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Domestic Homicide Review

Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Nicola
in April 2020

Chair: Gary Goose MBE

Report Author: Christine Graham

July 2022

Preface

The Safer West Sussex Partnership and the Review Panel wish at the outset to express their deepest sympathy to Nicola's family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by the Safer West Sussex Partnership on receiving notification of the death of Nicola in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

1. Section One - The Review Process

1.1. Reason for conducting the Review and timescales

1.1.1 This summary outlines the process undertaken by the West Sussex Community Safety Partnership domestic homicide review panel in reviewing the murder of 'Nicola' who was a resident in their area.

1.1.2 The following pseudonyms have been used in this review for the victim and perpetrator:

1.1.3 Nicola for the victim. Nicola was a white British woman who was 52 years old when she was murdered.

1.1.4 The perpetrator will be known only as the 'the perpetrator'. He is a white British man who was 47 years old when he killed Nicola.

1.1.5 Nicola's murder occurred in April 2020 and was discovered after various messages were received by family members from the perpetrator, the nature of which led to concerns for her welfare. When they attended the address, they found her deceased with a number of injuries. Police attended and commenced a murder investigation. The perpetrator had left the area: he was located by police and arrested. He was subsequently charged with Nicola's murder. At his trial, the perpetrator pleaded not guilty to murder and not guilty to manslaughter. He refused to answer any questions about how Nicola met her death. He was found guilty of murder. In February 2021, he was given a life sentence and must serve just over 16 years before he is can begin to be considered for parole.

1.1.6 The Safer West Sussex Partnership was advised of the death of Nicola by Sussex Police on 15th April 2020 – Sussex Police requested that a DHR was considered.

1.1.7 At a meeting of the West Sussex Domestic Homicide Oversight Panel on 26th May 2020, the decision was made that the criteria for a DHR were met and would be commissioned.

1.1.8 An Independent Chair and Report Author were appointed in July 2020. On 8th July 2020, the Community Safety Partnership wrote to Nicola's family to advise them that a review was to be undertaken and advised that the Chair and Report Author would be in contact with them.

1.1.9 On 4th August 2020, the Home Office was advised that a DHR was to be undertaken.

1.1.10 A scoping exercise was initially undertaken, and all agencies were asked to secure and preserve any written records that they had pertaining to any prior contact with the victim, perpetrator and any relevant information relation to their children.

1.1.11 The panel met four times and the review concluded in July 2022.

1.1.12 The review could not be completed within six months due to the need to proceed in limited scope until the conclusion of the trial, and the extra pressure that the COVID-19 placed on agencies. Time was also spent seeking the support of Nicola's family.

1.2. Contributors to the Review

1.2.1 The following agencies contributed to the review:

- Arun District Council – IMR and panel member
- Clinical Commissioning Group – IMR and panel member
- Department of Work and Pensions – Summary report
- Optivo – IMR and panel member
- Safe in Sussex (Specialist domestic abuse service) – panel member
- Safer West Sussex Partnership – Panel member
- Sussex Community Foundation Trust – IMR and panel member
- Sussex Police – IMR and panel member
- United Response – Summary report
- West Sussex County Council (Adult Social Care) – IMR and panel member
- West Sussex Hospital Trust – IMR and panel member

1.2.2 The Independence of panel members and IMR authors was established through the review process.

1.3. The Review Panel Members

1.3.1 The members of the Review Panel were:

Table 1: Members of the Review Panel

Name	Role	Organisation
Gary Goose	Independent Chair	
Christine Graham	Independent Report Author	
Cathryn French	Safeguarding Officer	Arun District Council
Georgina Bouette	Communities and Wellbeing Manager	Arun District Council
Sharon Saunders	Regional Manager	Optivo
Sharon Howard	Service Manager	Safe in Sussex (specialist domestic abuse service)
Alison Cooke	Named Nurse, Adult Safeguarding	Sussex Community NHS Foundation Trust
Gillian Field	Designated Nurse, Adult Safeguarding	Sussex NHS Commissioners
Bryan Lynch	Deputy Director of Social Work	Sussex Partnership Foundation Trust
Jane Wooderson	Detective Sergeant, Strategic Safeguarding Team	Sussex Police
Pam Mariner	Safeguarding Adults Nurse Specialist	University Hospital Sussex NHS Foundation Trust
Lisa Ekinsmyth	Matron for Quality	University Hospitals Sussex NHS Foundation Trust
Wendy Shepherd	Operations Manager, Adult Social Care and Health	West Sussex County Council
Philippa Gibson	Senior Commissioning Manager, Substance Misuse Services	West Sussex County Council
Keely Mitchell	Service Manager, Adolescent Family Resource Team	West Sussex County Council
Faye Mills-May	Domestic and Sexual Violence and Abuse Community Safety Lead Officer	West Sussex County Council
Emma Fawell	Violence Reduction Partnership Lead	West Sussex County Council

1.3.2 All members of the panel were independent of engagement with either Nicola or the perpetrator.

1.4. Engagement with family

1.4.1 In July 2020, the Safer West Sussex Partnership wrote to Nicola's children to advise them about the review. As one child was under 18, a letter was sent to their father explaining the process, with the letter to the child enclosed.

