South Staffordshire Council

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

L – December 2016

Chris Few

June 2019

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INTRODUCTION

1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was revised in December 2016 and that revision provided the framework within which this Review was conducted[1].

1.3 A Domestic Homicide Review (DHR) is defined[2] as:

1.4 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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

1.5 held with a view to identifying the lessons to be learnt from the death.

1.6 The purpose of a 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; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse; and,
- Highlight good practice.

1.7 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

[1] www.homeoffice.gov.uk.
[2] Domestic Violence, Crime and Victims Act (2004), section 9 (1).

2 Summary of Circumstances Leading to the Review

2.1 The victim (L) and perpetrator (M) lived together in an intimate relationship. In December 2016 the emergency services were called to their address by M, who stated that he had found L deceased on the floor at the foot of the stairs. L had a number of injuries and M was arrested.

2.2 An initial post-mortem examination of L was inconclusive, and M was released from custody after interview.

2.3 A DHR Scoping Panel met on 8 February 2017 to consider the circumstances. On the information available at that time the Panel was unable to reach a conclusion on whether the criteria for commissioning a Domestic Homicide Review had been met. This position was endorsed by the Chair of the South Staffordshire Community Safety Partnership (CSP) who was present. It was agreed that once the further post-mortem investigations were completed the Chair of the Scoping Panel would make a recommendation to the CSP Chair on whether a Domestic Homicide Review should be initiated.

2.4 In November 2017 M was re-arrested and charged with murder and causing grievous bodily harm with intent. He appeared at Court in December 2017 and was bailed pending his trial. Consequent to this the CSP Chair agreed to commission a Domestic Homicide Review on 20 December 2017.

2.5 In December 2018 M pleaded guilty to manslaughter through gross negligence and was subsequently sentenced to 3 years and 8 months imprisonment.

3 Terms of Reference

3.1 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.

3.2 The Review considered in detail the period from March 2016, to ensure that the whole of the relationship between L and M was considered, until the date of L's death in December 2016.

3.3 The focus of the Review was on the following individuals:

Name	L	M
Relationship	Victim	Perpetrator
Gender	Female	Male
Age (December 2016)	26 years	38 years
Ethnicity	White British	White British

3.4 In the context of the areas for consideration outlined at Section 4 of the Statutory Guidance the Review specifically considered whether domestic abuse was occurring in the relationship of L and M, and if so, why this was not known to any agency.

4 Review Process

4.1 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Staffordshire, and Worcestershire which may

have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review and Summary Information Reports.

4.2 Management Review Reports and Summary Information Reports were submitted by:

- Staffordshire Police
- West Mercia Police
- West Midlands Ambulance Service NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- Worcestershire Clinical Commissioning Groups (in respect of primary health care services)
- Worcestershire County Council Children's Social Care
- Wyre Forest District Council

4.3 Consent to access M's primary health care records was not provided by him. M's GP practice however agreed to allow the CCG access to M's medical records and conduct interviews with practice staff in order to properly contribute to this Review[3].

4.4 Reference was also made to the Sentencing Remarks of the honourable judge in relation to M[4].

4.5 It was identified that CAFCASS had had involvement with M in respect of private law Family Court proceedings and a request was made for them to provide any information which they held which could be relevant to the Review. They confirmed that they had had involvement with M in 2012-13, but declined to provide further detail without leave of the Courts concerned. They confirmed that they had no contact with M, or L, during the period considered in detail by this Review.

4.6 The Review Panel was chaired and the Review was written by Chris Few, an Independent Consultant. Mr Few has had a career in law enforcement and undertaken responsibility in senior leadership roles. He has completed the Home Office online DHR learning provision in 2013, attended a Home Office sponsored AAFDA/STADV facilitated training workshop for DHR chairs in 2017. Since 2008 he has worked as an Independent Consultant in Somerset, Bristol, Gloucestershire, Oxfordshire, Bedfordshire, Northamptonshire, Nottinghamshire, Nottingham City, Derbyshire, South Yorkshire, Stoke on Trent and Staffordshire.
Since that time, he has chaired Review Panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide and Serious Case Reviews as outlined. He has no current or historic personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

4.7 The Review Panel comprised the following agency representatives:

- Mark Harrison
  Investigator – Policy Review and Development Team
  Staffordshire Police

- Victoria Downing
  Senior Investigating Officer
  Staffordshire Police

- Helen Marshall

[3] GPs are not subject a requirement to cooperate with a Domestic Homicide Review or comply with the statutory guidance under the Domestic Violence, Crime and Victims Act (2004). The statutory guidance does however (paragraph 100) state that the Department of Health considers it reasonable that GPs should cooperate with DHRs in the same way that they must do in Child Serious Case Reviews.

