Learning Review into the death of Louise, who died in July 2018

(In order to protect the identity of the victim but also family members, Louise is a pseudonym)

Independent Chair & report author: Kevin Ball

Date: January 2021

1. Introduction to the case under review

1.1 Louise died in July 2018. The circumstances of her death remain unclear however based on the account given by her partner at the time, Louise, aged 53 years, was initially thought to have died at her partner's accommodation as a result of setting herself on fire and smoke inhalation. Following the post-mortem and then further enquiries it was determined that the injuries Louise received as a result of the fire would not have been enough to cause her death; other tests identified that she was already dead before the fire ignited. The post-mortem also identified that Louise had suffered injuries to her throat.

1.2 Initially this case was judged by the Safer West Sussex Partnership in July 2020, to have met the criteria for conducting a Domestic Homicide Review. However, following a Police investigation and subsequent criminal trial which concluded in November 2020, a 'not guilty' verdict was delivered by the Jury against the accused. Based on this outcome, and there being no evidence of an abusive relationship between Louise and the accused, the Safer West Sussex Partnership judged it no longer appropriate to continue with a review under the statutory framework. Nevertheless, it was still determined that there may still be some learning to capture for the Partnership and as such a Learning Review was judged the most appropriate way to examine the case. The Coroner however, determined that Louise was unlawfully killed.

2. Synopsis of the case

2.1 Louise was born in the Chagos Islands and moved to the United Kingdom in June 2013. She arrived with her youngest child, aged eight years, whilst her husband, with whom she had been married to for 35 years remained in Mauritius. On arrival to the UK, Louise requested urgent support from Crawley Borough Council with housing, also seeking advice from the Citizens Advice Bureau. The assessment of her housing situation did not result in an offer of accommodation and private rented accommodation was found. Louise's' youngest child started at a local secondary school whilst her older adult children, already resident in the UK, were working.

2.2 Louise registered with a local GP Practice shortly after her arrival in the UK but never attended the Practice and was therefore never seen by any of the GPs or Nurses. She subsequently re-registered at another local GP Practice in October 2017, but again Louise

never made contact other than one recorded entry, in April 2018, which referred to Louise wanting to talk with a GP about some problems her youngest child was having; this was never followed through by Louise.

2.3 Other than the registration with the two GP Practices, there was no contact by Louise or involvement from any of the agencies listed in section 3.

2.4 Information gathered as part of the Police investigation has confirmed that Louise had been in an intimate relationship with a 54-year-old male, Adult A, for a number of months having met through their work. Adult A originated from Mauritius. Louise's family were not aware of this relationship.

2.5 In July 2018, the Police were contacted by Adult A's brother who reported that Louise had set herself on fire. On arrival at Adult A's accommodation, there was evidence of smoke damage to a bedroom with Louise laying on the floor. Despite attempts by the Police and Paramedics to revive her, Louise was pronounced dead. Adult A and his brother were arrested the same day and were released on bail pending further investigations. Further enquiries, and the post-mortem, revealed that Louise died before the fire was started and that she had suffered injuries to her throat. However, it has not been possible to categorically prove how these injuries were caused given the emergency medical procedures used by Paramedics in an attempt to revive her. The outcome of a criminal trial concluded with a 'not guilty' verdict in respect of Adult A with there being insufficient evidence to prove, beyond all reasonable doubt, the circumstances and cause of Louise's death. Louise's family are at a loss to understand the outcome of the trial. An Inquest was held in October 2021 with the Coroner determining that Louise was unlawfully killed.

2.6 A member of Louise's family has described Louise as very committed to her family and '… *the light in the house, and a good woman … someone who would not take her own life …* '. She was described as forward thinking, with one example of that being that she was very keen that her youngest child would go to University and that coming to the UK to find a better life, particularly for her youngest child, was a driving force for her. Louise was of Catholic faith and attended Church on a regular basis.

