# DOMESTIC HOMICIDE REVIEW

## East Sussex Safer Communities Partnership

### Executive Summary of the report into the murder of Pamela (Adult F)
### March 2016

**Author: Davina James-Hanman OBE**
**March 2017**

*Mum*

The loss of my youngest daughter was a devastating shock and in such violent, unloving and cruel circumstances is something that I will never recover from.

I retired last year and was planning to move to East Sussex to be near to Pamela and spend some quality time with her. My lifestyle would have improved by moving nearer the coast and I was planning to help Pamela with her business a couple of days a week so that she had more time for herself. Pamela moved away from the family home when she was a teenager and then to Sussex in her late twenties. I was looking forward to having more time with Pamela during my retirement years.

The realisation of losing her hits me in waves and I find it hard to control my tears. I will never again be able to cuddle my youngest daughter, see her smile and hear her laugh or sing. I was denied being able to see her to say goodbye. I now have Pamela's dog which is my last link with her.

I will never get over the loss of my daughter in such tragic circumstances or of not having the chance to say goodbye.

*Sister*

The impact of losing my younger sister will stay with me for the rest of my life.

The day I visited her home to check on her will stay with me forever, with the events which followed still seeming unreal. I have the memory of opening her front door to the sight of heavily blood stained clothing and a dog, which is usually happy and bouncing, looking downcast and unsure. At this point, I shut the door.

Following my 999 call, which I was hoping would be a waste of time, the fear and horror of what I had seen made me realise that this was not a good situation. The hardest thing I have ever had to do was to tell my Mum that her daughter had passed away and gradually, as more information was given, share this with my Mum in a way that enabled me to support her whilst dealing with my own upset later so as not to distress her further.

I have never known a life without my sister; we were so close in age that there was less than a year between us.

I have been overwhelmed by the way that my Mum's and my own life has changed or will no longer be as planned. I had planned to move midway between East Sussex and London to be nearer to Pamela and Mum when she moved. Instead of myself and Pamela growing older together and sharing the highs and lows as we always have, I will now have to deal with things alone. I will no longer share the responsibility for our Mum as she grows older but will have to support her and help her to make decisions by myself.

My sleep pattern is not great as I constantly have visions of my sister and how she was left. I now spend many nights restless followed by days when I feel exhausted and fall asleep when I return home from work.

I am also burdened with sharing a birth date with the person responsible for the demise of my sister and feel that this will just act as a constant reminder of him each year.

I do not believe the full reality of the situation has hit me yet and when I think of how my sister spent her last minutes I feel immense hurt and sadness that her last moments were not spent hearing kind loving words and actions but of fear, disbelief and pain.

# Glossary

CSP: Community Safety Partnership
CPS: Crown Prosecution Service
DAU: Domestic Abuse Units
DASL: Designated Adult Safeguarding Lead
ESCC: East Sussex County Council
DHR: Domestic Homicide Review
DI: Detective Inspector
DVA – Domestic violence / abuse
HMIC: Her Majesty's Inspectorate of Constabulary
IDVA: Independent Domestic Violence Adviser
IMR: Individual Management Review
ISA: Independent Stalking Advocate
MARAC: Multi-Agency Risk Assessment Conference
MASH: Multi-Agency Safeguarding Hub
PCSO: Police Community Support Officer
PIN: Police Information Notice
PND: Police National Database
RMS: Risk Management System
SPFT: Sussex Partnership NHS Foundation Trust
SPOC: Single Point of Contact

# DHR EXECUTIVE SUMMARY INTO THE MURDER OF PAMELA, MARCH 2016

## Preface

The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Pamela[1], and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies. She is joined by the Review Panel in thanking James Rowlands for the impeccably efficient administration of the DHR.

## 1. Introduction

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should 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 she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself;

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

Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-Government definition as issued in March 2013.

1.2 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 identify what needs to change in order to reduce the

[1] Not her real name

risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

1.3. This Domestic Homicide Review (DHR) examines the circumstances leading up to the death of Pamela who was murdered in March 2016 by her partner, Lance. The decision to undertake a DHR was made by East Sussex Safer Communities Partnership in consultation with local specialists. The Home Office was duly informed. An independent Chair was appointed at the end of May 2016 and the Panel met for the first time in July 2016 where IMRs were commissioned and agencies advised to implement any early learning without delay. In consultation with the Senior Investigating Officer, it was decided to delay some aspects of the DHR, such as meeting with family members, until the criminal investigation had concluded. Three further meetings of the Panel were subsequently held in September, November and January.