[4] https://www.judiciary.uk/wp-content/uploads/2018/12/

Community Safety Officer
South Staffordshire District Council

- Julie Long
  Principal Community Safety Officer
  Staffordshire County Council

- Sue Coleman
  Chief Executive
  West Mercia Women's Aid

- Ellen Footman
  Designated Nurse for Safeguarding Children and Adults
  Worcestershire Clinical Commissioning Groups

- Deborah Narburgh
  Head of Safeguarding
  Worcestershire Acute Hospitals NHS Trust.

4.8 In addition to the Scoping Panel Meeting in February 2017 the Review Panel met on two occasions, in April 2018 and February 2019 to consider contributions to the Review and emerging findings.

4.9 This Overview Report was endorsed by the Review Panel on 12 June 2019 and forwarded to the Chair of the South Staffordshire Community Safety Partnership. On 9 September 2019 the report was presented to and endorsed by the South Staffordshire Community Safety Partnership.

5 Parallel Processes

5.1 The criminal investigation into the death of L was conducted in parallel with this Review.

5.2 HM Coroner for South Staffordshire opened and adjourned an inquest pending the outcome of the criminal trial. That inquest will not now be reconvened.

6 Family Engagement

6.1 Family members of L were advised that the Review was taking place at its outset. Contact with family members was established through the Police Family Liaison Officer who hand delivered and explained letters from the Review Panel Chair along with Home Office leaflets describing the review process and available support services.

6.2 Following conclusion of the criminal prosecution the mother and father of L met with the Review Panel Chair on 6 February 2019. The chair offered the family the condolences of the panel. L's sister also contributed to the Review, releasing to the Panel six witness statements which she had earlier made to the Police. The contributions of family members to the Review are incorporated into this report.[5]

6.3 M was advised in writing, via his Solicitor, that the Review was taking place and provided with an explanation of the review process. He did not wish to contribute.

[5] Family members were asked if they wished a pseudonym to be used for L in this report. They stated that they did not and initials, having no relationship to those of individuals, have therefore been used to anonymise the report.

6.4 Members of L's family were given sight of this report on completion and prior to its submission to the Home Office. An amendment to the report requested by L's father was incorporated in the submitted report.

6.5 Equality and Diversity

6.6 The Equality Act 2010 sets out the protected characteristics that may be considered in this review by the panel. Those characteristics include: Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

6.7 **Equality** is about ensuring everybody has an **equal** opportunity and is not treated differently or discriminated against because of their characteristics. **Diversity** is about taking account of the differences between people and groups of people and placing a positive value on those differences.

6.8 The review has considered all of the characteristics in this case and concluded that the issue of discrimination does not apply in these circumstances. This conclusion was reached because there is no evidence of any discrimination, no barriers to services in context of age or sex, and no reduction in service provision because of discriminatory factors.

THE FACTS

7 Background of L

7.1 The Victim, L, was aged 26 years at the time of her death. She lived for most of her life in Worcestershire. L had two older brothers and a sister. Her parents are separated.

7.2 L moved out of the family home when aged 16 and had one child, born when she was 17.

7.3 Between 2010 and 2013 L accessed hospital services on three occasions following excessive consumption of alcohol. On one occasion this was accompanied by an overdose of over the counter medication and she was reviewed by the hospital Mental Health Liaison Team. On another occasion L was found unconscious after falling down stairs and banging her head whilst intoxicated.

7.4 A healthcare professional at L's GP surgery, who had known L from a young age, gave a 'pen picture' of L, describing her as outgoing and trusting. She described L's lifestyle as lacking a sound structure and routine and with family relationships that were not always supportive. She further described L as vulnerable, with her abusing alcohol and engaging in risky behaviour.