3. Summary of the case review process & contributions from family members

3.1 Following the decision in June 2020 to commence a review, requests for information about any contact or involvement with Louise, her youngest child, and Adult A were made to the following agencies;

Agencies contacted:

- Surrey & Sussex Healthcare
- Integrated Care 24 (out of Hours GP Services)
- Brighton & Sussex University Hospitals NHS Trust (Princess Royal Hospital)
- Western Sussex Hospitals NHS Foundation Trust
- Sussex Community NHS Trust
- Sussex Partnership NHS Foundation Trust
- South East Coast Ambulance NHS Service Foundation Trust
- NHS Commissioners
- Crawley Borough Council
- School A
- Kent, Surrey & Sussex Probation Services

- Sussex Police
- Victim Support
- National Probation Service

Services for those experiencing domestic abuse in Sussex:

- Safe in Sussex and My Sister's House
- Citizens Advice Bureau, providing a local specialist service for support diverse groups access support

Services for those experiencing domestic abuse in Sussex:

- Worth Services

Services for people needing assistance with drug or alcohol dependence:

- Change – Grow – Live Services
- The Rivers Learning Project Community, offering local specialist support to women.

West Sussex County Council:

- Adult Services,
- Children's Services including the Multi-agency Safeguarding Hub (MASH),
- Education Services
- Early Help: Youth Interventions Service,
- Fire & Rescue Service

3.2 The Chair of the Safer West Sussex Partnership appointed Kevin Ball as the Independent Chair and report author for this review[1].

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

3.4 Also in August 2020, an initial Review Panel meeting was convened in order to provide oversight and scrutiny to the process, agree the Terms of Reference, offer relevant expertise but also ensure the smooth and timely conclusion of the review. Given the findings from the initial information requests being extremely limited, and the desire to be proportionate a second Review Panel meeting did not take place until December 2020 following the conclusion of the criminal trial. Due to the Covid-19 restrictions in place, all of these meetings were held virtually by video. The Review Panel consisted of the following representatives;

[1] Kevin Ball is an experienced Chair and case review author and has completed training in the conduct of Domestic Homicide Reviews. He is independent of the Safer West Sussex Partnership and has no association with any agencies that have contributed to this review which would result in a conflict of interest.

Agency	Role
Independent Consultant	Independent Chair & report author
West Sussex County Council, Communities Directorate	Violence Reduction Unit Lead & representing Safer West Sussex Partnership
Sussex Police,	Detective Sergeant, Strategic Safeguarding Team
Clinical Commissioning Group	Representing Primary Care/GP Services
Crawley Borough Council	Community Safety Team
WSCC Children's Services	Service Manager

3.5 Following the initial Review Panel meeting in August 2020 the Independent Chair contacted Louise's family to seek their contributions. This was followed up again in November and December 2020 after the criminal trial had concluded and then again in May 2021 to go through the findings of the report; this meeting had been delayed due to Covid-19 visiting restrictions. The family representative has asked that the pseudonym Louise is used as it had a particular meaning to the deceased.

3.6 After the criminal trial had concluded the Independent Chair made contact with a family member of the acquitted Adult A to advise them of the review and seek their contributions. The family member was distrustful of the approach, assuming it was from the media and was reluctant to engage. The request was followed up with an email however to date there has been no further contact with the Independent Chair.

3.7 Given the initial requests to agencies and organisations provided very limited information the Terms of Reference inevitably reflected this, and as such were constrained to the following issues;

1. Each agency's involvement with Louise, and youngest child, from January 2013 to July 2018.

2. Practice relating to the ethnic, cultural, linguistic, religious identity, immigration status of the respective family members and whether any special needs on the part of the victim or family were explored, shared appropriately, and recorded.
3. Whether there were any concerns amongst family / friends / colleagues or within the community and if so, how such concerns might have been harnessed to enable intervention and support.

4. Findings & learning from the review

4.1 In response to the specific terms of reference, the following findings and learning has been captured;

Information known to agencies and professionals from January 2013 to July 2018

4.2 Information returned from agencies has highlighted a lack of contact with services by Louise, other than registration with two GP Practices and a brief contact with the Citizens Advice Bureau. Whilst ordinarily this may not be an unusual situation and the lack of contact with agencies should not necessarily be viewed as problematic there is some

critical context to consider in this case regarding the ethnicity, culture, and immigration status of the deceased; this is explored further in section 4.2. Adult A was also not known to any services. The lack of any identified contact with Louise by any agency led to the decision not to request the production of Individual Management Reviews from any one single agency. Relevant information has however been gathered from other sources to inform the learning for this review.

