthing Churches Homeless Project 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. By the end of October 2010, his brother referred him to the local Substance Misuse Services but he did not attend.

5.16. Laura's attendances at the local Hospital during this period have been reviewed and there is no evidence that they were considered to be related to domestic abuse. There is also no obvious significance to both Laura and David attending A&E three times at the same time, in October 2010, or there being any domestic abuse related behaviours/ concerns noted.

5.17. 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. She declined to give any explanation for her injuries or have them photographed. The Officers also recorded that she declined to receive any information about domestic abuse support or interventions and that both Laura and David had been drinking. When the Caution was reviewed it was withdrawn as the evidence to justify it was insufficient. On the first two occasions, a DASH form was completed with the risk graded as 'standard' and on the third occasion, there was more concern and the risk was graded as 'medium' on the DASH form. This meant it would have been shared with the independent domestic abuse services had Laura agreed.

5.18. 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 first Coroner's Inquest concluded that her death was accidental.

5.19. Laura's family insisted that they never accepted this explanation. They made two consecutive complaints against Sussex Police which were each reviewed, but not upheld i.e., they did not find in the complainant's favour. 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, with a jury making findings about other matters posed to them (see section 6, paragraph 2).

5.20. David was charged and convicted in 2017 of Laura's murder and Rachel's manslaughter; he was sentenced to life imprisonment. At the point of conviction, David was 43 years old; he was of white British origin.

5.21. 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.

6. Findings & analysis

1. As noted in paragraph 1.6, the passage of time from when Laura and Rachel respectively died to this DHR being commissioned and drawn to a conclusion, is a critical factor. 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, and avoid hindsight bias.

2. As also noted in paragraph 2.3 this DHR will 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 have 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. It is argued that it unnecessary to set out the detailed findings from these legal processes, given clear outcome statements provided following these respective processes.

3. Therefore, of interest and relevance to this review are the outcome statements from the 2021 Article 2 Inquest and response by the jury to the questions posed to them. These are;

   Question: Was the decision to declare the death of [Rachel] unexplained and/or the decision not to have a homicide investigation a significant failure? 'Yes – the decision to declare [Rachel's] death was premature and did not allow for additional investigations to be made'.

Question: If you considered this decision to be a significant failure, did this cause or contribute to the death of [Laura]? 'Don't know – we … cannot conclude with certainty that the significant failure did cause or contribute to [Laura's] death'.

Question: If you considered this decision to be a significant failure may this have caused or contributed to the death of [Laura]? 'Yes – we have concluded that there is a realistic possibility that [Laura's] death may have been prevented if [Rachel's] death was declared and investigated as suspicious.

Question: Was the decision by the Pathologist (instructed by the Coroner conducting the post mortem on [Laura]) not to refer the case to a Home Office Forensic Pathologist when they were unable to find the site of any ruptured aneurysm a significant failure? 'Yes'.

Question: If you considered this to be a significant failure, did this cause or contribute to the death of [Laura]? 'Yes'.

Question: In light of the information recorded in Sussex Police's database, the answers you have given to questions 1 and 4 and any additional information you consider ought reasonably to have been obtained by the AVU (Anti-Victimisation Unit), did Sussex Police know or ought reasonably to have known that [David] posed a real[4] and immediate[5] risk to [Laura's] life before she was killed? 'Yes'.

Question: If Sussex Police knew or ought to have known of this risk, did they take such measures as could have reasonably been expected of them to avoid this risk from occurring? 'No'.

Question: If such measures were not taken by Sussex Police did this cause or contribute to [Laura's] death? 'Yes'.

4. 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.

5. It is further argued that whilst recognising the circumstances of what happened to Laura and Rachel, the most helpful approach for this DHR to take now – given the considerable passage of time - is to gain an understanding about what changes and improvements have occurred in the intervening period. The challenges of disentangling what was known at the time, what has emerged as a result of more recent investigations and inquiries, and recognising the influence of hindsight, cannot be minimised.

6. This section of the report will consider the original lines of enquiry set for the review against information that has been submitted by those agencies that came into contact with Laura and Rachel at the time, as well as the additional information gathered.

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[4] Real risk – a significant risk or substantial risk, rather than a remote or fanciful one. The risk must be to life rather than of harm, even serious harm. From notes to jurors, Coroner's Inquest, 2021.

[5] Immediate risk – an immediate risk to life means that one is 'continuing and present'. The risk does not have to be imminent. The risk is present at the time and not a risk and not a risk that will arise sometime in the future. From notes to jurors, Coroner's Inquest, 2021.

7. 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. His mental health was assessed several times by the Mental Health Liaison Service at the Worthing Hospital Accident & Emergency Department. He was never diagnosed as mentally ill nor did he receive formal treatment, although he was sometimes considered to be depressed. He received support in relation to his alcohol dependence through Worthing Churches Homeless Project Hostel, Addaction, and the GP Surgery. There were also periods when he was not drinking.

- David did not have a conviction in relation to domestic abuse although he had been Cautioned in November 2003 for common assault. There were also two incidents to which the Police were called in 2004 and 2005 involving the same female victim. On the first occasion she did not want any action taken and on the second one the Police could find no evidence of any crime having been committed. 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 Hostel were not aware of the above Cautions. 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. If they became aware of a relationship between two residents in the Recovery Project or one of their other residential services, they would ask one of them to leave. In 2010, however, they had no information to suggest that David was a risk to other residents or clients and their managers have explained that they do not think that he and Laura had started their relationship while they were residents. While staff were aware of Rachel's death, this is not something that they would have discussed with other residents or clients.

- 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. They decided to Caution David for assault. Laura made it clear that she did not want to be provided with information or support. 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.

Communication between services and outcomes.

6.1. Whether an improvement in communication between services might have led to a different outcome.

6.2. 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. This related to their contact and attendance in respect of the death of Rachel in 2006 and deciding not to pursue a homicide investigation. As there was no homicide

investigation, the contact and attendances to domestic abuse related incidents involving Laura were not viewed from the perspective of David being a serial offender against women given previous knowable history; hence opportunities being lost to take more robust action at the time. These findings therefore highlight improvements that were needed to internal communication systems by Sussex Police. Section 7 examines improvements that have taken place during the intervening years that remedy the deficits identified.