7.5 Following L's death, the trial of M heard friends of L describe her as "fun, bubbly, loving" and a "free spirit, full of fun, said it how it was. A lovely girl". L's sister informed the Court that L liked a drink and could consume large quantities, but that she was happy when she was drunk and never aggressive.

8 Background of M

8.1 M was aged 38 at the time of L's death. He is believed to have lived mainly in Worcestershire. The Review Panel was advised by the Police that he was affluent, owning a number of properties and businesses in the UK and abroad.

8.2 M has a child from a previous relationship.

8.3 In February 2010 West Mercia Police attended a domestic incident involving M and his then wife. She alleged that during the course of an argument in which she accused him of having an affair he had punched her in the face injuring her. M was arrested but subsequently released with no further action being taken as his wife did not wish to pursue the allegation.

8.4 In January 2011 M was reported by his wife to have visited her address and, when she refused to speak with him about their children, to have smashed a window and gained access to the house. M was arrested and charged with criminal damage. It was noted that M had been drinking at the time of the incident. The case was later dismissed at Court with no evidence offered. Police records indicate that by March 2011 M's wife had been granted a Restraining Order in respect of him, which he was complying with.

8.5 In May 2012 M's wife reported to the Police that M had threatened to take their child out of the country. She was noted by the Police to have been drinking alcohol and informed them that she had alcohol misuse and mental health problems. The child was found safe and well with M's mother and no further action was taken in relation to the alleged threat.

8.6 The primary health care records of M contain no record of any contact that might be relevant to his relationship with L or her death.

9 Relationship of M and L

9.1 L met M around June 2016 consequent to M and L's father being acquainted through them frequenting the same pubic house and having a shared interest in horse racing.

9.2 L subsequently told her family that she was employed by M as his Personal Assistant and had been provided with a car. It was however evident to them by July / August 2016 that there was a personal relationship between L and M. This was confirmed by L who told her father that they had been staying at a local hotel, joking that they had used her father's surname to book in as a married couple.

9.3 L was stated by her parents to have changed as a result of this relationship, becoming more responsible and adopting a more ordered lifestyle. L informed her father that M arranged for her to have elocution lessons.

9.4 L's father informed the Review Panel Chair that L seemed happy in the relationship and never said anything to suggest otherwise. He had however thought that the relationship "would end in tears" because of the different backgrounds of L and M.

9.5 L's sister stated that L was really happy with M and he seemed smitten with L. She stated that she had never known L to be so happy and content with life.

9.6 From evidence given at the trial of M the Court concluded that apart from "the stresses and strains that happen in nearly all relationships" L and M were happy and planning a future together.

9.7 Early in the relationship L told her sister that M enjoyed "rough sex" which would include using a belt to smack her. L showed her injuries resulting from this. L's sister was not surprised by this as she was aware that L had engaged in "kinky" sex with previous partners, although she was not aware of L sustaining bruises during sex in any earlier relationship.

9.8 L also told her sister that she and M were occasional users of cocaine, but were not dependent upon it.

9.9 Towards the end of October 2016 M and L moved in together at a rented property in South Staffordshire. At that time L informed her parents that she and M intended to live as a family with her child and M's child.

9.10 L's sister has stated that M paid all of the bills for the shared property and at the time of L's death M was giving her £200 each week for general living expenses.

10 Summary of Events

10.1 During the period examined by this Review L had potentially relevant contact with healthcare professionals, as outlined below. M had no relevant contact with any professional prior to the death of L.

10.2 <u>July 2016</u>

10.3 In July 2016 L saw the healthcare professional at her GP surgery. She stated that she was finding it hard to get a job, boyfriend and housing, was living off benefits and was just managing to pay her rent. L stated that she had to move out of her current address (a private tenancy) by September 2016 and felt isolated. She described crying, feeling tingling in her hands and feet, not sleeping well and feeling worried about herself and her child (then aged 8).

10.4 L was advised to speak to her sister for support and was referred to a housing and debt support organisation[6]. She was prescribed a 7-day course of medication (DiaLepam) and advised to see her GP if her symptoms persisted.[7]

10.5 September 2016

10.6 In September 2016 L saw the healthcare professional at her GP's surgery with an injury to her lower leg. She stated that she believed it was a spider bite. The wound was treated with topical antibiotic cream.

