east sussex safer communities partnership

DOMESTIC HOMICIDE REVIEW (DHR)

Overview Report

SIGNIFICANT INCIDENT LEARNING PROCESS

Subject: Deborah
Month of Death: July 2020

SILP™ SIGNIFICANT INCIDENT LEARNING PROCESS

Review Chair: Donna Ohdedar
Review Author: Allison Sandiford
Completion Date: 1st December 2021
Submitted to the Home Office: 20th December 2021

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Introduction

1. This report of a domestic homicide review (DHR) examines agency response and support given to Deborah, a resident of East Sussex, prior to the point of her death in July 2020.

2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

3. The brief circumstances of this domestic homicide are that Deborah was found deceased at her home address by her children's carer. She had sustained multiple stab wounds to her face and upper body. Her husband, Paul was found guilty of murder.

4. The Review Chair, Review Author and Domestic Homicide Review panel send their condolences to Deborah's family and friends and would like to thank those who have contributed to this review. Their support and cooperation at such a difficult time is greatly appreciated. East Sussex Safer Communities Partnership is confident that, together with its partner agencies, the findings of this review can be used to further improve collective response to victims of domestic abuse.

5. Whilst it was agreed that the review should consider agencies contact/involvement with Deborah and Paul predominantly from the 6th of March 2020, the time when Deborah reported a significant decline in Paul's mental health, until her death in July 2020, some safeguarding practices were undertaken prior to this timescale and have been included as they relate to later agency involvement and decisions.

6. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Timescales

7. The review began on the 4th of December 2020 and was concluded on the 1st of December 2021. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. This review was delayed as contact with Paul in prison proved difficult. Initial contact with the prison resulted in the report author being directed to the 'Find a Prisoner Service'. The author consequently requested from this service that consent be sought from Paul for contact to be made directly with him. Despite several follow up emails from the author, a response from Paul wasn't ever forthcoming and the author recontacted the prisoner governor. On this occasion the Assessment and Intervention Team agreed to take the matter forward and successful contact was made with Paul.

Confidentiality

8. Deborah and Paul were 58 and 62 years old respectively at the time of the murder. Both are White British.

9. These names and those used within the report for family members and contributors are pseudonyms which have been agreed with the family and are used to protect the identity of the individuals involved.

10. During the DHR process the findings of the review remained confidential with information only being available to participating officers/professionals and their line managers.

11. The findings of the review will be made more widely available once the Home Office has agreed publication.

Methodology

12. East Sussex Safer Communities Partnership (ESSCP) approved the circumstances of this case as fulfilling the criteria for a statutory domestic homicide review and notified the Home Office on the 5th of August 2020.

13. The Significant Incident Learning Process (SILP) review model was the methodology used. This involves agencies[1] producing timelines and analytical reports of their involvement and encourages learning to be identified by the staff involved in the case and so far, as possible, aims to involve members of the families affected by the incidents.

14. To ensure a thorough multi-agency review of the circumstances in which Deborah died, the review was asked to consider the following:

1. What was known about Paul's mental health and his aggression and anger?
2. Were agencies aware of Paul having any drug or alcohol misuse issues?

[1] Table of agencies and their involvement appear at paragraph 22 and Appendix 1

3. What risk factors had agencies identified during previous involvement with the family dating from 2017/2018 and how did this affect their responses to concerns within the scoping period?
4. Could communication and information sharing have been improved during the scoping period.
5. What was understood by services about Deborah's recognition of risk of domestic abuse?
6. Please comment on agencies' identification and assessment of risk.
7. Were there missed opportunities to exercise professional curiosity and were opportunities missed to identify risk at any stage?
8. What did professionals understand about the lived experience of the family and how did agencies work with one another to manage the complexity of their situation?
9. Were there any barriers to Deborah accessing services?
10. Identify examples of strong practice, both single and multi-agency.

15. Staff who had been involved, and the agency report writers, were brought together at a Learning Event to discuss the reports and issues and themes emerging, focusing on Key Episodes identified from the reports. A Recall Day followed to discuss a first draft of the Overview Report.

16. The detailed Terms of Reference and Project Plan appear at Appendix 2

Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community.

17. The Review Chair, Review Author and the Domestic Homicide Review Panel would like to thank Tracy[2] and Sally[3] for contributing to this review.

18. The Home Office DHR leaflet for family members has been sent to both contributors. Neither have communicated to the reviewer through an advocate or specialist but communications were made via a Family Liaison Officer and a qualified social worker respectively until the contributors advised that they were happy with direct contact between the author and themselves.

19. The author kept both contributors updated of the review progress. Contact with Tracy was made both by virtual platform and in person, under socially distanced pandemic guidelines. Contact with Sally was via a virtual platform. Both Tracy and Sally were very helpful in providing insight into the life and circumstances of Deborah and Paul; their valued contributions are woven into the body of this report.

20. Prior to publication, the Terms of Reference and the draft report were shared with both Tracy and Sally. Both agreed that the scoping period, areas for consideration and resulting report reflected key agency interactions with both Deborah and Paul leading up to the incident.

[2] Pseudonym - Deborah's sister

[3] Pseudonym - The children's carer who was also a friend to both Deborah and Paul.

21. The Review Author contacted Paul through the HM Prison and Probation Service. She introduced herself and the DHR by electronic letter and provided a copy of the Home Office DHR leaflet. Paul agreed to answer some questions about the support services that he received for his mental health and met with the reviewer by video link. His voice is included in the report.

Contributors to the Review

22. Agencies and contributors to the review are listed below and at Appendix 1. The Individual Agency Management Reports have been provided by independent review officers from within the agencies. The Individual Agency Management Report authors have not been directly involved with either Deborah or Paul.

23. The following agencies contributed to the review.

Agency	Agency Management Report	Learning Event Attendance	Recall Day Attendance
Change Grow Live	✓	✓	✓
Sussex Partnership NHS Foundation Trust	✓	✓	✓
Sussex Police	✓	✓	✓
Children's Services	✓	✓	✓
Primary Care Clinical Commissioning Group	✓	✓	✓
Adult Social Care & Health	✓	✓	✓
East Sussex Health Care	✓	✓	✓
Children's Disability Service	✓	✓	✓

The following agencies and organisations contributed to the review by returning a detailed summary of involvement request and chronology and information relating to all and any contact with the victim, perpetrator and any relevant information related to involvement in supporting the children:

- Chailey Heritage Foundation
- Turning Point
- Demelza Hospice Care

The Review Panel Members

- **Donna Ohdedar -** Independent Chair, Review Consulting. Attended and Chaired panel meetings, the Learning Event, and the Recall Event.
- **Allison Sandiford -** Independent Author, Review Consulting. Attended all panel meetings, the Learning Event, and the Recall Event.
- **Natasha Gamble –** Strategy and Partnership Officer, Domestic Abuse, Sexual Violence and Abuse and Violence Against Women and Girls Joint Unit, Brighton and Hove and East Sussex.
- **Kaveri Sharma –** Joint Strategic Commissioner for Domestic and Sexual Abuse and Violence Against Women and Girls, Domestic Abuse, Sexual Violence and

Abuse and Violence Against Women and Girls Joint Unit, Brighton and Hove and East Sussex.

- **Jane Wooderson –** Detective Sergeant, Safeguarding Reviews, Strategic Safeguarding Team, Sussex Police.
- **Douglas Sinclair –** Head of Safeguards and Quality Assurance, Children's Services, East Sussex County Council.
- **Debbie King –** Service Manager, Change Grow Live, East Sussex Domestic Abuse Service.
- **Fiona Crimmins –** Designated Nurse Adult Safeguarding, Sussex Clinical Commissioning Groups.
- **Sergio López-Gutiérrez -** Designated Nuse Children's Safeguarding, Sussex Clinical Commissioning Groups.
- **Gail Gowland –** Head of Safeguarding (adults and children), East Sussex Health Care Trust.
- **George Kouridis –** Head of Service Adult Safeguarding and Quality, Adult Social Care and Health Department, East Sussex County Council.
- **Bryan Lynch –** Director of Social Work, Sussex Partnership NHS Foundation Trust.

24. The panel met on the following dates:

1.	Scoping Meeting	04.12.2020
2.	Learning Event	29.04.2021
3.	Recall Event	09.06.2021
4.	Final Panel	07.10.2021

Chair and Author of the Overview Report

25. The review has been chaired by Donna Ohdedar. Donna has 16 years public-sector experience, including her last role as Head of Law for a leading metropolitan authority. Now a safeguarding adviser and trainer, Donna is involved in serious case reviews in both children's and adults' safeguarding, domestic homicide reviews and SILP.

26. The report has been authored by Allison Sandiford. Allison has legal training and has worked for Greater Manchester Police, specialising in Safeguarding. Allison has conducted children's and adults' safeguarding reviews and domestic homicide reviews, both independently and with SILP.

27. Both are independent with no links to the ESSCP or any of its partner agencies.

Parallel Reviews

28. A criminal investigation was on-going parallel to this review commencing. In February 2021, following a not guilty plea, a jury delivered a unanimous guilty verdict convicting Paul of murdering Deborah. He was sentenced to life imprisonment with a minimum term of 25 years. The criminal trial concluded prior to family members and friends being approached by the author.

29. There was no Coroner Inquest as the Coroner was able to obtain the necessary information in the criminal trial.

30. SPFT have undertaken an internal Serious Incident Review which is a single comprehensive root cause analysis investigation. The review conclusions are within this report at paragraph 140.

31. No Serious Case Reviews have been undertaken in respect of Deborah's children at the time of this report reaching completion.

Equality and Diversity

32. The review considered the nine protected characteristics under the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). Deborah was female, and Paul is male. Deborah and Paul were married to each other. Both identify as White British. They both followed the Christian faith but there was no evidence that religion was a relevant factor in this case. Deborah was 58 years old at the time of her death and Paul was 62 years old.

33. Paul has no known disabilities. Deborah lived with diabetes. Diabetes can be seen as a disability under the Equality Act but because the Act treats each person as an individual, ultimately only a court or tribunal could decide. The key thing is that diabetes is a long-term condition that could have seriously affected Deborah's ability to do normal day-to-day things if she hadn't been able to have her medication or treatment.

34. Whilst the review understands that domestic abuse can affect anyone, regardless of age, disability, gender identity, gender reassignment, race, religion or belief, sex, or sexual orientation, it is recognised that in the year ending March 2020, an estimated 1.6 million females aged 16 to 74 years experienced domestic abuse[4]. This is in comparison to an estimated 757,000 males. More women are killed as a result of domestic abuse than men.

35. Change Grow Live[5] assisted the panel to be better informed on issues relating to women experiencing domestic abuse and the support available.

Dissemination

36. Once agreement for the final report has been given by the Home Office Quality Assurance Panel, this DHR report will be available on the council, Safe in East Sussex website. The DHR report will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 1998.

37. All organisations involved with the review will receive a copy of the DHR report. In addition, the following will also receive a copy of the DHR report:

- The East Sussex Safeguarding Adults Board

[4] Domestic abuse in England and Wales: November 2020 - GOV.UK (www.gov.uk)

[5] Change Grow Live offer support to anyone aged 16+ who has been affected by domestic abuse and violence.

- The East Sussex Safeguarding Children's Board
- Office of the Sussex Police and Crime Commissioner
- The Domestic Abuse Commissioner

Background Information (The Facts)

38. Deborah met Paul in 1994. They married in 1995. Within a couple of years, they had decided to foster children and proceeded to adopt Harry in 2007 and Isobel in 2013. The children have complex needs and require extensive support.

39. Deborah's friends and family describe her as having had lots of friends and having been a sociable person. She was an active member of the local church and a disability rights activist who was involved in many successful campaigns. Deborah would take the lead in the community and others would often go to her for support and help in regard to disability rights. Paul was less sociable but supported Deborah and they are described as 'working as a team'; Deborah being the 'organiser' of the family and Paul being the main carer who cooked, cleaned, and primarily attended to the basic needs of the children.

40. Paul was known to suffer with anxiety and depression. He had been accused of abuse by a previous partner before he met Deborah, and he had misused alcohol historically. There are indications that he may have started drinking again. In April 2020, following a deterioration to Paul's mental health, Deborah and Paul separated, resulting in Paul living away from the family home.

41. In July 2020, the children's carer attended the home address and found Deborah deceased in her bed. She had sustained multiple stab wounds to her neck and upper body. Isobel aged 9 years, was in the cot. Harry aged 16 years, was not in the address at the time due to being cared for in a residential home under voluntary placement. No one else was present at the address.

42. Deborah died due to a stab wound to her neck. Paul was found guilty of murder and sentenced to life imprisonment with a minimum term of 25 years.

43. When talking to family and friends it was apparent that Deborah had not discussed any domestic abuse with them or spoken of any problems within the relationship other than Paul's mental health.

Chronology and Overview of the Key Episodes

Key Historical Events Prior to the Scoping Period

44. In 2014 Paul disclosed to a social worker that he had been experiencing a decline in his mental health since October 2013. The following day he attended A&E and was admitted as a voluntary patient to a Psychiatric Ward.