Practice relating to the ethnic, cultural, linguistic, religious identity, immigration status of the respective family members and whether any special needs on the part of the victim or family were explored, shared appropriately, and recorded.

4.3 Clearly, given the lack of contact by Louise with agencies examining practice which relates to ethnic, cultural, linguistic, religion and immigration status is not possible. However, this lack of contact with agencies has allowed the review to focus on the context.

4.4 Given Louise's ethnicity and cultural heritage originating from the Chagos Islands, and her settling with her family on arrival in the UK in an area where there is a large community of Chagossian's and Mauritians, it is important for this review to consider whether there were, or could be in the future, any barriers to someone accessing support services. Although having no direct, or indirect link to Louise's death, the history and context in which the local Chagossian and Mauritian community live and operate does highlight some potential learning for all agencies whether they are statutory, private, or voluntary. Whilst this history and context is known about, and well documented by many professionals in the local area, the review has provided an opportunity to re-emphasise it from the perspective of those that might seek help. The Chair and Review Panel took the opportunity to examine factors that may create barriers to accessing local services, not just in relation to domestic abuse. This learning is captured as a result of the Chair's enquiries with local services about the ease, and likelihood, of members of the Chagossian and Mauritian community in the local area being able to access and engage with services that might offer support.

4.5 History and events over time are important to help us understand the current issues that members of this community may be facing and for which Louise may have faced. The Chagossian population have a long history of being marginalised and discriminated against. This is well documented[2], but in summary originates from the Chagos islands being colonised by the French in the late 18th century, the British in the 19th century and then the United Kingdom and United States government in the 20th century.

4.6 The history and context highlight an explicit narrative of the Chagossian and Mauritian communities experiencing discrimination and marginalisation. Over time, these experiences have been experienced at an individual, cultural and institutional level and could be perceived as creating hardship and injustice of individuals or groups that have been relatively powerless within the social structure. This discrimination and marginalisation have generated a level of distrust by some members of the Chagossian and Mauritian community particularly in relation to the actions of those in authority. For those members of the Chagossian and Mauritian population that have come to live in the UK, this distrust has continued and remains deeply embedded in their view of those in

[2] a) Chagos Islands - The Guardian 2016 & b) Written Questions & Statements - UK Parliament 2016

authority. Alongside the distrust, some members of the community face additional barriers which include language, cultural, financial as well as being fairly represented to argue any issues they may experience. Further to this, some members of the community are unclear and uninformed about how to access universal services to gain support and advice; this view was expressed by Louise's family representative, particularly in relation to health and welfare-based services. Louise's understanding of the English language was described by the family representative as very limited and that she would have struggled to know who to contact if worried about anything.

4.7 The difficulties identified above can easily be extended to impact other minority communities that have, or do, face barriers and multiple forms of disadvantage because of discrimination or bias, for example Black, Asian, minority ethnic groups, or travelling families. Whilst members of those communities may appear to have access all universal or targeted services, i.e. health services, local authority services and social services (children & adult), etc within the County, they may experience obstacles because of, for example, capacity to understand what is available, language and communication barriers, individual or cultural bias. Overcoming such obstacles at times of family crisis, acute need or in relation to public protection or safeguarding issues can then appear reactive rather than preventative.

4.8 In order to better understand the particular needs of the local Chagossian and Mauritian population representatives from three local services were spoken with by the Independent Chair. Firstly, a local community engagement programme, funded by the local Borough Council[3] has been established to build relations with the community in an attempt to develop trust and cohesion, reduce tensions, promote engagement with key statutory agencies as well as identify any barriers to engagement. A full time Community Development worker supports and drives this initiative. Using existing contacts within the community the aim is to offer a safe and inclusive space for all Chagossians within Crawley to come together, have a sense of belonging to maintain their culture and heritage, in addition to finding out about key mainstream services. Key statutory agencies and local service providers are encouraged to get involved as and when required based on community need, interest, and appetite. Secondly, the Citizen's Advice Bureau offers a service to connect diverse groups and offer specialist support[4]. Again, a full time Project Lead supports and leads this initiative. Finally, the Rivers Learning Project Community[5] provides support to women who find it hard to engage with mainstream support services for a variety of reasons.

