Domestic Homicide Review Report

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.

This Overview Report has been compiled as follows:

Section 1 begins with an introduction to the circumstances that led to the commission of this review, and the process and timescales of the review.

Section 2 is a chronology in the years and months leading up to Nicola's murder.

Section 3 sets out a detailed analysis of agency involvement.

Section 4 sets out what the review has learned about Nicola.

Section 5 analyses the issues pertinent to this review.

Section 6 brings together the lessons identified, and **Section 7** collates the recommendations that arose.

Section 8 draws the conclusions from this review.

Appendix One provides the terms of reference against which the panel operated.

Appendix Two sets out the ongoing professional development of the Chair and Report Author.

Appendix Three lists the perpetrator's previous contact with the police that are relevant to the review.

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1. Section One – Introduction

1.1. Summary of Circumstances leading to the Review

1.1.1. On a day in April 2020, various family members received messages, by text, from the perpetrator that raised their concerns for Nicola's welfare. They were unable to contact her, so went to the address and found her deceased in bed with what appeared to be injuries inflicted by someone else.

1.1.2. Police attended and commenced a murder investigation. The perpetrator had informed family that he had left the area: the next day he was located by police and arrested. He was then charged with Nicola's murder. At his trial, the perpetrator pleaded not guilty to murder and not guilty to manslaughter, and refused to answer any questions about how Nicola met her death. He was found guilty, by a jury, of murder. In February 2021, he was given a life sentence and must serve just over 16 years before he is considered for parole.

1.2. Reasons for Conducting the Review

1.2.1. This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2. The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3. In this case, the victim was the partner of the perpetrator, therefore the criteria has been met.

1.2.4. The purpose of the DHR is to:

- 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
- 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
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity

- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.2.5. The review also considered:

- Whether thresholds for intervention were appropriately calibrated and applied correctly in this case, and that of Nicola's children
- Whether an improvement in communication between services identifying mental health issues, alcohol dependence and prescribed medication, might have led to a different outcome
- Whether there were concerns amongst those who knew Nicola, and if so, whether these concerns could have been harnessed to enable intervention and support
- The impact that the COVID-19 lockdown had in this case.

1.3. Methodology and Timescales for the Review

1.3.1. 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.

1.3.2. 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 was met and would be commissioned.

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

1.3.4. 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.

1.3.5. Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998, which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 2018 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.3.6. A chronology was compiled, bringing together the information that was known by each agency.

1.3.7. The panel met for the first time on 10th August 2020 on Microsoft Teams. At this meeting, the process and ethos of Domestic Homicide Reviews was discussed. The following agencies were present:

- Clinical Commissioning Group (these have since been replaced with Integrated Care Boards).
- My Sister's House (specialist domestic abuse service)
- Optivo (Nicola's landlord)
- Safer West Sussex Partnership
- Sussex Police
- West Sussex County Council – Children's Social Care
- West Sussex County Council – Drug and alcohol services commissioner

1.3.8. Apologies were received from:

- Sussex Partnership Foundation Trust (mental health service provider)
- West Sussex County Council – Adult Social Care

1.3.9. As the trial had not yet concluded, the review proceeded in limited scope. After the trial had concluded, Individual Management Reviews were commissioned from:

- Arun District Council
- GP for both Nicola and the perpetrator
- Optivo
- Sussex Community Foundation Trust
- Sussex Police
- West Sussex County Council – Adult Social Care
- West Sussex Hospital Trust (This organisation is now University Hospitals Sussex)

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

1.3.11. 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.

1.4. Confidentiality

1.4.1. The content and findings of this review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2. To protect the identity of the deceased, and her family and friends, the victim will be known in the report by the pseudonym of Nicola. As Nicola's family had chosen not to engage with the review, the pseudonym was chosen by the Report Author.

1.5. Terms of Reference

1.5.1. The Domestic Homicide Review sought to explore the following areas:

- Identification of the key opportunities for assessment, decision-making and effective intervention in this case, from the point of any first contact onwards.
- Whether any actions taken were in accordance with assessments and decisions made, and whether those interventions were timely and effective.
- 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.
- The quality of the (risk) assessments undertaken by each agency in respect of Nicola and the perpetrator

1.5.2. The full Terms of Reference can be found at Appendix One. The Terms of Reference were drawn up at the beginning of the DHR before all the details were known and therefore there are some elements of the Terms of Reference are not addressed given the information that came to light.

1.6. Dissemination

1.6.1. The following individuals/organisations will receive copies of this report:

- Domestic Homicide Review Panel
- Safer West Sussex Partnership Board
- Children and Adult Safeguarding Boards
- Health and Wellbeing Board
- Domestic Abuse Commissioner

1.7. Contributors to the Review

1.7.1. Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs, and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2. All panel meetings included specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by this Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3. However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation, either by attendance at the panel or meeting for an interview.

1.7.4. The following agencies contributed to the review:

1.7.5. 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

1.7.6. 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.

1.7.7. 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.

1.7.8. The panel considered the appropriateness of this approach but, given that the adult child felt unable to meet with the Chair and Report Author, the panel felt that this provided the only opportunity for input from the family. The Chair and Report Author felt that the value of this information outweighed any limited conflict of interest that could have been present.

1.8. Engagement with Family and Friends

1.8.1. 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.

1.8.2. 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.

1.8.3. 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. The police had, through the murder investigation, no contact for Nicola's siblings.

1.8.4. 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.

1.9. Review Panel

1.9.1. The members of the Review Panel are listed in the table below:

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

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

1.10. Domestic Homicide Review Chair and Overview Report Author

1.10.1. Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high- profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011, Gary was employed by

Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility, as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner, developing a performance framework.

1.10.2. Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.10.3. 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.

1.10.4. 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]

1.10.5. 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.

1.11. Parallel Reviews

1.11.1. The coroner did not reopen the inquest following the criminal trial.

1.11.2. There were no other parallel reviews undertaken.

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

1.12. Equality and Diversity

1.12.1. 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

1.12.2. 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'.[2] 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[3]. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[4]

1.12.3. The majority of perpetrators of domestic homicides are men – in 2017/18, 87.5% of domestic homicide victims were killed by men[5]. Furthermore, in 2017/18, 93% of defendants in domestic abuse cases were men[6], and in 2017, 468 defendants were prosecuted for coercive and controlling behaviour, of which 454 were men and only nine were women[7].

1.12.4. 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. Later in this report, the impact that EUPD had on her and how she coped with the pressures that she faced, are discussed in more detail. These aspects are not duplicated within this section as they would still need to be repeated, in context, later within this report.