45. The Children's Disability Service commenced a family assessment during which Deborah disclosed two incidents of aggression by Paul towards her. One incident dated back to 1999

whereby Paul had allegedly become verbally aggressive and thrown a glass of water over Deborah. Another incident, a few year later, was disclosed whereby Paul reportedly became verbally aggressive after consuming alcohol making Deborah feel uncomfortable.

46. After one month Paul was discharged from the Psychiatric Ward into the care of the Adult Mental Health Crisis Team for support in the community. A doctor concluded that he had suffered a depressive episode and that his prognosis was positive.

47. In November 2017 Paul became verbally aggressive and raised his voice to carers who were looking after Harry. Paul later cited low mood and anxiety with anger and aggression and was offered supported self-help anger management which he engaged in. He also attended his GP and was prescribed medication and referred for counselling.

48. In December 2017 Deborah disclosed to children's services that Paul had been drinking and shoplifting.

49. Paul started to attend Alcoholic Anonymous meetings and reported to his GP that he stopped drinking on Boxing Day and that he was also privately accessing Cognitive Behavioural Therapy.

50. Following Section 47 enquiries relating to parental capacity, Paul's mental health and Paul's alcohol consumption, the children were made subject to Child Protection Plans under the category of emotional abuse in February 2018. The plans were discharged In May 2018.

51. In July 2019 a professional reported Paul smelling of alcohol whilst driving the children. Paul denied alcohol use. Deborah, who was on holiday at the time, reported that she had no current concerns about Paul and as far as she was aware he hadn't started to drink alcohol again.

The review highlighted the following as key episodes in the case, during the scoping period:

Assessment and Response to Paul's decline in Mental Health

52. On the 6th of March 2020, Paul attended the hospital with Deborah. He was assessed by Mental Health Liaison Team (MHLT) Nurse 1, initially alone, and then with Deborah. Paul described that his mood had been dropping for several months and that he was struggling with sleep and low energy levels. He and Deborah spoke of the pressures of caring for their children and Paul spoke of financial concerns around repairs to the family home despite Deborah reporting that they were financially comfortable. Paul said that he hadn't used alcohol for two years and regularly attended Alcoholic Anonymous meetings.

53. MHLT prescribed Paul medication to aid his sleep short-term and gave him information on counselling. He was advised to contact his GP if things didn't improve. This is usual practice and follows The National Institute for Health and Care Excellence (NICE) guidance which suggests that in the absence of concern of high risk thresholds, anti-depressants are initially tried in Primary Care.

54. The following day, Paul re-presented at the hospital disclosing suicidal thoughts. He was assessed by MHLT Nurse 2 and Nurse 3. Again, he was seen initially on his own, and then in the presence of Deborah. Paul requested inpatient admission to have a quiet place in which to feel safe and recover but a bed was not available for another 48 hours. In the interim staff scheduled him a home visit from the Crisis Resolution Home Treatment Team (CRHT) for the following day.

55. The following morning, the 8th of March 2020, CRHT was contacted by Deborah. She said that she had found Paul holding a knife to his throat. Upon attending the emergency department at the hospital, Paul was transferred to the Urgent Care Lounge where he was assessed by CRHT Nurse 1 and Nurse 2. The nurses assessed Paul on his own and also in the presence of Deborah. Paul now disclosed that he had drank two bottles of wine a couple of weeks ago and admitted that he hadn't been attending Alcoholic Anonymous meetings for a year. This was not explored further with Paul at the time as the purpose of this assessment is to evaluate treatment. And an untruth about alcohol does not often raise any concerns as it is usual for a person to minimise alcohol use during contact with professionals. However, in this case, Paul's alcohol use could have been considered alongside the complexity of the care he and Deborah had described required by his children, and the subsequent responsibilities and stresses on the whole family.

56. Following this contact it was agreed that Paul would remain in hospital until a bed became available. Paul's aggression level is recorded as 'low' during all of the contacts on the 6th/7th/8th of March but there is reference to Paul and Deborah acknowledging Paul presenting as aggressive historically. At this time, consideration was given to raising a safeguarding concern but for unknown reasons, one was deemed to not be necessary, possibly because Paul and Deborah had told the nurse that he was now able to deal with difficult situations and remain calm. Nevertheless, the Children's Disability Service (CDS) contacted CRHT for more information following Deborah updating them of events. Upon reflection staff have agreed that not raising a safeguarding concern to children's services was an oversight.

Lesson 1

Staff in A&E must raise safeguarding concerns to Children's Social Care in accordance with their safeguarding policy and procedure, when deteriorating mental health and alcohol misuse is disclosed.

57. Paul was admitted to a Psychiatric Unit on the 10th of March 2020 where CRHT provided regular face-to-face support.

On-going Support and the Response to the Overdose

58. Following Paul being discharged from the unit to the family home on the 22nd of March 2020, he received regular home visits from nurses and support workers from CRHT. He also completed three sessions of cognitive behavioural therapy for insomnia which, owing to the UK Prime Minister announcing a national lockdown in an attempt to stem the coronavirus pandemic on the 23rd of March 2020, were delivered by a Psychologist over the telephone.

59. On the 9th of April 2020, during a telephone call, CRHT informed Paul that he had been allocated a Lead Practitioner in Assessment and Treatment Services and he would be reviewed the following week for discharge from CRHT. Paul reported that he appeared to be improving but he was concerned that he would not be able to access help quickly enough if he should deteriorate again. He was reassured that the Lead Practitioner would work on plans to support him with this.

60. On the 10th of April 2020 CRHT was contacted by Deborah. She reported that Paul had taken an overdose of Oramorph which had been previously prescribed for Harry and had been in the house for around five years. Paul was taken to hospital by ambulance. Paul was unsure whether he had deliberately overdosed.

61. The following day, MHLT Nurse 3 assessed Paul. His suicide risk was recorded as high, and it was agreed that he would be informally admitted to a Psychiatric Unit as the risks to himself were not being mitigated by community support. Deborah told the nurse that she was very worried about Paul harming himself and she expressed that she wasn't comfortable having him back in the house at this time. This presented an opportunity to further explore Deborah's and the children's safety, but the MHLT did not deem it necessary at the time as any risk was now managed by Paul's admission. However, deeper exploration could have helped to assess future risk and potential domestic violence abuse.

62. The hospital wrote to Paul's GP to update of the incident, but the letter was filed without being reviewed by a clinician. This was a missed opportunity for anyone to have assessed what impact Paul's action had on the family.

The Management of Paul's Discharge following Deborah's Decision to Separate

63. Whilst Paul was an inpatient, Deborah voiced her decision to separate stating that she would not have him back in the house with the children due to his increasingly risky and deceptive behaviour. During a 1:1 session with a nurse on the ward, soon after Deborah had communicated this decision to separate, Paul spoke of having lots of jealousy towards his wife. Within days, he told a social worker that when he thought about the marriage breakdown, he had a desire to hurt either himself or Deborah and that he couldn't bear to see her with anyone else. Around this time Deborah contacted Change, Grow, Live for advice around changing the locks on the house. Deborah was unaware of the comments Paul had made to the social worker and so she did not relay this information to Change, Grow, Live.

64. With parents' agreement the children were transported to care services on a short term basis whilst Children's Services commenced Section 47 enquiries. A few weeks later in May 2020, an initial child protection conference convened to consider Paul's deteriorating mental health difficulties and Deborah's ability to manage the children's needs as sole carer. Both children were made subject to plans under the category of emotional abuse.

65. Paul's comments were assessed by a Psychologist and Paul was asked what he would do if he experienced intrusive thoughts of harming himself or others after discharge. Paul

replied that he would contact professionals and would not harm his wife. It was decided that a safeguarding concern did not need to be raised.

66. A review of Paul on the 4th of May determined discharge for the 6th of May 2020 with a referral to CRHT for support. As Paul and Deborah had now separated, Paul had arranged accommodation for himself – a room in a privately rented shared house. During a CRHT assessment the following day, Paul shared his apprehensions about returning to the community but said that he was feeling much better. He said that he recognised now that the Oramorph medication was not taken as a suicide attempt but was because he had been unable to sleep. He said that he should have asked for help with caring for Harry as it had become a chore that was beating him.

67. No multi-agency discharge meeting was convened - the ward imparted during the Learning Event that this was not deemed necessary because there was ongoing liaison, contact and discussion with Children's Social Care, as is evidenced within their notes. However, it was recognised that a multi-agency discharge planning meeting has the advantage of specific purpose and convening one would have provided the opportunity for holistic discussion focussing upon all aspects of discharge, for everyone involved.

68. Following discharge, the CRHT nurses and support workers had daily telephone contact with Paul. He described feeling isolated in his new home because the other residents were younger. He also said that he had lost contact with previous friends, but that interactions with Deborah had proved amicable and that he had attended the family home on several occasions with Deborah's agreement to collect possessions. He did say that he wanted to sort out the finances, but Deborah was not ready to discuss this yet. The CRHT nurses did not consider contacting Deborah for any reflection upon how Paul was managing post discharge as having separated, patient confidentiality would have prevented them from discussing Paul's circumstances with her. However consideration could have been given to seeking Paul's consent to contact Deborah given that he was attending the home, and that Deborah was supervising contact with the youngest child.

69. 5 days following discharge, the Assessment and Treatment Services made an introductory call to Paul to agree a plan prior to his care being transferred to them. Paul presented as settling into his new house and spoke of cooking and exercising. 11 days after discharge Paul told CRHT that he was happy for the care to transfer to the Assessment and Treatment Services. He denied having any thoughts of self-harm.

70. In a telephone call outpatient appointment with a Community Consultant Psychiatrist on the 15th of June 2020, Paul was co-operative and reported improved sleeping and variable appetite. He said that he was sad about the marriage separation but hopeful that things would get better. During a telephone call with his Lead Practitioner on the 23rd of June 2020, Paul described his mood as good, and spoke of job interviews. Fortnightly telephone calls with the Lead Practitioner were agreed until the next outpatient appointment with the Consultant Psychiatrist when discharge would be considered if his mood had remained stable.

71. Deborah was found deceased at the family home prior to this appointment.

The Voice of Deborah

72. Deborah's younger sister Tracy has told this review that Deborah faced life with a big smile, a lot of sass and bucketloads of determination.

73. At the time of her death, both of Deborah's parents had passed away. But Deborah was a much loved daughter and remained a much loved sister, and auntie.

74. Growing up, Deborah was a well-liked and respected school pupil. Deborah, Tracy, and their parents were highly active within the church community and Tracy reports that their parents instilled in them the importance of friends and of supporting those less able.

75. Consequently, community was always important to Deborah, and she undertook many unpaid roles including church bellringer, Sunday school teacher, play group leader and Guider.

76. Upon leaving school, Deborah studied Residential Social Work. When she qualified as a Social Worker, Deborah left home (aged 18) to undertake various roles within residential children's homes/schools.

77. Deborah loved to travel and had travelled most of Europe and had visited New Zealand, Singapore, and America, solo. These trips were for leisure but on one occasion Deborah travelled to Japan for three months to help teach Japanese staff in the care of a child with cerebral palsy whom Deborah had been a carer for in the UK.

78. Deborah moved back home due to ill health (Myalgic Encephalomyelitis) when she was aged 22 years.

79. Upon completing a Social Work diploma in 2001, Deborah started work for East Sussex Children's Services.

80. As mentioned, Deborah married Paul in 1995. Deborah and Paul decided to foster children and later, adopt. Tracy has told this review that they only ever considered children with extra needs as they felt they had the experience, knowledge and compassion that was required. Tracy has described Deborah as a loving and caring mother. She describes her as being the 'organiser' of the family and very good at ensuring that the children had everything they needed and were entitled to.

81. Throughout her life Deborah always made time for her friends. She stayed in close contact with many friends from school, college, and work. Deborah naturally warmed to, and supported, families who were experiencing the same as her with regards to raising children living with disabilities. She offered emotional support and would use her own experiences to signpost parents to appropriate agencies.

82. Deborah has been described to this review as a champion for those who could not, or found it difficult to, speak out. Tracy describes Deborah as a person who fought injustice, and a formidable force to be reckoned with.

83. To example Deborah's determination, in 2019 she started an online petition which generated over 88,000 signatures in support of her campaign for incontinence pads for disabled children. As a result, Deborah was invited to meet the Social Care Minister in Parliament.

84. In summary, Deborah was a popular, sociable person with lots of friends. She was an active member of her community and had a strong identity as a disability rights campaigner.

The Voice of the Perpetrator

85. Paul has told this review that his mental health declined because he was struggling to manage the children's care and desperately needed a break from the caring role. He recognises that there was a support package in place and that respite was offered but has said that the reality of the support felt very different in practicality as to how it looked on paper.

86. Paul described to the reviewer how he would get up at 5am every day to start the children's care routines, often after a disturbed night as although Harry had night nurses, they couldn't do everything, and he would still sometimes be required to help. Also, Isobel would sometimes wake in the night. The nurses would stay until 7am but Deborah wasn't always able to then help with the children, as she suffered with her own health.

87. Paul took the children to school around 8am and would then do housework, laundry, and other jobs before collecting them from school later in the day. A carer would help Paul in the evenings with making feeds, medicines, and washing and changing the children.