6.3. In their IMR submitted in 2018, Worthing Churches Homeless Project commented on one factor that they consider may have been helpful, and although not directly related to improved communication does concern ongoing involvement with Laura. They raise the point that they were '… not sure what we could have done to avoid the death of Laura with the extent of the knowledge that we had at the time. Potentially the provision of assertive outreach engagement may have provided additional insight into what was happening with the relationship … we could have been more risk aware post her death as despite Police findings, the balance of probability of the same event happening twice in similar circumstances is unlikely. This will lead in the future to us not just basing our assessments on just the facts, but also the feelings and beliefs attached … a similar sequence of events in the future would lead us to being more open to communicating our risk concerns …'.

6.4. There is no information in the IMRs submitted from other agencies that had contact with Laura, i.e., GP Practice, Sussex Partnership NHS Trust, Change – Grow – Live, or Adur & Worthing Councils, to indicate that improvements in communication with one another might have led to a different outcome.

6.5. David did not engage with Change – Grow – Live until long after Laura's death in 2011, and information about both Laura and Rachel's deaths was not known to the service. Information would not have been shared by the Police given the outcome, at the time, of both deaths' being judged accidental/natural causes. Similarly, David's contact with Sussex Partnership NHS Trust, would not have resulted in an information exchange given his limited contact with them but also there being no indication that information did need to be exchanged between agencies.

Organisational professional standards regarding domestic abuse, stalking & harassment.

6.6. 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.

6.7. As noted above, this review will not examine the conduct of Sussex Police in respect of their response or investigations into attending domestic abuse incidents for either Laura or Rachel, nor the quality and effectiveness of their response to the deaths of Laura or Rachel at the time. These matters have been thoroughly examined through other legal processes, and suffice to say, clear findings have been made indicating that standards, policy, and procedures were not adhered to.

6.8. At the time of submitting their IMR Worthing Churches Homeless Project commented that '… all actions and standards were adhered to following our organisational standards. Our Recovery Project is CQC (Care Quality Commission) registered and all inspections have

identified the service as being fully compliant, with no areas for improvement and identified areas of outstanding practice …'.

6.9. NHS Coastal West Sussex Clinical Commissioning Group (CCG) submitted documentation in 2018, in respect of any contact or involvement Laura, Rachel and David had with GP services. Significant difficulties have been cited in being able to access medical records during the timeframe under review, not least because CCGs only came into being on the 1st April 2013 and tracking back to review medical records has been problematic, but also records appear to be incomplete. CCG's provided minimal safeguarding support for GPs/primary care services prior to April 2016. It was not until this point that commissioning arrangements confirmed that CCGs would have some responsibilities regarding assurance and support for primary care services. However, on those records where it was possible to undertake some review, the Named GP for Safeguarding Children & Adults in West Sussex was able to identify that David was appropriately signposted to services that may have been able to help with identified needs i.e., alcohol, bereavement support services.

6.10. NHS Coastal West Sussex Clinical Commissioning Group have highlighted significant changes between 2006 and now in respect of safeguarding awareness and procedures for GPs and primary care services. These are commented on in section 7.

6.11. Sussex Partnership NHS Foundation Trust submitted an IMR in 2017. The Trust is responsible for providing mental health services for children and adults in the area. They have commented that David was seen sporadically by Trust services from April 2009 to November 2016. Assessment and interventions opportunities included; one-off crisis type interventions at the Worthing Hospital A&E Department from mental health services; assessment by mental health services at the request of the Police Court Liaison & Diversion service from Police in the local station or custody suite in Worthing; mental health assessments on three separate occasions in either Worthing or Crawley. They have no records of any contact or involvement with either Laura or Rachel.

6.12. In summary, the Trust reflected on their contact and involvement with David noting '… on review of David's electronic health care record evidence of good communication/shared care working between the local Mental health Liaison Service, General Hospital, Adult Community Mental Health Services, Street Triage Services, Police and Court Liaison & Diversion Service and primary care/GP services was found. … Interventions by Trust staff specifically assessments/reviews were carried out as planned/per policy where the patient was able to co-operate; flexibility with requests met expected requirements/remits for services involved …'. They go on to conclude that '…it appears from a full record review carried out, it would be fair to say that David lived a fairly chaotic life linked to substance misuse and had a history of Police/Court involvement. Although on the surface it appeared David engaged with services this never really materialised in his engaging with further services/organisations/interventions that were assessed as being of possible benefit …'. The Trust has highlighted that all their activities were in line with expected professional standards in place at the time and therefore have not identified any actions or recommendations for themselves at this time.

6.13. In their IMR submitted in 2018, Change – Grow – Live (West Sussex Drug & Alcohol Wellbeing Service) have highlighted that there were no safeguarding issues identified in 2016 when they had contact and involvement with David. They have identified that the referral and assessment process took longer than expected for David, that no contact was made with

Worthing Churches Homeless Project Hostel who had also referred David to the service, and that there was no evidence that the engagement and re-engagement protocol was followed by workers. Although at the point of case closure, due to non-engagement by David, the GP and staff at Worthing Churches Homeless Project Hostel were informed, there were no recorded attempts to re-engage him via Worthing Churches Homeless Project; as would be expected in the protocol. On reviewing their involvement, they also identified that although an initial risk assessment (low risk) was conducted, there was no risk management plan – as there should have been for all service users.

The organisational response to referrals regarding domestic violence, stalking & harassment.

6.14. 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.

6.15. Information was known to Sussex Police about two of David's former partners prior to him entering a relationship with Laura; one of these former partners was Rachel. In reviewing their contact with these partners, Sussex Police recognise that they did not make best use of the information they had available on their electronic databases in order to inform their assessment of risk when attending incidents involving David and Laura in 2011.

6.16. As was noted in the Inquest, due to the passage of time and requirements regarding data retention, no papers records remain in relation to the domestic abuse incidents between David and Laura. The Police IMR also notes '… there was little opportunity to establish a relationship with the victims in this case owing to the circumstances of Police contact. At best, any relationship between Police and Laura was formed during face-to-face completion of three DASH forms, two of standard risk and one of medium risk. In terms of medium risk, it is recorded however that on the day of the incident, Laura was too drunk to engage in any meaningful way which necessitated Police re-attending the following morning …'. The IMR goes on to quote from policy at the time (516/2009) '… all risk assessments will be routed to the Divisional Adult Protection Teams (APTs). Every high and medium risk will be subject to secondary risk assessments by a member of APT. This is a dynamic process and assessments and subsequent risk management plans will be adjusted to take account of new incidents, changing circumstances and intelligence. Standard risks are subject to periodic dip-sampling …'.