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[2] (Women's Aid Domestic abuse is a gendered crime, n.d.)
[3] ONS (2018), 'Domestic abuse: findings from the Crime Survey for England and Wales: year ending March 2018' (pdf)
[4] (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.)
[5] Ibid.
[6] CPS (2018), 'Violence against women and girls report, 2017-18' (pdf)
[7] Ministry of Justice (2018), 'Statistics on women and the criminal justice system 2017' (pdf)

2. Section Two - Chronology

2.1. Chronology

2.1.1. It is believed that Nicola and the perpetrator were in a relationship from around 2014. The rationale for this is that in October 2014, the perpetrator reported an incident to the police and gave Nicola's address.

2.1.2. 2017

2.1.3. From March through to June 2017, Nicola was in contact with the police over a range of bullying issues that seemed to be directed to her children. These issues appeared to have increased her anxiety and in July she attended the GP with stress. She cited these problems as the cause, said that she was not eating or sleeping well, and that her mind was 'racing'.

2.1.4. On 27th October, Adult Social Care received a safeguarding referral through the single point of access, Carepoint, from Nicola's GP, as Nicola felt unable to care for her adult child in the way that was needed, due to her own health issues. The community team were asked to contact Nicola to offer a carer's assessment. When they called Nicola, there was no reply, and a message was left. A follow-up call was made later in the day and again there was no reply, so the case was closed.

2.1.5. 2018

2.1.6. On 4th January, Nicola had a long consultation with her GP. She had several issues to discuss and said that she was suffering with anxiety, lack of energy, low BMI, and back pain. She was particularly concerned about a letter she had received from Department of Work and Pensions (DWP) about an assessment she needed to attend. She asked the GP to write to DWP stating that, as in the past, she needed a home assessment as she was 'too unwell' to get there.

2.1.7. On 7th March, Nicola attended the eye clinic, as an optometrist had noticed 'pigmentary changes to the lens'. She was discharged from the clinic as all appeared 'normal.'

2.1.8. On 10th March, the perpetrator attended A&E with his girlfriend[8] and adult child. He had suddenly had a headache. He was seen by a doctor who noted that the perpetrator, while relaxing in bed between 10-11 am, experienced sudden neck pain behind left ear which radiated down his neck. He had never had it before, and the impression was this was musculosketal pain. He was given co-codamol to take home. It was noted that he said that he had ran out of tramadol and could not take ibuprofen. It was suggested that he use ibuprofen gel and to see his GP if the symptoms persisted. Whilst he was in the department, the relative of another patient spoke to the doctor. He said that he was a retired GP, that the perpetrator's girlfriend was formerly his patient, and that she had a history of drug addiction. He said that he had overheard the patient, or his girlfriend, trying

[8] The review cannot be certain if this was Nicola as her name was not taken.

to buy tramadol on the phone. By this point, the perpetrator had left the department.

2.1.9. Nicola called the police on 19th March as she had invited a friend to her house, on the previous Friday night, and the friend had brought people that Nicola did not know. After they had left, she had realised that her two mobile phones were missing. As there were no lines of enquiry, the call was recorded and filed.

2.1.10. On 19th April, Nicola spoke to the GP about a further letter for DWP, as they were asking her to attend another assessment. The GP noted that it was difficult to write as the surgery very rarely saw her and so had very little evidence of her ill health. The GP asked Nicola to come into the surgery within the next month for a check on her blood pressure, which was needed due to HRT medication she was taking.

2.1.11. Nicola was seen by the nurse at her GP practice on 14th May. She was having a problem with her ears, and it was agreed that she would phone the GP for an appointment the next day. There was not enough time to do the HRT check, so she was asked to rebook.

2.1.12. On 12th June, Nicola had an extended consultation with her GP. She requested another letter for DWP. The GP suggested that, as she had written two letters, Nicola ask DWP to state what they need the letter to say. During the appointment, Nicola spoke at length about how stressed she was due to situations her children were facing. She said that she was unable eat due to her 'nerves'. She had not attended her HRT check and was reminded of the risks of extended use. The GP said that she thought they ought to be working towards a position where she could get back to work, although she had not worked since she was 30. The GP suggested that Nicola should return in 4-6 months to see if more help could be given in changing her medications. It was thought that Nicola needed more 'mind space' to resolve issues.

2.1.13. On 3rd July, Nicola's Employment Support Allowance was suspended after she failed to attend her work capability assessment. She had, until that point, been receiving Employment Support Allowance (paid fortnightly) from 21st August 2013.

2.1.14. On 16th July, Nicola had a telephone consultation with her GP. She advised the GP that her benefits had been stopped 10 days earlier as she had not attended her review appointment. She reported that she had high levels of stress, dreadful backache, felt sick, and was unable to eat. The GP said that she would write again to DWP.

2.1.15. On 16th August, Nicola saw her GP and said that her ESA had now been stopped as she failed to attend assessment appointments. She had been told by DWP that this was their final decision. Nicola was very distressed and talked about the reasons that she was unwell. She said that the situation was now much worse due to stress/lack of money, getting threatening letters, etc. The GP suggested to Nicola that she needed to appeal the decision but that she could not do this on Nicola's behalf, as she wanted; however, she said that she would support her appeal.

2.1.16. In September, following a review, Nicola's Employment Support Allowance was reinstated and backdated to 3rd July. Her benefit continued to be paid until August 2020, as DWP were not aware of Nicola's death.

2.1.17. Nicola had a lengthy telephone conversation with her GP on 13th September. She was upset as she had fallen out with her sister who had criticised Nicola's life and her ability to care for her children. Nicola said that she did have good friends who she saw often. She was still having difficulty eating as she felt 'so sick all of the time'. After reviewing and changing her medication, the GP gave her a certificate stating that she was not fit for work until 12th October. The reason given was anxiety and depression.

2.1.18. On 17th September, Nicola had a telephone call with United Response in which an assessment was undertaken. In this call, she explained the many challenges that she had faced over the past two years. The worker from United Response telephoned Nicola again on 18th. Nicola was quite unwell and was described as 'manic, ranting and rambling'. She spoke at length about her benefits: the worker agreed to call them on Nicola's behalf. When the worker called the HMCTS court of appeal in Cardiff, on 19th, they were told that they were waiting for paperwork from ESA. When ESA were telephoned, they had no knowledge of this but said that they did have a note of a mandatory reconsideration and two failed appointments, so Nicola was not entitled to appeal her rate of benefit. The worker also asked the ESA to email the appeals department advising them of the four letters from the GP supporting Nicola. She asked them to deal with this urgently and/or issue a payment as she had received no money since May.

2.1.19. The United Response worker called, unannounced, at Nicola's home on 1st October: they had been concerned that if they had called ahead, Nicola may not let them in. Nicola did reluctantly let the worker in as she had received two conflicting letters about her benefits.