# 2. Overview

## Persons involved in this DHR

| Name | Gender | Age at the time of the murder | Relationship with victim | Ethnicity |
|---|---|---|---|---|
| Pamela | F | 47 | Victim | White UK |
| Lance[2] | M | 50 | Partner and perpetrator | White UK |

Pamela had no children. Lance had three children from a prior marriage who were all adults at the time of her death.

This report also includes examination of a number of instances where Lance was reported to the police by women. To preserve their privacy, pseudonyms – in alphabetical order – have also been used for them and include (with their relationship with Lance at the time of the harassment): Anna (partner), Barbara (partner), Catherine (partner), Dawn (brief encounter), Elizabeth (unproven, partner), Frances (business relationship), Georgina (business relationship), Helen (partner) and Iris (partner).

## Summary of the case

Lance was born and raised in Hampshire, moving to East Sussex around 2013. During the time Lance was residing within Hampshire, eight women (with a ninth unproven) reported him for harassment which resulted in four first warning harassment letters being issued. Many of these relationships appear to overlap and with hindsight, patterns of behaviour can be seen, namely that Lance would often escalate the relationship very quickly, he appeared to contribute little in financial terms to his relationships, he seemed to feel entitled to all of his partner's time and attention, he made accusations of infidelity and he would often threaten suicide when the relationship was terminated. Post 2011, Hampshire Constabulary have no records of Lance.

[2] Not his real name

Pamela and Lance started a relationship round June 2014. By September 2014, Pamela and Lance were living together and had merged their businesses.

For a time, all seemed well although they were working extremely long hours and the stress of this sometimes led to arguments. Both family members and friends observed Lance exhibiting controlling and sometimes disrespectful behaviour towards Pamela. In June 2015, Lance's mother died and this placed an additional strain on the relationship. By October 2015, Lance was sleeping with another woman and seeking emotional support from another. Pamela grew suspicious about this, and other matters, and saw her GP about her low mood. She was referred for counselling. There was a temporary split between Pamela and Lance in November 2015 with Pamela finally ending it in March 2016. Lance moved out but continued to make frequent contact with Pamela via texts, calls and social media. At one point he was calling ten times an hour.

Nine days after the end of the relationship, Pamela spoke on the phone to her mother explaining the situation with Lance. She told her mother that Lance had moved out of her home and she was now feeling optimistic about her future. Pamela ended the call to her mother at around 11am, stating that she thought Lance was at the door and that she would phone her back.

On opening the door, Lance launched into a frenzied knife attack in the hallway, stabbing her at least 29 times. Lance left her to die from her injuries while he cleaned himself up and left the knife in the bathroom sink. He took her shop takings and keys before returning to his fishing chalet (attached to his shop).

Growing concerned that Pamela hadn't returned calls to her mother or sister, the following day they drove to her home. When they arrived it was clear to them that something was amiss and they called the police. Officers attended and found Pamela's body slumped against a door inside the house. A manhunt was launched for Lance.

He was found with self-inflicted knife wounds to his neck and stomach and was taken to hospital. His wounds were only superficial and he was taken into police custody later that evening.

Lance was charged with murder and originally pleaded not guilty. However, he later changed his plea to guilty and was sentenced to life with a minimum of 22 years.

A more detailed version of events and analysis of agency interactions with both Lance and Pamela can be found in the main report.

## 3. Parallel reviews

There was a criminal trial which resulted in a life sentence with a minimum of 22 years. An appeal against the sentence is being considered.

An inquest was opened by Her Majesty's Coroner, and was adjourned pending the outcome of the criminal trial. Communication channels were established with the Coroner who at the time of writing this report is deciding whether to re-open the inquest. To aid in this process, it was agreed that a confidential copy of this report would be provided prior to Home Office approval.