10.7 The healthcare professional recorded that the wound looked like a human bite mark. She reported, when interviewed for this Review, that she thought the bite was related to sexual activity but did not raise this with L as she felt it was not her business to ask. It was documented that L reported being happy in a four-month-old relationship but there was no specific discussion of whether domestic abuse was present in the relationship.

10.8 Early on the following morning L presented at the Kidderminster Minor Injuries Unit (Worcester Acute Hospitals NHS Trust) with the same injury, stating that it was a spider bite which she sustained two days previously. She was prescribed anaesthetic cream. There is no indication that L's explanation for the injury was considered questionable during that consultation, or that it should have been.

10.9 December 2016

10.10 In mid-December 2016 L and M were intending to take a holiday in the Middle East. L and her child (then aged 8) were booked to fly out one day, with M and his child (then aged 9) following the next day. Before the planned holiday L said to her father that she was "ever so scared". Her father thought that she was referring to her first long haul flight, travelling alone to the Middle East, and did not query what L meant by the remark.

10.11 On the morning of the day before L was due to fly out on holiday in December 2016 the emergency services were called by M to the address shared by him with L. He stated that he had found L, not breathing, on the floor at the foot of the stairs.

10.12 When WMAS staff arrived they were met by M. L was naked except for a skirt and lying at the foot of the stairs. Her body was cold and rigor mortis was evident. L was recorded as having numerous bruises, a possible skull fracture, serious eye injury and bleeding from her vagina.

10.13 L's child was not present at the address, having stayed overnight with M's child at the home of a relative.

10.14 The Police were called to attend and an investigation of L's death was commenced.

10.15 M was arrested on suspicion of rape and murder. In interview M said that he and L had spent the previous evening at a football match and had then been driven home, stopping for a takeaway meal and arriving around 2300 hours. They were happy with no issues. Witnesses interviewed by the Police support this account.

[6] This organisation, "Buddy", no longer exists and it is not known whether L engaged with them.

[7] The Review Panel was advised that a short course of medication is one of the options appropriate for patients presenting with low mood. It would be expected that the patient would return to the surgery if this was not effective and that proactive follow up would not normally be required.

10.16 M said that they had consumed alcohol and cocaine and following their return home engaged in consensual rough sexual activity.

10.17 M said that after leaving L for a short time he found her at the foot of the stairs, bleeding from a head wound and clutching the bannister. He said L was incapable of getting back up the stairs and that he was unable to carry her. He left her at the foot of the stairs and went to bed, finding her deceased when he woke the following morning.

10.18 The final pathology report in relation to L identified her cause of death as a combination of multiple blunt force trauma and alcohol intoxication. Her blood alcohol level was 389 mg alcohol per 100 ml of blood, potentially a fatal level and nearly five times the drink drive limit. L was also identified as having taken cocaine, amphetamines and 'poppers'[8].

10.19 M was also intoxicated, although not to the same degree, with a blood alcohol level of 259 mg alcohol per 100 ml of blood[9]

10.20 When interviewed in November 2017 M maintained that he and L had engaged in consensual sex on the night before her death which had caused some of her injuries. He offered no explanation for the head and eye injuries.

10.21 At M's trial in November/December 2018 the Court heard evidence that L had told others that she and M had an interest in masochistic sex. The Court also heard that the couple seemed to be happy on the evening prior to L's death. Further, that during the evening L and M were overheard joking about their forthcoming holiday and that they would need to calm down their sex life so that L would not have visible bruises when wearing a bikini.

10.22 Part way through his trial a plea of guilty by M to manslaughter through gross negligence was accepted by the Crown Prosecution Service. The Court directed the jury to return not guilty verdicts in respect of the murder and grievous bodily harm charges.

10.23 M's plea of guilty to manslaughter by gross negligence related to him leaving L unsupervised and failing to contact the emergency services in circumstances where "a risk of death as a result of her condition would have been obvious."

10.24 The Court was informed that L's family were consulted and were entirely content with the Crown Prosecution Service decision to accept M's guilty plea to manslaughter. L's parents informed the Review Panel Chair that this was seen by them as the least bad option, set against the probability that M would otherwise be found not guilty.