2.1.20. Whilst the worker was there, Nicola's GP phoned, as promised, about her fitness to work. The GP recorded that she thought that the appeal had gone in Nicola's favour, but that she had several conflicting letters and was being supported by United Response. She had, however, been paid some benefit money. It was left that she would call the GP if she needed further medical input.

2.1.21. Once the call to the GP was complete, the United Response worker helped Nicola to ring all the benefits departments. She had also received two payments totalling approximately £1,400. The worker took some of the letters away to deal with – Council tax to see if she could receive housing benefit and the school about money owed for her youngest child's guitar lessons. The worker then wrote to Arun District Council about housing benefit, enclosing the letters about her reinstated benefits.

2.1.22. On 7th December, the United Response worker saw Nicola again – Nicola had received threatening letters from a debt recovery agency about money that she owed for NHS dental charges that had been incurred when her ESA had been suspended. The worker sent a letter in the hope that, if they provided proof of entitlement or reinstatement of ESA, they would rescind

the charges. (There is no further contact with United Response until June 2019).

2.1.23. 2019

2.1.24. On 3rd January, the perpetrator's GP received a letter from the Maxillofacial Unit saying that the perpetrator had a lesion on the right side of his nasal bridge, and that he would be placed on day case surgical list for removal of lesion.

2.1.25. Nicola visited her GP on 10th January about HRT. Her GP recorded that she looked calmer and better than she had seen for a long time. She had been supported by United Response with her financial worries, which had improved her emotional health. They had a brief conversation about diagnosis of Borderline Personality Disorder or Emotionally Unstable Personality Disorder.

2.1.26. On 11th February, the perpetrator was admitted to hospital for the removal of the lesion.

2.1.27. On 22nd February, contractors on behalf of Optivo Housing attended Nicola's address to inspect damage to the walls; however, they could not access the property, so the visit was rebooked.

2.1.28. Nicola contacted the police on 25th February to report that whilst she and her friend had been walking home, her bag had been dropped. When they realised, they had looked for the bag and when they found it, her mobile phone and purse were missing. Her purse had contained her bank card and £80 in cash. As there were no lines of enquiry, the case was recorded and filed.

2.1.29. The perpetrator attended A&E on 8th March with pain and lacrimation to his right eye. It had started with a foreign body sensation, but it was not known if there was a foreign body in the eye. He was prescribed antibiotic eye drops and referred to the eye clinic at St. Richards Hospital. Oral antibiotics were also prescribed as 'in view of proximity of recent surgical site'.

2.1.30. On 9th March, the perpetrator returned to hospital as his eye was worsening. He was reviewed and advised to continue with prescribed medication. He attended the eye clinic on 12th March and no follow-up was needed.

2.1.31. On 21st March, the contractors on behalf of Optivo Housing carried out an inspection in Nicola's property and found damp and condensation. The walls affected were in the living room and kitchen. Further inspection also identified that, outside, some pointing needed renewing and a downpipe was blocked going into the ground. An order was raised for this to be unblocked and the guttering/downpipes to be renewed or unblocked, as well as repairing the pointing. The kitchen fan was to be renewed, and a 'hit and miss' vent was to be installed in the living room.

2.1.32. On 27th March, Optivo Housing attended Nicola's property to carry out a routine asbestos survey.

2.1.33. On 2nd June, Nicola left a long answerphone message for United Response. She was asking for support as she was struggling. She had a hospital appointment coming up and further problems with DWP. Her nephew had passed away recently, and she said that she would appreciate a call back. On 4th June, the United Response worker sent a message to Nicola offering her an appointment on 17th June at her home. After speaking to her manager, the worker advised Nicola that, unfortunately, they could not support her to go to the dental appointment in London.

2.1.34. In June, Nicola requested a form from Optivo to allow her to claim compensation. This was sent out to her but was never returned.

2.1.35. The United Response worker went to see Nicola on 17th June and Nicola described her mind as chaotic and 'mince'. She said that she had a compensation form to apply for from Optivo, for all the hassle that she had experienced, regarding the damp, over the previous four years. She could not cope with filling the form in and so asked the worker to write to them. They wanted a letter and photos. There was no further contact with United Response until 29th October.

2.1.36. Nicola saw her GP on 29th July when she had attended about her liver function tests: she also wished to discuss her adult child who she was worried about. She was re-referred to a dietician as she had not been seen for several years.

2.1.37. On 2nd August, the community dietician received the referral. Nicola was sent a letter inviting her to contact the department for an appointment. As she did not do this within one month, she was sent a further letter. She did not respond to this, so the GP was notified by letter on 23rd September.

2.1.38. On 18th September, there was a no speech 999 call made. People could be heard arguing: the police traced the call to Nicola's address. Police attended and found Nicola intoxicated. She said that she had been assaulted at the off-licence. The police attended the off-licence. It was found that they had refused to serve her more alcohol due to her intoxicated state, and she had become verbally abusive. The staff had tried to persuade her to leave and blocked her from going into the store any further; however, Nicola began to push and hit the staff. The staff did not wish to make a complaint, although the incident had been captured on CCTV, so no further action was taken.

2.1.39. In October, Optivo received a request from Nicola for a replacement compensation form, and this was provided to her.

2.1.40. On 28th October, Nicola saw her GP to ask for a letter to support her application for Discretionary Housing Allowance. She said that she was currently paying the bedroom tax as she had a bedroom for her adult child should they need to stay with her. The GP said that if Nicola provided details of what she needed, she was happy to do this.

2.1.41. On 29th October, Nicola spoke to the worker from United Response about the compensation form and letters from the council. She said that she had heard from them again and needed to fill in another compensation form. She also said that she was going to make a claim for PIP, and that she would do the initial phone consultation and get the forms. The worker offered to help her with them when they arrived.

2.1.42. On 16th November, the perpetrator was assaulted by three men. He had gone out with his adult child who had had too much to drink. When he was trying to escort them home, three men thought he was attacking them, and they came to their rescue. The perpetrator was kicked in the face. The police were not involved. Over the weekend, he had caught his nose and it had become more painful, so he saw the nurse at his GP surgery.

2.1.43. On 5th December, the perpetrator was seen in the maxillofacial clinic. There was no further follow-up as he declined an operation to straighten his nose.

2.1.44. 2020

2.1.45. On 7th January, Nicola saw her GP. Her brother had died suddenly the previous day and so she was still in shock. She said that she was hoping to get the money together to allow her to attend the funeral. The GP made an appointment for a double appointment for the following week: Nicola needed both her HRT and mental health reviewed, as she was not coping as well as she had recently. She said that she had been supported by United Response but had not heard from them for some time.

2.1.46. On 9th January, Optivo attended Nicola's address to overhaul the kitchen units: this was due to general wear and tear. The lead technician said that the team visited on several occasions and did not see a male, or anything that would cause them to suspect domestic abuse. He confirmed that his team would not have hesitated to raise a report if they had any safeguarding concerns.