6.17. The IMR states, from attending an incident in March 2011 '… Victim [Laura] very reluctant to provide Police with any information on this incident. She has suffered numerous facial cuts and bruises and had her hair pulled out. She appears to be an alcoholic and was very confused and unsteady on her feet when visited by officers in the morning. Officers believed she is withholding the full facts of what happened and is at risk of further violence hence graded as medium risk. Victim refused any DV support agency details or intervention'. The IMR goes on to comment that '… the domestic assault by David on Laura [March 2011] was graded medium risk on the accompanying DASH form. The rationale for this grading provided by the officer completing the form was that there was concern that Laura may not be revealing the extent of the abuse she was suffering at the hands of David. The DASH form indicates that the custody officer reviewed the quality of the investigation (to date) and was satisfied. The findings were endorsed on the DASH form. There is however, no further review by a 'specialist officer' recorded on the form as required by policy. If it was done, it is not recorded …'.

6.18. 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.

6.19. Worthing Churches Homeless Project commented in their IMR that '… both clients [Laura and David] were comprehensively assessed for our services with individually tailored support plans aimed at providing a flexible client centred approach. A joint agency approach was adopted in supporting both Laura and David … All of the services were fully aware of David's history from when he first entered our services. We were also aware of the fact that all the alleged offences had as far as we were concerned had been fully investigated by the Police with David being found not guilty of any crime …'. They go on to comment '… assessments and decisions made in a way that reflected the client centred nature of our work in working with people with complex and enduring needs …'.

6.20. The Project has highlighted an important issue around explicit but also implicit tensions that can be created by working with both victims and perpetrators at the same time; and this this may create risk. They have commented '… this case highlights how a seemingly well-mannered and articulate man could be allowed to continue a pattern of offending and successfully navigate to continue his behaviour … we are probably more used to dealing with direct and obvious risks from high-risk clients who demonstrate this through obvious direct behaviours. This case highlights the flaws in the investigation carried out by Police into both of David's victims' deaths. This has prompted us to believe our gut feelings as much as the outcome of investigations, this leaves us in a difficult position as in order to quantify risk we would normally focus on the facts, rather than subjective feelings and emotions … this case has sparked considerable reflection within the organisation as we knew both Laura and David well …'.

6.21. NHS Coastal West Sussex Clinical Commissioning Group have noted in their IMR submitted in 2018 that a letter from a Mental Health Liaison Worker in April 2009, highlighted that David had told them that he had a 13-year-old child whom he visited when sober. It appears that this statement was simply recorded, but not necessarily with a view to it conveying any risk of potential harm to the child. Since this time, all professionals should have a greater awareness and understanding about potential risks to children from adults with either/or mental health or substance misuse issues, and that there may be grounds to

justify greater professional curiosity about the situation but also warrant a referral to the Multi-Agency Safeguarding Hub.

6.22. Change – Grow – Live submitted an IMR in 2018. As a result of them reviewing their contact and involvement with David, they have concluded '… David was self-referred to the service [July 2016]. Whilst the initial referral was being processed, he was re-referred by Worthing Churches Homeless Project [July 2016] and, in the meantime, he had stopped drinking alcohol. At this time, he was seeking support with relapse prevention. David was assessed [August 2016] and presented as low risk. He was offered relapse prevention support through groups and a wellbeing appointment as he had previously been drinking at dependent levels. This was appropriate to his presenting need in relation to his goal to maintain abstinence. David did not engage with the groups offered or his wellbeing assessment. It is recorded that he only attended one group session [October 2016]. David did not respond to a letter sent [November 2016], asking if he would like to continue with treatment. It was agreed his case would be closed due to lack of attendance [December2016]. The details in relation to the previous two relationships where his partners had died were not known to the service. [At that time] New presentations were not cross referenced with any data base that would highlight previous domestic violence … and we based our risk assessment on self-disclosure and information shared by other involved agencies. David self-reported his risk of harm to others and domestic violence, both present and historic was gone … Since 2016 when David presented to services there have been changes made to the referral and assessment process. These relate to improved information gathering, shorter wait times and clearly identified pathways for drugs and alcohol. We have launched new assessment paperwork and there is ongoing work in relation to improving the quality and frequency of risk assessment and management …'. At around the time of David being involved with Change – Grow – Live there was a transition of databases and information held. As such, at the time there was no cross referencing with previous presentations to the service; this has now changed and the new database system does allow previous involvement and history to be seen. Change - Grow – Live had no evidence of any contact or involvement with Laura at any point.

6.23. The National Probation Service also submitted an IMR in 2017. They had no contact or involvement with either Laura or Rachel. They had no contact with David prior to 2016. This is similarly the case for Kent, Surrey & Sussex Community Rehabilitation Company, who only came into contact with David in early 2016.

6.24. No formal risk assessments were carried out by any other agency during the time period under review. On the basis of the available information, there is no suggestion that had risk assessments from other agencies been available for review they would have included anything of significance.

6.25. There is no information to indicate that David posed a direct threat or risk to children. It is however widely accepted [6] that children can be victims of domestic abuse too, often in a secondary way to the primary adult partner, though being directly and physically harmed when in the same room as an incident may be occurring, but also (and often more

[6] Stanley, N., Cleaver, H., & Hart, D., The impact of domestic violence, parental mental health problems, substance misuse and learning disability on parenting capacity, in, The Child's World, 2nd Edition, The comprehensive guide to assessing children in need, Edited by Horwath, J., Jessica Kingsley Publishers, 2010

profoundly) emotionally harmed, by hearing and witnessing domestic abuse. It was known that Rachel had children in the same household when she was living with David. The perception that children are passive bystanders in domestic abuse should always be challenged.

Safeguarding related training provided to adult-focussed services.

6.26. 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.

6.27. At the point of submitting their IMR in 2018, Sussex Police training on domestic abuse at the time consisted of training provided during the initial stages of becoming a Police officer, as well as ongoing refresher training as and when necessary.

6.28. The Worthing Churches Homeless Project commented in their IMR submitted in 2018 that '… staff were well trained and informed in dealing with issues around abuse and neglect as this is a common concern in our area of work, in working with such a marginalised group. The organisation had, and has in place, a core training plan for all staff, with individual training needs identified through supervision and appraisals. The organisation employed qualified Social Workers and at the time employed a qualified mental health nurse. Staff received support through supervision, team meetings and client reviews …both clients were deemed to have capacity although temporary loss of capacity will have been present when heavily under the influence of alcohol …'. In terms of any risk that David posed the Project noted that '… although David met Laura in our Recovery Project and we have a policy of no 'special relationships' while people are in treatment with us, we are not in a position to enforce this once they leave our services. Laura unfortunately died post leaving our service and so effectively was not in our care at the time. At the time, they formed a relationship we were not in a position to share with her David's history or to give insight into future risk given that the initial death of his previous partner had been fully investigated, with no prosecution …'.