## 4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following agencies:

- East Sussex County Council (ESCC) Adult Social Care - Kellie Clark, Adult Safeguarding Manager
- ESSC Safer East Sussex Team / Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit – Brighton & Hove and East Sussex- James Rowlands, Strategic Commissioner and Josi Enright, Joint Partnership Officer
- The local specialist domestic abuse service (provided in East Sussex by Change, grow, live (CGL), which is a delivery partner in 'The Portal[3]) – Micky Richards, Director
- Eastbourne Hailsham and Seaford (EHS) and Hastings and Rother (HR) and High Weald Lewes Havens (HWLH) Clinical Commissioning Groups – Gill Field, Designated Nurse Safeguarding Adults
- Hampshire Constabulary – Ruth Attfield, Crime Standards Department
- Hampshire County Council Adult Services - Jude Ruddock-Atcherley - Strategic Domestic Abuse Manager
- Office of the Sussex Police & Crime Commissioner - Sara Jones, Business Manager Victim and Witness Services
- Wealden District Council – Jeremy Leach, Principal Policy Advisor
- Sussex Partnership NHS Foundation Trust – Marianne Trendall, Deputy Director Social Work - Principal Social Worker
- Sussex Police – Jane Wooderson, Crime Review Team.

## 5. Independence

The author of this report, Davina James-Hanman, is independent of all agencies involved, as well as the East Sussex Safer Communities Partnership, and had no prior contact with any family members. Davina James-Hanman is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence having been active in this area of work for over three decades.

All Panel members and IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact. Mark Coulter, the independent expert, was similarly independent of all agencies involved in this case.

## 6. Terms of Reference and Scope

6.1. The full terms of reference can be found in the main report. In summary, these were as follows:

1. Each agency's involvement with Pamela from January 2014 and with Lance from 2006.

3 The Portal is a partnership of leading Sussex Domestic and Sexual Abuse Charities – including RISE, Survivors' Network and CGL – and provides a single point of access and helps victim/survivors of domestic and sexual violence and abuse to find advice and support in Brighton & Hove and East Sussex. For more information go to http://www.theportal.org.uk

2. Whether, in relation to the family members, an improvement in communication between services might have led to a different outcome

3. Whether, in relation to the perpetrator, there are any lessons to be learnt in how previous incidents of domestic violence and abuse that occurred when he was resident Hampshire were managed.

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

5. The response of the relevant agencies to any referrals relating to the victim, concerning domestic violence or other significant harm from April 2014 onwards until the point of the 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 were offered/provided and/or relevant enquiries made in the light of any assessments made.
(d) The quality of the risk assessments undertaken by each agency in respect of both parties.

6. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

7. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

8. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the adults were explored, shared appropriately and recorded.

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

10. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

11. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?

6.2. Agencies were asked to search their records from 2014 for Pamela when her relationship with Lance began and from 2006 for Lance which is the first time that Police were aware of him. An earlier record for Lance was identified from the 1990's but it was not felt to be relevant to this review.

# 7. Confidentiality and dissemination

7.1. The findings of this report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication, by the Home Office Quality Assurance Panel.

7.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used and precise dates obscured. The name Pamela was chosen by her family.

7.3 A number of learning events have been planned to ensure that the lessons are disseminated as widely as possible; the first of these will be a confidential briefing to key local partners which will share critical learning from this and another local DHR which is taking place in April 2017. Once permission is granted by the Home Office to publish, this report will be published on the East Sussex Safer Communities Partnership website and will be disseminated to memberships of the East Sussex Safer Communities Partnership Board, the Local Safeguarding Children Board and the Safeguarding Adults Board for consideration and dissemination within their own organisations, as well more widely to local professional networks.

# 8. Methodology

8.1. The agencies listed below submitted an IMR:

- Sussex Police
- Hampshire Constabulary
- Health in Mind (part of Sussex Partnership NHS Foundation Trust).

8.2. A chronology was also provided by Pamela's GP and a short report was provided by the Crown Prosecution Service. The National Probation Service was requested to provide information but could not do so as records had been destroyed.

8.3. This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) and short reports
- The Police Senior Investigating Officer
- The criminal trial (including witness statements) and associated press articles
- Pamela's Facebook page
- DHR Panel discussions
- Information from friends, family members and the perpetrator.

The East Sussex Community Safety Partnership is responsible for monitoring the implementation of the action plan.