2.1.47. On 10th February, Optivo received the compensation claim form from Nicola. In February, Nicola also requested another claim form.

2.1.48. On 13th January, Nicola had a long consultation with her GP. She was very distressed about her brother's death and other family issues.

2.1.49. On 7th February, Nicola left a message for United Response about her anxiety, depression, and high blood pressure. She was worried about her adult child. She said that she was planning to dispute her bedroom tax deduction, and that her GP had written her a supporting letter. During the call, Nicola admitted to using cannabis and neglecting her weight. The worker spoke to Nicola the same day, and, after a long conversation, they made an appointment to go and see her again on 2nd March, to discuss the two compensation claims and the PIP application.

2.1.50. Between 3rd February 2020 and 12th April 2020, Nicola was paid £162.74 in Discretionary Housing Payment by Arun District Council.

2.1.51. On 2nd March, the United Response worker spent a couple of hours with Nicola. They discussed the compensation forms and tried to speak to various people in connection with this. Messages were left for different people to contact the worker. The forms were sent, and the PIP form was almost completed; however, the worker needed to leave to go to the next client. Nicola's benefits were now up to date, and she was wearing a 24-hour blood pressure monitor. During the visit, they discussed the emotional pressures that Nicola was facing. The worker arranged to call in a week or so to arrange another visit to complete the PIP, if Nicola had not managed to do it.

2.1.52. Nicola next saw her GP on 9th March, when they had a long conversation about her current stressors, particularly in relation to her children.

2.1.53. On 11th March, Nicola submitted a second compensation claim to Optivo. A public liability form was requested, as the claim would need to be processed by the insurance department. However, this was not returned, so no further action was taken.

2.1.54. On 16th March, Nicola saw her GP. Nicola was expecting a diagnosis of COPD so that she could enter this on the PIP application that she was being supported by United Response to complete. The GP said that there was no evidence of COPD at the present time. The GP said that if she continued to smoke, she may, like her siblings, develop COPD, and must focus on stopping smoking to prevent this. It was agreed that, rather than being seen in one year, she would be seen when the COVID-19 outbreak had subsided and routine chronic disease management was being done again.

2.1.55. On 20th March, due to the COVID-19 lockdown, United Response suspended all home visits – the worker phoned Nicola to explain this. Nicola said that, with the help given over the phone, she would complete her PIP form and post it herself. The worker said that she would continue to chase Optivo about the work and the compensation.

2.1.56. The United Response worker phoned Nicola on 23rd March to explain that they were working from home and taking some leave, so would catch up with her on the phone on 6th April to see how she was doing.

2.1.57. Nicola was seen remotely by a different GP at the practice on 25th March. Nicola was very stressed. Her blood pressure results suggested that she needed to begin medication, but Nicola was reluctant to do this and opted to have another test in a month's time. The GP told her that her asthma increased her risk of COVID-19.

2.1.58. On 27th March, Nicola had a remote consultation with a third GP at the practice. She felt that worrying about her blood pressure was making things worse and so she would like to start on medication. This was prescribed.

2.1.59. Nicola had a remote consultation with the same GP on 6th April. 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 Nicola 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.

2.1.60. On 6th April, the United Response worker filled in a further compensation form for Nicola and posted it. 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.

2.1.61. In the next few days, Nicola was found deceased.

2.1.62. On 29th April, the GP surgery received a list of those individuals who had registered with the Government as shielding. The GP wrote to Nicola to advise her that she did not need to be shielding as she was not high risk (as she had only had two admissions to hospital with asthma in the previous 12 months).

3. Section Three – Detailed Analysis of Agency Involvement

3.1.1. The Chronology in Section 2, details the information known to agencies involved. This section summarises the totality of the information known to agencies, and analyses their involvement.

3.1.2. ARUN DISTRICT COUNCIL

3.1.3. The Revenues & Benefits Team received an application for a Discretionary Housing Payment (DHP) by Nicola on 19th December 2019, for assistance towards housing arrears accrued. This document was supported by her caseworker from United Response. There was no reference to domestic abuse or economic abuse on the application. The arrears were self-reported as being related to bedroom tax for the property, which led to a reduction of benefits.

3.1.4. Between 3rd February 2020 and 12th April 2020, Nicola was paid £162.74 in Discretionary Housing Payment.

3.1.5. The review notes that, although interaction with Nicola was very limited, as a result of her death, the council has reviewed their working practices and a number of changes have been made:

3.1.6. A dedicated area on the council's website has been created (rather than just appearing in the housing section as previously) that gives advice in different languages to represent the diversity of the communities in Arun, along with a safe exit button.

3.1.7. Training in domestic abuse was provided to key operational staff in November 2019. Refreshing training was undertaken in June 2020 and was included as part of Adult Safeguarding training in June 2021.

3.1.8. Domestic Abuse has been added to the priority of Serious Violence, under the Safer Arun Partnership – April 2021

3.1.9. Representatives from Arun District Council's Housing Options team have now been identified for the Arun DA MARAC.

3.1.10. There are no specific recommendations for Arun District Council.

3.1.11. SUSSEX CCG ON BEHALF OF GP PRACTICE

3.1.12. Nicola had been registered with her GP for many years prior to her murder. She was known to have some physical and mental health problems, and was seen by her GP on numerous occasions during the scope of the review.

3.1.13. There was a good working relationship with Nicola at the practice, and Nicola was able to see or speak to a doctor when she needed. Nicola and her eldest child went to some consultations together. There was evidence of continuity of care, and Nicola consulted frequently about her mental health, health anxiety, and life stressors. Nicola preferred to talk with her GP rather than engage with mental health and wellbeing services. The consultations were often about her benefits, ongoing family relationship issues, and were

usually lengthy. There was a pattern of talking about stressful events and then talking about her physical symptoms, with switching between these themes giving a chaotic feel to consultations: this was felt to reflect Nicola's life in some respects.

3.1.14. Nicola received appropriate assistance from the practice in getting benefits (PIP), and had support from United Response with positive outcome. Nicola intermittently accessed talking therapies, and was concordant with her medication for depression, anxiety, and pain. She was prescribed diazepam to manage acute anxiety and co-codamol for chronic pain, and she was likely to have had a degree of dependency on these medications (noted by GP), but this did not interfere with her functioning. There was no mention or indication of alcohol dependence in the primary care record, but Nicola would drink socially. The was no substance misuse in the record.

3.1.15. Appropriate actions and decisions were taken for Nicola's physical and mental health. Although Nicola's eldest child could, on occasion, be verbally abusive to Nicola, there were no safeguarding concerns for Nicola and no referrals necessary. There was no history or disclosure of domestic abuse, and Nicola never told her GP that she had a partner, despite the numerous lengthy consultations about family relationship dynamics. It was the view of Nicola's GP that she hadn't wanted to disclose that she had a partner.