6.29. Other agencies that have contributed IMRs to this review confirmed that training was available to staff. There is no indication that staff training, or a lack of it, was significant in this case. Section 7 expands on updates to training that is now available.

The calibration & application of thresholds for intervention.

6.30. Whether thresholds for intervention were appropriately calibrated, and applied correctly.

6.31. The review has highlighted that threshold for taking alternative action by Sussex Police i.e., in terms of prematurely declaring Rachel's death in 2006 unexplained and not conducting a homicide investigation was judged a significant failure by the jury in the Coroner's Court. Threshold in relation to DASH assessments could also have been considered differently in relation to involvement with Laura in 2011.

6.32. Threshold decisions were applied by Worthing Churches Homeless Project; their reflections have prompted the Project to consider how decisions are informed by gut feeling and inherent human bias, prompting them to seek additional support for practitioners and managers involved in forming judgements and making threshold decisions.

6.33. Access to services for David, with Sussex Partnership NHS Trust and Change – Grow – Live were informed by eligibility criteria – which were met; however, David did not consistently engage or maintain contact with these service offers.

Practice relating to protected characteristics.

6.34. Whether practices by all agencies were sensitive to the protected characteristics of the respective family members and whether any special needs on the part of either adult were explored, shared appropriately and recorded.

6.35. No information has been submitted to this review from either agencies or services that had contact with either Rachel or Laura, or from family members, that indicates any sensitivities in respect of the protected characteristics of age, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, or sexual orientation.

6.36. The protected characteristics of sex and disability have been considered relevant to this 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[7], and being the greater victims of homicide[8]. The characteristic of disability, in this case one of David's former partners, and victims, having a physical disability is relevant; as is, the characteristic of mental health difficulties. Two of David's victims experienced mental health problems and when placed alongside substance/alcohol misuse this highlights additional levels of vulnerability. Recent research conducted by the Home Office[9] into domestic homicides highlights its relevance '… Of the victims, for 34% a vulnerability was mental ill-health, for 28% there was problematic alcohol use, and for 22% illicit drug use. For 12% of the victims, physical disability was assessed as a vulnerability and for 5% a learning disability …'.

The use of escalation to senior management or other organisations and professionals.

6.37. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

6.38. In respect of decisions needed by more senior managers/officers, in their IMR, Sussex Police have commented '… records indicate that the Caution was administered (March 2011) but that it was subsequently unsustainable given the evidential content on the file. This may have been because Laura declined to have her injuries photographed, make a statement or otherwise substantiate an allegation. Removal of the Caution was sought and the incident was subsequently filed as 'undetected' …'.

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

[8] Home Office, Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews, September 2021.

[9] Home Office, Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews, p. 11, September 2021.

6.39. No other issues have been identified from any other agency involved, which would have justified escalation to senior managers.

The impact of any organisational change over the period covered by the review.

6.40. 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.

6.41. No issues have been identified by those agencies that have submitted an IMR that indicate organisational change was an influencing factor in the quality and effectiveness of their service delivery. As such, there has been no indication that organisational response or effectiveness needed to be shared with partner agencies at the time. Section 7 provides further details about the changes and improvements made to multi-agency working, the multi-agency response to domestic abuse, and the strategic approach to violence against women.

Concerns amongst family or friends or colleagues or within the community.

6.42. 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?

6.43. Section 4 above outlines information and concerns, as expressed by both Laura and Rachel's family members. While Laura's family were concerned about her relationship with David, they were not aware of any risks in terms of domestic abuse. A neighbour had heard various incidents of domestic abuse and made reports to the Police, which resulted in their home visits. No other information has been provided to indicate other people being concerned that Laura would become a victim of domestic abuse.

Summary statements

6.44. Rachel had originally fled from an abusive relationship to live in Sussex, coming to live in a refuge. This was around the year 2000. She met David over four years later and no information was found regarding any significant contacts she had with agencies and services in the local area. There was, for example, no reference to any concerns about domestic abuse in her GP records. Prior to the Police attending her death, the Police had access to information about a Caution David received in 2003 relating to domestic abuse, and had assaulted a woman with whom he had been in a relationship with, whilst under the influence of alcohol. The victim did not wish to take any further action.

6.45. The principal contacts agencies had with both Laura and with David were in relation to alcohol misuse, but also homelessness. Indeed, Police contacts with them both were almost always when they had been drinking. It is therefore critical in learning from this case to focus on how to prevent domestic abuse and work with victims and perpetrators in the context of significant alcohol misuse and homelessness. Domestic abuse statutory guidance discusses this '… Some victims may use alcohol and drugs as a coping mechanism in response to abuse. Alcohol can also be embedded in a relationship with perpetrators of domestic abuse with perpetrators using alcohol to control victims …'.

6.46. It has also been noted that Laura and David's developing relationship was not disclosed to Worthing Churches Homeless Project while they were living at the Recovery Project. While staff at the Project were aware of Rachel's death and that David had been with her when she died, they were also aware that there had not been a prosecution and that her death had been found to be from natural causes. There was therefore no reason or justification for them to share this information with other residents, including with Laura.

6.47. When the Police saw Laura at the three incidents to which they were called in January and March 2011, they would not have had the authority to tell her of David's three cautions. They completed DASH forms and would have made referrals for support had Laura agreed. The level of risk evidenced by these incidents and David's known previous behaviour was not judged to reach the threshold for referral to the Multi Agency Risk Assessment Conference.

6.48. The information available to this DHR has not revealed that any health or substance misuse service staff had any awareness of the potential risk to Laura. There were several occasions when she attended the Accident & Emergency Department accompanied by David. None of her injuries were ascribed to domestic abuse and there is no information to suggest that they should have been.

6.49. This DHR has found that at the time that Laura was killed, David had not been assessed as being a high risk of harm to others. This limited the ways in which agencies would have responded to any concern about him. There was no evidence available to agencies that would have justified the exchanging of information between agencies without the consent of the parties concerned.

It is considered that being between accommodation and her reliance on alcohol may have made Laura more vulnerable at the time she met David.

7. Lessons learnt as a result of this review

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

- Research[10] 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. Statutory guidance - Domestic Abuse - (2022) – 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

[10] 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.

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 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[11], 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 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[12].

- 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[13] 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

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[11] 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.

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

[13] 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.

victims. For those services that provide support to individuals who have more unsettled accommodation or who lead more transient 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.

8. Learning considered in the current context of policy, procedure & practice

8.1. The following section considers the current context. Given the considerable passage of time, it is argued that this is necessary in order to provide current leaders, managers and practitioners the opportunity to learn from the past in order to shine a light on current practice.