4.9 Discussions by the Independent Chair with local professionals from these three services outlined above, firmly support a view that the distrust, but also uncertainty, extends into members of the community often not accessing local support services, whether they be statutory, private, or voluntary. Information gathered also suggests that there are divisions and tensions within the Chagossian and Mauritian communities in the local area itself, based on differing views, strength of feelings and cultural loyalties. This makes it difficult for all members of each community to feel free and able to engage and access local services. The relevance and importance of this issue for this review concerns the

[3] Crawley Borough Council - Community
[4] Citizens Advice Bureau - Crawley Connects
[5] The Rivers Learning Project Community

accessibility of support services for those individuals that may be from marginalised communities, may be vulnerable and where culture and religion may create barriers that prevent access.

4.10 In this case, Louise had one initial contact with the Citizen's Advice Bureau within the first six months of arriving in the UK, however this was for a relatively common issue requiring advice about an application for benefits; Louise did not access any of the other voluntary or community-based organisations. No information has emerged to indicate that Louise needed advice or support and it will never be known if this would have been useful to her or not. The learning for this review, following the discussions with the three local services is that it would have been, and still is, difficult for someone in communities such as the local Chagossian and Mauritian, to access personal support about an issue such as domestic abuse or relationship difficulties.

4.11 Information gathered as part of this review, but also evidence submitted to the criminal proceedings has made no direct or indirect link between the historical narrative associated with the two communities, local community tensions and Louise's death; however it is important to note that the defendant in the Court trial was a member of the Mauritian community with cultural affiliations; although it would be speculative to consider the presence of coercive control in the relationship, it will be important for all those that work with vulnerable and marginalised groups need to remain alert to the presence of such factors especially when considering the ease of access to support services.

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

4.12 Discussions with a family representative by the Chair confirmed that they had no idea that Louise was in a relationship and saw no behaviour from her to indicate that she was troubled or worried about anything.

5. Lessons learnt

5.1 Given the circumstances of this case, the absence of evidenced contact or involvement with statutory agencies by Louise, and the outcome of the Court process, it can only be concluded that Louise's death could not have been predicted; in turn, there were no preventative measures that could have been taken in order to prevent Louise's death. As such, there are no lessons for this review to highlight which relate directly to the actions taken by any individual agency or professional.

5.2 The review has however highlighted the importance around the accessibility of services, whether they be specifically provided within a local area i.e. local community groups, or are available more generally i.e. social services. This does not solely apply to members of the Chagossian and Mauritian communities but other minority community groups and populations that may experience multiple forms of disadvantage. In this context, the importance of having dedicated resources which attempt to build connections, identify, and overcome barriers to engagement, and which may be viewed with greater trust and openness should not be under-estimated.

6. Conclusion

6.1 This Learning Review was commissioned as a result of the death of Louise in July 2018. Despite a thorough and systematic process of trying to gain information, this review has not been provided with any information which has highlighted any lessons to be learnt by local statutory agencies, or any steps that could have been taken to prevent Louise's death. Information provided by agencies, family or the Police investigation does not support a view that Louise was experiencing domestic abuse, although questions clearly remain about the circumstances and cause of her death. The review has established that Louise was part of a local community that has a history of experiencing institutional discrimination and oppression, the impact of which still continues to effect individual's day to day lives. In discussion with local services that offer support for those experiencing domestic abuse it has been established that members of the Chagossian and Mauritian community are less likely to come forward to seek support or advice about relationship issues. The review has therefore recognised the importance of services being accessible to all within their community, irrespective of cultural alliances, ethnic or religious persuasions or practices.

6.2 The Chair would like to thank members of Louise's family for their contributions to this review.

7. **Recommendation**

7.1 The Safer West Sussex Partnership, in collaboration with the West Sussex Safeguarding Adults Board and Children's Safeguarding Partnership, ensure there is sufficient focus and attention given to engaging minority communities that might face multiple barriers in accessing support services. In doing so, there may be merit in encouraging meaningful participation from members of those communities in order to better understand their needs.