3.1.16. Nicola was not under alcohol or drugs services, and there was no disclosure of cannabis use. Nicola had previously accessed help through MIND and had the option of contacting talking therapies: she was not under a psychiatrist. Nicola didn't pursue any psychological interventions for her personality disorder.

3.1.17. In the final consultation on 6th April 2020, Nicola mentioned that she felt very anxious due to COVID-19, feeling particularly vulnerable because of her asthma, and was shielding and isolating for 3 months. Nicola mentioned that her only support mechanism was 'a friend' living with her and was keen that the practice gave her documentary evidence of her shielding so that he could shield with her, thereby reducing the risk of him bringing covid into the home. Nicola did not disclose this to be her partner (the perpetrator), and the friend was described as supportive, so there was no further exploration.

3.1.18. The review notes that Nicola chose to shield due to her anxiety about COVID-19: she was not high risk (as she had only had two admissions to hospital with asthma in the previous 12 months). On 29th April, the GP surgery received a list of those individuals who had registered with the Government as shielding. The GP wrote to Nicola to advise her that she did not need to be shielding as she was not high risk.

3.1.19. The GP practice note that Nicola was vulnerable by reason of her mental health problems, her health anxiety, dependence on medication, and her physicality; however, she came across as knowing what she wanted when she visited the practice. Nicola received continuity of care, which is important for vulnerable patients, particularly those with mental health problems. The care she received was person-centred and empathic.

3.1.20. There are no specific recommendations for this organisation.

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

3.1.22. Nicola

3.1.23. On 27th October 2011, Nicola was taken to A&E, by ambulance, with an injury to the back of her head. It was reported that she had been drinking alcohol with friends and had fallen. She was recorded as being uncooperative and irrational in the department.

3.1.24. The A&E records include a screening question about domestic abuse, but it is not recorded if this was asked of Nicola. Given her injuries, this may have prompted further questions or actions. Given the length of time since this incident, it is not possible to ascertain exactly what happened. It may have been difficult for staff to ask the questions given the circumstances at the time: it is recorded that Nicola was intoxicated, disruptive, and uncooperative in the department.

3.1.25. The review notes that a safeguarding referral was made in respect of Nicola's two children, which is an example of good practice. This would have ensured that any issues relating to domestic abuse would have been followed up.

3.1.26. This event was included in the review as it referred to the good practice set out above. The panel had asked if Nicola was asked a routine screening about her alcohol use. Although this did not happen at the time (2011), the review has been assured that now this happens as a matter of course.

3.1.27. The perpetrator

3.1.28. The perpetrator had eight contacts during the scope of the review.

3.1.29. There were two of the eight occasions where professional curiosity and sharing information with the police could have been considered.

3.1.30. First: The visit to the Maxillofacial clinic on 5th December 2019.

3.1.31. It is possible that the perpetrator's version of events was accurate. However, had the police been involved, they may have decided to investigate further to gather his adult child's perspective.

3.1.32. Second: On the visit to A&E on 10th March 2018, the perpetrator said that he had ran out of tramadol and had taken some of this girlfriend's diazepam. It was also reported, once he had left the department, that he or his girlfriend had been heard on the telephone trying to buy tramadol.

3.1.33. Tramadol is an opioid painkiller and, as with diazepam, it is widely used illicitly and can become addictive. They are both prescription-only medications, making them illegal to possess without a prescription. If this

had been reported to the police, they could have decided whether to investigate further.

3.1.34. The Trust has recently reframed the importance of sharing information with the police in domestic abuse situations. Staff are encouraged to inform police of any criminal activity, and if this has not been done when the Safeguarding Adults Team see an adult safeguarding concern raised, then the team will ensure the information is shared appropriately with the police and Children's Social Care.

3.1.35. Recommendation

3.1.36. Given that these two instances fall outside of the safeguarding process, it is recommended 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.

3.1.37. The review is advised that plans are underway to have an Independent Domestic Violence Advocate (IDVA) in the hospital.

3.1.38. Recommendation

3.1.39. It is recommended 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.

3.1.40. OPTIVO HOUSING

3.1.41. Nicola rented her property from Optivo Housing.

3.1.42. Nicola had reported problems with damp in her property. On 21st March 2019, the contractors on behalf of Optivo Housing carried out an inspection in Nicola's property and found damp and condensation. The walls affected were in the living room and kitchen. Further inspection also identified that, outside, some pointing needed renewing and a downpipe was blocked going into the ground. An order was raised for this to be unblocked and the guttering/downpipes to be renewed or unblocked, as well as repairing the pointing. The kitchen fan was to be renewed, and a 'hit and miss' vent was to be installed in the living room. Over the next few months, this work was completed.

3.1.43. On 9th January 2020, Optivo attended Nicola's address to overhaul the kitchen units: this was due to general wear and tear. The lead technician said that the team visited on several occasions and did not see a male, or anything that would cause them to suspect domestic abuse.

3.1.44. The review notes that the lead technician confirmed that his team would not have hesitated to raise a report if they had any safeguarding concerns.

3.1.45. There are no specific recommendations for this organisation.

3.1.46. SUSSEX POLICE

3.1.47. The contact that the police had with Nicola, or the perpetrator, is detailed in the chronology. There are no incidents involving both Nicola and the perpetrator, and they were not aware of the relationship.

3.1.48. 18th September 2019

3.1.49. The police attended Nicola's address and she was intoxicated. Whilst her youngest child was there, there were two other adults (a male and a female) present who were not intoxicated. The police did not consider the child was at any risk and Nicola spoke lovingly of her son to officers. There were no obvious signs of alcoholism or mental health, and so no referrals were raised.

3.1.50. There are no recommendations for this organisation.

3.1.51. UNITED RESPONSE

3.1.52. United Response is a charity that provides advice, information and support for people aged 18+ affected by mental health problems living in Bognor Regis and the surrounding area.

3.1.53. United Response had engagement with Nicola from 17th September 2018 to 12th April 2020. The role of the organisation is to provide a practical pathway for people to access a range of social and practical support, covering:

- Support with integration within community settings
- Support with accessing local facilities
- Support with accessing benefits, housing, and financial advice
- Advice and encouragement with seeking medical advice when necessary.

3.1.54. September 2018

3.1.55. Nicola was seen on 17th and 19th September 2018, when she was described, in the worker's notes, as 'very unwell'. The worker described that Nicola was concerned about her benefits. The worker promised to call them, on her behalf, the next day. The worker spoke to them on 19th September and explained the situation. The worker asked ESA to email the Appeals team to make them aware of the four GP letters in support of Nicola. She also requested that they make a payment to Nicola as she had not received any money for four months.