1.4.2 The Chair and Report Author also wrote letters to the children (in the same way as above), and the police hand delivered the letters: they also provided details of AAFDA (Advocacy After Fatal Domestic Abuse). Following the trial, a further letter was sent in May 2021. There was no response received. The Review Panel considered if anything further might be possible to encourage them to engage, but it was felt that, considering the action taken, this would not be appropriate. The panel fully understands the children's wish not to engage with the review.

1.4.3 Given that the review was not able to learn about Nicola from her family, the police, on behalf of the panel, were asked to identify any others who may be able to assist the review in understanding Nicola and her relationship with the perpetrator. Unfortunately, no others were identified.

1.4.4 Once the Overview Report was drafted, further contact was made to see if they wished to see the report. This was by way of a personal visit from the officer in the criminal case. The family chose not to engage with the review, and the panel respects their decision.

1.4.5 The perpetrator was approached by the Chair and Report Author early in the process, but did not feel able to engage in the review at that time. Once the draft report was completed, he was contacted again in prison and, through his offender manager, he replied that he had no recollection of his actions in the commission of the offence. Additionally, he claimed that there were no domestic issues leading up to the offence and had led an offence-free life from 1997 until then. He therefore had no information he thought could be of benefit to the review.

1.4.6 A member of the panel had known the perpetrator's adult child in a previous role, and so was able to meet with them and obtain their input into the review. The adult child confirmed to the panel that they had made their father aware that they were contributing to the review. The Chair and Report Author acknowledge the contribution of this panel member in facilitating this.

1.5. Independent Review Chair and Overview Report Author

1.5.1 The Independent Chair for this Review was Gary Goose MBE. The Overview Author was Christine Graham.

1.5.2 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and, reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England, and Adult Care Reviews.

1.5.3 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review, nor have, at any point in the past, been associated with any of the agencies.[1]

1.5.4 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse). Details of ongoing professional development are available in Appendix Two of the Overview Report.

1.6. Terms of Reference for the Review.

1.6.1 Overarching Aim

1.6.2 The over-arching intention of this review is to learn lessons from the homicide in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion, bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future, and how they can work more effectively with other partners.

1.6.3 Principles of the Review

1. Objective, independent & evidence-based.
2. Guided by humanity, compassion and empathy, with the victim's voice at the heart of the process.
3. Asking questions to prevent future harm, learn lessons, and not blame individuals or organisations.
4. Respecting equality and diversity.
5. Openness and transparency whilst safeguarding confidential information where possible.

1.6.4 Specific Areas of Enquiry

1.6.5 The Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with Nicola and the perpetrator.

2. Whether, in relation to the either Nicola or the perpetrator and the children identified, an improvement in communication between services might have led to a different outcome for Nicola.

3. Whether the work undertaken by services in this case was consistent with each organisation's professional standards.

4. Whether the work undertaken by services in this case was consistent with each organisation's domestic violence policy, procedures, and protocols.

5. The response of the relevant agencies to any referrals, including attendances at services, relating to Nicola until the point of death. It will seek to understand

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

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 and alternative wrap around support were offered/provided, and/or relevant enquiries made, including specialist domestic abuse support referrals, in the light of any assessments made.

d. The quality of the (risk) assessments undertaken by each agency in respect of Nicola and the perpetrator.

6. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case and that of the children of Nicola. A number of assessments completed between 2009 and 2013 resulted in no further action, and did not result in Children In Need Planning and Review Meetings, nor Child Protection plans.

7. Whether an improvement in communication between services identifying mental health issues, alcohol dependence, and prescribed medication dependence, might have led to a different outcome.

8. 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?

1.6.6 Family Involvement and Confidentiality

1.6.7 The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members, and to identify other people they think relevant to the review process.

1.6.8 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support, and any existing arrangements that are in place to do this.

1.6.9 We will identify the timescale and process, and ensure that the family are able to respond to this review – endeavouring to avoid duplication of effort and without undue pressure.

1.6.10 Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMRs. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.

- The Independent Chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.

- A criminal investigation is running in parallel to this DHR, therefore all material received by the panel must be disclosed to the SIO and the police disclosure officer.

- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.

- Individuals will be granted anonymity within the Overview Report and Executive Summary, and will be referred to by pseudonyms.

- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

1.6.11 Timescales

1.6.12 All Domestic Homicide Reviews are to be submitted to the Home Office within 6 months of notification. Any delays to this deadline will be communicated to the Home Office.