8.2. In their submissions to the Coroner in July 2021, Sussex Police outlined a number of changes to how they identify and respond to victims of domestic abuse. This information has been made available to the review, and includes;

- '… The approach of Sussex Police to incidents of Domestic Abuse in 2011 was the same as it is today in 2021. It is one of risk management, with the aim of reducing the risk of serious harm or homicide, increasing the safety, health and wellbeing of victims, as well as holding perpetrators to account for their actions. However Domestic Abuse Policy 516/2019 which is active in Sussex Police now reflects the current procedures and incorporates changes in the legislation which have significantly aided … risk management in relation to domestic abuse …'.

- '… Domestic abuse incidents and crimes are unique compared to other recorded crime in Sussex. All other recorded crime which, after call handling have no identified solvable or vulnerable factors, will be screened out with no further Police action. This is not the case with domestic abuse crimes and incidents. Sussex Police recognises the threat, harm, risk and vulnerability associated with domestic abuse and as such contact will be made

with all victims. The response is determined based on the immediacy of the incident being reported. This can range from an emergency response to a planned response via video within 48hrs. In order to manage the demand from domestic abuse the grading of these calls is critical in providing a risk-based response …'.

- '… Since 2011 our compliance with the National Crime Recording Standards in terms of both crime recording and crime related incidents has improved significantly. At the last inspection by the HMICFRS [Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services] in 2016 the compliance rate was 94.59% and Sussex Police was given a rating of 'good' ...'.

- '… The current crime, intelligence and case management system in place in Sussex is called Niche. This allows for domestic abuse crimes and incidents to have markers (signals/flags) against them to distinguish them against other crimes and incidents within the system. The benefit of this means that officers are quickly and easily able to identify those crimes and incidents that are domestic related. Niche is a much easier system to access and navigate for officers and staff. Identification of domestic abuse on Niche through the use of markers is visually much clearer for officers to identify. The conversion to Niche and compliance with NCRS [National Crime Recording Standard] means, with a high degree of certainty that all domestic abuse is recorded correctly. This now provides officers with all available information about the perpetrator and the victim, ensuring that information in the DASH is consistent, and updated when new incidents are reported. The expectation being that, in the case of [Laura] our compliance now with NCRS, and the change to Niche, would mean information to inform the DASH risk assessment was easier to access …'.

- The introduction of Multi-Agency Safeguarding Hubs (MASH) – a multi-agency information sharing and decision-making hub for considering information in relation to children, young people and adults. This provides a single point of contact, but also single repository of information.

- '… Divisional Safeguarding Investigation Units that hold responsibility for the management of criminal and safeguarding aspects of investigations involving child and adult abuse, high risk domestic abuse, rape and other serious sexual offences. … Also responsible for reviewing all high-risk DASH forms and referral to the MARAC14 if necessary …All medium risk DASH forms are referred to the MASH …'.

- Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO) became effective in March 2014 as a civil remedy. A DVPN can be issued by the Police at the time of attending an incident; a DVPO can be issued by a Magistrates Court to prevent the perpetrator from returning the home address and allow some breathing space. Both of these options do not necessarily require the consent or cooperation of the

[14] MARAC – Multi-Agency Risk Assessment Conference were first established in Wales in 2003 and then later rolled out across the UK. They are a multi-agency meeting where statutory and voluntary agency representatives share information about high-risk victims of domestic abuse in order to produce a coordinated action plan to increase victim safety.

victim. These options may have been a useful mechanism at the time the Police came into contact with Laura.

- '… Evidence Led Prosecutions - previously referred to as victimless prosecutions. Although these were in place in 2011, their use was to some extent limited for a number of reasons not least around the difficulty in capturing evidence from victims who would not engage ...' This was an issue when Police were responding to incidents involving Laura.

- The introduction of Domestic Abuse Champions to support with a coordinated approach to delivering a consistent and effective response to victims of domestic abuse, led by current best practice.

- The introduction of Local Resolution Teams, specialist investigators who examine incidents of low-risk domestic abuse and trying to engage victims to offer support and advice.

- '… In March 2021 Sussex Police developed and launched its multi-agency high harm serial perpetrator unit. Some of the design principles for this team were taken from another Force. This is a multi-discipline team consisting of Police, mental health, substance misuse and an Independent Domestic Violence Adviser (IDVA15). The aim of the team is to identify those high harm, most active and dangerous domestic abuse perpetrators and with their cooperation address their complex needs and when appropriate offer them help and support through the Building Better Relationship Programme. Identification of these individuals examines frequency, recency, gravity and severity of offending coupled with any indicators of impaired mental health. If after identification, the perpetrator doesn't want to cooperate with the Police then an enforcement and disruption plan is created to target all unwanted and criminal activities ...'.

- Improved technology mechanisms to allow victims to make direct contact with the Police via a system named TecSOS. The introduction and use of body worn video cameras has also assisted first responders gather evidence when attending incidents of domestic abuse.

- Mandatory domestic abuse training to all Police first responders, including investigations, response, neighbourhood teams, Public Protection and communications departments.

- On the 1st April 2021, Sussex Police introduced the Victim Hub which will transform the support provided to victims of all types of crime. Central to this will be further improving the service to victims of domestic abuse and sexual violence, ensuring that they are given support from the most appropriate agency and preventing them having to engage with multiple support workers. The victim hub will also provide an opportunity for Sussex Police to enhance support to partnership arrangements in relation to the

[15] An IDVA is a specialist professional who works with a victim of domestic abuse and aims to assist them become safe, rebuild their life, navigate the criminal justice system and represent the views of the Multi-Agency Risk Assessment Conference.

management of domestic abuse cases and to increase the capacity of Police staff who provide direct support to victims of domestic abuse.

- At a more strategic level, a Domestic Abuse Advisory Group has been established comprising of victims of abuse that can share their perspectives in order to strengthen policy and procedural aspects of the Police response. Also, a Domestic Abuse Scrutiny Panel has been established which brings together representatives from various Police departments with responsibility for responding to domestic abuse, to offer scrutiny, consider patterns and improve learning for the Police.

8.3. In conclusion, Sussex Police have noted '… In the case of [Laura], if this legislation had been available at the time, it would have given Police better enforcement options, and allowed space and time for other agencies and Police to work with [Laura] over a period where [David] was not permitted to be in her house. In the light of the legislative and Police changes and the advancements made in technology, we would be able to better protect a person in Laura's position should she come to Police attention as a victim of domestic abuse in 2021 ...'.