3.1.56. A further call was made to Benefits by the worker on 1st October, whilst with Nicola in her home. The worker also helped Nicola to go through several letters that she had received, and they established that she had received a payment. The worker took away some letters – one from council tax and one from the school. The worker was able to sort out the issue with the school. She also contacted Arun District Council and requested that the council tax benefit was reinstated.

3.1.57. The review notes that the worker was able to resolve some of the practical issues that were causing Nicola stress. This is an example of good practice.

3.1.58. December 2018

3.1.59. The worker made a file note on 7th December in which it is noted that the ESA, council tax, and school issues were resolved. Nicola had now received threatening letters from NHS Dental about charges that had been passed to a debt recovery agency. The worker sent letters on Nicola's behalf in an attempt to have these charges rescinded. The worker spoke to Nicola and asked her to let them know if she received any letters or calls.

3.1.60. June 2019

3.1.61. On 2nd June, Nicola contacted the service and left a message asking for help, as she would appreciate a call back. She said that she had a family bereavement, and was due to attend a hospital appointment (she asked for financial help in getting to this and was having issues with DWP once again). On 4th June, she was sent a message by Facebook Messenger offering her an appointment on 17th June at her home. The message also confirmed that they could not assist with the finances needed for the hospital appointment.

3.1.62. The worker saw Nicola on 17th June and described her as 'chaotic'. She had a compensation form that had been sent from Optivo for her to make a claim. Nicola asked the worker to assist her with this as she could not cope with doing it – as she needed to write a letter and send photographs. The worker agreed to help her to collate the evidence.

3.1.63. October 2019

3.1.64. On 29th October, the worker spoke to Nicola about the compensation form and letters from the council. Nicola said that she needed to complete another compensation form. Nicola also said that she was thinking of putting in a claim for PIP. She said that she would make the initial phone consultation and obtain the necessary forms.

3.1.65. February 2020

3.1.66. On 7th February, Nicola left a message for the worker as she was struggling with a number of issues, including her health, her family, and a problem she was having with the bedroom tax. The worker spoke, at length, to Nicola on the telephone and explored where Nicola was with the compensation claim and the PIP. The worker arranged to see Nicola on 2nd March.

3.1.67. On 2nd March, the worker spent a couple of hours with Nicola at her house. They talked about the compensation forms, and the worker tried to speak to various professionals. She was not able to speak to the right people so left a number of messages for them to contact her. The forms that were required were completed and posted. They then spent time completing Nicola's PIP application. As the worker had to leave for their next appointment, they asked Nicola to complete the forms and post them, or to wait until her next visit to finalise them.

3.1.68. On 20th March, the worker advised Nicola that they were not able to see her face-to-face due to the COVID-19 lockdown. As they were going on leave, the worker said they would telephone Nicola on 6th April.

3.1.69. April 2020

3.1.70. The worker called Nicola, as arranged, on 6th April. The worker completed a further compensation form and posted this on Nicola's behalf. Nicola sounded much brighter and calmer, although she disclosed that she had panicked when lockdown was announced.

3.1.71. This was the last contact with Nicola.

3.1.72. Initial review of the worker's notes that were submitted to the review, suggest that the interaction with her was sporadic. However, in October 2019, the worker noted that they did not visit Nicola regularly as there was no need, but Nicola knew she could contact them if she needed help. It was noted that they may go several weeks without hearing from Nicola when she was coping. This explains the apparent sporadic interactions with Nicola, and it can be seen that Nicola did feel able to make contact when she needed help.

4. Section Four – What is known about Nicola?

4.1.1. Some of Nicola's friends gave statements to the police as part of the criminal process: these have been shared, confidentially, with the Chair and Report Author alone, to allow their recollections of Nicola to be included in this report. Attempts were made by this review to seek to ask further questions of them, but this was unsuccessful.

4.1.2. Nicola has been described as an attractive, vivacious woman who was warm and loving. She was very small in stature – barely five feet tall and weighing little more than six stone. She was described by the judge as 'physically tiny and fragile'. Despite being small, Nicola was described by a friend as strong and feisty with a 'sweet heart'. Another person described her as a lively and bubbly person.

4.1.3. Nicola was a loving and protective mother. She always sought to care for and protect her children. She has been described as a fighter who stood up for herself and did what she thought was right for her friends and family. We have seen evidence of her contacting the police when her youngest child was in difficulty. She spoke to her GP on several occasions about her anxiety about her children, as she wanted the best for them.

4.1.4. Nicola has been described as the centre of her family and keeping everyone together: always making sure that she rang people on their birthday or sent a card. She would ring around and wish everyone a merry Christmas. She would always 'go the extra mile for people and always help people out'.

4.1.5. Nicola had several challenges to face in her life. She had a chronic back injury that had been caused when she fell down some cellar steps many years earlier when working in a bar. She was underweight: her GP said that this was due, in part, to her high anxiety level that would cause her to lose her appetite or be unable to eat adequately. Whilst she did not attend a dietician as suggested by her GP, she did take nutritional drinks on prescription.

4.1.6. She 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. She sometimes spoke of the pressures of parenting.

4.1.7. Nicola was prescribed medication for depression, anxiety and pain, and was concordant with this medication. She was prescribed diazepam to manage acute anxiety and co-codamol for chronic pain. Her GP notes that she was likely to have some degree of dependency on these medications, but this did not interfere with her functioning. The review is aware that Nicola told friends and family that she regularly took cannabis to help her to manage her pain.

4.1.8. Nicola's GP noted that there was no mention or indication of alcohol dependence in her primary care record, but it was thought that Nicola drank socially. All those who knew Nicola and spoke to the police, spoke of her being a binge drinker or an alcoholic.

4.1.9. The review was concerned about this disparity and specifically asked the GP if Nicola would have been routinely asked about her alcohol use (and the answer recorded). The response was that there were no concerns about alcohol, as in 2018, when asked, Nicola said that she did not drink alcohol.

4.1.10. Nicola had a diagnosis of Emotional Unstable Personality Disorder (EUPD).

4.1.11. Nicola displayed feelings of panic and terror. She experienced challenges in managing her psychological and emotional wellbeing. She was very distressed about the COVID-19 lockdown and the fear that she may be infected with the virus. This may have been exacerbated by her losing her potentially protective network that she would access when she was able to go out.

4.1.12. Sadly, Nicola's GP noted that she had persistently declined engagement with mental health services, preferring to continue to see a GP. Had she felt able to engage with specialists, whilst her EUPD could not have been 'cured', she may have been able to learn coping mechanisms that would have helped her to cope, more effectively, with everyday life.

5. Section Five – Analysis

5.1. Domestic abuse

5.1.1. A 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.

5.1.2. 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.