88. Paul talked about the support that the family got in detail. He described how although all of the carers were a big help, their being in the family home brought with it an element of intrusion that was sometimes hard. He spoke of respite being offered to allow him and Deborah time to be alone and the opportunity to go away. He said that on a couple of occasions they did try to have a holiday, but they were asked not to travel too far and one time, had to return. He also spoke of mistakes being made by carers and professionals regarding the children's feed and/or medication and consequently, even if the children were at school or in respite, he constantly worried that something was going to go wrong and that a professional would misunderstand a dosage or instruction. He said that he and Deborah often spoke about whether respite was worth it as there was so much preparation to be done and worry whilst they were there.

89. It was this pressure and these worries that led to him seeking support for his mental health in March 2020. Paul understands why he wasn't immediately admitted to a mental health unit at this time but wishes that someone had tried to understand where his decline in mental health had come from and help him to address the underlying drivers. He is frustrated that

the threshold for admittance on to a ward is so high that you have to first reach the point of feeling suicidal.

90. Paul recognises that he is not a sociable person and describes himself as insular. He finds it hard to confide in a person or to seek support. He also described how he doesn't like to make a fuss and is a co-operative, compliant man by nature. This temperament meant that he did not easily volunteer information to professionals, and he feels that more effort should be made to help people like himself to 'open up'. Paul explained how on the wards, it is the patients who are most difficult and argumentative who seem to get the most attention.

91. Paul remembered making the comment about wanting to hurt Deborah. He recalled speaking to the social worker at the time that he made the comment, but he does not recall any other professionals ever broaching the subject with him again before or at discharge. Paul told the reviewer that Deborah had been informed of his comments at the time.

92. Paul said that he didn't feel ready for discharge, but he was told that he no longer needed to be on the unit. He is not sure that his mental health ever improved whilst he was there, but he does feel that upon discharge he felt a little better because he was able to go out and he met with a chaplain friend on a few occasions – he said the conversation they shared helped him.

93. Paul talked of the professional support he received by telephone (owing to Covid) and said that in the absence of visual contacts it was very easy for him to say he was 'okay'. However, post discharge, by the time he recognised his mental health was in further decline, he didn't discuss it anyway as he had lost faith in the system and any hope for the future.

94. In summary, Paul feels that professionals must be careful not to overlook patients who are co-operative and quiet by nature, or to presume that because a patient is not being aggressive or has not reached the point of feeling suicidal, that they aren't in dire need of support. He also believes it is very important that the crux of a decline in mental health is fully explored.

The Voice of the Children

95. As previously mentioned, Deborah and Paul adopted two vulnerable children: Harry in 2007 and Isobel in 2013.

96. Both of the children have complex needs and require extensive support. Consequently, the children had a carer, Sally who supported Deborah and Paul at the family address daily.

97. Sally has contributed to this review and has described Harry as a very sensitive and caring young man who loves a good joke, football, shopping, and social activities with his friends. Sally has described how Harry enjoys being the centre of attention and loves to listen to other people's conversations. But this practice puts Harry in danger of finding out information before he should, which can subsequently cause him worry and upset. The danger in this being that such upset can cause Harry to have a seizure and other health issues.

98. Isobel is described as a cheeky happy young lady who loves going for trips out and singing along to music. Her enjoyment is described as contagious.

99. Domestic abuse always has a significant impact upon children. With regards to physical abuse, even if the children are not exposed to the domestic abuse directly, they can hear it from another room, and may notice injuries and/or damage around the home. With regards to the outcome of childhood exposure to coercive control abuse, the voices of children who have lived in households where there is coercive control is limited[6]. However, Callaghan Et Al found (in their interviews with 12 girls and 9 boys in the United Kingdom) that children are significantly affected by coercive control. This is echoed in an Australian study - recently published in January 2023[7] which found that *children are often used as tools to enact coercive control.* The study reports that the evidence suggests similar impacts on children exposed to coercive control as those exposed to other forms of domestic abuse.

100. The psychological effects of experiencing domestic abuse are compound. It can result in behavioural changes including challenging behaviour, withdrawal, and can cause a child to struggle to interact with other individuals, including their parents. A child who has experienced domestic abuse may become fearful of conflict, worried, anxious, and depressed. Experiencing domestic abuse can impact a child's ongoing development and lead to overactive stress responses.

101. Post the scoping period of this review, the Domestic Abuse Act 2021(which came into force on the 31st of January 2022) has recognised that children who experience domestic abuse are victims in their own right whether or not they have been present during incidents. The incident leading to this DHR occurred pre this legislation coming into force but this effect of ongoing abuse on children was still recognised by the professionals involved with this review.

102. Due to their complex needs, neither child is able to engage with this DHR to help the review understand their lived experiences. The review, however, acknowledges the ongoing impact domestic violence and coercive control would have had upon them and has sought to incorporate their voices via Sally.

103. Around April 2020, both children were transported to care services (with parents' agreement) whilst Children's Services commenced Section 47 enquiries. However, following Paul being discharged from hospital and moving into his own accommodation, Isobel returned home to live with Deborah. It is important this review highlight that potentially at this time, the risk of abuse and significant harm drastically increased as the risk of abuse continues beyond the point of separation. Meaning, Isobel continued to be at risk of experiencing domestic abuse.

Analysis by Theme

Following multi-agency discussions of the Key Episodes and Terms of Reference[8], the following themes have been identified for practice and organisational learning:

[6] Callaghan Et Al 2015
[7] Coercive Control Takes Significant Toll on Children - Neuroscience News
[8] See Appendix 2

The Effect of the National Lockdown

101. In December 2019 a coronavirus emerged which was swiftly labelled a pandemic. Every Country was advised to take urgent action, and major disruption followed. With a rising death toll across the world, hospitals in the UK began a prominent focus on how they were going to protect patients, visitors, and staff.

102. In order to manage the impact of the virus and infection control, several adaptations to health working practices had to be made. Organising this depleted hospital resources and had a direct impact upon the working practices within wards as:

- Practitioners being redeployed to other teams to give additional support, left some teams with skeleton staff.
- Units being moved to different areas resulted in staff needing more time to take patients from one department to another.

103. Despite this, Paul's experience of hospitals/health centres, at a time when staff were frenetically preparing for the pandemic does not seem to have been adversely affected. His transition into the mental health unit was timely and appropriate and his discharge back into the community has not been established by professionals as premature. In addition, initial assessments of Paul by the MHLT and CRHT still included Deborah.

104. Tracy told the review that the lack of activities available for Paul whilst he was in the mental health unit was a worry and she spoke of being concerned that having nothing to do could have had a negative impact upon his recovery. During the Learning Event it became clear that the lack of activities was due to covid restrictions, and it is now apparent that this may not have been explained to Paul effectively at the time.

105. The major adaption to working practice that Paul had to navigate was post both discharges from the units when face-face contact with the CRHT was replaced by telephone contact[9]. Similarly, so were his sessions with a psychologist. Paul engaged with these and there is nothing to evidence that these remote contacts had any adverse effect with regards to the frequency of contact and substance of the psychological work undertaken him. However, Paul has described how the lack of face to face contact post discharge made it easier for him to just say he was 'okay'.

106. Deborah's contact with Change, Grow, Live (CGL) in April 2020 was affected by the pandemic as staff, consequently working from home[10], lost the in-office immediate oversight of line managers and Independent Domestic Violence Advisers (IDVA). This resulted in Deborah's case not being recorded as advice and sign posting was on a short-term work

[9] The UK Prime Minister announced the lockdown on the 23rd of March 2020. Professionals working around Deborah and Paul, had to rapidly adapt to new working conditions which included many face-to-face appointments being replaced with telephone appointments and many workers leaving the office to work independently from home.

[10] Many professionals were required to now work from home. Although there was a certain amount of relief at the safety and flexibility of doing this, staff had to quickly adapt their home living spaces to the needs of multiple family members working from home whilst simultaneously attending to their children. And working from home came with an element of professional isolation. Some staff were left feeling unsupported - in particular regarding the lack of IT support which could be highly frustrating. They were unsure of new working methods and missed the reassurance that working alongside more experienced colleagues and supervisors brought.

log, therefore a full case file was not opened. Subsequently the case file would not have been subject to full case management processes by the line manager, who may have suggested further actions.

107. Both parents' contact with the children was affected by the covid pandemic and contact was replaced with virtual methods of communication until Isobel returned to Deborah's care in May 2020. It was good practice that the CDS continued with some home visits and that one of the children's social workers, in recognition of the importance of Paul maintaining contact with the children, assisted Paul with the technology.

108. The main issue for both Deborah and Paul appears to have been their access to their usual social support. Tracy told the review how social distancing had affected Deborah who had spoken of feeling isolated when the children were being cared for in a residential facility and social distancing was preventing her from going out. She usually interacted with the community on a regular basis and was supported by a circle of friends.

109. Paul cited covid as being a factor which worsened his mental health. He said that as it loomed, he worried about its impact – both on him and the rest of the family.

110. Given the extent that the pandemic affected working practices[11], it is to the professionals' credit that the biggest impact upon Paul and Deborah lay within the social distancing and fear of the unknown, and not a lack of professional support/services during such difficult personal times.

111. However, it must be explored whether professionals' lack of face-to-face contact impacted their ability to fully understand the family's lived experience. It is recognised that this is less likely in the case of Deborah as she was undergoing assessments regarding the children and upon Isobel returning home, continued to be supported by a carer who attended the home address frequently.

112. Paul however was now living independently in a new address whilst simultaneously recovering from a decline to his mental health. Barriers to gaining an understanding of a person's lived experience include any difficulties in communication and engagement. As such, the pandemic must automatically have had an effect on this area of work. Paul's new life was complex; his circumstances had vastly changed. It would have been challenging for practitioners to understand the impact upon him of these changes without face-to-face contact in the home at different times of the day.

Use of Language in Recording and Assessment

113. Paul was described as 'aggressive' and to have shown 'aggression' in some of the chronology and reports submitted to the DHR. This was because it was a word that had been used to describe Paul within practitioner's notes. In contrast, family and friends who have

[11] Work routines changed significantly. In the absence of face-to-face work with both service users and colleagues, virtual communication platforms such as Zoom and Microsoft Teams started to be utilised. At first, different sectors used different virtual platforms which stilted inter-agency communications and not everyone had access to computer stations or all of the equipment that they needed. Those that did weren't always familiar with the communication tools, and they had to rapidly learn how to use them.

contributed to the review, report that he wasn't an angry man and that they hadn't ever seen anger or aggression directed from Paul to either Deborah or the children. The use of language within the case notes conjures up a different image of Paul than that described by those who knew him.

114. Language, written or spoken is an indispensable tool but words are influential and can be misinterpreted. Meaning, that the way language is used in multi-agency communications should be subject to much consideration in an attempt to helping professionals understand a situation from case notes.

115. The words used to describe Paul in case records guided the assessment of other professionals reviewing them, but each practitioner would have formed their own view based upon their own interpretation. For example, the word 'aggression' will be construed differently by different people because we learn the meaning of words through our own experiences and emotions. For this reason, recording and assessment always benefit from the inclusion of context descriptions to accompany subjective terms.

116. Information provided to the review which is referring to Paul's behaviour during a youth group session, records that Paul was *vocally aggressive;* had *aggressive body language,* and displayed *irrational behaviour.* The record makes it clear that Paul's aggression was borne out of disagreements with staff regarding Harry's care needs, but it would have benefitted from more description about the circumstances and whether this presentation was unusual for Paul. Professionals followed up the behaviour with a telephone to Paul a few weeks later, during which he said that he regretted his behaviour but had been frustrated. Even so, from reading the notes, the situation remains unclear and leaves many unanswered questions; Was this behaviour out of character? Was any belligerence understandable in the situation? Was Paul under any particular pressure that day? In what manner had he been vocally aggressive? What was his irrational behaviour?

117. In contrast CGL recorded that Deborah had disclosed some historic aggression by Paul. Upon her saying this the CGL worker asked further questions, and this resulted in fuller description. It becomes clear when you read the notes that Deborah was referring to behaviour which included getting *very close* to her face and shouting threats to *smash* her up and *smash* her face up; and that he did this when he had been drinking alcohol. This is a good example of further description.

118. This use of extra description distinguishes between fact and opinion within the case notes. Although inclusion of opinion is not essentially a problem - it should be substantiated by fact. For example, it is better to note that a person; *was being aggressive. He shouted, in front of the children, and told her that she was incompetent, and he shook his fist at her*, than to just record: *He was being aggressive*. The extra text helps a reader to understand the situation and not mistake any opinion of the author of the case notes for fact.

119. This deeper understanding of case notes is crucial as what is recorded in files can have a huge impact on what next steps are taken and what support package is put in place.

Lesson 2

All practitioners should understand the importance of using descriptive language in case notes to help a reader distinguish between fact and opinion.

Recommendation 1

East Sussex Safer Communities Board should produce guidance regarding best practice 'use of language' in recording and assessment and ensure that all partner agencies incorporate it into their staff training.