### Involvement of family and friends

8.4. The family of the victim were informed about the commencement of the DHR and invited to participate. Prior to meeting (whilst the criminal investigation was still on-going) contact was made through the Family Liaison Officer (FLO) which allowed them an opportunity to comment on the Terms of Reference. Once the trial had concluded, the Chair met with her mother and sister. Regular updates continued after this meeting and later also included their advocate from Advocacy After Fatal Domestic Abuse (AAFDA). A copy of the draft report was sent prior to submission to the Home Office and their

comments and views were incorporated into subsequent drafts. Pamela's mother and sister also provided access to paperwork and photographs of Pamela's home which were invaluable in aiding understanding.

8.5 The family kindly provided the following pen portrait of Pamela:

*Pamela was a warm, loving person who would do anything for anyone. She saw the best in everybody and tried to keep all those around her happy. She was trusting and would not hear a bad word said about anyone.*

*Pamela was raised in a close family which consisted of maternal grandparents, mother and sister. Her father abandoned the family to live abroad when she was five years old. The paternal side of the family did not maintain contact. Pamela was devastated when she finally made contact with her father in her early thirties to be told that he wanted nothing to do with her and that his life and association with all his family in England had ended when he emigrated.*

*Her shop, selling antiques & collectibles and latterly fishing tackle, in [location redacted] was not just a business, it was also a place where people felt welcome. People used to visit for her friendly ways, sunny smile, a chat and a cup of tea and often not to purchase anything. Pamela helped anyone who needed it and took care of an elderly gentleman who was also a friend of her deceased husband. The gentleman's family had very little contact and Pamela supported him through his cancer illnesses, taking him to hospital appointments and looking after him in his final months. Pamela also sorted out appropriate care and supported her last partner in looking after his mother when she became seriously ill.*

*Pamela loved children and was devastated that she was unable to have her own. Children loved her as the crazy 'aunt' that would indulge them and do crazy things just to amuse them.*

*Pamela enjoyed life and lived it to the full. She tried many different hobbies over the years. As a teenager and into her twenties, she took up horse riding and loaned a horse. Unfortunately, a fall led to her being unable to continue riding. She had a full motorbike license and enjoyed this until her late thirties. She also tried gliding and enjoyed the thrill of this. Pamela had other hobbies which she enjoyed, photography, singing (she had singing lessons) and amateur dramatics (she was a member of an amateur dramatics group).*

*Pamela suffered with periods of extreme pain and fatigue for a number of years before being diagnosed with Fibromyalgia. Once this was medicated she seemed to suffer less and managed to have a normal lifestyle for the majority of the time. A side effect of this for her was depression.*

*Pamela had been married three times. The first marriage was to her childhood sweetheart (they met at 15), this broke down, in part, due to her being unable to have children and the stress caused by IVF treatment. Her second marriage was with someone she met through work; unfortunately this marriage also broke down after ten years together which in part was due to the loss of a child in the early stages of pregnancy. Her third marriage was to her soul mate who tragically passed away when he was just 47. Pamela was devastated. Pamela then met the man who promised her happiness and although it had happened very quickly, thought she was lucky to be given another chance to be in a loving relationship, with the man who she thought would be her fourth husband. Despite family and friends making her aware of their concerns, Pamela again saw the best in this person until about eighteen months into the relationship when she realised things were not as they seemed and she became aware of the way she was being controlled. She then sought counselling to help her become stronger to move on, on her own. Both ex-husbands attended Pamela's funeral.*

*Pamela did not enjoy working for other people but when employed her role was administrative. Pamela was self-employed for a number of years having jointly owned a fish and chip shop on the coast, a franchise magazine, party planner, photography services, freelance book-keeper, antiques & collectibles dealer and then owning a fishing tackle business.*

*Pamela loved animals and had a number of dogs, all… [except one], were rescue dogs. She also had cats, always two or three at a time. You could see the love that Pamela had for her pets and how they trusted and adored her.*

*Pamela had a sense of humour which she shared with her sister and her nephew. It could be described as 'wicked' but not in a nasty or unkind way. They would find the same, often silly things, funny and be in bits whilst no-one else 'got it'.*

8.6 Post-conviction, the perpetrator was contacted through his Offender Manager and agreed to participate. An independent expert, Mark Coulter, was commissioned to visit him in prison on the Panel's behalf which took place in January 2017.