10.25 M was subsequently sentenced to 3 years and 8 months imprisonment.

[8] Poppers is the street name for a range of chemical compounds belonging to the alkyl nitrite family which are legally available and used to enhance sexual arousal and as a muscle relaxant.
[9] This is based on a back calculation as being the level at 0300 hours on the date of L's death.

FINDINGS AND CONCLUSION

11.1 The Government definition of domestic abuse, adopted in Staffordshire, is:

> Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:
> - Coercive control
> - Psychological and/or emotional abuse
> - Physical abuse
> - Sexual abuse
> - Financial abuse
> - Harassment
> - Stalking
> - Online or digital abuse.

11.2 The judgement of the honourable judge when sentencing M, supported by legal precedent, was that an individual cannot in law consent to being assaulted to cause at least actual bodily harm and that accordingly, notwithstanding the consensual nature of the sexual activities between M and L in the period just prior to her death, M had acted unlawfully in causing L actual bodily harm[10]. It follows that L was by definition a victim of domestic abuse at the hands of M, at least during the period just prior to her death. Bruises to L which were observed earlier by her sister and the lesion observed by the healthcare professional at L's GP surgery, if this was a human bite mark, could also be the result of domestic abuse.

11.3 The Review Panel considered that there should be greater professional awareness of legal precedent around consensual sexual activity and the implications of this in the context of responding to domestic abuse and make a recommendation for the promotion of this.

11.4 This case has now been superseded by the implementation of the of the Domestic Abuse Act 2021, in that it clarifies by restating in statute law the general proposition that a person may not consent to actual bodily harm or to more serious injury or, by extension, is unable to consent to their own death. Therefore, no death or other serious injury, whatever the circumstances should be defended as rough sex gone wrong, and the law now states this is unacceptable. Consent to harm for sexual gratification is now clearly removed as a defence in the future.

11.5 There is no evidence that L regarded herself as a victim of abuse and all indications are that she did not. Other than injuries sustained during sexual activity there are no indications that domestic abuse was a facet of their relationship.

11.6 In the context of a relationship which was by all accounts happy it is therefore unsurprising that L did not seek assistance from the domestic abuse services available in Staffordshire[11] or of the professionals with whom she came into contact during her relationship with M.

[10] The honourable judge also cited precedent in his judgment regarding the vaginal injury to which the grievous bodily harm charge against M had related and in respect of which the prosecution offered no evidence, that; "A woman may lawfully consent to having something inserted into her vagina (or rectum) for the purposes of sexual gratification but without an intention to cause injury, even if doing so carries a risk of injury, and injury is indeed caused."

[11] Since 1 October 2018, a new holistic domestic abuse service has been operating across Staffordshire and Stoke-on-Trent, jointly commissioned by the Staffordshire Commissioner's Office, Staffordshire County Council and Stoke-on-Trent City Council. Services for victims are provided by Victim Support and support for perpetrators is provided by the Reducing Re-offending Partnership; both are based in Staffordshire and operate under the name of "New Era".

11.7 The school staff who saw L when dropping off and collecting her child observed no injuries and had no other indication that L might be a victim of domestic abuse.

11.8 Staff at the Minor Injuries Unit attended by L in September 2016 did observe the lesion to L's leg but did not identify this as anything other than as described by L. They similarly had no indication that L might be a victim of domestic abuse or basis on which they should have explored the potential for this[12].

11.9 The healthcare professional at L's GP surgery saw her on three occasions during the period examined by this Review. In September 2016 L visited the Practice with a lesion to her leg which she attributed to a spider bite. The healthcare professional recorded that the wound looked like a human bite mark but did not raise this with L as she thought the bite was related to sexual activity and she felt it was not her business to ask.

11.10 It was documented by the healthcare professional that L reported being happy in her four-month-old relationship but there was no specific discussion of whether domestic abuse was present in the relationship.

11.11 Department of Health Policy is that routine enquiry, asking all patients about their experience of domestic abuse regardless of any visible signs of abuse, should take place in maternity and adult mental health settings. In other settings Department of Health Guidance[13] is that domestic abuse should be explored "…if things are not adding up…" The Review Panel considered that there was a missed opportunity to explore the potential for domestic abuse in this case, albeit it is highly unlikely that this would have led to identification of L as a victim of domestic abuse.