Consideration of Paul's use of Alcohol in Assessments

120. When Paul first presented to MHLT he denied alcohol being a current issue. He said that he hadn't drank for two years and was attending Alcohol Anonymous meetings. Two days later, he backtracked and disclosed that he had drank the previous month and was no longer attending Alcoholic Anonymous meetings. Professionals demonstrated a reliance upon Paul's version of events regarding his alcohol use by not undertaking further exploration. There is no evidence of any further questions asking Paul why he had stopped attending Alcoholic Anonymous meetings, or what might have triggered him to drink again. Similarly, there is no evidence of any conversation[12] with Deborah being had in confidence to provide her an opportunity to disclose more information or discuss any suspicions of Paul using alcohol on other occasions.

121. Such a conversation may have gleamed extra information as interestingly the DASH[13] assessment that was completed by CGL asked Deborah whether Paul had problems with alcohol within the last year and she commented that he had been *hiding alcohol*, *secretly drinking* and *was a recovering alcoholic*.

122. Professionals at the Recall Day discussed how mental health and alcohol is a 'chicken and egg' situation – alcohol is sometimes used by people to manage symptoms of anxiety and depression, but alcohol use can lead to low mood and anxiety and/or can worsen existing symptoms. Patients in mental health hospitals are asked about their alcohol consumption, as was Paul, but he did not disclose any level of alcohol consumption that would put his health at an increased risk. Per se, he wasn't referred for any specialist advice or treatment and his alcohol use wasn't deemed to need any deeper exploration.

123. However, the disparity of Paul's information is concerning when considering any possible risk to Deborah and the children. This is because during a family assessment in 2014, Deborah had disclosed two incidents of aggression by Paul towards her that had occurred whilst he was consuming alcohol. This suggests that Paul may be prone to being angry when drinking. The first incident dated back to 1999 - Paul had thrown a glass of water over her and the second incident (date unknown) involved Paul becoming verbally aggressive. There are no other reports of domestic abuse, but this highlights why a good understanding of Paul's alcohol use was essential to generate an accurate assessment of the current risk.

[12] Paul's alcohol use was questioned in parenting assessments, but it is recognised that this would not be an environment during which Deborah would likely feel able to confide any concerns.
[13] Domestic Abuse, Stalking and Honour Based Violence

124. Domestic abuse is not caused by alcohol misuse and this report is not intimating that alcohol caused Paul's abuse or was to blame. But research[14] indicates that problem-drinking is often found amongst those who commit intimate partner violence. In addition, it is known that having a mental disorder puts a person at a higher risk of a domestic abuse incident compared to the general population[15]. Subsequently, Paul's comorbidity of alcohol and ill mental health, could have been recognised as an indication of possible increased risk to his family.

Interaction between Professionals and Deborah

125. Family and friends who have contributed to this review have reported that they did not have any suspicions of abuse, nor is there any '*evidence*' of any ongoing domestic abuse incidents between Paul and Deborah.

126. Deborah had a strong personality and a solid identity of professionalism. This may have encouraged others to be over-reliant on her and may have created a presumption that she understood and would recognise the risks of domestic abuse. Her confident demeanour may have clouded professionals' curiosity of her understanding of her situation.

127. There were many opportunities to be professionally curious and ask Deborah about domestic abuse without Paul being present. Some opportunities for routine enquiry into domestic abuse were exercised well by professionals, but other opportunities when Deborah attended routine medical appointments, went unnoticed. Deborah had on-going physical health problems including a diagnosis of diabetes for which she attended annual reviews. Clinicians needed to remember to be aware of the 'key indicators for domestic abuse' and as per NICE guidelines[16], to *make sensitive enquiries of people presenting with indicators*. Although no concerns are recorded on Deborah's notes, there is no evidence of questions being asked.

128. In addition, depression screening questions should have been asked during Deborah's diabetic annual reviews (and documented even if there was no disclosure). These standard questions have the advantage of supporting professionals to be professionally curious and can open further dialogue.

Lesson 3
Clinicians must remember to ask procedural questions about depression/domestic abuse when seeing patients with non-specific symptoms or symptoms suggestive of domestic abuse and record the reply.

Recommendation 2
East Sussex Safer Communities Board to ensure that health practitioners are aware of the NICE quality standard regarding clinical indicators of domestic abuse.

[14] McCord 1993
[15] Trevillion et al 2012; Oram 2013
[16] Key indicators for domestic abuse | Domestic abuse | Royal College of Nursing (rcn.org.uk)

129. Following Paul having been taken to hospital after he had overdosed on Oramorph, the police attended Deborah at her home address on a joint visit with the CDS. This joint visit is a good example of an opportunity to ask Deborah about domestic abuse being affected.

130. Whilst the primary purpose of the visit was to assess whether the children might be at risk of any significant harm, it is evident that Deborah was offered the opportunity to disclose information about any domestic abuse. She spoke at length about her concerns for her husband and spoke openly of events leading up to the incident. But she made it clear that she was concerned for Paul and wanted him to get the treatment that he needed. She said that she was not making any allegations against him about his treatment of her or the children. Deborah did not make any disclosure or indicate in any way that she had been the victim of any form of domestic abuse.

131. One of the police officers in attendance reflected that Deborah had been very open about her concerns and did not hint at any previous abuse or fear of future abuse. This officer has a wealth of experience in the field of domestic abuse investigation and understands how it is often possible to read signs when a person is withholding information.

132. Nevertheless, the police and the social worker offered to refer Deborah to a domestic abuse charity (CGL), but Deborah said that she was unsure whether her experiences could be categorised as domestic abuse. The police and worker reassured her that abuse wasn't just classed as physical abuse but also coercion and control or emotional abuse. Deborah still didn't feel that a referral as necessary.

133. However, three days later Deborah contacted CGL. She told them that CDS had said that there was domestic abuse within her relationship and that she should contact CGL for specialist support. Deborah said that there wasn't any abuse in the relationship but that she wanted advice about her rights to change the locks on the property given that it was shared ownership. Even so, the staff member rightly followed CGL process and completed a pre assessment form and a DASH.

134. Deborah only answered yes to three questions; have you recently separated or tried to separate, has Paul had problems in the past year with drugs, alcohol or mental health and has Paul ever threatened or attempted suicide. Notably she answered 'no' to the question, has Paul ever used weapons or objects to hurt you, but commented that he had been aggressive in language.

135. Following completion of the DASH by CGL there was no further exploration of the differing opinions between Deborah and CDS who had stated that domestic abuse was a component of the marriage.

136. Consideration must be had that not everyone recognises domestic abuse, particularly if it is not physically violent. Domestic abuse is complicated and even some people who have, or are, experiencing it are unclear as to what constitutes abusive behaviour. Deborah may have thought that she had a good understanding of domestic abuse because of her professional training; but her training was over thirty years ago when little empirical knowledge existed. And this meant that social workers were not well trained to deal with domestic abuse at that time. Domestic violence was then seen as a family matter and a

private, personal issue. Publications such as 'The Battered Woman' written by Lenore Walker in the late seventies attempted to conceptualise domestic violence and they did help by bringing attention to the problem, but they mainly assumed that violence must occur repeatedly to be domestic abuse and they didn't fully explain it to those working in the field.

137. Since this time, the Home Office has defined domestic violence abuse as being any 'incident or pattern of incidents of controlling, coercive, 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 includes psychological, physical, sexual, financial, and emotional abuse (Home Office, 2013). This focus, alongside public awareness campaigns has helped society to develop a better understanding of what constitutes domestic abuse, but we must remember that an individual's understanding will still differ.

138. Professionals needed to be sure that they were being professionally curious and were asking enough questions to fully explore and identify any risk indicators within Deborah's circumstances. They needed to ask questions which would help to identify any abusive behaviours and provide assurance that Deborah understood her situation. These questions are a prerequisite to assessing risk. Not asking enough not only resulted in domestic abuse not being fully discussed with Deborah, but also had the effect of halting further analysis with CDS.

139. It wasn't immediately recognised that this was a missed opportunity to explore Deborah's circumstances and to explain how domestic abuse represents an application of control – not a loss of control - because, as mentioned previously, staff working from home due to the pandemic restrictions lost the in-office immediate oversight of line managers and IDVAs. In addition, the worker recorded the case discussion on a short-term work log, instead of opening a full case file which would have been reviewed under case management process.

140. The role of CGL is to support anyone affected by domestic abuse and violence. CGL can support people to report the abuse they are experiencing and refer or signpost into services to meet specific needs. When Deborah contacted them there was a window of opportunity to gain an understanding of Deborah's lived experience, help her to understand the effects of domestic abuse and to provide her with support.

Lesson 4
Professionals must remember that not everyone understands what constitutes domestic abuse behaviour.

Recommendation 3
East Sussex Safer Communities Board to raise the public awareness of domestic abuse.

141. Although Deborah did not disclose domestic abuse, she wanted the lock changed for a reason – do we know what that reason was? The duty social worker who took the call recollects that Deborah wanted the locks changed to demonstrate her protectiveness of her children to CDS, and that at no point in the conversations did Deborah make reference to being fearful of Paul. Both probing and clarifying questions needed to be asked in an

attempt to identify her understanding of abuse and help to confirm whether she was concerned about anything else.

142. Clarifying questions and probing questions are fundamentally different. Clarifying questions are brief and designed to clarify the subject being discussed. Typically, they include: Is this what you said? How did it happen? Probing questions are designed to deepen the understanding. They are typically open-ended and intended to explore a person's thoughts and feelings. Deborah could have been asked; What do you fear might happen if you don't change the locks? How do you think that might happen? What makes you think that?

143. As already mentioned, Deborah was able to present herself in a professional and confident manner. This may have made it harder for some professionals to ask probing questions about her relationship in order to assess her situation. Indeed, it is recognised that assessing anyone's personal experiences within their private relationships can be uncomfortable.

144. In the current climate of limited resources, assessment can feel like a tick box exercise but should be seen as an opportunity to understand someone and work with them collaboratively. On paper, assessments are rigid with an established questioning format, but how you ask the questions is your choice. Questions can be reframed to help the person answering to think about the situation.

145. *'Learning to ask questions that open up possibilities is an art form that takes practice'*[17] and practitioners at the Learning Events discussed how personal questions have to be placed correctly into a conversation. Asking them too early can cause a person to feel defensive and shut down.

Lesson 5

Practitioners must be aware of the importance of probing questions being asked in a sensitive, timely manner and they must be supported to acquire such skill. Such questions should not be omitted in any circumstances, including when the person/client is one with a professional background and/or a confident manner.

146. CGL referred Deborah to legal services. There was no follow up to this at the time, but the homicide investigation established that Deborah did approach a solicitor enquiring about an Occupational Order[18] against Paul. No order was sought as Paul voluntarily left the home address but records from the initial contact between Deborah and the solicitor show that during a consultation Deborah stated that her husband had been 'emotionally abusing her and she was scared that he could become violent, although he had not been violent so far'. This is not expanded upon or referred to again. However, it demonstrates a different mindset of Deborah.

[17] Graybeal C (2001) Strengths-based social work assessment: Transforming the dominant paradigm' Families in Society, Volume 82, Number 3, pp233-42, (p241)

[18] An occupation order is a court order under the Family Law Act which specifies who is and who is not able to live in the family home. It can also specify who can enter the surrounding area.

147. Practitioners working with Deborah would never have become aware of her disclosure of emotional abuse to the solicitor as solicitors do not routinely share information with safeguarding agencies.

148. Deborah had updated a social worker of her contact with CGL and advised that CGL had informed her that her case was *borderline* in regards of domestic abuse history. This review has seen no query of what Deborah meant by the word *borderline* and it is not a word used in the CGL reports.

149. This reaching out to another service was seen as positive and a mitigating factor in terms of risk as it was unusual for Deborah to do this. It should also have been viewed as a possible indicator of the true extent of difficulties that Deborah was facing at the time.

Assessing Heightened Risk

150. Deborah disclosed the Oramorph incident to CDS who called a strategy meeting and conducted a joint visit to the home address with the police.

151. The strategy meeting concluded that section 47 enquiries would be completed without police involvement with a view to proceeding to an Initial Child Protection Conference. In the meantime, both children would stay in respite care. The omission of police involvement is sensible given the absence of any allegations or evidence of criminal offences.

152. Around this time Deborah told Paul of her decision to end the marriage and she also told the consultant on the mental health ward. She said that she did not want Paul to return to the family home even if he was mentally well.

153. As previously mentioned, during a 1:1 session with a nurse on the ward soon after Deborah had communicated her decision to separate, Paul spoke of having lots of jealousy towards his wife due to her having a good support network, the money, the house, and the children. Within days, he told a social worker that when he thought about the marriage breakdown, he had a desire to hurt either himself or Deborah and that he couldn't bear to see her with anyone else.

154. In 2019 criminology expert Dr Jane Monckton Smith established a homicide timeline which could be tracked by professionals to help them to prevent deaths. The timeline follows an eight-stage pattern.

155. The eight steps Dr Jane Monckton discovered in almost all of the 372 killings she studied were:

- A pre-relationship history of stalking or abuse by the perpetrator
- The romance developing quickly into a serious relationship.
- The relationship becoming dominated by coercive control.
- A trigger to threaten the perpetrator's control - for example, the relationship ends, or the perpetrator gets into financial difficulty.
- Escalation - an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide

- The perpetrator has a change in thinking - choosing to move on, either through revenge or by homicide
- Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone.
- Homicide - the perpetrator kills his or her partner, and possibly hurts others such as the victim's children.