8.4. When asked to provide an update (in November 2021) about actions and changes in the intervening years for the DHR, Sussex Partnership NHS Foundation Trust, who submitted an IMR to this DHR, identified the following improvements to their service delivery in relation to domestic abuse;

- The Trust now has a larger dedicated safeguarding team to support system wide engagement and improved practice.

- The Royal College of Nursing has released the intercollegiate document16 which provides a clear framework identifying the competencies required for all healthcare staff in respect of safeguarding practice.

- The Trust's training around safeguarding has developed in response to the revised intercollegiate document and there is an ongoing rolling programme to keep staff refreshed.

- The Trust have developed mandatory training regarding domestic abuse and updated policies in response to developing knowledge and learning from DHR's across the region.

8.5. When submitting their IMR in 2018, Worthing Churches Homeless Project (now re-named to Turning Tides) reflected that at the time of their contact and involvement with Laura and David in 2010, they did not have an allocated safeguarding lead and safeguarding policy was not as strong or robust as it is now. They reported investments to improving their policy, procedures, response, training and raising safeguarding standards. Also, their services being more closely aligned with statutory partners, particularly West Sussex County Council, Sussex Partnership Foundation Trust and Change – Grow – Live. The Project had been able to increase its local influence and through regular safeguarding audits, they report being able to demonstrate higher levels of transparency and quality assurance, particularly for those high-risk individuals with a history of homelessness and substance misuse. Having reflected on this

[16] Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate document, First edition: August 2018, due for revision in 2021, Royal College of Nursing.

case, they commented '… it is difficult to establish what the nature of the safeguarding concerns would have been for Laura. The level of information we had and the fact that David had been found not guilty of a previous offence, made it difficult to establish what the nature of the concern would have been … in our more recent work with David [post Laura's death in 2011, but prior to the Police re-investigation in 2016] we were much more risk aware specifically post Laura's death, supporting the Police in mitigating against risk while he was being re-investigated …'. The Project also introduced externally facilitated reflective practice sessions which have proven invaluable for discussing challenging cases, especially those where staff feel conflicted. Changes to their risk assessment process were also introduced, alongside strengthened case management systems and processes. The Project cited good practice in their 2018 IMR, in relation to being able to evidence an audit trail many years after events, despite staff changes and people leaving the organisation. In a more recent update provided in January 2022 they have commented on the following current practices and activities:

- In all high support residential services twice daily risk assessments of all clients using traffic light system are completed to identify real time changes in risks and concerns, to support more comprehensive risk assessments.

- Contributions to local rough sleepers/risk meetings held on a weekly basis as part of a multi-agency response to working with high-risk clients.

- Participation in the local MARAC meetings.

- Greater connectivity to local strategic forums such as representation on the Safeguarding Adults Board and the Domestic Violence Strategy Group by the Head of Operations.

- Employing a number of specialist workers including specialist Woman's Workers and qualified Social Workers, and working closely in partnership with Safe in Sussex and Brighton's Woman's Centre.

8.6. Having submitted an IMR in 2018, NHS Coastal West Sussex Clinical Commissioning Group (CCG), highlighted changes in GPs having a greater awareness and understanding about domestic abuse, mental health and substance misuse since 2011. In a more recent update provided in January 2022 the following improvements are noted:

- Embedding of domestic abuse awareness in both adult and child safeguarding training available to CCG and Primary Care staff including; the importance of routine screening for domestic abuse, improved recognition, and response to domestic abuse including appropriate onward referral to specialist services.

- Updated training includes the impact upon children who are experiencing domestic abuse and the appropriate referral pathways to follow. This includes updated materials to reflect the Domestic Abuse Bill 2021.

- Training now also includes awareness of physical and emotional health symptoms that may indicate a person is experiencing domestic abuse.

- Training and communications to primary care regarding the importance of flagging and coding of primary care records in relation to domestic abuse to enable practice staff to be aware of a family experiencing abuse and to follow up in subsequent attendances.

- Reminder to primary care regarding the importance of accurate record keeping and documentation, and this has been enhanced in training packages.

- Three conferences held across Sussex for primary care and other health staff in relation to DA with a focus on coercion and control.

- Development of CCG domestic abuse policy and toolkit to support staff who may be experiencing domestic abuse and also guidance on the issues of staff who may be perpetrators of abuse.

- Regular domestic abuse up-dates in briefings and newsletters for primary care.

- Identified CCG domestic abuse lead.

- Plan to produce a domestic abuse policy for adoption by primary care practices to be developed by July 2022.

- Planned roll out of MARAC awareness training to improve primary care understanding and participation in MARAC.

8.7. Change – Grow – Live highlighted improvements made in their IMR which was submitted in 2018. This included improved communications and working relationships about individual service users with Worthing Churches Homeless Project Hostel, weekly non-medical prescriber clinics run at the Project to support engagement with those harder to reach service users who are also involved with criminal justice organisations and homeless, improved training and coaching sessions for front-line workers to support consistency and improved risk assessment/management, and improved quality assurance processes to identify practice issues, such as missing episodes. In a more recent update provided in January 2022 they have specifically commented on the updates to their practices, based on the original learning identified in 2017:

- West Sussex Drug and Alcohol Wellbeing Network are now part of a new 'Tri-Cluster First Step Service.' The First Step team manage all referrals into all CGL services across Sussex and Kent. This service is designed to ensure that all referrals are processed and contacted in a timely way and that reengagement attempts are made for those who do not respond to initial calls. All referrals are now contacted within two days of referral, to complete a Triage Assessment and book in for a Personalised Assessment with a named Recovery Worker.

- The National CGL Reengagement protocol was retired on 20th June 2019, as it was not seen as fit for purpose for all services across the organisation. The service now takes the opportunity to discuss and agree the elements of the service offer which the service user has decided to engage with and how they would like us to respond if they miss appointments or choose not to engage. Such engagement actions should be individual and proportionate and take into consideration known risks for the service user, such as mental capacity for over 16's and the safety of children and others they may have contact or caring responsibilities for.

- Service users who have known risk factors who are not engaging in treatment continue to be monitored through daily team briefings, weekly clinical meetings, as well as during individual supervision and caseload segmentation meetings.

- A Risk and Recovery Plan is generated for all services from their Personalised Assessment. The assessment cannot be completed without generating a Risk and Recovery Plan. Service users are booked for Personalised assessment by the First Step Service.