5.1.3. 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 limited 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.

5.1.4. 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.

5.1.5. 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.

5.1.6. Recommendation

5.1.7. It is recommended 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.

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

5.1.9. The review is not able to conclude about the part that domestic abuse played in this relationship. The review did consider whether there was evidence of controlling and coercive behaviour and other forms of abuse such as economic abuse. Having considered the limited information that was available we return to our position of being unable to identify any

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

evidence that other forms of abuse were present. It is would be speculation to come to a view that there must have been abuse in the relationship.

5.1.10. The only thing that we can say for certain is that Nicola received up to eight blows to her head and body, that there were 17 different injuries to her body, and that she was left to die over several hours. The perpetrator cleaned up the evidence and moved Nicola's body upstairs and said that this was 'out of sight, out of mind'. He then continued to live in the house with her for two days. He went to the home of his adult child and behaved as though nothing had happened. He then fled and said that he was going to Wales when, in fact, he went to the Isle of Wight.

5.1.11. In interview, the perpetrator refused to give any detail about what had happened. The judge described him as 'callous and manipulative'. The judge went on to say that he had shown no remorse. Not only did he not plead guilty to murder or manslaughter, but he refused to answer any questions in court. The judge described this as 'a way of controlling the situation as best you can'.

5.1.12. The judge referred to Nicola's vulnerability and fragility, which has been discussed in this report. It is very possible that her vulnerability would have made her more susceptible to an abusive relationship.

5.1.13. The perpetrator's relevant previous convictions are included at Appendix Three.

5.2. Drugs and alcohol

5.2.1. This review has explored the part that drugs and alcohol played in the life of Nicola and the perpetrator, and in their relationship.

5.2.2. The perpetrator had a long history of drinking alcohol. When he saw his GP in November 2019, he said that he was drinking 4-8 cans a day and had been drinking more heavily in the past. Although the GP spoke to the perpetrator about the risks of drinking heavily, he was not signposted to alcohol services. The GP has advised the review that patients who express a desire to address their drinking would usually be given details about alcohol services. The consultation suggested that the perpetrator minimised the significance of his drinking. At this consultation, no drug taking was identified.

5.2.3. The perpetrator was described by those who knew him as a heavier drinker than Nicola: she would, however, smoke cannabis on a daily basis. It was said that they both drank heavily, more so the perpetrator, and he could get 'a bit gobby' with it.

5.2.4. Nicola's medical records show no mention or indication of alcohol misuse. Whenever asked, Nicola would either reply that she drank socially or not at all. There is no substance misuse recorded by her GP.

5.2.5. United Response was involved with Nicola in the months leading up to her murder. In the worker's case notes, the only reference to drugs or alcohol is on 7th February 2020 when Nicola 'admits to being a cannabis user'. This

entry suggests that the worker had no previous concerns or had ever seen Nicola when she was under the influence of drugs or alcohol.

5.2.6. There is a sense of Nicola being open about her use of alcohol with some friends, whilst not with others. Some spoke of never having been aware of any issues, and that Nicola only drank socially – certainly not every day.

5.2.7. We know that Nicola used cannabis on a regular basis. This may have been to manage the pain that she experienced from her chronic back pain.

5.2.8. Whilst the review can see that drugs and alcohol were present in the life of both Nicola and the perpetrator, and in their relationship, the review is not able to conclude that either considered it to be a particular problem. We can see that both were willing to seek help from their GP for depression and anxiety, but neither disclosed drugs or alcohol to be a problem.

5.2.9. The judge described the last week of Nicola's life as 'it was a heatwave and you spent your days idly in the garden appearing to everyone to be making the best of it, drinking and smoking'. The judge, in sentencing, said that the perpetrator used alcohol and drugs to fuel his rage when he took Nicola's life.

5.2.10. Research finds that between 25% and 50% of those who perpetrate domestic abuse, have been drinking at the time of the assault[10], and cases involving severe violence are twice as likely to include alcohol[11]. It has been found that in an intimate relationship where one partner has a problem with drugs and alcohol, domestic abuse is more likely to occur[12]. However, the impact of alcohol on domestic abuse is complicated.

5.2.11. It is important that we remember that domestic abuse is about power and control by one partner over the other. Not all those who are alcohol dependent are abusive and not everyone who abuses their partner is dependent on alcohol. Whilst we can say that alcohol is a compounding factor in a person being abusive towards their partner, we must avoid suggesting that it causes it. Alcohol is not the cause of the abuse or the violence, the desire for power and control is. Alcohol may be offered as a reason, or an excuse, for the abuse but this should not be accepted. Also, the responsibility for his actions should not be removed from the perpetrator on account that he was drunk.

5.3. What part did COVID-19 play in this case?

5.3.1. The first national lockdown began on 23rd March 2020. At this point, Nicola was living at home with her youngest child – the perpetrator would stay at her home several times during the week. COVID-19 appeared to have a

[10] Bennett L and Bland P, Substance Abuse and Intimate Partner Violence, National online recourse centre on violence against women, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies
[11] McKinney C et al (2008), Alcohol Availability and Intimate Partner Violence Among US Couples, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies
[12] Galvani S, (May 2010), Supporting families affected by substance misuse and domestic violence, The Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire, ADFAM, p5 cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

significant adverse impact on Nicola's anxiety levels and increased her worry about her physical health.

5.3.2. Just prior to lockdown, Nicola had seen her GP expecting to receive a diagnosis of COPD, as several of her family members had this disease. On 16th March, Nicola saw her GP and was told that there was no evidence of COPD at the present time but, if she continued to smoke, she may develop it in the future.

5.3.3. Despite this, Nicola remained anxious about the risk of contracting COVID-19, and she arranged for her youngest child to live with their father for a short time to reduce the risk of infection. After some discussion, Nicola and the perpetrator agreed that he would move in with her to help care for her; however, Nicola was concerned that he was still working.

5.3.4. During a remote consultation with her GP on 6th April, Nicola 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 her only support 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 Nicola and thereby reduce the risk of him bringing COVID-19 into the home. The GP agreed to email a copy of the consultation, although the GP did not recommend that Nicola should shield.

5.3.5. The GP surgery has confirmed to the review that, in April 2020, Nicola's name appeared on a list provided by the Government detailing those in the surgery who were shielding. The GP wrote to Nicola on 29th April to advise her that she was not high risk (at the time a patient with asthma was only advised to shield if they had had two hospital admissions in the previous 12 months) and therefore did not need to shield.

5.3.6. The information that is available to the review demonstrates the anxiety that Nicola experienced: much of this related to her health, which is quite understandable. The whole country experienced fear and uncertainty at the beginning of lockdown and this, given her diagnosis of Emotionally Unstable Personality Disorder, would have been exacerbated for Nicola.