156. Had a professional considered Paul against the pattern it would have been recognised that the relationship fit the early stages of the model and that his current threats of suicide and thoughts of revenge and/or homicide indicated that he had reached stage 5 and 6.

157. The timeline was not used but a psychologist worked through the comments with Paul and asked him what he would do if he experienced intrusive thoughts of harming himself or others after discharge. Paul replied that he would contact professionals and would not harm his wife. It was decided in a team discussion that the comments would be considered in the next full ward review.

158. A safeguarding concern was not raised. The clinicians involved recalled that when Paul spoke of his feelings, the impression was more of risk to himself than to others. The ward SPFT social worker stated that although Paul had made a comment of concern regarding thoughts of harming Deborah, this seemed to be a passing comment made without intent. The acting ward consultant, who had experience within forensic services, stated that there appeared to be no anger towards his wife and no real depth of emotion - Paul appeared to accept that his marriage was over and to acknowledge his own responsibility for the this.

159. Whatever the rationale, the decision not to raise a safeguarding concern meant that the information was not shared with other agencies, and professionals lost an opportunity to re-assess their support in light of Paul's comments. This is discussed further in the next section of this report.

160. Neither were the comments shared with Deborah - as Paul did not consent for information to be shared with her or any other family members (although he did acknowledge that Deborah remained his next of kin legally). As they were now estranged, it was not routine to discuss Paul's care with Deborah and staff have said that they did not have any concerns about risk that would have warranted breaching his confidentiality.

161. The ward review on the 28th of April 2020 did not identify any ongoing acute mental health needs for Paul but unfortunately, there are no notes detailing this discussion which would give insight into how this risk formulation was reached. A provisional discharge, with CRHT support, was set for the following week. Paul said that he wished to return to the family home temporarily until he found suitable accommodation.

162. The social worker did contact Deborah to inform her of the discharge and Deborah repeatedly said that Paul could not return to the family home. The social worker explained that she had no legal basis to stop him from doing so and when the social worker contacted

Deborah again a few days later, Deborah said that she was seeing a solicitor with a view to obtaining an occupational order against Paul for domestic violence.

163. There are ward notes that record that Paul denied any domestic violence towards Deborah but there are no further details to indicate whether he volunteered this information or was asked. And if he was asked, how the question was framed.

164. Given that professionals are aware that the risk of domestic abuse is heightened at the point of separation and that no type of abuse automatically ends when a relationship ends, deeper consideration could have been had to sharing Paul's information with Deborah. At the least, in light of his comments, advice could have been given to Deborah at the point of discharge, about the risk of domestic violence at separation. She could have been advised that a perpetrator will look for ways to control and abuse their partner, often using child contact arrangements or finances to disguise continuing power. Conversation could have been had with Deborah about what signs to look out for. This was also a further opportunity to utilise the aforementioned homicide timeline. Sharing it with Deborah would have given her a tool to help her to recognise and articulate her situation.

165. Deborah was aware that Paul had been accused of abuse by a previous partner and as she and Paul had married the year after their relationship started, she may have recognised her own relationship in the early stages of the timeline. This may have raised her guard and understanding.

Lesson 6
The Dr Monckton Smith homicide timeline supports both victims and professionals to recognise risks of domestic abuse.

Recommendation 4
East Sussex Safer Communities Board to raise awareness across all partner agencies of Dr Jane Monckton Smith's eight-stage domestic homicide pattern model and ensure that they are aware of the benefits of incorporating it into practice.

166. Since Deborah's death, SPFT have undertaken an internal Serious Incident Review which is a single comprehensive root cause analysis investigation. The review has not identified any root cause, meaning that no specific action or omission on the part of the mental health staff could have prevented this tragedy. However, it has concluded that Paul's behaviours and the risk factors could have been explored further and his risk to others detailed. Focus was on Paul's personal safety and suicide risk and allegations of domestic violence should have been discussed in detail with both Deborah and Paul. The importance of gaining collateral information from family members even when there are relationship difficulties was also noted. A list of the recommendations made by the report can be found in Appendix 3.

167. SPFT have assured this review that their risk assessment and formulation processes are comprehensive and are supported by mandatory domestic abuse training. They also ensure

that the regular updates received from the Domestic Abuse, Sexual Violence and Abuse & Violence against Women & Girls Joint Unit are cascaded to staff.

168. However, SPFT do recognise that as in the case of Paul and Deborah, there are times where identifying the correct course of action is less clear. Working primarily with the perpetrator, as Paul became, whilst maintaining links with partners, ex partners and family, is complicated and SPFT have assured this review that other approaches such as 'think family'[19] are now well embedded. SPFT have also assured the review that staff are very clear in regard to linking in with MARAC where concerns are known. In addition, East Sussex wards have had Quality Improvement projects to ensure that all patients have 1:1 nursing time each day, and that there is proper documentation of this on our recording system: 'Carenotes' and identification of any issues for discussion in MDT handover. This may provide a space to explore any unusual comments/behaviours.

169. The SPFT Director of Safeguarding is to review the Trust Domestic Abuse and Sexual Violence policy this year. He is aware of this DHR, and the learning will be considered in the review. In addition, The Trust is also developing a new domestic abuse policy for staff entitled, Responding to Trust staff who are experiencing or perpetrating domestic abuse. Again, the learning from this DHR will be considered in the drafting of this policy.

Consideration of the Whole Family.

170. The review has highlighted opportunities for professionals to apply the Whole Family approach to this case – an approach that encourages services to consider the family as a whole, as opposed to responding to each problem, or person in isolation.

171. As discussed, in April 2020 Paul informed professionals at the mental health unit of his desire to hurt either himself or Deborah and of the struggles he was having coming to terms with the separation. SPFT have explained that in therapeutic environments, it is usual for dark thoughts to be expressed and it would not be practical for safeguarding enquiries to be raised every time such a threat was voiced. Instead, the comments are risk assessed internally and explored. On this occasion the experienced consultant in charge of Paul's care worked through the threats with Paul and did not deem risk.

172. However, the question: would Paul have further disclosed any thoughts of harming Deborah, must be asked. A study: Healthcare experiences of perpetrators of domestic violence and abuse[20], has identified factors that act as barriers to a perpetrator disclosing domestic violence in a healthcare setting, as including a fear of other services being informed and involved. Paul understood the social care system well and would have known the consequences of children's social care learning of his thoughts.

[19] The Think Family principle is referred to as Whole Family across East Sussex
[20] Healthcare experiences of perpetrators of domestic violence and abuse: a systematic review and meta-synthesis | BMJ Open

173. Although the practicalities of raising a safeguarding concern every time a patient in a therapeutic environment voices a want to hurt someone is recognised, the non-sharing of Paul's spoken desire to hurt Deborah, whether deemed a risk or not by SPFT, prevented other safeguarding agencies from having the opportunity to complete a DASH and/or consider any risk posed by Paul.

174. This is dangerous as it is those who work with the family within the community who have the broadest picture of the situation. Significantly, in this case, the professionals working with Deborah and Paul had a good understanding of their stresses as carers for the children and would have been able to take this into consideration when risk assessing. Professionals working in acute settings are only able to assess the risk against the limited picture that they have. For example, any information re risk which was known by the Primary Care substance misuse services and/or Health in Mind would not have been apparent to SPFT as their information does not automatically pull through to the systems used by secondary services. Consequently, SPFT staff only had limited background information against which to assess him.

175. Also, the focus of risk assessment may differ between agencies; SPFT knowing that Paul and Deborah were to separate may have lessened their focus upon safeguarding the family (as they perceived Paul moving out of the family home as a protective factor). Their focus may have been more about the risk that Paul posed to himself.

176. In addition to not sharing with agencies the information was not shared with Deborah due to a risk not being deemed significant enough to warrant a breach of data protection. Subsequently when on the 17th of April 2020, Deborah contacted CGL Deborah was unaware of the comments Paul had made to staff at the unit regarding his jealousy and desire to hurt either himself or her. CGL was not aware of the comments either and subsequently they were not taken into consideration when CGL assessed risk.

177. This review has heard that the Whole Family approach was considered by CGL but ultimately an assumption was made that because mental health professionals and CDS were involved with the family, risk (should there be any) would be being managed. This assumption combined with Deborah presenting as confident during conversations, meant that the worker took everything at face value and that no follow up contact was had with any other agencies known to be involved.

178. SPFT shared Paul's admission with his GP and on the 15th of April 2020, the surgery received a notification letter. A rapid response nurse had documented within it that there had been concerns about the safety of Paul's wife and children when Paul had been most unwell but that this was now reduced, and children's social care were aware. There was no further explanation regarding the recent concerns to the family, and the letter was filed.

179. In line with the Whole Family approach, good practice upon receiving this letter would have been to contact Deborah to check whether she or the family needed any additional help. This should have been regardless of previous knowledge of historical concerns. Historic

concerns of Paul displaying aggressive behaviour toward Deborah and professionals were cited in the documentation sent from CDS following a child protection conference in 2018 but this documentation was not easily viewable on the system. More helpful practice would include a code being visible to anyone viewing the family records, to draw their attention to such information being in existence.

Lesson 7
The GP surgery must assess risk management, and apply the Whole Family approach, to all letters received from outside agencies.

180. Finally, the omission of a multi-agency discharge meeting resulted in the agencies working with the family outside of the SPFT having less knowledge of the situation. This resulted in a less accurate assessment of risk and a lack of opportunity to consider how Paul's discharge would affect everyone around him. A multi-agency discharge planning meeting would have provided a last chance to share information and consider the Whole Family before Paul returned to the community.

Lesson 8
Opportunities for multi-agency working could be enhanced through more effective information sharing when a patient is discharged by means of a discharge planning meeting.

Recommendation 5
East Sussex Safer Communities Board to review existing training programmes and ensure that practitioners embed a 'Whole Family' approach into their practice, that includes:

- **How practitioners respond to threats of risk of harm to family members, and**
- **Identification of carers' stresses and any resulting risk to others**

Communication between Services and Significant Others.

181. It is known that family involvement and engagement can be key to recovery for individuals diagnosed with mental illness. Previous studies have found that people using mental health services are more likely to stick to their treatment plans and have better outcomes when their supportive friends and family members are involved in their care. Most government policies and mental health guidelines suggest that staff members should involve carers in patients' treatment. Despite this, carers frequently report feeling excluded from patients' care and from giving or receiving information about the patient. This is particularly a problem in hospital settings, when someone is admitted to an inpatient ward following a mental health crisis[21].

182. Communications between services within the SPFT and Deborah could have been better during the timescale of the review. They had diminished because it was very soon after Paul's admission onto the unit that Deborah voiced her decision to separate, and

[21] Involving family and friends in treatment - Unit for Social and Community Psychiatry (qmul.ac.uk)

without Paul's consent mental health professionals did not have the authority to share any of Paul's information.

183. Nevertheless, including Deborah in Paul's care planning could have proved invaluable to Paul's recovery, Deborah's safety, the children's safety, and everyone's emotional welfare. Even in the event of separation it would have been worth having a conversation with Paul to encourage him to give consent to continue to share his information. The benefits of including another in his care plan could have been explained and in the event of him still refusing to share with Deborah, he could have been encouraged to choose another relative or friend to support him. The quality of SPFT's safeguarding could be improved with refreshed learning of how best to involve significant others of patients in their care.

184. There would have been a benefit to including Deborah, or a significant other, in discussions about Paul's background, and the changes in his behaviours as his mental health had deteriorated, as their input would have improved professionals understanding of Paul. It would also unquestionably have reduced the reliance that professionals had on Paul's self-reporting. Which had already on occasions, been proven contradictory when he had spoken about his alcohol use, how he felt about his father, and why he took the Oramorph.

185. The only information that could have been considered to be shared without Paul's consent was the threats towards Deborah but as previously established, assessment did not deem this to be a true risk. As such, disclosure was not justified. Had the assessment deemed him to pose a risk, Deborah could have been told and as a result she would have been in a better position to answer CGL's questions more thoroughly when she sought their advice.

Support for Deborah following Separation.

186. The first agency that considered support for Deborah in her own right, following the marriage separation was CGL. The CDS and the police had suggested that she contact them for advice, and it was thereafter deemed to be a positive sign when Deborah followed this advice and contacted them.

187. As the contact was made directly by Deborah, CGL were totally reliant upon the information that Deborah was able to, and chose to, provide. A full referral into the service would have required Deborah's consent but would have ensured that CGL had more information such as CDS's concerns and the domestic violence abuse that they had advised Deborah she was at risk of. Records suggest that the CDS and the police did initially offer to refer Deborah to CGL but that she refused because she had said that she was unsure whether her situation could be categorised as domestic abuse.

188. MARAC[22] could not be utilised to support Deborah as the threshold was not reached. Paul was not a prolific offender; police checks showed no traces of violent behaviour; there

[22] A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, IDVAs and other specialists from the statutory and voluntary sectors.

were no known police referrals relating to domestic abuse and no wider concerns from any professional.