8.7 The conclusion of the interview was as follows:

*Lance was cooperative throughout. He was consistent in his narrative that in his opinion, he is essentially a good person who does all he can to help others, with the best intentions. He mentioned a number of examples where he had organised charity events because he wanted to do the right thing including a sea-fishing competition in June 2014. He also emphasised that he has never been in trouble with the law-except for a previous community order- and that he's not like loads of then in here (prison), stating that 'I'm old school'.*

*Throughout the two hours I spent with him, I did not detect any sense of him taking responsibility for many of the events in his life; there was always someone else to blame-be it the relationship with his wife - having an affair; not seeing his children - they were poisoned; numerous allegations of harassment - all the women conspired; the allegations of debt - Pamela being reckless; in describing the development of their relationship, Lance described it as though he was powerless to resist Pamela's advances.*

## 9. Equality and diversity

All nine protected characteristics in the 2010 Equality Act were considered by the DHR Panel. Several protected characteristics were found to have relevance to this DHR. These were:

**Marital status:** Pamela and Lance were not married although he had proposed to her and discussed a wedding in Italy. Unbeknownst to Pamela, Lance was not at that point divorced although this is something she discovered later on in their relationship. Research shows that co-habiting couples are slightly more at risk of domestic violence than married couples although it could be argued that this is because co-habiting couples include those with a greater degree of varying commitment to their relationship than married couples. Nevertheless, Pamela occupied the group which experiences the highest rate of domestic homicide, namely the recently separated.

**Ethnicity**: Pamela and Lance were both of white British origin and this was not felt to be a factor.

**Sex:** Sex is also relevant as there is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured or killed[3].

Latest published figures show that just over half of female victims of homicide in the UK aged 16 or over had been killed by their partner, ex-partner or lover (54%). In contrast, only 5% of male victims aged 16 or over were killed by their partner, ex-partner or lover.

With respect to the agencies involved in this review, the Panel concluded that none of the protected characteristics impacted on the services delivered.

[3] Smith, K. et al. (2011) Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin 01/11. London: Home Office

# 10. Key findings and lessons learned

### a. Understanding of domestic violence amongst the general public

Whilst it is clear that Lance was controlling towards Pamela, she did not 'name' this experience as domestic abuse and nor did the other people who also observed Lance's controlling behaviours towards her.

It is relatively recently that coercive control has become a criminal offence and it is still not widely understood by professionals let alone the general public. One way of understanding coercive control is to see it as actions by the perpetrator which either literally or metaphorically make the victim's world smaller. In this case it is striking how much Lance *literally* made Pamela's world smaller; when their businesses merged, it rapidly stopped being an antique shop and became solely a fishing tackle shop; when Lance moved in with Pamela, his belongings took up so much physical space in their home that it was necessary to walk sideways down the hall and in other rooms, including the bedroom, only a small path for access existed between the many boxes and belongings that Lance had stored; he posted several times from her Facebook page and took active steps to distance Pamela from her friends and family.

Lance displayed patterns of behaviour that are not widely understood as indicators of someone being an abuser. He repeatedly threatened suicide in his relationships, he repeatedly displayed an unjustified sense of entitlement with respect to money within a relationship, he repeatedly had an expectation that he was entitled to all of his partners' time and attention, he repeatedly accused women with whom he was partnered of having affairs (even as he was himself having multiple relationships) and his relationships always escalated very quickly; from meeting someone to living with them often occurring in a matter of weeks. It was not known by any woman with whom he was partnered to be a pattern of behaviour that he repeated with each of them but when each one was subjected to it, it did not immediately lead them to identify him as an abuser. It is also worth noting that in common with many abusers, Lance was skilled at keeping the hope alive that he would change. He promised Pamela on multiple occasions that he would go to a GP about his depression, that he would access counselling to help them stop having so many arguments. Promises that he would change are also evident in his other relationships. These never materialised.

It is also true that victims of domestic abuse are widely considered to be a 'type' and that few women, even when experiencing abuse, identify with the popular stereotypes that exist. Women like Pamela who considered herself capable and competent can resist seeing themselves as a victim in need of external interventions.

### b. Understanding of domestic abuse by professionals

The Panel felt that Pamela's disclosure that she was experiencing relationship difficulties should have prompted a direct enquiry about domestic abuse by the GP. The referral to Health in Mind was appropriate but unfortunately occurred before the SPFT had completed its revision of its domestic abuse policy and procedures.