- There are clear expectations that service staff who hold caseloads attend daily risk meetings and weekly clinical meetings to communicate and escalate these risks. Attendance at these meetings is mandatory. Further to this, all case holding subcontracted staff complete caseload segmentation meetings every 4-6 weeks. During these meetings reports are generated and caseloads are reviewed to identify and discuss any identified risks.

8.8. Adur & Worthing Councils submitted information in January 2022 commenting on changes in law, policy, procedure and practice specifically relating to domestic abuse and how it affects their work. The following information is helpful to gaining assurances about how they approach domestic abuse:

- Developing a trauma informed approach - managers and front-line staff receiving specialist training to recognise the impact of domestic abuse and other trauma.

- Building strong relationships with Worth, Safe in Sussex, Brighton Women's Centre, Emerging Futures, PAUSE which provides support for women who have experienced or risk repeated removal of children from their care and YADA which delivers frontline projects aimed at raising awareness and preventing the sexual exploitation of women and young people.

- Uses grant funding to strengthen the community and voluntary sector's response to domestic abuse - having provided grant funding to Daisy Chain (pro bono legal support for injunctions), Safe in Sussex, The Juno Project & Probation.

- Facilitated National Domestic Violence Helpline Training for all housing providers in Adur & Worthing Council through the Hate & Anti-Social Behaviour Risk Assessment Conference (HASBRAC) forum.

- Referring to and attending the MARAC to ensure multi-agency responses and safety planning for the domestic abuse cases that are brought to their attention.

- Integrating Domestic Violence Services within the Housing Department to provide advice for frontline workers, referrals into services & safety planning upon initial contact.

- Safety planning for identified vulnerable females who are at potentially at risk of harm within Statutory Accommodation Pathways.

- Stating our intent as an organisation to challenge violence against women and girls in all forms including public place violence and sexual harm and also domestic abuse.

- Revenues & Benefits (Council Tax collection and Benefit administration respectively)

- Staff from the Revenues & Benefits Service have received training to identify vulnerable customers and to take appropriate action (e.g., referring potential safeguarding cases, and in respect of debt collection to pause recovery and refer customers to support services).

8.9. University Hospitals Sussex NHS Foundation Trust, responsible for providing Hospitals (Worthing, St Richards's and Southlands), submitted an IMR. Although no domestic abuse was identified at the time, in their update, they have commented that current practice expectations would be for staff to be more curious about A&E presentations and ask more questions. They also note that based on David's disclosure of possibly wanting to rape someone, as well as informing the Police (which they did) there would now be an expectation that Children's Services would also be informed given his own family circumstances. The Trust also note improvements;

- Training across the Trust concerning both children and adult safeguarding related matter, and the need to think about all members of a family.

- Improved awareness about domestic abuse, stalking and harassment.

- Additional support to be provided to Trust hospital staff in the West area, by independent domestic violence advisers. Resourcing is currently under review, but not yet to be secured.

8.10. Although not involved with either Laura, Rachel or David at the time of the incidents, the Probation Service have provided an update about learning that they captured as a result of their contact with David given that there were some observations about the quality and timeliness of actions taken when David was sentenced in 2016. These consisted of general practice and procedural expectations and include:

- To complete more routine Police Intelligence Checks, where appropriate, as a further source available to monitor risk and relationships with a domestic abuse context.

- To liaise more routinely with victim services / domestic abuse services in the community, to further monitor risk and facilitate multi-agency working.

- To ensure reporting frequency is in line with the assessed level of risk.

- To ensure compliance is thoroughly monitored and enforcement decisions and actions are recorded.

- To ensure reviews are completed within the required timeframe.

8.11. More strategically, and beyond the local issues identified through single agency reporting set out above, a number of other changes have occurred. These have been as a result of both developments nationally through legislation and policy initiatives, but also local learning and improvement as a result of other reviews which have been completed in West Sussex and which await publication. These other reviews include Domestic Homicide Reviews, Adult Safeguarding Reviews and children's Serious Case Reviews/Child Safeguarding Practice Reviews – but all of which have some identifiable features that resonate with the learning identified in this DHR. For ease of reading, these are summarised below;

- The development of the West Sussex Domestic and Sexual Abuse and Violence (DSAV) Steering Group, a Pan Sussex strategic framework and action plan - which aims to ensure 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 and how to seek help for themselves and others in a way which meets their needs.

- The appointment of a Domestic and Sexual Violence and Abuse Community Safety Lead officer role within West Sussex.

- The development of community safety social media pages detail services and support information.

- Resources have been committed to domestic abuse awareness campaigns, spanning social media and digital campaigns and, more recently, in response to the increased risks following lockdown restrictions, linking in with the Government 'you are not alone' COVID-19 campaign.

- The Safer West Sussex Partnership has run training webinars regarding domestic abuse, community engagement events with Sussex Police, conferences pre COVID-19, and media promotion including perpetrator response provision, white ribbon day events and international women's day events. The approach adopted has intended to raise awareness and to encourage greater recognition of the signs of domestic abuse by altering language and vocabulary used so that people are more able to identify and recognise signs of domestic abuse, and themselves as victims of domestic abuse. This work is inclusive of encouraging reporting by the LGBTQ+ community.

- Partnership working with Sussex Police is integral to the way services manage risk and align responses. Sussex Police have worked in partnership with Safe Lives and developed nationally recognised Domestic Abuse Matters training, which has been delivered to all Sussex Police Officers. This is now a rolling programme as part of their initial training.

- WORTH is the West Sussex Specialist Domestic Abuse Service which supports people at high risk of harm or homicide as a result of domestic abuse. They have teams of independent domestic violence advisors (IDVAs) across West Sussex who work to identify, assess and assist people at risk. WORTH meets regularly with Police, statutory and voluntary sexual violence services, ensuring best practice and to improve the victim experience. They also provide training to other agencies

- Multi-Agency Risk Assessment Conferences (MARACS) have been established since 2010-11 and there is a responsibility on all agencies to share information in these settings. The purpose of the MARAC is to share information to increase the safety, health and well-being of victims/survivors, adults and their children. They also seek to determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community. West Sussex have also developed a 'MARAC plus' process which provides an even greater level of multi-agency case management for highly-complex high-risk cases.

- Work has been undertaken so that flags can be added to GP notes following MARAC so they can see patients experiencing domestic abuse. To maintain this vital link and support for GP MARAC liaison dedicated administrative post is currently funded by

health. Specific training has been provided to GPs in response to the recommendations from historic reviews.

- Worthing Women's Aid has expanded to cover West Sussex; and is known as Safe in Sussex, and operates refuges, a drop-in centre, educational work in schools and support groups for women who have been victims of domestic abuse.