189. This left Deborah with little support specific to herself. The CDS reflected in the Recall Day that further consideration could have been given to gaining a greater understanding of Paul's deteriorating mental health by using an Antecedent-Behaviour-Consequence (ABC) approach[23] . This would have helped to gain a greater understanding of Deborah's distress and the dynamics within the relationship and ultimately could have led to a more informed assessment of risk relating to domestic abuse. Additionally, it may have led to a better exploration of the impact of a relationship breakdown, and it could have offered greater insight into the effect of the breakdown upon Paul. The ABC approach is a useful tool to refer back to for greater understanding of a situation.

190. Post discharge, Paul was supported by the CRHT and the Assessment and Treatment Services. He maintained contact with the children by means of virtual platforms and following Isobel being returned home to the care of Deborah, he had contact with Isobel in the community - supervised by Deborah. Harry became a looked after child with the agreement of both Deborah and Paul.

191. Social workers from the CDS were also maintaining contact with Paul and were of the view that he was compliant with Deborah's wishes and the expectations of social care. There were no concerns raised to social care regarding his behaviour towards either Deborah or the children at this time.

192. Hence, post Paul's discharge, given their perceived 'amicable' relationship and Deborah's agreement, Deborah was in a position whereby she was facilitating contact between Paul and Isobel alongside having to have difficult conversations with him about the practicalities of the marriage breakdown, such as dividing the finances and property. This left Deborah in a vulnerable position with increased opportunities for Paul to control her and the criminal offence of 'controlling or coercive behaviour in intimate or familial relationships' (though always central to the domestic abuse) now becomes particularly pertinent.

193. *Coercive control is now recognised as the behaviour that underpins domestic abuse. It is a pattern of behaviour which seeks to take away the victim's sense of self, minimising their freedom of action and violating their human rights*[24]. Coercive control can be hard to recognise as the abuser will exert power over a victim through intimidation or humiliation. Only Deborah and Paul truly know the extent of control that Paul potentially had over Deborah, but her responsibility to manage his contact with Isobel (and the necessity of dissolving the marriage), served to dramatically increase her contact with him and heighten her risk as child contact provides an opportunity for coercive controlling parents to continue their abuse.

[23] The Antecedent-Behaviour-Consequence (ABC) Model is a tool that can help people examine behaviours they want to change, the triggers behind those behaviours, and the impact of those behaviours on negative or maladaptive patterns.
[24] Coercive Control | from Research in Practice for Adults and Womens' Aid (ripfa.org.uk)

194. In May 2020 the children were made subject to a protection plan under the category of emotional abuse. Although this was due to the concerns around the deterioration of Paul's mental health, Deborah expressed to CDS that she felt that *she* was being punished for his behaviours.

195. Deborah reiterated her uneasiness towards the plan and social care when she confided in a Forward Facing[25] worker and said that *she wasn't scared of* Paul but was *more scared of social services.* Deborah spoke of not being able to say what she wanted because social care might take her children away from her.

196. Children's Social Care were initially involved, not because Deborah or Paul had caused significant harm to the children, but because they were parenting in circumstances of adversity given the children's complex needs. When Paul's mental health started to decline, Deborah reached out to CDS and kept them updated of the situation. Following Paul's admission to the unit, Deborah found herself in the position of being subject to child protection investigations, which resulted in her children being made subject to a child protection plan. Potentially, from Deborah's point of view, she had asked for support and was now being punished. Professionals may argue that the plan was initiated to support the children and Deborah, but as evidenced through her conversation with the Forward Facing worker, Deborah clearly viewed it as an ongoing assessment of her ability to meet the children's needs and to keep them safe. She could therefore have potentially worried about any affect disclosures of domestic abuse would have had on social care's view of how she could care for her children and keep them safe.

197. Friends and family who have contributed to this review are in agreement that this made her feel defensive and added extra stress to her situation. Deborah's opinion of the plan, regardless of whether it was right or wrong, undoubtedly served as a possible barrier to her being open about any new concerns she may have had regarding the actions of Paul. As such, voluntary disclosure of any emerging concerns was less probable.

Lesson 9

There may be a barrier preventing victims of domestic abuse accessing support where they are concerned for the implications such disclosure would have on their perceived ability to meet their children's needs.

198. And this probably wasn't the only barrier that came into play at this stage of the separation; a study[26] into the barriers and facilitators of disclosures of domestic violence identified many, including self-blame, embarrassment, and fear of disruption to the family. Post discharge, Deborah and Paul were in regular contact. It is possible that Deborah may have felt sorry for Paul living alone; and guilty and embarrassed for the situation that the family now found themselves in. It is also possible that Paul influenced any guilt - Tracy has talked of how Deborah was often upset after phone calls with Paul following the separation.

[25] A charity supporting children and young people with long term illnesses or life threatening conditions.

[26] Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. The British Journal of Psychiatry 198(3), 189-194

199. The review recognises that some of this is speculation but sadly Deborah is no longer able to communicate how she felt. What is indisputable is that Deborah had no choice but to continue to consult with Paul over child arrangements and finances. Their informal childcare arrangement allowed Paul access to Deborah which may not have been in the best interest of either of them. It may also have slowed Paul's mental health recovery and heightened Deborah's stresses.

Deborah's Lived Experience

200. At the beginning of the scoping period, it was known by health professionals that Deborah was very worried for Paul's mental health, and that both Deborah and Paul were under pressure caring for their children who had complex needs and required extensive support.

201. Over the next month, at the times when Paul was not an inpatient of the Psychiatric Unit, Deborah was managing Paul's behaviours in the family home. This was whilst both parents continued to care for the children with the support of the children's carer, Sally.

202. During this time the country was subject to lockdown owing to the Covid pandemic. Consequently, Deborah lost access to her usual social support, and she confided in her sister that she felt isolated and missed her circle of friends.

203. In April 2020, Paul overdosed on Oramorph and was formally admitted to a Psychiatric Unit. Deborah was now able to voice to professionals that she wasn't comfortable having Paul back in the house at this time.

204. Deborah soon communicated her decision to separate to Paul. Unbeknown to Deborah, upon learning of the separation, Paul told a Social Worker that he had a desire to hurt either himself or Deborah. At this time, it was already known to Children Services that there had been two domestic incidents dating from just before and around 2000, as Deborah had disclosed them during the adoption process. In addition, the mental health liaison team had learned of Paul having presented as *aggressively* in the past and the police had learned of the incidents when they and staff from the Children's Disability Service had visited Deborah following Paul's overdose.

205. Upon recognising that Paul's discharge from the Psychiatric Unit was imminent, Deborah reached out to CGL and asked for advice regarding changing the household locks. During this communication Deborah disclosed the historic domestic incidents but didn't disclose any further incidents. In addition, because Paul's desire to hurt himself or Deborah hadn't been disclosed to Deborah, she was not able to inform CGL of this. Deborah told the worker that she wanted the locks changed to demonstrate her protectiveness of the children to CDS. It was good practice that Deborah was signposted to legal advice re the locks, but Deborah's understanding of domestic abuse went unassessed.

206. Paul was discharged to his own property in May 2020. Deborah was now in a position whereby she had to facilitate Paul's contact with Isobel alongside discussing her want to end the marriage and the arrangements regarding their finances and property.

207. At this point of marriage separation, when statistics and the domestic homicide timeline[27] evidence that the risk of abuse and significant harm had drastically increased, Deborah found herself isolated from her usual social network of friends due to Covid, managing Paul's contact with their children, and unsupported by domestic abuse services. No single agency recognised this full picture and consequently there was no full understanding of Deborah's lived experiences on which to assess risk and decision-making.

208. In reality, Deborah, having made the decision to separate from Paul, was unable to continue a path of complete estrangement because Paul used the children to regain entry to her life. Without a full understanding of Deborah's lived experience, professionals were unable to encourage Deborah to utilise support services and develop support plans that took the difficulty of child contact into consideration.

209. This review hopes that its reflection upon professionals understanding of Deborah's lived experience will serve as a driver of change moving forward and lead to better practice.

Good Practice

During discussion and within records, there is evidence of much good practice within several agencies who supported Deborah and Paul and it is equally important to develop learning from this good practice as it is from any shortcomings.

210. The family were in receipt of an extensive jointly funded Social Care and Continuing Care (health) package of support which included carers in the home address, nurses to support trips out and overnight residential respite for the children.

211. The police officer who attended the joint visit was very experienced in the field of domestic abuse investigation and spoke in depth to Deborah. Despite no criminal offences being disclosed, a marker was still put on the address to concern call handlers to the background information.

212. CDS had a good level of multi-agency liaison and a good understanding of the complexities of the children's needs.

213. CGL have demonstrated a good understanding of descriptive language when completing their pre-assessment form.

214. It was good practice that one of the children's social workers assisted Paul with understanding technology during covid restrictions.

215. The allocated social worker from CDS is a domestic abuse specialist having undertaken enhanced domestic abuse training.

[27] Homicide Timeline - The 8 Stages - YouTube

Developments since the scoping period

216. Since the scoping period of this review, all agencies have learned to better incorporate the restrictions placed upon practice due to the pandemic, into their working procedures. With the provision of Personal Protective Equipment and a growing understanding of the virus, professionals have adapted their behaviours and homes, and accelerated their digital innovation.

217. SPFT have conducted an internal review which has identified many actions and improvements, in particular about domestic violence abuse training.

218. ESHT have developed a rapid domestic abuse screening tool. It relies upon individual staff to utilise it but it does serve as a reminder.

219. CDS, transitions and health are co-ordinating a multi-agency Learning Event to circulate key learning from this DHR and key messages from other serious care reviews and DHRs.

220. The CCG are offering a joint adult and child domestic abuse training workshop. This has been introduced for clinicians to highlight awareness of domestic abuse. It looks at the use of professional curiosity in relation to domestic abuse and how it may present when non-specific symptoms are noted during consultation with patients of all ages is emphasised throughout training.

221. In October 2020 a Health Independent Domestic Violence Advisor was reinstated for two general hospitals[28]. This will assist a consistent approach to domestic abuse, but it is recognised that safeguarding is a process that relies upon close partnership working and all practitioners need to have a good understanding and awareness of domestic abuse in order for consistency to be reached.

Conclusions

222. Deborah was the tragic victim of a domestic homicide perpetrated by her husband after they had separated. Neither agencies or family/friends were aware of Deborah being subject to any ongoing domestic abuse although some professionals were aware of two historic incidents between Paul and Deborah. These had occurred when Paul was known to be misusing alcohol but following Paul seeking support and addressing his alcohol problem, no further incidents were reported.

223. Deborah did not voice any concerns regarding Paul's behaviours to the CDS, the police or CGL. However, we have heard from family and friends that Deborah had expressed that she was unable to say what she wanted to because social care might take her children away. She did not elaborate on this and did not disclose any domestic abuse to anyone within her personal support network – familial or friend.

[28] Funding had been previously withdrawn.

224. Information held by agencies was never sufficiently high risk enough to identify Deborah as a high risk victim of domestic abuse but there is a disparity between what different agencies knew as only the mental health unit knew of the comments made by Paul regarding wanting to hurt Deborah.

225. The homicide occurred during the covid pandemic. Whilst Paul had spoken of the effect that the pandemic had on him, and Deborah had talked of missing social interactions with her friends, there is nothing covid related, that has led to learning for this review.

226. Following discharge from the mental health unit and upon the approach to Deborah's tragic murder, there was no visible decline to Paul's mental health. If Deborah did have any concerns, she did not disclose them, although she does appear to have been worried about something because she sought advice about changing the locks and considered an Occupational Order.

Lessons to be Learnt.

Lesson 1
Staff in A&E must raise safeguarding concerns to children's social care in accordance with their safeguarding policy and procedure, when deteriorating mental health and alcohol misuse is disclosed.

Lesson 2
All practitioners should understand the importance of using descriptive language in case notes to help a reader distinguish between fact and opinion.

Lesson 3
Clinicians must remember to ask procedural questions about depression/domestic abuse when seeing patients with non-specific symptoms or symptoms suggestive of domestic abuse and record the reply.

Lesson 4
Professionals must remember that not everyone understands what constitutes domestic abuse behaviour.

Lesson 5
Practitioners must be aware of the importance of probing questions being asked in a sensitive, timely manner and they must be supported to acquire such skill. Such questions should not be omitted in any circumstances, including when the person/client is one with a professional background and/or a confident manner.

Lesson 6
The Dr Monckton Smith homicide timeline supports both victims and professionals to recognise risks of domestic abuse.

Lesson 7
The GP surgery must assess risk management, and apply the Whole Family approach, to all letters received from outside agencies.

Lesson 8
Opportunities for multi-agency working could be enhanced through more effective information sharing when a patient is discharged by means of a discharge planning meeting.

Lesson 9
There may be a barrier preventing victims of domestic abuse accessing support where they are concerned for the implications such disclosure would have on their perceived ability to meet their children's needs.