1.6.13 The location of meetings will be confirmed in light of current social distancing measures. Some meetings may be held virtually.

1.6.14 Media Strategy

1.6.15 Any media enquiries prior to the conclusion of the trial must be referred to West Sussex County Council. Post-trial, enquiries should be directed to the Chair, who will agree a media strategy with West Sussex County Council.

1.6.16 Chairing & Governance

1.6.17 An Independent Chair has been appointed to lead on all aspects of the review and will report to the Chair of the WSCC Strategic Community Safety Partnership.

1.6.18 A panel has been convened specifically to overlook the review process. This is a mix of statutory and voluntary sector agencies, and includes specialist domestic violence services.

1.6.19 The WSCC Strategic Community Safety Partnership will sign off the final report and submit it to the Home Office Quality Assurance process.

1.6.20 Agency Roles and Responsibilities

- Delegate a senior officer to lead on the review on behalf of their organisation

- Senior officers will attend all panel meetings

- Complete Individual Management Reviews within agreed timeframes
- Contribute to the Review Report.

1.6.21 Information Sharing & Confidentiality

1.6.22 The principles outlined in Sussex Criminal Justice Board Information Sharing Guidance[2] will be applied at all times. In addition to this, further reference will be made to the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

1.7. Equality and Diversity

1.7.1 Throughout this review process, the panel has considered the issues of equality. In particular, the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.7.2 Women's Aid states: 'domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family'.[3] According to a statement by Refuge, women are more likely than men to be killed by partners/ex-partners, with women making up 73% of all domestic homicides, with four in five of these being killed by a current or former partner[4]. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[5]

[2] Safer West Sussex Partnership Information Sharing Protocol
[3] (Women's Aid Domestic abuse is a gendered crime, n.d.)
[4] ONS (2018), 'Domestic abuse: findings from the Crime Survey for England and Wales: year ending March 2018'. (pdf)
[5] (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

1.7.3 The majority of perpetrators of domestic homicides are men – in 2017/18, 87.5% of domestic homicide victims were killed by men6. Furthermore, in 2017/18, 93% of defendants in domestic abuse cases were men[7], and in 2017, 468 defendants were prosecuted for coercive and controlling behaviour, of which 454 were men and only nine were women[8].

1.7.4 Whilst not registered as disabled, Nicola had been diagnosed with Emotionally Unstable Personality Disorder (EUPD) and had several chronic health conditions. These impacted on her day-to-day life.

[6] Ibid.
[7] CPS (2018), 'Violence against women and girls report, 2017-18' (pdf)
[8] Ministry of Justice (2018), 'Statistics on women and the criminal justice system 2017'.

2. Section Two - Summary Chronology

2.1.1 It is believed that Nicola and the perpetrator had been in a relationship from around 2014. The only rationale for this is that in October 2014, the perpetrator reported an incident to the police and gave Nicola's address. Information relating to the nature of their relationship has been difficult to obtain, either during the police murder enquiry or indeed this review. We do know that they did not live together until the onset of Lockdown One, initiated as the Government response to Covid, at the end of March 2020.

2.1.2 Nicola was a person who suffered with acute stress and anxiety and in the years before her murder was involved with a range of services who were supporting her to overcome the stresses that were in her life. Such services included regular consultations with her GP, adult social care, housing services and services supporting her with her financial situation. None of the stressors disclosed related to her relationship with this perpetrator. They were discussed in depth and were largely relating to her own health and issues with her children.

2.1.3 That level of stress seemed to increase as the issue of Covid 19 became more newsworthy and it is clear that she was very worried about the effect that Covid could have upon her and her health. There were regular discussions with her GP about how she would manage this.

2.1.4 Similarly, there were no issues that affected the perpetrator in his interaction with any services prior to the murder that would give any indication of any issues in relation to his relationship with Nicola. In fact, there is no record of Nicola being his partner in any organisation's files.

2.1.5 The last known contact Nicola had with services was on 6th April. On that day she had a remote consultation with her same GP. She said that the COVID-19 crisis was making her feel more anxious, given her vulnerability because of asthma. She said that she was shielding and isolating for 12 weeks. As the only support that she had was from a 'friend' who was living with her, she requested a copy of this consultation so that his employer would allow him to shield with her and thereby reduce the risk of him bringing COVID-19 into the home. The GP agreed to email a copy of the consultation. The GP did not recommend that Nicola should shield. This friend is believed to be this perpetrator.

2.1.6 On the same day a support worker filled in a further compensation form for Nicola and posted it in relation to an issue she was helping her with. The worker spoke to Nicola for 45 minutes on the phone. She was much brighter than she had been the week before when the lockdown had been imposed. At that time, she said that she had panicked about money and getting food. She said that she and the perpetrator would lockdown together at her house. He had lent her £200 and bought food. She said that she had access to food vouchers if she needed them but thought she would be fine now that the perpetrator was there. They agreed that they would speak on the phone on 14th April.