11.12 The Review Panel identified that the village where L and M were living together, their previous addresses and the GP surgeries at which both were registered are all in a small area of rural South Staffordshire / Worcestershire. They considered the impact on the identification of Domestic Abuse and responses by practitioners living and working in rural communities with those to whom they are providing services, particularly where relationships are longstanding.

11.13 The Review Panel considered that the familiarity between L and the healthcare professional at her GP's surgery over a period of 20 years may have blurred professional boundaries and led the healthcare professional to feel she did not need to explore the potential for domestic abuse when she saw L with what appeared to be a human bite mark in September 2016.

11.14 Conversely the Review Panel also identified that disclosure of Domestic Abuse is more likely where a victim feels safe and able to talk openly. Whilst this may be achieved through sensitive proactive enquiry by properly trained professionals[14], a longstanding relationship may also contribute to the required trust in the professional.

11.15 The Review Panel concluded that alongside professional training on identification and responses to domestic abuse, professionals living and working in small and rural communities should have regard to the potential for this to impact on their practice. In this regard the Review Panel were advised of a recent Case Review in Worcestershire which had addressed this issue and recommended that "Practitioners should be aware of the influence

[12] Worcestershire Acute Hospital Trust outlined to the Review Panel a comprehensive range of measures to ensure that their staff respond appropriately to domestic abuse. These include training for all staff which covers relevant pathways and making opportunities to speak to potential victims alone.

[13] Responding to domestic abuse - A resource for health professionals https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

[14] Over the last 5 years Worcestershire CCGs provide a rolling programme of training to GP Practices which includes Domestic Abuse. L's GP Practice has an up to date Domestic Abuse Policy.

and pressure that can be exerted when professionals and subjects reside in close proximity and particularly within small communities." L's GP practice is in Worcestershire and is subject to the implementation plan for that recommendation. The Review Panel did however consider that this issue is equally applicable across South Staffordshire and adopted this as a recommendation of this Review.

11.16 It is worth mention that Policing and individuals have the ability to understand the risk that their partner poses. This scheme is called the domestic violence disclosure scheme (DVDS) or otherwise known as 'Clare's Law'. Often individuals or family members have the right to ask the police if there is a risk to them or the family member in question and this then is a decision for the Police to consider as to what action they take if any. Conversely the Police can consider informing persons of the risk under the other ability which is called 'right to know'. Both of these common law rights are to be incorporated into the new Domestic Abuse Act 2021.

11.17 Despite 'Clare's law being in place for some years it was not used by the victim or her family in this case, no doubt because as the panel concluded she did not consider her position as requiring that information and as for the 'right to know', the Police were not engaged in this relationship so it would not have arisen. No events in this case presented opportunities to increase the awareness of the victim as to whether she was subject to domestic abuse in its wider sense or not.

11.18 The Review Panel considered whether the disparity in the age and wealth of L and M may reflect or have led to a relationship in which L was subject to coercion.

11.19 The Review Panel noted that L was dependent upon M through him providing her with a home and a desirable lifestyle. West Mercia Police informed the Review Panel that the ability to provide such a lifestyle and the reluctance of partners to give it up were believed to have been exploited by M in previous relationships. It was suggested that this may have been the case in M's relationship with L.

11.20 The review panel also considered whether L's situation (particularly in July 2016) may have made her more vulnerable.

11.21 It is clear that the relationship led to L having a materially more desirable and secure lifestyle It is equally clear that L was happy in the relationship. The Review Panel took the view that the distinction between a relationship in which a more affluent partner shares their lifestyle with the other and one in which this could be seen as coercive is likely to be a fine and subjective one. In this case the Review found no indication that L saw herself as coerced by M or that this was the intent of M.

11.22 Notwithstanding any of the above considerations regarding the relationship between M and L, there is no basis on which anyone, other than M, could have predicted that L would die in the circumstances that she did, or prevented this.