- The implementation of Operation Encompass, a locally implemented but national initiative, for the Police to report to schools when a child has been involved in, or exposed to a domestic abuse incident so that the school can provide the child with support. This complements any other additional support or assessment provided by the Multi-Agency Safeguarding Hub (MASH).

8.12. Legislative and central Government changes of particular note include, for example;

- In 2014, the Care Act 2014 brought the arrangements for safeguarding vulnerable adults onto a statutory footing and included domestic abuse as a category. This has prompted changes at a local level, many of which have been outlined above.

- The introduction of the Domestic Violence Disclosure Scheme (DVDS) – often known as Clare's Law since 2014 - now enables the Police to provide members of the public with information regarding a current or ex-partner about whether they have a history of violence and abusive offending that may pose a risk to that person. A disclosure can also be requested by a third party – a family member, friend, colleague or neighbour to protect some they believe to be at risk from their partner17.

- Tackling violence against women & girls, July 2021, HM Government – a national strategy which sets out the Government's approach to dealing with crimes which disproportionately affect women and girls.

- The Domestic Abuse Act 2021 which amongst other items, introduces a statutory definition of domestic abuse and establishes a Domestic Abuse Commissioner in law, and powers for responding to domestic abuse.

[17] The scheme has two elements: the "Right to Ask" and the "Right to Know". Under the scheme an individual or relevant third party (for example, a family member) can ask the Police to check whether a current or ex-partner has a violent or abusive past. This is the "Right to Ask". If records show that an individual may be at risk of domestic abuse from a partner or ex-partner, the Police will consider disclosing the information. The "Right to Know" enables the Police to make a disclosure on their own initiative if they receive information about the violent or abusive behaviour of a person that may impact on the safety of that person's current or ex-partner. This could be information arising from a criminal investigation, through statutory or third sector agency involvement, or from another source of Police intelligence. A disclosure can be made lawfully by the Police under the scheme if the disclosure is based on the police's common law powers to disclose information where it is necessary to prevent crime, and if the disclosure also complies with established case law, as well as data protection and human rights legislation. It must be reasonable and proportionate for the Police to make the disclosure, based on a credible risk of violence or harm. Home Office, HM Government, November 2021.

8.13. Local learning from other reviews[18] relating to the safeguarding of adults, has touched on issues relating to information sharing, record keeping, agency assessment and risk management. Of note, none of the 12 Adult Safeguarding Reviews completed in the last five years featured domestic abuse or alcohol and drug misuse. Of the children's Serious Case Reviews/Child Safeguarding Practice Reviews conducted in West Sussex a number have featured domestic abuse.

8.14. The high-level descriptors such as information sharing, record keeping, agency assessment and risk management are familiar subjects for statutory reviews to make findings on[19], and which reflect the often-complex nature of multi-agency working arrangements. These findings highlight the constant need for a better understanding about how these core practice areas are interpreted and the human processes which contribute to identifying, assessing and making decisions about risk from a front-line perspective – an aspect that is all too apparent in this case, given the findings of the criminal Court and Coroner's Court. Given the greater public awareness about domestic abuse since Rachel's death in 2006, but certainly since Laura's death in 2011, it is argued that there is a much stronger narrative in professionals' awareness of the issues. It therefore must be hoped that this encourages professionals' interactions with those subject to domestic abuse, to be more alert and more inquisitive when working with victims of domestic abuse.

9. Conclusion

9.1. This Domestic Homicide Review was commissioned in April 2017 following the convictions for murder and manslaughter conviction of a 43-year-old male. The male had been found guilty of murdering a woman in March 2011, and the manslaughter of another woman in 2006. At the time of their respective deaths, the Police did not consider it necessary to conduct homicide investigations and their deaths were ruled as either accidental or of natural causes. Through legal challenge, the parents of one of the deceased campaigned, resulting in the convictions and a ruling by the Coroner of unlawful killing being given in July 2021.The Inquest made clear findings about the conduct of Sussex Police at the time of their involvement with both victims. The legal challenges resulted in the DHR having to be paused pending the outcome.

9.2. Given the inextricable links between both victims, this Domestic Homicide Review has sought to examine – albeit some ten and fifteen years after their respective deaths – the contact and involvement of both victims with agencies and services. The terms of reference, lines of enquiry and methodology sought to examine – in the best way available given the passage of time – information that shed light on past practice, whilst shining a light on current arrangements for responding to domestic abuse. Whilst purposely limiting the detailed information which was thoroughly and systematically examined in the criminal trial

[18] Summary analysis of Adult Safeguarding Reviews conducted in the last 5 years, by the West Sussex Adult Safeguarding Board, October 2021, unpublished.

[19] a) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews, 2011 to 2014, May 2016, University of Warwick & University of East Anglia, HM Government, b) Complexity and challenge: a triennial analysis of SCRs 2014-2017, March 2020, University of Warwick & University of East Anglia, HM Government, c)

and Coroner's Inquest, the review has identified a number of factors which agencies and services need to remain alert to. These include;

- Mental ill health, substance misuse and the perpetrator having a previous abusive history are commonly found in relationships where there is domestic abuse.

- Victims of domestic abuse often find it difficult, due to their circumstances, to disclose abuse or seek support.

- Abusive partners can often exercise control over their victim partners in ways that are not always obvious to those around them.

- Those living in unsettled accommodation, and who misuse alcohol, may be more vulnerable to forming relationships that become abusive.

- The cumulative impact of those living with domestic abuse where risk assessment appears to indicate a persisting lower level of harm, should never be minimised.

9.3. The review originally benefitted from the contributions of family members, of both victims. In the closing stages of this review, Laura's parents chose not to read the report, where-as Rachel's son was able to contribute and express a view.

9.4. In drawing this review together, the Safer West Sussex Partnership have commented '… the Safer West Sussex Partnership (SWSP) are currently updating information regarding DHR's for professionals and are due to publish resources on the West Sussex County Council website that will provide helpful information for residents and professionals. The SWSP are working closely with colleagues and partners across Sussex to ensure that learning from domestic homicide reviews is disseminated effectively between agencies across each of the authorities to ensure that common themes arising are not limited to one geographic area and that recommendations are embedded across organisations and geographic boundaries …'. These updates and initiatives are a positive step forward.

10. Recommendation

10.1. As detailed in section 7, considerable changes and improvements have taken place in the intervening years since events occurred. However, the specific lessons learnt identified in section 7 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 Strategic Framework 2020-2024 has been created, which in turn, provides for a local West Sussex Strategic Framework Action Plan and 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 above are known about, and plans are in place to tackle them.

- 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.

- 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.

- 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.