5.3.7. It is clear that although agencies changed the way in which they worked during lockdown, it did not have an adverse impact on the services that she received. She was able to speak to her GP on the telephone whenever she needed to and her United Response worker continued to support her, albeit over the phone.

5.3.8. Despite limited involvement with Nicola, Arun District Council reviewed its working practices in light of her murder, and a number of changes have been made:

5.3.9. Prior to the first lockdown in March 2019, reference to domestic abuse was only mentioned in the housing section of the council's website. Since then, a dedicated area has been created, giving advice in different languages to represent the diversity of the communities in Arun. A safe exit button has also been added.

5.3.10. A leaflet has been devised outlining local and national support – this has been shared via our social media, printed for Arun Police attending domestic abuse incidents, and printed and provided to Boots Pharmacy consulting rooms in Arun.

5.3.11. Domestic abuse training was provided to key operational staff in November 2019. Refreshing training was undertaken in June 2020.

5.3.12. From June 2021, domestic abuse will form part of Adult Safeguarding training.

5.3.13. Domestic abuse has been added to the priority of Serious Violence, under the Safer Arun Partnership – April 2021.

5.3.14. A report has been prepared for Arun District Council in respect of the Domestic Abuse Bill – April 2021, with recommendations for us as a District Council.

5.3.15. Representatives from Arun District Council's Housing Options team have now been identified for the Arun DA MARAC.

5.4. The impact of COVID-19 on alcohol consumption

5.4.1. The panel was concerned about the impact that the COVID-19 lockdown may have had in terms of alcohol consumption – not only of Nicola and the perpetrator, but society in general.

5.4.2. Public Health England published a report that set out alcohol consumption and harm during the COVID-19 pandemic[13]. This reports that data from the consumer purchasing panel (that measures off-trade volume sales of alcohol) shows that between 2019 and 2020 (before and during the pandemic), volume sales increased by 25%. This increase was consistent and sustained for most of 2020. Increases were seen for all product types, with the largest increases for beer (+31.2%), followed by spirits (+26.2%), wine (+19.5%) and cider (17.6%).

5.4.3. However, the Institute of Alcohol Studies makes the point that in 2019, 28% of alcohol sold in Great Britain was bought and drunk in pubs, clubs, cafés, and restaurants. If the pubs were closed, it would be possible to buy 40% more alcohol from the supermarket and barely end up drinking more than before.

5.4.4. The Public Health England survey data measuring self-reported alcohol consumption, suggests a polarisation in drinking. Most respondents reported drinking the same volume and the same frequency as they did before the pandemic. Roughly similar proportions of respondents reported drinking more and more frequently, and drinking less and less frequently. Where surveys measured a respondent's drinking before the pandemic, they suggest that people who reported drinking more during the pandemic than before, tended to be heavier drinkers.

[13] Monitoring alcohol consumption and harm during the COVID-19 pandemic, Public Health England, July 2021

5.4.5. This polarisation was reinforced by a study in April 202014 which found that the number of people who reported attempting to cut down their drinking, increased significantly, whilst at the same time, so did the number of people reporting that they were drinking at high-risk levels.

5.4.6. The article from the Institute of Alcohol Studies said that it is hard to make sense of the data. They said that they thought (from their many years studying alcohol consumption patterns) that we were probably drinking less on average but that some people, particularly heavier drinkers, were drinking more.

5.4.7. Public Health England concludes that tackling alcohol consumption and harm must be an essential part of the Government's COVID-19 recovery plan.

5.4.8. This Review considered making a recommendation about reinforcing the messaging to supermarkets and other off-sales premises about not selling alcohol to those who are intoxicated. However, on balance we felt that the evidence in this case did not justify making such a recommendation when it remains unclear if this perpetrator actually bought alcohol whilst intoxicated. To make such a recommendation would imply that he did and thus perhaps wrongly imply that the premises were at fault.

5.4.9. **Recommendation**.

5.4.10. This Review does however, feel that the community and those organisations serving them would benefit from raising the profile, awareness of and the access routes to alcohol support services.

[14] https://onlinelibrary.wiley.com/doi/full/10.1111/add.15295 cited in Ibid

6. Section Six – Lessons Identified

6.1.1. ARUN DISTRICT COUNCIL

6.1.2. 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.

7. Section Seven – Recommendations

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

7.1.2. 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.

7.1.3. 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.

7.1.4. SAFER WEST SUSSEX PARTNERSHIP

7.1.5. 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.

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

8. Section Eight - Conclusion

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

8.1.2. 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.

8.1.3. 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.

8.1.4. 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.

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

8.1.6. 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.

9. Appendix One – Terms of Reference

DOMESTIC HOMICIDE REVIEW (DHR) into the death of Nicola

TERMS OF REFERENCE

Overarching Aim

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.

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.

Specific Areas of Enquiry

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 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?

Family Involvement and Confidentiality

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.

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.

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.

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.

Timescales

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.

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

Media Strategy

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.

Chairing & Governance

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.

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.

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

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.
- Information Sharing & Confidentiality

The principles outlined in Sussex Criminal Justice Board Information Sharing Guidance 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.

10. Appendix Two – Ongoing Professional Development of the Chair and Report Author

Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
- Ensuring the Family Remains Integral to Your Reviews – Review Consulting (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
- Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
- Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
- Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
- Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
- Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
- Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
- Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
- Suspicious Deaths and Stalking, Professor Jane Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
- Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
- Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)
- Giving children a voice in DHRs – AAFDA (November 2021)
- Cross Cultural Training Webinar: Incels and Online Hate – HOPE Training (November 2021)

Christine has completed the Homicide Timeline Online Training (Five Modules) led by Professor Jane Monckton-Smith of University of Gloucester.

Gary and Christine have:

- Attended training on the statutory guidance update (May 2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended Conference on Coercion and Control (Bristol, June 2018)
- Attended AAFDA Learning Event (Bradford, September 2018)
- Attended AAFDA Annual Conference (March 2017, 2018 and 2019)
- Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)
- Attended AAFDA DHR Chair Refresher Training (August 2021)

11. Appendix Three – The Perpetrator's Previous Contact with the Police

In areas other than Sussex:

1. 2 x Offences against the person (1993) – robbery, wounding, ABH (2 years YOI).
2. 5 x Offences against property (1988 – 1995) – criminal damage
3. Multiple other offences that are not relevant for the purposes of this review.

Records held in Sussex

1. 8th October 2010 – Concern for child while in care of father (perpetrator) & mother (former partner). The perpetrator was using cannabis
2. 11th June 2011 – Verbal altercation between the perpetrator and his ex-partner
3. 9th January 2012 – The perpetrator slapped his child during an argument in the street
4. Other offences in 2008 and 2010 that are not relevant for the purposes of this review.