RECOMMENDATIONS

12.1 The Review Panel made the following two recommendations:

12.2 ***That the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should promote professional awareness of the influence and pressure that can be exerted when professionals and subjects reside in close proximity and particularly within small communities through domestic abuse training provision and in connection with publication of this Review.***

12.3 ***That the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should promote professional awareness of legal precedent around consensual sexual activity and the implications of this in the context of responding to domestic abuse.***

12.4 Recommendations for action to improve services were also made by Worcestershire Clinical Commissioning Groups that:

L's GP Practice, in line with provision at all GP practices, should:

- ***Ensure that all GPs and other clinical staff at the practice have completed Domestic Abuse training which includes recognition of the indicators of Domestic Abuse (by 31.5.2019) and provide on-going training for staff to ensure they continue to meet their roles and responsibilities in line with current guidance.***

- ***Raise awareness with all GPs and other clinical staff at the practice of the local Multi-agency Domestic Abuse Pathway; and of policies and processes in relation to domestic violence and abuse, which includes the pathway for victims, perpetrators and children including referral to MARAC/SARC/Women's Aid etc (by 31.5.2018).***

- ***Raise awareness with all GPs and other staff at the practice of the Practice's Domestic Abuse Policy (by 31.5.2018).***

12.5 When published following Home Office Quality Assurance Panel approval, this report and its recommendations will be specifically brought to the attention of Safelives and the Home Office. Implementation of action plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the South Staffordshire Community Safety Partnership.

Appendix A

TERMS OF REFERENCE

DOMESTIC HOMICIDE REVIEW

SOUTH STAFFORDSHIRE PARTNERSHIP

December 2016

Author: Chris Few

Date Of Scoping Panel: **8 February 2017**

Date Last Amended: **26 March 2019**

1 Introduction

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[15], hereafter referred to as "the Guidance".

1.2 The relevant Community Safety Partnership (CSP) must always conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:
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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3 An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

1.5 The purpose of a 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 homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- **Contribute** to a better understanding of the nature of domestic violence and abuse; and
- **Highlight** good practice.

2 Background

2.1 The victim (L) lived in an intimate relationship with the perpetrator (M). On 18 December 2016 the emergency services were called to their address by M, who stated that he had found L deceased on the floor at the foot of the stairs. L had a number of injuries and M was arrested. An initial post mortem examination was inconclusive and M was released from custody after

[15] Home Office – last updated December 2016.

interview. Following further post mortem investigation M was re-arrested and charged with Murder and Sexual Assault. In December 2018 M pleaded guilty to manslaughter through gross negligence and was subsequently sentenced to 3 years and 8 months imprisonment.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 8 February 2017 to consider the circumstances. On the information available the Panel was unable to reach a conclusion on whether the criteria for commissioning a Domestic Homicide Review had been met. This position was endorsed by the Chair of the Community Safety Partnership (CSP) who was present. It was agreed that once the further post mortem investigations were completed the Chair of the Scoping Panel would make a recommendation to the CSP Chair on whether a Domestic Homicide Review should be initiated.

3.2 The CSP Chair agreed to commission a Domestic Homicide Review on 22 December 2017, on the basis that:

CRITERIA:	
There is a death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect.	**X**
The alleged perpetrator was related to the victim or was, or had been, in an intimate personal relationship with the victim.	**X**
The alleged perpetrator was a member of the same household as the victim	**X**

4 Scope of the DHR

4.1 The Review should consider in detail the period from March 2016, to ensure that the whole of the relationship between L and M was considered, until the date of L's death in December 2016.

4.2 Agencies have knowledge of L and M from incidents prior to March 2016 and the Review will gather and consider summary information regarding these.

4.3 The focus of the DHR will be maintained on the following subjects:

Name	L	M
Relationship	Victim	Perpetrator
Gender	Female	Male
Age (December 2016)	26 years	38 years
Ethnicity	White North European	White North European

4.4 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the Domestic Homicide Review should be produced.

4.5 An Overview Report will be prepared in accordance with the Guidance.

4.6 The key issue to be addressed within this Domestic Homicide Review is whether domestic abuse was occurring in the relationship of L and M, and if so why this was not reported to any agency. This should be considered in the context of the general areas for consideration listed at section 4 of the Guidance.

5 Individual Management Reviews (IMR)

5.1 Individual Management Reviews are required from the following agencies:

- Staffordshire Police
- Worcestershire Clinical Commissioning Groups (in respect of primary health care services)
- Worcester Acute Hospitals NHS Trust

5.2 IMR Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subject of the DHR or their family members. IMRs and Summary Reports should confirm the independence of the author, along with their experience and qualifications.