### c. The limitations of a risk-led approach

The Panel were concerned about the apparent gap in services for someone like Pamela whose level of risk was apparently low and who was not 'naming' her experience as domestic abuse. Positive mention was made of initiatives such as the recent storyline in '*The Archers'* which has the potential to reach victims who may not otherwise identify their experience as domestic abuse and thus never approach a domestic violence service. However, even if Pamela had named her experience as domestic abuse, her conviction

that she was not in any danger from Lance places significant limits on what services may have been available.

**d. The importance of family and friends**

Pamela's family and others observed Lance's controlling behaviours towards Pamela but they too did not 'name' this as domestic abuse. They were also not aware of where to get help and had no knowledge of the Domestic Violence Disclosure Scheme.

**e. Impunity for repeat offenders**

The repeated use of harassment warnings (now PINs) and failure to act on breaches of Restraining Orders may have given Lance reassurance that his behaviour was 'not that serious'.

Fortunately national practice on these matters has now changed and guidance is now that PINs should not be used.

**f. Awareness and identification of harassment / stalking by professionals**

Many of the responses to Lance's harassing behaviours between 2006 -2011 would now be treated very differently. The approach developed by Hampshire Constabulary since that time deserves to be replicated in other police areas.

**g. Probation records**

The Panel were not able to assess the interaction Probation had with Lance as records have been destroyed. This is a recurring theme in DHRs.

# 11. Recommendations

## Single agency recommendations:

Hampshire Constabulary:

- The areas for improvement have been addressed through changes in policy, procedure and practice over the last 10 years. There are no areas of concern that have been identified that require a specific recommendation to be made as a result of this Review.

Sussex Police:

- That the one day domestic abuse training is converted into a 'requestable course' within six months and that a review process is put in place to establish numbers requiring training.

Health in Mind (Sussex Partnership NHS Foundation Trust):

- All staff to have completed BARTA Training
- All staff to be aware of and able to use MARAC DASH tool
- DASLs to be in place in Health in Mind and promoted to all clinicians as points of guidance/ consultation.
- Learning to be shared across the Trust/ organisation

GP Practice:

- Develop a specific domestic abuse policy
- All staff to undergo domestic abuse training

## Multi-agency recommendations

- The East Sussex Safer Communities Partnership should ensure there is further publicity to raise awareness amongst the general public of the following issues:
  - Coercive control and the risks associated with it
  - Stalking behaviours and the help available
  - Domestic Violence Disclosure Scheme with particular emphasis on the range of people who have the 'right to ask'.
- The responsible commissioner (Hastings and Rother Clinical Commissioning Group) should work with the lead commissioners for specialist services (East Sussex County Council, Safer East Sussex Team) and providers (the East Sussex Healthcare NHS Trust, the Sussex Partnership NHS Foundation Trust and specialist services) to evaluate the impact of the IRIS pilot and, if it is successful, sustain and embed this provision locally.
- The other Clinical Commissioning Groups in the county (Eastbourne, Hailsham and Seaford Clinical Commissioning Group and NHS High Weald Lewes Havens Clinical Commissioning Group) should, if the IRIS pilot is successful, review the findings in order to consider its wider rollout in other General Practice settings across East Sussex.
- That East Sussex Safer Communities Partnership request a report from Sussex Police outlining changes made with regard to practice on stalking and harassment cases.
- The East Sussex Safer Communities Partnership should review pathways so that victims of domestic abuse incidents (not just crimes) are offered a referral to a domestic abuse specialist service.
- Office of the Police and Crime Commissioner and the East Sussex Safer Communities Partnership should review the current commissioning arrangements for standard risk victims, identifying how to ensure that all victims are able to access help and support from a domestic abuse specialist service.

## National recommendations

- The National Probation Service and Community Rehabilitation Companies to review their record retention policy with reference to crimes of violence against women and to report the findings to the Home Office DHR Quality Assurance Panel.
- The Crown Prosecution Service to undertake a thematic review of charging decisions on stalking and harassment cases. This should particularly focus on offenders who move across geographical borders and include consideration of the criteria used to determine whether a charge of harassment or stalking is applied.