2.1.7 In the next few days, Nicola was found deceased. Prior to her death there had been no calls to any service about their relationship.

3. Section Three - Key issues arising from this Review

3.1.1 Domestic Homicide Review is tasked with identifying a trail of domestic abuse in the relationship. This review has looked at the evidence of domestic abuse in the relationship between Nicola and the perpetrator.

3.1.2 Whilst there is evidence that Nicola spoke openly to her GP and the support worker from United Response, she did not disclose any domestic abuse. There is no evidence, however, that either organisation specifically asked her about domestic abuse. If this had been done, it may have provided an opportunity for her to discuss her relationship and disclose abuse.

3.1.3 Several people who were interviewed during the murder investigation[9] agreed that the relationship could be volatile. They said that Nicola would argue with the perpetrator, and he would walk away. There was no information that came to light to say that the perpetrator was previously violent towards Nicola. That said, we do know that he had a history of violence, albeit some time earlier. One person who knew the perpetrator, described his relationship with Nicola as being different; he was much happier with Nicola, and they were content.

3.1.4 The review has noted that whilst all the friends talked about physical violence in the relationship, which is probably unsurprising as they were being spoken to after Nicola's violent death, there is no mention of other forms of abuse. We do know that they would separate for a few days as at a time and then resume their relationship.

3.1.5 The review notes that there is still a need to ensure that the public understands that domestic abuse is not just about physical abuse, and that there are many forms of abuse. This ongoing lack of understanding means that both victims and their family and friends do not recognise when abuse may be occurring and, equally, do not know where to seek help. We make a recommendation in relation to this.

3.1.6 The review cannot know if, for example, emotional abuse or coercive and controlling behaviour was a feature of the relationship.

3.1.7 As a result, this review has looked at the impact of drugs and alcohol in relation to them increasing Nicola's vulnerability.

3.1.8 We have also looked at the impact of Covid 19 upon services and lessons that can be learned from the implementation of the lockdowns.

[9] These statements were shared confidentially with the Chair and Report Author.

4. Section Four – Lessons Identified

4.1. ARUN DISTRICT COUNCIL

4.1.1 Domestic abuse was only covered in the housing section of the council's website. Since Nicola's death, a dedicated area on the council's website has been created that gives advice in different languages to represent the diversity of the communities in Arun, along with a safe exit button.

5. Section Five – Recommendations

5.1. UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST (WORTHING, ST RICHARD'S AND SOUTHLANDS HOSPITAL)

5.1.1 That the Trust reviews its training and awareness raising about sharing information with the police when clinical staff suspect criminal activity. This will allow consideration to be given to the challenge of balancing sharing information with patient confidentiality.

5.1.2 That the Trust refreshes its training and awareness raising about domestic abuse and continues to work towards securing a Health Independent Domestic Abuse Advisor (HIDVA) to work within the hospitals to support domestic abuse awareness and service provision.

5.2. SAFER WEST SUSSEX PARTNERSHIP

5.2.1 That Safer West Sussex Partnership implements a programme of awareness raising for victims and their family and friends to help them to recognise the wider abuse that can occur in relationships.

5.2.2 That the Partnership raise the profile, awareness of and the access routes to alcohol support services.

6. Section Six - Conclusion

6.1.1 The death of Nicola occurred within the first few weeks of the first COVID-19 lockdown. The timing is relevant in this case.

6.1.2 Nicola and this perpetrator had maintained a relationship for several years. They had not lived together until lockdown. The reasons for Nicola being murdered by this perpetrator within weeks of that decision, have never been properly established. He has refused to say how or why it happened. There are no incidents or triggers that have ever been exposed, during either the police murder investigation or this review, that can shed a light upon Nicola's death.

6.1.3 What is known is that Nicola was a particularly anxious person. That anxiety increased during the onset of COVID-19, and she was in receipt of support in managing that anxiety in the weeks before she died. That service had no indicators that the perpetrator moving in with her was an additional danger, in fact it was considered that she had more support by him being there.

6.1.4 Nicola consulted her GP regularly about her mental health, health anxiety, and life stressors. She would speak about her physical symptoms as well as stressful events, such as the problems with her benefits. Nicola's GP sought to refer her to a range of other services, but they were largely unsuccessful in engaging with her.

6.1.5 The perpetrator in this case had a number of previous criminal convictions, however, most were many years previously and none were for domestic abuse.

6.1.6 What has become clear from those spoken to within the community by the police investigation, is that in some parts of the community, domestic abuse is still considered only as 'violence'. If violence is not identified, then the wider definition of abuse seems largely unrecognised. It is in this area that this review feels others could be better protected in the future.