5.3 Where an agency has had involvement with the victim and perpetrator and/ or other subject of this Review, a single Individual Management Report should be produced.

5.4 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Julie Long, Staffordshire County Council, to facilitate the prompt commissioning of an IMR.

5.5 Third Party information: Information held in relation to members of the victim's immediate family, should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.

5.6 Staff Interviews: All staff who have had direct involvement with the subjects within the scope of this Review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning Manager has received written consent from the Police Senior Investigating Officer. This is to prevent compromise of evidence for any criminal proceedings. Participating agencies are asked to provide the names of staff who should be interviewed to Julie Long, Staffordshire County Council, who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance.

5.7 Where staff are the subject of other parallel investigations (Disciplinary, SI, etc) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the Independent Review Panel Chair, supported by Julie Long, Staffordshire County Council.

5.8 Individual Management Review reports should be quality assured and authorised by the agency commissioning manager.

6 Summary Reports

6.1 Where an agency or independent professional has had no direct contact with the identified subjects within the period under review, but has had historic involvement with them, involvement with their extended family or is able to provide information regarding the provision of local services, a Summary Report should be prepared.

6.2 Summary Reports are required from the following agencies:

- West Mercia Police
- West Midlands Ambulance Service

- Worcestershire County Council Children's Social Care
- Wyre Forest District Council

6.3 Summary Report Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subject of the DHR or their family members. Summary Reports should confirm the independence of the author, along with their experience and qualifications.

6.4 The Summary Report should commence from the point at which the agency first became involved with the subjects until that involvement ceased. A chronology of **significant** events relating to family members should be attached to the report.

6.5 The purpose of the Summary Report is to provide the Independent Overview Report Author with relevant information which places each subject and the events leading to this review into context.

6.6 Summary Reports should be quality assured and authorised prior to submission.

6.7 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Julie Long, Staffordshire County Council, to facilitate the prompt commissioning of an IMR.

7 Parallel Investigations:

7.1 Where it is identified during the course of the Review that policies and procedures have not been complied with agencies agency should consider whether they should initiate an internal disciplinary processes. Should they do so this should be included in the agency's Individual Management Review.

7.2 The IMR report need only identify that consideration has been given to disciplinary issues and if identified have been acted upon accordingly. IMR reports should not include details which would breach the confidentiality of staff.

7.3 The Police Senior Investigating Officer (SIO) should attend all Review Panel meetings during the course of the Review.

7.4 The SIO will act in the capacity of a professional advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service.

8 Independent Chair and Overview Report Author

8.1 The Review Panel will be chaired and the Overview Report prepared by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews. He has no personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

9 Domestic Homicide Review Panel

9.1 The Review Panel will comprise senior representatives of the following organisations:

- Staffordshire Police
- Worcester Clinical Commissioning Groups (in respect of primary health care services)
- Worcester Acute Hospitals NHS Trust
- South Staffordshire District Council
- Staffordshire County Council

- West Mercia Women's Aid

10 Communication

10.1 All communication between meetings will be in confirmed in writing and copied to Julie Long, Staffordshire County Council, to maintain a clear audit trail and accuracy of information shared. Email communication will utilise the dedicated Staffordshire County Council DHR email account.

11 Legal and/or Expert Advice

11.1 Individual Management Review Authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.

11.2 The Overview Author will include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and Learning Reviews conducted locally and nationally.

12 Family Engagement

12.1 The Review Panel will keep under consideration arrangements for involving family and social network members in the review process in accordance with the Guidance. Any such engagement will be arranged in consultation with the Police Senior Investigating Officer and, where relevant, Family Liaison Officer.

12.2 The Review Panel will ensure that at the conclusion of the review the victim's family will be informed of the findings of the review and have sight of the Overview Report. The Review Panel will also give consideration to the support needs of family members in connection with publication of the Overview Report.

13 Media Issues

13.1 Whilst the Review is ongoing the Police Media Department will coordinate all requests for information/comment from the media in respect to this case. Press enquiries to partner agencies should be referred to the Police Media Department for comment.

14 Timescales

14.1 The review commenced with effect from the date of the decision of the Chair of the Community Safety Partnership. Completion of the Review is planned for June 2019, 6 months from completion of the criminal proceedings in respect of M.