Previous Relevant Reviews

227. The 2018 Independent Review of the Mental Health Act highlights the importance of involving loved ones and friends in the care of a patient. Following separation Deborah was not involved in Paul's care as practitioners considered that any sharing of Paul's information would breach confidentiality. The Mental Health Act Review has recommended that alongside a Nearest Relative, or Nominated Person, a patient should be able to record who else they would like to receive information about their care. This has the effect of helping staff share information without worrying potential breaches to patient confidentiality.

228. It is recognised that upon learning of Deborah's decision to separate Paul no longer wanted his information sharing with her, but a discussion regarding who else to share his care information with would have created an opportunity for him to choose a different significant other. If he had chosen another it would have allowed the unit to share their information with someone who could subsequently have considered it within the context of the whole family situation and may have recognised any risk.

229. In 2014, ESSCP commissioned a DHR with similar circumstances to this one; there was no history of abuse, and the wife was murdered by her husband who suffered with low mood and depression, following separation. In contrast to this review though, there had been little agency involvement with the family, but Mrs B had visited her GP. Consequently, the panel at the time discussed the importance of ensuring that health practitioners were aware of domestic abuse, including potential clinical indicators. As a result, a recommendation was made to develop a consistent process to support practitioners' awareness of domestic abuse in primary care settings.

230. This review has recognised similar as Deborah suffered a number of physical ailments which required both routine and investigative appointments. Records do not demonstrate how much she was asked about any domestic abuse within the appointments, and/or whether any consideration was given to her health being a potential indicator of abuse.

231. There have also been further DHRs, recently completed in East Sussex where routine enquiry and knowledge and/or exploration of health issues being potential indicators of abuse were missing. As a result, some good progress has now been made through the introduction of specific domestic abuse training. Although best practice is understood to be routine enquiry regarding Domestic Abuse, it is not possible to make it mandatory across primary care as GPs practices are independent. To mitigate this, the CCG have introduced

specific domestic abuse training and are working closely with partners to highlight the importance of routine questioning in relation to domestic abuse and how this can be managed within time constraints of short appointment times.

232. Interestingly, in all three DHR's available on the ESSCP website, the homicides have occurred within a few months of separation. Data from The Office for National Statistics identifies that this is a national finding; between March 2014 and March 2016 49% of domestic femicides occurred within one month of separation and 15% between 1 and 3 months. This proven heightened risk at separation must always be taken into account.

Recommendations

The review would like to thank agencies for their single agency learning[29] outlined within their reports.

The following ***single-agency recommendation*** is made to SPFT:

- SPFT to address how practitioners respond to threats of risk of harm to family members made by an inpatient of mental health service and consider whether a policy needs producing or whether an existing policy needs amending.

The review would ask that ESSCP monitor action plans and that outcomes are impact assessed within the organisations. The following ***multi-agency recommendations*** are made to ESSPC:

Recommendation 1

East Sussex Safer Communities Board should produce guidance regarding best practice 'use of language' in recording and assessment and ensure that all partner agencies incorporate it into their staff training.

Recommendation 2

East Sussex Safer Communities Board to ensure that health practitioners are aware of the NICE quality standard regarding clinical indicators of domestic abuse.

Recommendation 3

East Sussex Safer Communities Board to raise the public awareness of domestic abuse.

Recommendation 4

East Sussex Safer Communities Board to raise awareness across all partner agencies of Dr Jane Monckton Smith's eight-stage domestic homicide pattern model and ensure that they are aware of the benefits of incorporating it into practice.

Recommendation 5

East Sussex Safer Communities Board to review existing training programmes and ensure that practitioners embed a 'Whole Family' approach into their practice, that includes:

[29] See Appendix 3

- How practitioners respond to threats of risk of harm to family members, and
- Identification of carers' stresses and any resulting risk to others.

Glossary

Acronym/Abbreviation	Full Title
AA	Alcoholics Anonymous
ABC	Antecedent-Behaviour-Consequence
ASCH	Adult Social Care and Health
ATS	Assessment and Treatment Team
CCC	Children's Continuing Care
CDS/CSC	Children's Disability Service/Children's Social Care
CGL	Change Grow Live
CPP	Child Protection Plan
CRHT	Crisis Resolution Home Treatment Team
DHR	Domestic Homicide Review
ESHC	East Sussex Health Care
ESSCP	East Sussex Safer Communities Partnership
GP	General Practitioner
ICPC	Initial Child Protection Conference
IDVA	Independent Domestic Violence Advisor
LP	Lead Practitioner
MHLT	Mental Health Liaison Team
SPFT	Sussex Partnership NHS Foundation Trust

Appendix 1: Agencies

The following agencies contributed to the review.

Agency	Agency Management Report	Learning Event Attendance	Recall Day Attendance
Change Grow Live	✓	✓	✓
Sussex Partnership NHS Foundation Trust	✓	✓	✓
Sussex Police	✓	✓	✓
Children's Services	✓	✓	✓
Primary Care Clinical Commissioning Group	✓	✓	✓
Adult Social Care & Health	✓	✓	✓
East Sussex Health Care	✓	✓	✓
Children's Disability Service	✓	✓	✓

Appendix 2: Terms of Reference and Project Plan

EAST SUSSEX

SAFER COMMUNITIES

PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

TERMS OF REFERENCE & PROJECT PLAN

SUBJECT: DEBORAH

DATE OF BIRTH: REMOVED

DATE OF DEATH: JULY 2020

VERSION 2: 18.12.2020

1. Introduction:

1.1 This Domestic Homicide Review is commissioned on behalf of East Sussex Safer Communities Partnership in response to the death of Deborah. Deborah was found deceased at the family home in East Sussex. She had suffered multiple stab wounds. Paul has been charged with her murder and is currently remanded in custody.

1.2 Deborah and Paul had been married for 25 years when Deborah made the decision in April 2020 that their marriage was over, due Paul's increasingly risky and deceptive behaviour. Paul had a history of mental health problems and had attempted to harm himself twice in March and April 2020. He also had a history of misusing alcohol.

1.3 Upon his discharge from hospital in May 2020, Paul moved into a different address. Deborah and Paul have 2 adopted children, both with special needs. The youngest child remained living with Deborah whilst the eldest resided away from home in a residential placement. The youngest was present in the address when Deborah was found deceased.

1.3 The East Sussex Safer Communities Partnership is keen to establish how agencies may have worked individually and together to better safeguard Deborah. It wants to explore whether there were missed opportunities to have engaged with the family. The review will explore whether the risk to Deborah was recognised and whether there were any barriers to Deborah accessing services. If so, what can be done to raise awareness of domestic abuse in such circumstances and of the services available to victims of domestic violence and abuse.

2. Legal Framework:

2.1 A Domestic Homicide Review (DHR) must be undertaken when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

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

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

2.2 The purpose of the DHR is to:

a) 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;

b) 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;

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)

3. Methodology:

3.1 This Domestic Homicide Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focusing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

3.2 This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3 The SILP model of review adheres to the principles of;

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

4. Scope of Case Review:

4.1 Subject Deborah: Date of Birth: Removed

4.2 Scoping period: from 06.03.2020[30] [the time that Deborah reported a significant decline in Paul's mental health] to July 2020 [the date that Deborah was found dead]

4.3 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period that agencies consider would add value and learning to the review.

5. Agency Reports:

5.1 Agency Reports will be requested from:

- Police
- Children's Services - Children Disability Service/ Children and Young Peoples Continuing Care
- Chailey Heritage Foundation
- Change Grow Live
- GP X2
- Adults Social Care

[30] This scoping period was agreed by the panel members as being key as agency involvement was limited before this time.

- Sussex Partnership NHS - Assessment and Treatment Service/Health in Mind/Mental Health Liaison Service, Crisis Resolution Home Treatment Team.
- Demelza Hospice Care for Children
- East Sussex Healthcare Trust
- Turning Point - The Sanctuary

5.2 Agencies are requested to use the attached Report Template.

6. Areas for consideration:

6.1 What was known about Paul's mental health and his aggression and anger?

6.2 Were agencies aware of Paul having any drug or alcohol misuse issues?

6.3 What risk factors had agencies identified during previous involvement with the family dating from 2017/2018 and how did this affect their responses to concerns within the scoping period?

6.4 Could communication and information sharing have been improved during the scoping period.

6.5 What was understood by services about Deborah's recognition of risk of domestic abuse?

6.6 Please comment on agencies' identification and assessment of risk.

6.7 Were there missed opportunities to exercise professional curiosity and were opportunities missed to identify risk at any stage?

6.8 What did professionals understand about the lived experience of the family and how did agencies work with one another to manage the complexity of their situation?

6.9 Were there any barriers, to Deborah accessing services?

6.10 Identify examples of strong practice, both single and multi-agency.

7. Engagement with the family

7.1 A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. The independent lead reviewer will follow up with the family by making contact with Deborah's sister who will be consulted on the terms of reference for the review (subject to consultation re: criminal process).

7.2 Further contact will be made to invite participation in the form of a home visit, interview, correspondence, or telephone conversation prior to the Learning Event. Contributions will be woven into the text of the Overview Report and she will be given feedback at the end of the process

8. Timetable for Domestic Homicide Review:

Stage	**Date**
Scoping Meeting	4th December 2020
Letters to Agencies	18th December 2020

Stage	Date
Agency Report Authors' Briefing	15th January 2021
Engagement with family	Begin once authorised
Agency Reports submitted to ESSCP	14th April 2021
Agency Reports quality assured by chair	14th- 20th March 20221
Agency Reports distributed	21st April 2021
Learning Event	29th April 2021
First draft of Overview Report to ESSCP	2nd June 2021
Recall Event	9th June 2021
Second draft of Overview Report to ESSCP	16th June 2021
Final Panel	7th October 2021
Presentation to ESSCP Subgroup	July 2021

Version 2: 18.12.2020

Appendix 3: Single Agency Recommendations

1. **CGL**
   - Contact to be made with statutory services undertaking assessments for clients who self-refer.
   - A full case file to be opened where there are no safeguarding concerns disclosed.

2. **SPFT**
   - Where a patient has a history of risk-taking behaviour, ensure that this is fully assessed, documented and handed over when a new team is engaged in care.
   - All allegations of domestic violence to be fully risk assessed and reported to the appropriate agencies.
   - Impact of Covid19 to be identified for all patients and risks documented and managed accordingly.
   - Ensure compliance with safeguarding training and a Think Family approach is employed and documented.

3. **CCC**
   - Discussion to be had with agency and care staff to address the inability to recruit and maintain nurses and carers in a home package.
   - Monthly reports from the care agency to continuing care to include a section to feedback any safeguarding concerns.

4. **Primary Care**
   - Review training provided for surgery admin staff.
   - Encourage use of codes to flag people at risk of domestic abuse, carers, child protection plan or children social care involvement.
   - Review of workflow policy.
   - Review practice new patient policy to ensure vulnerable patients are prioritised

5. **ESHC**
   - Cross-referencing of safeguarding notes between adult records and children records, where there are risks that affect care.
   - Ensure that Staff have an understanding of the correlation between Domestic Abuse and physical health presentations.
   - Where staff identify a potential risk that may warrant a referral for safeguarding documentation should clearly reflect whether this has occurred.

6. **CDS**
   - Practitioners to develop a greater awareness of the impact of mental health difficulties, particularly combined with domestic abuse, and alcohol misuse upon risk and to demonstrate greater professional curiosity in escalating situations.
   - Practitioners within the Transitions Service to increase their confidence and awareness of domestic abuse even when the lead social worker in their case for Child Protection is a CDS practitioner.

- Where cases involve parent carers who hold positions of authority and present as competent and confident, practitioners should be mindful not to accept information at face value, especially when there have been indicators of concern in the past.
- Where children have high levels of formal funded support, practitioners and managers should ensure that they don't become pre-occupied with the child's day to day care arrangements and lose focus on underlying risk factors and what else might be happening in the family.

Appendix 4: Multi-agency Action Plan: Overview Recommendations

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
1	**East Sussex Safer Communities Partnership (ESSCP) to review existing training programmes and ensure that DHR Panel agencies; ASCH, CS, SPFT, CGL practitioners and HIDVA embed a 'Whole Family' approach into their practice, that includes:** **• How practitioners respond to threats of risk of harm to family members, and** **• Identification of carers' stresses and any resulting risk to the carer**	Local	Partner agencies to undertake review of; - training packages, including e-learning - quality of supervision, incorporating a whole family approach to risk assessment and support - case audits where applicable to inform training and update as appropriate to ensure that a whole family approach is	Review including training underway Case audits being completed	July 2022	East Sussex Safer Communities Partnership	Practice is reflective and continually improving in response to victims of domestic abuse and their families. Improved safety planning for victims and their families, including informal carers and children.	Case audits Confirmation of training packages being updated from East Sussex Safer Communities Partnership agencies	Review and training actions: November 2022 Case audits: November 2023	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
			embedded into practice							
1		Local	Carer's assessments to be routinely offered to all those identified as an informal carer within a family unit as part of holistic assessments and support offered	Carer's assessment recording mechanism being explored	July 2022	Children's Services	Increased identification of informal carers and assessment to increase support offered.	Children's Services to ensure that mechanisms are in place to record the number of informal carers identified and assessment offered	November 2022	
1		Local	Practitioners should take an intersectional approach to completing holistic assessments with multi-agency input where issues and support	Review including training underway Case audits being completed	July 2022	Children's Services	Increased referrals to specialist support and safety planning for victims of domestic abuse in an informal caring role	Increase of both referrals and safety plans completed tracked via contract monitoring of community DVA services	November 2022	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
			needs, such as a person's alcohol misuse and their mental health – are considered as being potential risk indicators of domestic abuse.				Improved assessments, support planning and risk management to protect victims and their families.			
2	**East Sussex Safer Communities Partnership to raise awareness across all partner agencies of Dr Jane Monckton Smith's eight-stage domestic homicide model and ensure that they are aware of the benefits of incorporating it into practice.**	Local	Introducing the timeline through existing partnership training groups; East Sussex DVA training pathway, East Sussex Safeguarding Children's	Agencies updating training to incorporate the homicide timeline	July 2022	East Sussex Safer Communities Partnership	Improved response, safety planning and support for victims and their families through increased knowledge of risk indicators and opportunities	Training evaluation 6 months post completion to audit impact on practice	November 2022 – multiple DHR homicide briefings delivered throughout 2021, 2022 and subsequent years	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
			Partnership and SAB				for intervention by agencies			
2		Local	HIDVA training to incorporate the domestic homicide timeline and identification of stages and escalating risks	HIDVA training package being updated to include homicide timeline	July 2022	East Sussex Safer Communities Partnership	Improved response, safety planning and support for victims and their families through increased knowledge of risk indicators and opportunities for intervention by agencies	Training evaluation 6 months post completion to audit impact on practice	November 2022 - HIDVA training includes domestic homicide timeline	
2		Local	Briefing on the homicide timeline provided by the Joint Unit for Domestic Abuse, Sexual Violence and Violence	Briefing on homicide timeline to be submitted to the Safer Communities Board meeting in February 2022	July 2022	East Sussex Safer Communities Partnership	Improved response, safety planning and support for victims and their families through increased	Completion of DHR briefings	November 2022 – multiple DHR homicide briefings delivered throughout 2021, 2022 and	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
			Against Women and Girls to be circulated to the East Sussex Safer Communities Board, SAB, East Sussex Children's Safeguarding Partnership for dissemination around networks				knowledge of risk indicators and opportunities for intervention by agencies		subsequent years	
2		Local	DHR e-learning module incorporating homicide timeline to be developed and made available to partner agencies	Development of DHR Learning Module	July 2022	East Sussex Safer Communities Partnership	Improved response, safety planning and support for victims and their families through increased knowledge of risk indicators and	Training evaluation 6 months post completion to audit impact on practice	November 2023 – DHR Learning incorporate into e-learning module	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
							opportunities for intervention by agencies			
2		Local	Practitioners identify and refer high risk cases to MARAC, including the use of professional judgement		July 2022	East Sussex Safer Communities Partnership	Improved response, safety planning and support for victims and their families through increased knowledge of risk indicators and opportunities for intervention by agencies	Annual multi-agency MARAC audits	June 2022 – Practitioners ' Guide to MARAC updated and published on Safer Communities Partnership website, includes guidance on professional judgement for MARAC referrals	
3	**East Sussex Safer Communities Partnership should ensure partner agencies have guidance for practitioners regarding best**	Local	East Sussex Safeguarding Adults Board (SAB) Multi-Agency Domestic Abuse Guidance to	Update of Multi-Agency Domestic Abuse Guidance	July 2022	East Sussex Safer Communities Partnership to ensure action is completed by partner agencies	Improved accuracy of risk assessments, support and safety planning including within multi-agency forums	Audit by East Sussex Safer Communities Partnership agencies completed including Adult Social Care	July 2022 and annually – SAB Guidance is updated annually and includes DHR	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
	practice 'use of language' in recording and assessment and ensure that all partner agencies incorporate it into their staff training.		incorporate best practice 'use of language' in recording and assessment within the guidance				to improve safety of victims of domestic abuse and their families	and Health, Children's Services, Sussex Partnership Foundation Trust, HIDVA service	learning on best use of language	
3		Local	East Sussex Safer Communities Partnership to ensure that all partner agencies have access to the East Sussex SAB Multi-Agency Domestic Abuse Guidance and is shared within agencies to frontline practitioners	Confirmation agencies have access to the Multi-Agency Domestic Abuse Guidance, and it has been shared with frontline practitioners	July 2022	East Sussex Safer Communities Partnership to ensure action is completed by partner agencies	Improved accuracy of risk assessments, support and safety planning including within multi-agency forums to improve safety of victims of domestic abuse and their families	Audit by East Sussex Safer Communities Partnership agencies completed including Adult Social Care and Health, Children's Services, Sussex Partnership Foundation Trust, HIDVA service	July 2022 - SAB Guidance is available on SAB website and is regularly circulated around local agencies	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
3		Local	Case audits by East Sussex Safer Communities Partnership agencies including Adult Social Care and Health, Children's Services, Sussex Partnership Foundation Trust, HIDVA service, and others as applicable, to include audit of case notes and assessments with a focus on use of language and resulting response	Case audit and outcome reports	July 2022	East Sussex Safer Communities Partnership to ensure action is completed by partner agencies	Improved accuracy of risk assessments, support and safety planning including within multi-agency forums to improve safety of victims of domestic abuse and their families	Audit by East Sussex Safer Communities Partnership agencies completed including Adult Social Care and Health, Children's Services, Sussex Partnership Foundation Trust, HIDVA service	November 2022	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
3		Local	Agencies to review their training offer to ensure includes use of language in recording and assessment	Confirmation of training review	July 2022	East Sussex Safer Communities Partnership to ensure action is completed by partner agencies	Improved accuracy of risk assessments, support and safety planning including within multi-agency forums to improve safety of victims of domestic abuse and their families	Audit by East Sussex Safer Communities Partnership agencies completed including Adult Social Care and Health, Children's Services, Sussex Partnership Foundation Trust, HIDVA service	November 2023 – partner agencies have reviewed domestic abuse training offer to include use of language and completed case audits	
4	**East Sussex Safer Communities Partnership to ensure that health practitioners are aware of the NICE quality standard regarding clinical indicators of domestic abuse**	Local	Embed in training, including HIDVA and CCG training	Training evaluation being developed	July 2022	ESHT/ CCG/ CGL	Increased early intervention and support for victims of domestic abuse	Evaluation of training to measure the impact and how learning will be incorporated into practice via a dip sample review with	July 2022	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
								participants within 6 months of training completion		
4		Local	Exploration of clinical indicators of domestic abuse in MDT meetings and clinical supervision	Clinical indicators of domestic abuse discussed in a range of health meetings, including MDTs, strategy meetings and multi-agency	July 2022	ESHT/ CCG/ CGL	Increased early intervention and support for victims of domestic abuse	Audits of clinical supervisions and MDT meeting notes	July 2022	
4		Local	Health practitioners working with East Sussex hospitals to refer to the HIDVA for specialist support for victims	Increase in referrals to HIDVA service	July 2022	ESHT/ CCG/ CGL	An increase in the numbers of referrals to the HIDVA service leading to increased support and safety planning for victims	Number of referrals to the HIDVA and safety plans in place as a result, tracked via contract monitoring and KPIs of the HIDVA service	July 2022 and annually – HIDVA contract monitoring includes referral monitoring and training evaluation	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
4		Local	Domestic Abuse Act statutory guidance (draft and final versions) to be circulated to all health practitioners with particular reference to ch.3 impact on victims and ch.4 agency response to DVA; health professionals para 255-273.	Domestic Abuse Act statutory guidance circulated to CCG safeguarding leads	July 2022	ESHT/ CCG/ CGL	Increased early intervention and support for victims of domestic abuse	Confirmation that statutory guidance has been circulated	November 2022	
5.	**East Sussex Safer Communities Partnership to raise the public awareness of domestic abuse.**	Local	Maximise opportunities to raise awareness in local communities, such as street stalls,	Participation in community engagement events	July 2022	East Sussex Safer Communities Partnership	Increased confidence in members of the public reporting domestic abuse, supporting specialist providers,	Increase number of referrals to specialist DVA services, tracked via contract monitoring arrangements,	November 2022	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
			meetings, and open days.				police, and other partners to proactively disrupt abusers, hold them to account and protect victims	filtered by source Increase in reporting of domestic abuse, including self-referrals to CGL and reporting to the Police		
5		Local	ESCC White Ribbon UK Steering Group to co-ordinate with Districts and Boroughs and key agencies any opportunities to raise awareness in local communities	East Sussex County Council have submitted their application for White Ribbon accreditation	July 2022	East Sussex Safer Communities Partnership	Increased confidence in members of the public reporting domestic abuse, supporting specialist providers, police, and other partners to proactively disrupt abusers, hold them to account and protect victims	Increase number of referrals to specialist DVA services, tracked via contract monitoring arrangements, filtered by source Increase in reporting of domestic abuse,	February 2024	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
								including self-referrals to CGL and reporting to the Police		
5		Local	Annual 16 Days of Activism campaign; the Joint Unit to co-ordinate with partner agencies social media messaging on daily themes across agencies' platforms. To include promotion of specialist services and how to get help, advice and support and risk	Annual 16 Days of Activism campaign to incorporate key learning points	July 2022	East Sussex Safer Communities Partnership	Increased confidence in members of the public reporting domestic abuse, supporting specialist providers, police, and other partners to proactively disrupt abusers, hold them to account and protect victims	Increase number of referrals to specialist DVA services, tracked via contract monitoring arrangements, filtered by source Increase in reporting of domestic abuse, including self-referrals to CGL and reporting to the Police	November 2022 and annually in line with 16 Days of Activism campaign.	

Ref	Recommendations	Scope	Action	Key milestones and progress	Target date	Lead	Desired outcome of the action	Monitoring arrangements and evidence	Completion date	RAG
			factors/ indicators.							

RAG rating key: Complete In progress Not progressed

Note: this action plan is a live document and subject to change as outcomes are delivered.

Appendix 5: Home Office Feedback Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF
Tel: 020 703 54848
www.homeoffice.gov.uk

21st December 2023

Strategy and Partnership Officer for Domestic Abuse, Sexual Violence & VAWG
Brighton & Hove and East Sussex

Thank you for resubmitting the Domestic Homicide Review (DHR) report (Deborah) for East Sussex Safer Communities Partnership to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 22nd November 2023. I apologise for the delay in responding to you.

The QA Panel felt that the feedback and areas for development have been addressed with comprehensive additional information included. There is much more of a sense of who Deborah is and her voice is more evident throughout, as a result of contributions from her sister. Sections have also been added which help to give a better understanding of Deborah's life, the services she interacted with, and her lived experiences. There has been a positive addition in relation to the children, provided by a care worker. There was more of a sense of their experience of domestic abuse and the perpetrator's mental health from their perspective. The QA Panel felt the report makes good reference to domestic abuse legislation and theory and commented on the positive use of the homicide timeline.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The use of the term 'fatal incident' in the introduction downplays the murder.
- There is no section on equality and diversity to consider the victim's disability.
- There is a very limited review period which is not explained – the review only covers 6th March 2020 until the victim's murder later that year. The review briefly lists several relevant contacts with services before this period, but they are not explored in depth. This is a missed opportunity to understand and examine full agency involvement.
- There are gaps in the chronology in relation to the victim – almost all of the chronology relates to services accessed by the perpetrator. The victim's contact with Change, Grow, Live and consideration of obtaining an occupation order are introduced far into the report, and the victim's experience is not introduced until paragraph 199.
- The report still reads as a review mainly focused on the perpetrator and his mental

health, and that the murder is attributed to the perpetrator's declining mental health.

- There is no mention of adverse childhood experiences.
- The fact that the perpetrator had been accused of abuse by a previous partner is only mentioned at paragraph 164 and is missing from the background events.
- The report gives the impression that there is a lack of understanding of coercive and controlling behaviour – e.g., it is suggested that it is only relevant once the perpetrator is discharged from hospital, rather than being central to domestic abuse.
- There is a lack of exploration into how coercive control and domestic abuse is perpetrated through child contact, despite this being a key issue in this case.
- There was a lack of professional curiosity and routine enquiry regarding domestic abuse when the victim attended GP/PC appointments. Clinicians must remember to ask procedural questions about depression and domestic abuse when seeing patients with non-specific symptoms or symptoms suggestive of domestic abuse and record the response.
- There may be a barrier preventing victims of domestic abuse accessing support where they are concerned for the implications such disclosure would have on their perceived ability to meet their children's needs.
- Opportunities for multi-agency working could be enhanced through more effective information sharing when a patient is discharged, by means of a discharge planning meeting.
- Although there were lots of agencies involved due to the children's complex needs and care package, there was a lack of 'think household/family' across agencies.
- Recommendations are vague in many places – e.g., 'raising awareness of domestic abuse'. These recommendations are not SMART.
- The red lettering throughout the report needs changing.
- Comments on the action plan:
    - The text is unaligned.
    - It is unclear if the target dates are for all of the actions in the specific column.
    - There is no completion date and outcome section.
    - There is no local or national scope of recommendations mentioned.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel