



## **OVERVIEW REPORT of the Domestic Homicide Review relating to the death of Grace in 2019**

on behalf of:

**The East Sussex Safer Communities Partnership**

**Report Author:**

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Independent Chair

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**GLOSSARY**

<b>ABBREVIATION</b>	<b>DEFINITION</b>
<b>CCG</b>	Sussex Clinical Commissioning Group
<b>CCR</b>	Coordinated Community Response
<b>CDO</b>	Court Desk Officer
<b>CGL</b>	Change, Grow, Live
<b>CPS</b>	Crown Prosecution Service
<b>DASH</b>	Domestic abuse, stalking and honour-based violence check list
<b>ESFRS</b>	East Sussex Fire and Rescue Service
<b>ESSCP</b>	East Sussex Safer Communities Partnership
<b>ETE</b>	Education, Training and Employment
<b>HDC</b>	Home Detention Curfew
<b>IVA</b>	Independent Victim Advisor-Victim Support
<b>IDVA</b>	Independent Domestic Violence Advisor
<b>OM</b>	Offender Manager (Probation Service)
<b>MAPPA</b>	Multi-Agency Public Protection Arrangements
<b>MARAC</b>	Multi-Agency Risk Assessment Conference
<b>RUI</b>	Released under Investigation
<b>RUL</b>	Released under licence
<b>SCARF</b>	Single Combined Assessment of Risk Form
<b>VLO/ VLU</b>	Victim Liaison Officer /Victim Liaison Unit (Probation Service)
<b>The employer's HS</b>	Grace's employer Occupational Health Scheme

## 1 PREFACE

**1.1** This Domestic Homicide Review (DHR) examines agency responses and support given to Grace and her family before Grace's death in December 2019. The East Sussex Safer Communities Partnership determined that the criteria for a DHR had been met under DHR Statutory Guidance 2016, in particular paras 5(1), 18 and 27(c).<sup>1</sup>

The review will identify any agency involvement and will also seek to understand the family dynamics in the build up to Grace's death, whether support was accessed within the community, whether there are identified gaps in provision 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.

**1.2 DHR:** Domestic Homicide Reviews became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.

### **1.2.1 The Domestic Abuse Act 2021 defines domestic abuse as:**

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged sixteen or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse

(b) violent or threatening behaviour

(c) controlling or coercive behaviour

(d) economic abuse (see subsection (4))

(e) psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

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<sup>1</sup> DHR-Statutory-Guidance-161206.pdf(publishing.service.gov.uk)

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of “personally connected,” see section 2.

## **2 Definition of “personally connected”**

(1) For the purposes of this Act, two people are “personally connected” to each other if any of the following applies—

(a) they are, or have been, married to each other

(b) they are, or have been, civil partners of each other

(c) they have agreed to marry one another (whether or not the agreement has been terminated)

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated)

(e) they are, or have been, in an intimate personal relationship with each other

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2))

(g) they are relatives.<sup>2</sup>

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

**1.4 Time scales:** The review began January 2021 and concluded with submission to the Home Office in April 2022.

The DHR timeline was extended (with Home Office approval) due to a number of reasons:

- a) Criminal proceedings
- b) Impact of COVID-19 and the ability for professionals to produce IMRs under these circumstances.

**1.5 Incident summary:** The purpose of this review is to examine the circumstances surrounding Grace’s death, **December 2019**, when she was murdered by Samay.

**1.6 Confidentiality:** The detailed findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. A confidentiality agreement has been signed at each meeting of the DHR Panel.

**1.7 Dissemination:** The Overview Report, Recommendations and Executive Summary have been redacted to ensure confidentiality, with pseudonyms used for the victim and the family.

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<sup>2</sup> Domestic Abuse Act 2021 [www.legislation.gov.uk](http://www.legislation.gov.uk)

The reports have been disseminated to the following groups.

- Sussex Police and Crime Commissioner
- East Sussex Safeguarding Adult Board
- East Sussex Safeguarding Children Partnership
- Sussex Domestic Abuse Strategic Overview Group
- Domestic Abuse Commissioner

## 2 DETAILS OF THE INCIDENT

2.1 Sussex Police were contacted by the Metropolitan Police to report that Mark, Grace's son was concerned about her safety as he had not heard from her for a few days. Mark was aware that Samay had been released from prison and thought that he may have something to do with being unable to contact his mother, Grace. Neighbours visited Grace's home and saw all the lights on but were unable to get any answer from Grace.

The Police attended Grace's address and forced an entry. Grace was found dead in the hallway. The actual date of Grace's death is unknown.

**2.2 Post-mortem:** Following Grace's death the post-mortem found that Grace had severe neck and chest injuries from sustained beating and strangulation.

## 3 THE REVIEW

3.1 ESSCP was notified of Grace's death by the police on **14 January 2020** and the ESSCP decided that the criteria for a DHR had been met. Liz Cooper- Borthwick was appointed as Independent Chair in September 2020.

3.2 The DHR was commissioned by ESSCP in accordance with the revised Statutory Guidance for the conduct of Domestic Homicide Review<sup>3</sup> published by the Home Office in March 2016.

## 4 TERMS OF REFERENCE

4.1 Terms of Reference were agreed by the DHR Panel in January 2012<sup>1</sup> and were regularly reviewed and amended as further details of events in Grace's life emerged. They are included in Appendix One.

## 5 PARALLEL INVESTIGATIONS AND RELATED PROCESSES

### 5.1 Inquest

No inquest was held, and the Coroner's investigation was closed **28 April 2021**

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<sup>3</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/575273/DHR-Statutory-Guidance-161206.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf)

**5.2 Criminal Investigation**

Following Grace’s death, Samay was arrested the day after Grace’s death and was charged with her murder. Samay was tried by a jury in a Crown Court in **late 2020**. Samay was convicted of Grace’s murder and was sentenced to life and to serve a minimum of **twenty-seven** years.

**5.3 Her Majesty’s Prison and Probation Service Serious Further Offence Review (SFOR)**

Following Grace’s death, the Probation Service carried out a SFOR. Details of the purpose of SFOR are included in Appendix Two. The report and action plan were shared with the Independent Chair and the information, and the findings have been used to support the DHR.

**6. PANEL MEMBERSHIP AND REPRESENTATIVES**

The Panel consisted of senior representatives from the following agencies.

<b>NAMED OFFICER</b>	<b>ORGANISATION</b>	<b>ROLE</b>
Liz Cooper-Borthwick	LCB Consulting LTD	Independent Chair
Natasha Gamble	East Sussex Safer Communities Partnership	Strategy and Partnership Officer, Domestic Abuse, Sexual Violence and Abuse and Violence against Women and Girls (VAWG) Joint Unit, Brighton and Hove and East Sussex.
Jane Wooderson	Sussex Police	DS Safeguarding Reviews, Strategic Safeguarding Team.
David Satchell/Eleanor Gregory	Probation	Deputy Head East Sussex Probation Delivery Unit
Alex Morris	Sussex CCG	Assistant Head of Safeguarding Designated Nurse
Gail Gowland	East Sussex Health Care Trust	Named Nurse Safeguarding Children (Acting Head of Safeguarding)
Debbie King	Change, Grow, Live	Manager CGL
George Turner	Grace’s employer	Head of Corporate Investigations and Protective Security.
Stacey Criddle	East Sussex MARAC	MARAC Coordinator – shadowing the Review with the agreement of the Panel

The panel met five times during the period January 2021 to January 2022 (All virtual meetings).

### **6.1 Independence of Chair**

The Chair and Author of the review is Liz Cooper- Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council in Surrey. Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also been involved with several Serious Case Reviews. Liz has no connection with any of the agencies in this case.

## **7 SUBJECTS OF THE REVIEW**

The main subjects of this review are:

<b>DHR/SCR subject</b>	<b>Age at time of death</b>
<b>Grace (Victim of domestic abuse)</b>	58 years old
<b>Samay (Perpetrator of domestic abuse)</b>	35 years old

Significant others:

<b>Subject</b>	<b>Relationship</b>
Chris	Grace's husband-separated 2013
Mark	Grace and Chris's son
Paul	Grace and Chris's son

## **8 METHODOLOGY**

### **Contributors to the Review**

#### **8.1. Statutory and Voluntary Agencies:**

Each involved agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. Authors were asked to review agency involvement with Grace and Samay for the period of time, August 2017 up until Grace's death late 2019. This period reflected the time from Grace being assaulted and robbed by Samay, up until Grace's murder by Samay. Authors were asked to include any information prior to this time frame if they felt it was relevant and supported any learning. The IMR authors were independent of the incident and the reports were Quality Assured by the organisation. As the review progressed, additional agencies were identified who had contact with the family members and further information was requested. IMRs were received from:

- i. Sussex Police (the Police)
- ii. National Probation Service (NPS)
- iii. Sussex Clinical Commissioning Group (CCG on behalf of GP)
- iv. Change Grow Live-Specialist Domestic Abuse Service (CGL)
- v. Grace's employer (Grace's employer)
- vi. Victim Support (VS).

Sussex Partnership National Health Foundation Trust (SPFT) stated that they had minimal contact with Grace. Despite very little contact, SPFT continued to support the review by contributing and reviewing the overview report which enabled any learning to be incorporated into SPFT policy and practice.

East Sussex Hospital Foundation Trust had no records of Grace visiting the Accident and Emergency (A&E) departments of any of their local hospitals despite evidence that Grace had suffered broken ribs in April 2019. To ensure a comprehensive review of Grace's contact with agencies the Independent Chair contacted the following NHS Hospital Trusts, Maidstone and Tunbridge Wells, Western Sussex and Surrey and Sussex and none had any records of Grace visiting their A&E departments during the period of this review.

The panel has given detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

### **8.2 Involvement of Family and Friends**

Chris, Mark and Paul participated in the review. They wanted Grace's story to be told. The Independent Chair met with the family on several occasions using virtual media. The family were provided with the Home Office Family information leaflets about a DHR. The family also had the opportunity to review and contribute to the Terms of Reference, the final draft of the DHR Overview report and they were regularly kept updated on progress of the DHR. The family chose the pseudonyms for the victim, husband, and sons. The family made the decision not to include a pen portrait as they felt the DHR Overview Report reflected the attributes and strengths of Grace.

### **8.3 Contact with Samay**

The Independent Chair and a Panel member had a conference call meeting with Samay on 13 October 2021. Samay was accompanied by his Probation Officer. The meeting explored issues surrounding Samay's drug taking, his faith and his relationship with Grace. The Independent Chair and Panel member would like to thank the Probation Officer who not only set up the meeting but also helped facilitate the conversation.

### **8.4 Research and contacts by the Chair**

The Independent Chair contacted Latin American Women's Rights Service<sup>4</sup> (based in London) and who support Latin American migrant women living in the United Kingdom to gather an insight into Latin American culture and the role of the female in the family. Information provided has been used to illuminate the voice of Grace.

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<sup>4</sup> [www.lawrs.org.uk](http://www.lawrs.org.uk)

The Independent Chair did desk top research about the Hindu faith and spoke with the Sarvoday Hindu Association<sup>5</sup> to gain an understanding of the principles of the Hindu faith which has been used to inform the DHR

### 9 EQUALITIES

9.1 Grace was a heterosexual white British/South American woman.

9.2 Samay is a heterosexual British/Indian man (Hindu).

9.3 The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Four of these characteristics are considered by the review to have had an impact – sex/gender, age, race and religion. These characteristics are considered later within this report.

### 10 KEY PRACTICE EPISODES (KPEs):

#### Social Care Institute for Excellence (SCIE)- Learning Together <sup>6</sup>

10.1 Significant information has been made available for this review and the DHR Independent Chair has utilised the SCIE model “Learning together” to identify the key episodes in the lives of Grace and Samay leading up to Grace’s death.

10.2 The Key Practice Episodes (KPE) are identified below and will be referred to throughout the report.

- **KPE One:** Break up of Grace and Chris’s relationship
- **KPE Two:** Relationship between Grace and Samay and assault and robbery by Samay on Grace
- **KPE Three:** Lead up to Court Case and involvement of agencies.
- **KPE Four:** Samay in Prison and continued contact between Grace and Samay.
- **KPE Five:** Release of Samay from prison
- **KPE Six:** Death of Grace

### 11 BACKGROUND INFORMATION (THE FACTS) OVERVIEW OF FAMILY LIFE

11.1 Grace was from South America and her family still resides there. Grace met Chris in the early 1990s and Grace moved to England and married Chris and they had two sons, Mark and Paul. Grace was the homemaker and her Latin American upbringing ensured that their lives were very family orientated.

11.2 Once Mark and Paul started school Grace became a school dinner lady and in **2000** Grace then went to work for a multinational company in Sussex. In the family’s’ words “Grace was a

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<sup>5</sup> [www.sarvoday.org.uk](http://www.sarvoday.org.uk)

<sup>6</sup> <https://www.scie.org.uk/children/learningtogether/>

great asset to the airline as she spoke three languages.” Grace started in a visitor centre and then moved to customer services.

11.3 In **2013**, life changed dramatically for Grace, Mark left home permanently in **2013**, following his university studies, her marriage to Chris broke down in **2014** and Paul left the home in **2015** as he had finished university.

11.4 Grace was used to a house full of people and now she was very alone, and Grace became quite withdrawn.

11.5 Grace’s father had died in **1997** in South America and Grace became very close to her mother who remained living in South America. Grace’s mother fell in **2015** and died before Grace was able to visit her. Grace’s family stated that these events did have a profound impact on Grace, although she did seem to cope, she did have moments of sadness.

11.6 Around **2015/2016**, Grace met Samay who also worked at the airport as a baggage handler. Samay showed Grace attention and Grace responded to the attention and the friendship.

11.7 Information provided identified that Samay was a drug user and Grace’s family believe that Grace wanted to support Samay to try to resolve his drug problems as Grace also had a brother in South America who was also a drug addict and as Grace could not help her brother, she wanted to help Samay?

## **12 VOICE OF THE VICTIM**

(based on information provided by Grace’s family, the IMRs, and contact with agencies.)

The family said that “Grace was a beautiful person, gregarious and family focused person. Grace was the heartbeat of the family and nearby community. Grace’s Latin American background meant that family came first, and her focus was on supporting Chris, Mark and Paul.

Grace was well respected by her employer, her workplace and she was very valuable, speaking three languages and having excellent customer care skills”.

Grace showed great strength, leaving her birth family in South America, and moving to the United Kingdom and embracing community life. Although very difficult for Grace, she attended Samay’s trial for assault and robbery as a witness knowing it was the right thing to do despite having conflicting emotions about Samay.

Professionals who supported Grace following the assault and robbery by Samay in 2016 said that Grace was lonely, she had suffered a number of traumas in the last few years of her life, the break- up of her marriage to Chris, the loss of her mother in South America and her worries about her brother and his drug addiction. Grace felt isolated from her birth family and felt sadness that she could not help her brother.

Despite the violent robbery and assault by Samay, Grace stated that she could not get Samay out of her mind and the on/off relationship continued whilst Samay was in prison and following his release. Although Mark and Paul suspected that a relationship between their mother and Samay has restarted, Grace did not divulge to her sons that it had. Grace told professionals that she felt she was letting her sons down by still wanting a relationship with Samay. Grace never wanted to hurt her sons or her family.

## 13 CHRONOLOGY

The below information has been drawn from a range of sources; the IMRs submitted by agencies (referenced where appropriate), and information from the family.

### 13.1 Key Practice Episode One– Break up of Grace and Chris’s relationship. (2012-2015)

**13.1.1 Late November 2012**, SPFT received a referral from Grace’s GP stating that she was suffering domestic stress and depression. Grace had a face-to-face priority assessment with SPFT Health in Mind, and the risk assessment indicated that Grace was not suitable for Health in Mind but that she was planning to attend a family organised group which may help her with the breakdown of her relationship with Chris. Grace went on further to say that her father had died and her brother, a banker, was a drug addict and as he was in South America, and she could do nothing to support him. In **December 2012**, Grace was discharged from SPFT. (Source; Information from SPFT)

### 13 2 Key Practice Episode Two - Relationship between Grace and Samay and assault and robbery on Grace by Samay (2015-2017)

13.2.1 The relationship between Grace and Samay started sometime between **2015-2016**. They met at their place of work although they were employed by different companies within the physical workplace.

13.2.2 In **April 2017**, Grace had a month away from work with depression. Grace was signed off sick by her GP. (Source; the Employer IMR)

13.2.3 Grace and Samay first became known to agencies following an incident on **19 August 2017**. One of Grace’s neighbours phoned the police to report that Grace had been attacked and robbed of money by Samay. The police attended and Grace said that this was the first night she had spent with Samay since their relationship started two years earlier. Grace told the police that Samay had stopped to buy drugs on route to her home and that today, **19 August 2017** she had taken him to Crawley to buy more cocaine. Grace explained to the police that when she was tidying the kitchen, she accidentally had thrown Samay’s drugs away. Samay had become very angry, and he forced Grace to give him her bank card so he could buy more drugs. Grace refused and Samay began attacking Grace which culminated in Grace being thrown on the floor, being pinned down and Samay trying to strangle her. Grace was very fearful so gave Samay her purse. Samay ordered a taxi and made Grace go with him to withdraw £50. Once Grace had withdrawn the money, she gave it to Samay, they returned home and then Samay went off in the taxi, alone.

13.2.4 The police completed a SCARF<sup>7</sup> and a DASH<sup>8</sup> with Grace. The DASH was recorded as medium risk as this was the first incident between Grace and Samay. The SCARF and DASH was sent to the Portal, Change Grow Live IDVA Services, and the Victim Support Services. Grace was signed off from her work. (Source; Police, Employer and CGL IMR)

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<sup>7</sup> SCARF -A Single Combined Assessment of Risk Form that enables police officers and staff to raise concerns and observations in relation to the needs and vulnerability of individuals following them coming to notice during the course of duty.

<sup>8</sup> DASH-Domestic Abuse, Stalking and Honour Based Violence Risk, Identification, Assessment and Management Model 2009 [www.dashchecklist.co.uk](http://www.dashchecklist.co.uk)

(There was a missed opportunity for the police to refer this incident to a Multi-Agency Risk Assessment Conference (MARAC) which could have provided an opportunity for various agencies to understand what was happening in Graces' life, what she was experiencing and what support she needed).

13.2.5 Samay was arrested on the **21 August 2017** and was interviewed. Samay remained silent throughout the interview and did not answer any questions put to him. Samay was then released under investigation for several weeks and warned not to contact Grace. A Safeguarding Plan was agreed with Grace which included Grace remaining in contact with the Officer in Charge (OIC) and to call the police if Samay tried to contact her. Initially, Grace stated that she did not want any specialist domestic abuse support.

13.2.6 Evidence shows that Grace continued to contact Samay via text and WhatsApp with Samay turning up at Grace's home to apologise. (Source; Police IMR)

13.2.7 **21 August 2017**, Grace attended her GP practice, following the assault by Samay. The GP noted that Grace had bruising to both wrists and arms, under her right arm and left breast. The GP noted that the police were involved and due to Grace's acute anxiety following the assault she was given a short course of medication and referred to counselling. Grace was signed off from work (**until October 2017**) and was given access to the employers Occupational Health Services and help direct. (Source; details from GP and employers IMR)

### **13.3 Key Practice Episode Three: Lead up to Court Case and involvement of agencies with Grace. (2017-2018)**

13.3.1 Victim Support received a referral from the Police on **22 August 2017** regarding Grace's assault by Samay. The case was flagged as involving domestic abuse. On the same day, Change Grow Live (CGL), the specialist domestic violence support service received a police SCARF. CGL started to try to contact Grace from **25 August 2017**. Later that day, contact was made with Grace, and she was provided with information about a non-molestation order whilst waiting for charges/bail conditions to be put in place for Samay. CGL encouraged Grace not to contact Samay and she was advised to block his number and accounts. (Source; CGL, Victim Support IMR)

13.3.2 Grace contacted the Police on **28 August 2017** and told them she had contacted Samay via WhatsApp as she wanted to know why he had hurt her. Grace told the police that Samay's response was "Leave me alone, I have been to the station and we both have to move on." Grace admitted that she had made other contacts and Samay had told her to stop. The Police advised Grace to stop texting Samay as the matter was with the police. (Source; Police IMR)

13.3.3 Victim Support first contacted Grace on **29 August 2017**. An Independent Victim Advocate (IVA) completed a DASH with Grace which scored nine. Victim Support addressed Grace's immediate support needs including Grace's safety planning. Grace was provided with information about a mini chime alarm and was told that one would be sent in the post. Grace was also provided with details of the Victims' Code and rights regarding victim personal statement. (Source; Victim Support IMR)

13.3.4 **30 August 2017**, Victim Support contacted CGL to confirm that CGL had received a police referral, which they confirmed. CGL's Independent Domestic Violence Advisor (IDVA)

also confirmed that they had carried out safety planning with Grace and that she had been to see her GP who had confirmed she had cracked ribs. CGL also confirmed that they had made a National Centre for Domestic Violence<sup>9</sup> referral and had sent information about counselling to Grace which would be through Health in Mind. CGL confirmed that Grace said she would contact them if she required further support.

13.3.5 Later that day the Victim Support IVA called Grace to confirm that the police were waiting for CCTV and hospital reports as part of their criminal investigation. Grace told the IVA that she had contacted Samay as she wanted him to apologise but that he had become abusive, so she hung up. Grace said she would like some support and the IVA suggested that Grace may want to engage with CGL, and Grace agreed that the IVA could contact CGL on her behalf, including sharing her DASH. The IVA contacted CGL who agreed that they would contact Grace. Grace was notified about what had happened and Victim Support then closed the case. (Source; Victim Support IMR)

13.3.6 CGL contacted Sussex Police for a full assessment relating to Grace. The DASH risk assessment was rated as medium. CGL made a referral to Sanctuary and East Sussex Fire and Rescue Service (ESFRS). During this time, Grace was also receiving support from her employer in accordance with their absence policy (Source CGL and Employer IMR)

13.3.7 **8 September 2017**, The GP stated that Grace visited Accident and Emergency (A&E) for an Xray to her ribs and she also had a GP's appointment. (Source; GP information)

As already detailed the Independent Chair contacted all the A&E departments in the area and there were no records of Grace being seen or having an Xray.

13.3.8 **11 September 2017**, the Police took a statement from Grace with regards to the ongoing contact between Grace and Samay. Grace stated that she was frightened that the person who drove the car when Grace was assaulted by Samay was driving Samay to her home address (Source CGL IMR).

(A MARAC referral should have been considered as this identifies an increased risk to Grace from Samay and possibly an unknown person).

13.3.9 The police sent the case file to the Crown Prosecution Service on **26 September 2017**. On **28 September 2017** Grace contacted the police in a very distressed state on the 999-line saying that Samay was outside her house. Samay had knocked on the door and they spoke through the window, according to Grace, Samay had said "I am going to get three years for this. What have I done; I am sorry"? Grace had told Samay to leave and he left in a taxi. A police officer attended Grace's home and Grace told the police she had been texting Samay. The police officer spoke with Grace again about not contacting Samay as it would undermine the case against Samay, and a SCARF/DASH was completed and graded as standard. (Source; Police IMR)

13.3.9 Grace returned to work on **30 October 2017** and had a return-to-work interview. Grace was given notification in writing of an absence management review, stage one, which would

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<sup>9</sup> National Centre for Domestic Violence [www.ncdv.org.uk](http://www.ncdv.org.uk)

take place in **November 2017**. Grace said that she understood why she had the letter and that she was having a bad time at present. (Source; Employer IMR)

13.3.10 **10 November 2017**, the police took a Victim Personal Statement in which Grace described how she suffered depression since being attacked by Samay. Grace stated that she could not get the incident out of her head and that she was receiving support from other agencies to help her come to terms with what had happened. Grace said she felt she had let Mark and Paul down as she had maintained contact with Samay, and they did not approve of the contact between herself and Samay. (Source; Police IMR)

13.3.11 Grace did have her Absence Review Interview and formal letter at her place of work on **9 November 2017**. The letter did include the statement from Grace saying that she had mentioned support from family, friends and neighbours, the police had changed the locks at her home, there had been support from the victim support group and the assistance of the employers' Help Direct. (Source: Employer IMR)

13.3.12 Samay made an initial court appearance on **23 November 2017** at which he entered a not guilty plea to the offence of domestic violence robbery (wording within the IMR). **On the 27 November 2017**, in accordance with the enhanced service entitlements under the code of Practice for Victims, the Case Officer made an application for "special measures" requesting that Grace should be allowed to give evidence at trial from behind a screen due to her emotional distress and low confidence. On the same day, Samay contacted the police to say he had received a message from Grace which read "Happy Birthday". Samay had been advised by his solicitor to contact the police if he received any communication from Grace. (Source; Police IMR)

13.3.13 The following day, Samay contacted the police again to inform the police that he had received another message from Grace and that she had previously sent messages of an intimate nature and one which she declared her love whilst threatening suicide. Samay told the police he was feeling distressed and alarmed by the harassment. (Source; Police IMR)

13.3.14 **17 January 2018**, Grace had a further Absence Review Interview and a formal letter stating she would be placed on Stage 2 of the Absence Policy. Grace explained that she was stressed about attending court and that she had accessed Help Direct and that they have been supportive. Grace confirmed that the police were keeping her informed about the court process, that she was seeing her GP and was having ongoing counselling. Grace had also discussed with her line manager about swapping shifts at work to support appointments and the manager had been supportive about this arrangement. An Absence Improvement Plan was issued by the employer to Grace as she had not met the required standards of attendance at work. (Source; Employer IMR)

13.3.15 **8 March 2018**, CGL sent a letter to Grace's GP, to say how important it was for Grace to have a medical report which she could present to Sussex Police as this was delaying the case going to the Crown Prosecution Service (CPS) for review. The CGL portal worker also contacted the GP to tell them about Grace's low moods, anxiety and suicidal ideations. (Source; CGL IMR)

13.3.16 The CGL DA Caseworker contacted the police on **10 April 2018** and asked if a welfare check could be made on Grace who had stated that she felt suicidal and had been given some medication by her GP. The Police Contact Officer spoke with Grace at length and Grace said she would not harm herself as she would not do that to her sons. Grace said," she knew

she had to stay strong about attending court.” The Contact Officer offered Grace an ambulance, but she declined, and it was recorded that Grace was not presenting as being at risk of harming herself. (Source; Police IMR)

13.3.17 Samay’s trial commenced at Crown Court and Grace gave evidence with the protection of a screen whilst on the witness stand and a CGL IDVA was with Grace during the time she spent in court. (Source; Police, CGL IMR)

13.3.18 Samay was convicted of assault and robbery on **13 April 2018** and was sentenced to three years imprisonment. (Source Police IMR)

### **13.4 Key Practice Episode Four -Samay in Prison and continued contact between Grace and Samay. (2018-2019)**

13.4.1 **16 April 2018**, the Court Duty Officer (CDO) completed the required post sentence paperwork enabling the paperwork to be allocated to the Offender manager. The CDO assessed that the case required management by the National Probation Service and that the nature of the offence would mean a Multi-Agency Public Protection Arrangements (MAPPA) <sup>10</sup> oversight and potential registration at either level 1,2 or 3 depending on the judgement of the OM and any subsequent MAPPA referral and assessment. (Source; Probation IMR)

Samay’s MAPPA registration was level 1.

13.4.2 Between **April 2018 and August 2018** Grace missed over eight group appointments as part of her support with CGL. Grace disclosed to CGL that she has been in contact with Chris who was having a difficult time. Due to the stress that Grace was under, CGL offered Grace additional support from her peers and facilitators. The group work addressed unhealthy relationships and patterns of behaviour, what keeps a person in an abusive relationship and types of abuse. Grace was also referred to Health in Mind by her GP. (Source; GCL IMR)

13.4.3 Following on from Samay’s sentence for the offence, Grace was contacted by a Victim Liaison Officer (VLO) from the Probation Service Victim Liaison Unit (VLU). The purpose of the VLU was to offer Grace access to certain pieces of key information regarding Samay and also to be able to influence if there were any additional specific conditions to be added to a licence, to better protect a Grace once Samay was released.

13.4.4 Grace had a visit from the VLO on **24 July 2019** and Grace and the VLO had a lengthy discussion regarding Grace’s mixed feeling about Samay, stating her continued affection for him, whilst acknowledging that reuniting with Samay was not a positive idea and that Grace was unclear whether she wanted additional licence conditions. The VLO advised Grace against contact with Samay, and Grace did disclose that Samay had contacted her from prison with what she assumed was a smuggled mobile phone.

13.4.5 The VLO prepared a report, but this was not shared with the Samay’s Offender Manager (OM) as the report was not available to the OM, although it would be expected that a VLO would identify any significant information relating to risk of harm. (Source; Probation IMR)

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<sup>10</sup> Multi-Agency Public Protection Arrangements.

13.4.6 Whilst in prison, Samay did appear keen to participate in programmes and interventions. However, because of an incident, Samay was moved to another wing of the prison and this move restricted his ability to participate in any support programmes. Samay did undertake some employment in prison and undertook some in cell work, but Samay was unable to attend any offending behaviour programmes. Samay reported to probation officers that as his father had a part time role within the criminal justice system and that some of the prisoners were antagonistic to him, claiming it was his father's fault that they had been sent to prison. (Source; Probation IMR)

13.4.7 Grace attended another Absence Review Interview on **18 May 2018**, and she received a formal letter saying she would be placed on stage 3 of the employers Absence Review Policy. Grace was supported by her Union Representative at the meeting, but the summary of the absence did not refer to the court case. Grace was set another action plan and her formal letter described how Grace expressed how well supported she had been by her employer through a very difficult time. Grace went sick again in **August 2018** and this triggered an Absence Review Interview final stage on **24 September 2018**. This could have led to Grace's dismissal, but her manager considered the exceptional circumstances that Grace was experiencing, and Grace was placed on another action plan. (Source; Employer IMR)

### **13.5 Key Practice Episode Five- Release of Samay from prison and ongoing contact between Grace and Samay. (2019)**

13.5.1 **10 April 2019**, the employer received a sick note from Grace's GP for a period of three months. The sick note identified that Grace had fractured her ribs but no description of how. (Source; Employer IMR)

The Employer provided the information about the receipt of the sick note as this was not recorded on the GP records. The GP records identified that a sick note was issued **in June 2019** and when reviewed by the Independent Chair, she was informed that this sick note was a re issue relating to the fractured ribs in **April 2019**.

13.5.2 **31 May 2019**, Samay was released from prison with the condition of wearing an electronic tag, not to approach or communicate with Grace and not to enter the specific area near Grace's home or her work.

13.5.3 Around the time of Samay's release it is alleged that Grace found a severed sheep's head deposited in her garden which was found by Grace's gardener who disposed of it. Grace's neighbour said she was happy to speak with the police, but Grace said to leave it as she was concerned about any retribution from Samay. A few days later, Grace sent a social media message to her neighbours saying "Gadhimai Festival,"<sup>11</sup> where Hindus decapitate animals to appease a goddess. (Source; Police IMR)

13.5.4 **12 June 2019**, Grace had been away from work for over 21 days following a fall when she broke her ribs (in April 2019). This was confirmed within the GP notes received. Grace received a phone call from her manager to discuss next steps which included managing absence

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<sup>11</sup> Gadhimai Festival, a religious festival every five years held at the Gadhimai Temple involving the largest sacrificial slaughter of animals in the world with the goal of pleasing Gadhimai, the goddess of power. [www.en.wikipedia.org](http://www.en.wikipedia.org)

which affects an employee's ability to work on medical grounds. Grace received a further letter **15 August 2019** informing her that she had exited the Absence Management Review (Source; Employer IMR)

(Samay had been released from prison in May 2019 but there is no evidence that there was routine enquiry about DA by her GP)

13.5.5 Samay visited his probation office on **14 August 2019** as planned. Samay was positive about ongoing support from Education Training and Employment (ETE) however he was not achieving his pass marks for Construction Skill Certificate Scheme (CSCS) card.

13.5.6 **28 August 2019**, Samay reported that his Home Detention Curfew (HDC) tag was not working correctly as the system was not registering him leaving the house. Samay asked if the curfew could be extended to allow him to attend prayers at the Hindu temple, which was agreed. (Source; Probation IMR)

13.5.7 **11 September 2019**, Samay had a further visit to the probation office and prior to this he had an appointment with ETE and passed a mock CSCS card test. Samay denied substance or alcohol abuse and that he had not contacted Grace and he was waiting for his Home Detention Curfew tag to be removed so he could concentrate on trying to get work.

13.5.8 Samay had a further visit to the probation Office on **18 September 2019** but prior to the appointment Samay had failed a CSCS mock test. A discussion took place regarding a phone call that the OM had received from Samay's father. Samay's father stated that he was concerned about Samay's behaviour and drinking/drug relapse and gambling. Samay admitted to drinking a couple of bottles of beer to help him sleep as he had a lot on his mind. His ex-wife had been contacting him about their divorce and that he lacked structure within his day. Samay downplayed his gambling as it was the "occasional flutter," but the OM highlighted that Samay had the mindset that this gambling would solve his financial problems. Samay denied taking drugs and said he was happy to have a test which he did, and this came back negative. (Source; Probation IMR)

13.5.9 Again, Samay visited the probation office on **23 October 2019**, and it was recorded that he was still struggling with the CSCS test and that he would receive additional support from the ETE. Samay said he was still down despite the completion of the Home Detention Curfew (HDC). The OM told Samay that he had spoken with Samay's father again as there was a concern that Samay had been seen giving money to an occupant in a car, late at night outside the family home. The OM told Samay that his father was worried that Samay was taking drugs again or being bullied by people from the prison. Samay denied the incident and said his family were under a lot of stress due to his sister being ill. Samay took another drugs test which was positive for cocaine. The OM said that the service would send the drug test away for lab testing, but this did not happen. (Source; Probation IMR)

13.5.10 **20 November 2019**, Samay had another planned visit to the probation office and saw another probation officer. Samay said he was concerned about his sister and his alcohol consumption.

13.5.11 **18 December 2019**, Samay's father contacted the OM again and highlighted his concerns about Samay's drug use. Samay was contacted by the OM and told to report to probation the following day so a further drug test could be carried out. (Source; Probation IMR)

### **13.6 Key Practice Episode Six; Death of Grace (2019)**

13.6.1 Mark, Grace's son contacted the Metropolitan Police in **December 2019** as he was concerned that he could not get hold of his mother, which was out of character. The Metropolitan Police contacted Sussex Police who forced entry. Grace was found deceased in the hallway and it was clear that Grace had met an unnatural death and that the house was a crime scene. Samay was arrested as he sat in the waiting area of the probation office, and he was recalled to prison. Samay was found guilty of Grace's murder in late **2020** with a minimum sentence of **27 years**.

A summary of the Judge's summing up report at Samay's trial:

"On a night of late 2019, Grace took Samay to her home and they drank alcohol, but by early morning, around 07.00am Samay was involved in lengthy phone calls to a Crawley number. The last time Grace was seen was around 10.00am on the doorstep of her house with a male matching Samay's description, together with another male. The judge stated that he was in no doubt Samay needed money from Grace, either for drugs or to pay off people he owed money to. The judge said that Grace would not give Samay any money, and then over the next hour and a quarter, Grace was subjected to a prolonged and savage attack. Grace sustained twenty-three rib fractures and a traumatic brain injury of the type more commonly seen in high-speed car crashes. Samay then left Grace's house."

(Source; Police and Probation IMR and judge's summing up)

## **14 OVERVIEW- Engagement with other agencies and IMR Feedback**

This section has been compiled from the Individual Management Reviews (IMRs) submitted by the agencies involved in this case. The IMRs aimed to provide an accurate account of an agency's involvement with Grace and Samay up until Grace's death, evaluate their actions and identify improvements for the future. All IMRs have been challenged robustly by the panel and, where appropriate, have been subject to review and revision.

Some IMR comments have been included under the relevant KPE in the Facts section of the report, to provide a clear, chronological overview. Where this is the case, the IMR Source is clearly referenced.

### **14.1 Sussex Police**

14.1.1 Sussex Police (the Police) had contact with Grace following the incident which was within the defined terms of reference when Grace was robbed by Samay in 2017. During the investigation, the case officer maintained continuous contact with Grace ahead of the trial which led to Samay being convicted and given a custodial sentence.

14.1.2 The police have reflected that the decision made to release Samay on a Released Under Investigation (RUI) arrangement in 2017 was not in Grace's best interest and this would not

happen today as the Police, Crime, Sentencing and Court Act 2021, when it is enacted, will re-introduce a presumption in favour of pre-charge bail.

### **14.1. 3 Lessons Identified:**

The police identified that they were not aware of Grace's preoccupation with Samay and the fact she tried to acquaint herself with Samay on his release from prison.

14.1.4 If evidence of the liaison had been shared, then steps may have been taken to have him recalled to prison as he was on licence at the time of Grace's murder. The police were not involved in Samay's release, this was managed by the Prison Probation Service.

14.1.5 The Sussex Police Domestic Abuse Working Group will be undertaking work to ensure that when a DA offender is released from prison the police will revisit the DASH dynamic assessment by contacting the victim together with the National Probation Service and the IDVA for the purpose of discussing the relationship, risks and any safety planning.

### **14.1.6 Recommendations and implementation:**

That Sussex Police take steps to ensure DA suspects are never released on an RUI arrangement and protective measures are always considered with conditions and use of DVPO. The Domestic Abuse Act 2021 details powers for dealing with domestic abuse as a Domestic Abuse Protection notice. A senior police officer may give a DAPN to prohibit a person (P) being abusive towards a person aged sixteen or over to whom P is connected. (Domestic Abuse Act 2021, Part 3 section 22).

## **14.2 National Probation Service**

14.2.1 Samay had two previous convictions prior to the time frame of this review. In 2015 he was convicted of two offences relating to the possession and supply of class B drugs (namely cannabis). Samay was charged and convicted of possession of drugs, and he received a suspended sentence order of 140 hrs of unpaid work and six months supervision.

14.2.2 Samay was sentenced following the offence of robbery against Grace in 2017. He was given a determined sentence of imprisonment. Samay was entitled to early release on Home Detention Curfew.

14.2.3 Whilst in prison it was noted that Samay was compliant and cooperative but did little in prison in terms of constructive offence work despite the sentence plan requiring attendance on specific offence related programmes including addressing his drug use.

14.2.4 Following release, the NPS noted that Samay made good progress, trying to find work and the NPS received no Police Intelligence that Samay was in contact with Grace. When Samay received emails from Grace and a request via Facebook to engage with Grace, Samay asked for advice from his OM on how to deal with this situation.

14.2.5 The IMR author identified a lack of information exchange with regards to the report prepared by VLO1 who met Grace in July 2018 and the lack of contact with Grace from VL02 in response to the OM's feedback that Grace was trying to contact Samay. If the OM had been aware of Grace's allegations that Samay had tried to contact Grace from prison after he had been sentenced and that she was ambivalent about ending their contact/relationship, then this information would have been included in the report and may have influenced the risk level.

14.2.6 The IMR identified that case records held on Samay reflected some of the work undertaken with him, but this was limited.

14.2.7 Also identified was the lack of enforcement of the case. There were no recorded absences after Samay was released until he failed an appointment with ETE in mid-November 2019. The OM was unaware of the disengagement with the ETE services due to the lack of consistent recording by ETE until there was an email exchange, 12 December 2019 at which they agreed Samay was less motivated. The OM wondered if Samay had relapsed into drug use and at his next appointment 19 December 2019 Samay would undertake a drug test and if this proved positive then refer him to a relapse service. This appointment did not take place as Samay was arrested for Grace's murder.

14.2.8 The IMR author noted that there was some good practice within the service, including risk assessment and risk management planning. Appropriate measures were put in place to protect the victim including licence conditions and exclusion zones. There was good communication with his family and lots of support for Samay to find employment.

**14.2.9 Lessons Learnt** - The IMR author identified several areas for improvement,

1. Dealing with Substance Abuse- Probation staff should have tested Samay more frequently and be more proactive when Samay tested positive. Probation staff should have considered referring to counselling and sent the tests to a laboratory for testing.
2. There was a lack of information sharing between VLO and the OM which could have affected the OM's risk assessment.

### **14.2.10 Recommendations/Actions**

- a) Process has been put in place that there is regular contact between offender managers and the VLU team.
- b) The Probation Service to reinforce with Offender Managers and senior managers that MAPPA Level one reviews should follow best practice which includes information from agencies such as police, specialist domestic abuse services to make robust decisions about the requirements for the release of a perpetrator of domestic abuse and the safety planning requirements for the victim of domestic abuse.

**The Probation Service Serious Offence Review identified fourteen areas of service improvement with actions which have been and are being implemented.**

### **14.3 East Sussex Clinical Commissioning Group (GPs)**

14.3.1 The CCG provided information via a letter submission as the GP practice stated that there was little information about Grace, they did however supply a copy of the witness statement relating to the assault and robbery incident in December 2017 when Samay assaulted Grace and robbed her.

14.3.2 Grace was examined by her GP two days after the assault in August 2017. Details of the assault are outlined in the fact section of this report. A further two days later, Grace presented again as she was struggling to take deep breaths. Grace was again examined.

14.3.3 Early September, Grace visited the GP complaining of low moods and anxiety since the assault and that she was afraid to leave the house. The GP diagnosed acute reaction to stress and prescribed a short course of Diazepam.

**14.3.4 Lessons Learnt - None**

**14.3.5 Recommendations/Actions - None**

**The DHR Panel recommends that the CCG to work with GP practices to promote the importance of accurate and robust record keeping via training and guidance.**

### **14.4 Change Grow Live -Specialist Domestic Abuse Service**

14.4.1 CGL had thirty-five contacts with Grace during the period 22 August 2017 to 30 August 2018 including telephone, text, email, face to face, group work and court support. The IMR author noted that the contacts were meaningful with the focus on safety and wellbeing and updating of the criminal justice process. There was good evidence that when Grace missed appointments or did not respond to updates attempted contact was made.

14.4.2 The Peer support Group step down service helped Grace to try to understand the difference between a healthy and unhealthy relationships. The service also offered support through its mindful section to Grace as she identified unhealthy coping mechanisms such as smoking and alcohol consumption.

14.4.3 Case notes demonstrated that Grace was kept at the centre of support and intervention.

14.4.4 There was good professional liaison between Sussex police, Witness Care, and the GP.

14.4.5 An ESFRS referral was completed for a home safety check, smoke and monoxide detectors were fitted and replaced.

The IMR author identified the following:

#### **14.4.6 Lessons learnt-**

1. Professionals should use their judgment when receiving a predetermined DASH risk status on referrals into the service. e.g. in Grace's case when the SCARFS was received the judgement is that the risk should have been raised to high and the referring service (in this case the police) should be informed and a MARAC referral made.

#### 14.4.7 Recommendations

- a) Review predetermined risk status on referrals into CGL and consider immediate and projected risk. Professionals to use professional judgement to determine risk.
- b) Reduce multiple duplicate referrals for the same incident through a joint working agreement with VS.

To note, agreement is now in place with VSS. All medium Police referred SCARFS are received by VS for triage and initial contact, the victim is offered a referral to specialist DVA services. Any referrals where professional judgement or further assessment, including downgraded risk from the police, are forwarded to CGL IDVA service for review and consultation.

#### 14.5 Grace's Employer

14.5.1 Grace was employed by a multinational company from 2011. The IMR author identified that the employer's support for Grace was around the period of the assault by Samay in 2017. Grace was treated in accordance with the employers Absence Management Policy and as a result Grace had access to professional advice and support via her employer Health Services and Help Direct. Grace was also able to seek additional advice from an experienced Asset Protection security specialist.

14.5.2 The IMR author noted that the employers Absence Management Policy was applied correctly and although Grace was unable to comply with the improvement plan set due to the trial, the issue of termination was never applied.

14.5.3 Grace's managers did check that Grace was not just aware of accessing professional support but in addition support from the police and others.

14.5.4 The IMR author noted that allowances for the impact of the trial could have been made earlier in the EG300 process<sup>12</sup> but that the overall outcome was not affected. Keeping Grace in a formal procedure enabled formal management interventions which ensured Grace received the right support.

14.5.6 Grace had a significant period of absence from April 2019-30 July 2019 with an injury to her chest wall (the cause of injury was not known). The managers at Grace's workplace were not aware that Grace and Samay had restarted a relationship.

#### 14.5.7 Lessons Identified:

The employer IMR states that three broader issues have been identified which did not impact on the employer's support and management of Grace. These broader issues, subject of recommendations at 14.5.3, have been discussed at the employers Safeguarding Board, accepted and actioned.

#### 14.5.8 Recommendations/Actions

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<sup>12</sup> Grace's employer's employment practice.

- a) Review ways to improve managers access to the relevant information commensurate to their role that enabled them to be alert to the signs of domestic abuse, act in accordance with employers policies and guidance and signpost colleagues to the most appropriate support.
- b) Review ways to improve the current advice on domestic abuse and update its content and accessibility as required.
- c) Review improvements of how colleagues in key roles are equipped with sufficient knowledge to enable them to advise others appropriately on domestic abuse matters.

## **14.6 Victim Support**

14.6.1 Victim support had contact with Grace on three occasions in August 2017 of which all related to domestic abuse. The contacts resulted in the provision of immediate advice and support to Grace and linked her with the specialist domestic abuse support service, Change Grow Live.

14.6.2 Sussex police referred Grace to Victim Support late August 2017. The case related to an assault on Grace and was flagged as involving domestic abuse. VS tried to contact Grace the following day and on the second attempt, contact was made with Grace and an IVA completed a DASH with Grace (score 9) and addressed her immediate needs (support, reassurance, safety planning, information about mini chime alarm). Grace was provided with details of the Victims code and her rights regarding victim personal statement.

14.6.3 Following the call with Grace, the IVA checked with CGL as to whether they had received a referral about Grace. At the time of the incident of the robbery and assault, medium and high-risk DA referrals in East Sussex were also sent by SCARF to CGL. This duplication has now been addressed and in January 2020 the Victim Support service triages all medium risk cases except for SCARFS which have been downgraded from high risk to medium. This system ensures that victims are contacted only once.

14.6.4 VS contacted Grace again and it was agreed that the IVA would contact CGL based on sharing the DASH as she would like some support. This happened and Grace's case was closed.

### **14.6.5 Lessons Identified:**

- a) Duplicating of initial contact with a victim with CGL

### **14.6.6 Recommendation-Action**

- a) New process introduced 2020 as described above.

## **15. ANALYSIS**

15.1 This analysis is based on information provided in the IMRs and responds to the key lines of enquiry as detailed in the TOR and issues that have arisen in consultation with professionals. Where relevant this includes an assessment of appropriateness of actions taken (or not) and offers recommendations to ensure lessons are learnt by relevant agencies. The Chair and the

Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight.

15.2 Key Themes were identified through the IMRs and discussion with professionals involved with the family:

- Domestic Abuse: physical and coercive and controlling behaviour including economic abuse
- Loneliness and isolation of Grace
- Understanding a victim's behaviour including negative lifestyle choices, (lack of exercise, drinking and smoking)
- Confidence by practitioners to use professional judgment
- Impact of substance abuse on perpetrator behaviour
- Impact of delays in criminal investigation
- Cultural factors
- Management of release of offenders
- Absence Management Processes by employers and the understanding of the dynamics of domestic abuse

### **15.3 Awareness and Understanding of professionals and the wider community of the potential presence of coercive control and how it may have impacted on the behaviour of the victim and perpetrator.**

15.3.1 The information provided by agencies involved with Grace and her family identifies Grace as a victim of domestic abuse

- **Physical:** Samay physically assaulted Grace in **August 2017**. Samay dragged Grace around the house, then he threw her on the floor and grabbed her by the neck as she had inadvertently thrown Samay's drugs away.
- **Controlling, Coercive Behaviour:** Grace was described as lonely due to the breakdown of her relationship with Chris and with her sons leaving home to attend university. The feeling of isolation impacted on Grace further as her family was in South America, her father was ill and her brother (a banker) was a drug addict and she felt helpless as she was not able to support him. The family felt that Grace wanted to help Samay with his drug issue and Samay manipulated Grace's emotions to pay for his drug addiction. Following the incident in **August 2017**, Samay turned up at Grace's home and they spoke through a window, with Samay allegedly saying I am going to get three years for this, what have I done. Samay was trying to control Grace's emotions.
- **Economic Abuse-** Samay used Grace's money to buy drugs. Evidence suggests that Grace wanted to support Samay in trying to overcome his drug abuse, but Samay used Grace's money to buy drugs. Samay would extort money from Grace by manipulating her emotions including her loneliness.

15.3.2 Controlling coercive behaviour is described as a range of acts to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their

resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.<sup>13</sup>

15.3.3 Following the incident in **August 2017**, the police followed the Sussex Police Domestic Abuse Policy (516/2017), and measures were put in place to safeguard Grace throughout the course of investigation. A DASH was completed and rated as medium as the incident in August 2017 (KPE2) was the first occasion that there had been a police intervention between Grace and Samay. Although the police noted that Samay made serious threats and was violent to Grace, a referral was not made by the Police to a MARAC as the risk level was assessed as medium. The police policy at the time was that as there had not been three or more domestic abuse incidents, there was no indication of escalation.

15.3.4 What is clear is that the police had a good understanding of physical abuse but what is not clear is whether there was the consideration of the control that Samay was trying to exert, forcing Grace to take him to the cashpoint and for her to get money to fund his drug habit which is economic abuse.

#### **15.4 Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator e.g. Femicide men and women's roles in society, culture and religion**

- **Sex and Gender-**

15.4.1 Grace was killed as she was female. The Office for National Statistics identified that 1.6 million women and 757,000 men experienced domestic abuse in 2020.<sup>14</sup> The Office for National Statistics also state that over the period 2017-2019 most domestic homicide victims were female 77% or 274 victims. A large majority of defendants in domestic abuse related prosecution in 2020 were recorded as male (92%).<sup>15</sup>

15.4.2 Research show that females are more likely to be repeat and chronic victims of domestic abuse. There is evidence to confirm that Grace experienced domestic abuse in her relationship with Samay, physical, emotional, and economic.

15.4.3 Women's Aid identified that although both male and females may experience interpersonal violence and abuse, women are more likely to experience repeated and severe forms of abuse, including sexual violence. There are also more likely to have experienced sustained physical, psychological, and emotional abuse or violence which results in injury or death.<sup>16</sup>

- **Age**

15.4.4 Grace was 58 years old at the time of her death and Samay was 35 years old, an age difference of 23 years. Mark and Paul both commented that Grace was flattered by being attractive to someone much younger than she was. Grace understood that she was experiencing domestic abuse as she engaged with CGL, but she blamed herself for the abuse she was experiencing, and she desperately wanted to help Samay to resolve his drug addiction. SafeLives have identified that many crime surveys in England and Wales have excluded

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<sup>13</sup> Controlling Coercive Behaviour definition. [www.cps.gov.uk/legalguidance/controlling](http://www.cps.gov.uk/legalguidance/controlling) coercive behaviour.

<sup>14</sup> [www.ons.gov.uk](http://www.ons.gov.uk) Domestic Abuse victim characteristics, England and Wales; year ending March 2020.

<sup>15</sup> [www.ons.gov.uk](http://www.ons.gov.uk) Homicide in England and Wales. Year ending March 2019

<sup>16</sup> [www.womensaid.or.uk-Domestic](http://www.womensaid.or.uk-Domestic) Abuse is a gendered crime.

consideration for victims around the age of sixty years and beyond and awareness raising campaigns have consistently focused on younger victims and also specialist domestic abuse support services are more likely to focus on younger victims.

15.4.5 The research stated that people have the idea that domestic abuse affects younger women and especially those with children and that it does not readily impact on older people. The report highlighted that these assumptions may encourage health professionals to link injuries to age-related incidents and not domestic abuse. Grace presented to her GP with injuries and there was no routine enquiry about domestic abuse and therefore no referral to a support service.<sup>17</sup>

15.4.6 Professionals need to understand that domestic abuse can be experienced by anyone, whatever their age, and that services need to respond to older victims in an appropriate and targeted way and this should include advertising campaigns.

- **Culture**

15.4.7 Grace was South American with her family still living in South America. Grace's family said that Grace was all about the family. Grace was the centre of the family, and she would often extend the family with surrounding neighbours. Research by Stanford School of Medicine, Culture, Traditions, Beliefs, and Values highlight the importance of family in Hispanic /Latino culture at all levels, nuclear and extended. Needs of a family take precedence over individual needs. There is mutual respect between people, hierarchy, and trust building<sup>18</sup>.

15.4.8 Following the breakup of Grace and Chris's relationship and when Mark and Paul left home for university, Grace's cultural beliefs and heritage would have been impacted on. Grace was on her own, her family in South America and therefore Grace was isolated, lonely, and potentially very vulnerable.

- **Religion**

15.4.9 Samay is a Hindu and evidence both in the criminal trial and information with the IMRs would indicate that Samay is a practicing Hindu. Hinduism is one of the oldest religions in the world (over four thousand years old). Central to Hinduism is a belief in a supreme God, Brahm and Hindus believe in a life of birth, death and rebirth. They also believe that the next life depends on how a previous life was lived.

15.4.10 The basic building blocks of Hindu society is a joint or extended family, usually consisting of three or four generations living together. The women collectively cook and share domestic responsibilities and the men pool income. An important aspect of a Hindu family is the intergenerational dependencies between members. Marriage itself is a social and religious obligation rather than just a relationship between partners.

15.4.11 Hindus see sex as one of the most beautiful and legitimate pleasures on earth, but only within marriage. Sex before marriage is discouraged and stigmatised. At the criminal trial, Samay stated he did not want to sleep with Grace as it was "against his religion." What is evident from family and friends was that the relationship was intimate but again in discussion with the Independent Chair, Samay reiterated that although his relationship with Grace was intimate, they never had sex.

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<sup>17</sup> [www.safelives.org.uk](http://www.safelives.org.uk) Safe Later Lives; Older people and domestic abuse

<sup>18</sup> [www.geriatric.stanford.edu](http://www.geriatric.stanford.edu); Hispanic/Latino culture

15.4.12 There was also an incident discovered during Grace's murder investigation where Grace discovered a severed sheep's head deposited in her garden around late May 2019 after Samay's release from prison. Grace's gardener found the sheep's head. Grace researched the purpose of a dead sheep's head and it related to the Gadhimai Festival where Hindus decapitate an animal to appease a goddess. This did disturb Grace and would appear to show that Samay used his religion to intimidate and frighten Grace.

### **15.5 Whether there were any barriers experienced by Grace or her family /friends and colleagues in seeking support from professional service providers.**

Following the incident in **August 2017**, Grace did receive a range of support from different agencies.

- **Specialist Domestic Abuse Service.**

15.5.1 When Samay was arrested for the incident in **August 2017**, CGL received a SCARF referral from Sussex Police. Grace was contacted in line with service protocols and once contacted, Grace's medical and safety needs were explored. Over the next two years, Grace had thirty-five contacts with CGL including telephone, text, email and face to face group and court support. Grace, although fearful about being a witness in the criminal case against Samay, appears to have been well supported by CGL. CGL case workers liaised with the police and highlighted their concerns around the delay in charges and the lack of bail conditions. CGL highlighted that these issues were impacting on Grace's mental health and wellbeing and that there was a heightened risk of witness intimidation and manipulation from Samay to Grace. CGL supported Grace through the court process in a thorough and timely manner.

15.5.2 CGL worked with Grace to provide safety planning support including practical measures for her home. Support included home safety checks, smoke detectors and advice and instruction in the event of an emergency.

15.5.3 CGL also supported Grace by liaising with her GP around her mental health and referring Grace to a peer support group. Evidence suggests that Grace was well supported by CGL with safety planning, support around the criminal trial, emotional support through referral to a peer support group and liaison with other agencies including victim support, the police via home welfare checks, and her GP.

- **Employer**

15.5.4 The employer was aware of the relationship between Grace and Samay and the incident in August 2017. Following Grace's assault, she was signed off sick from her place of work for a number of weeks on different occasions. Grace was treated in accordance with the employer's Absence Management Policy. This process provided Grace with access to professional advice and support via the employer's Health Services and Health Direct and evidence indicates that Grace did utilise the services and found them helpful. The employer's Absence Management Policy was applied correctly, and allowances were made by managers to support Grace's attendance at the trial. Although Grace was not able to always comply with the improvement plan set by the employer, allowances were made and the spectre of termination of her employment was never applied.

15.5.5 Although the Independent Chair and the Panel did question whether the Absence Management process added additional stress for Grace during a time of trauma, a formal process did help ensure that Grace was accessing support services to help her. on numerous

occasions, Grace stated her thanks for the support she was getting from the employer and all the agencies involved in her life.

- **Protected Characteristics**

15.5.6 As identified in 15.4, Grace was an older women and may have been less likely to identify her situation as abuse, which can act as a barrier to the uptake of services and presents a challenge to outreach workers. Grace was offered group sessions by CGL but did not fully participate and it was not clear why. It may have been related to the fact that other females were younger than Grace. SafeLives research found that older women grew up in a time when the home was a private domain and when they were younger there were no specialist domestic abuse services and therefore, they were not aware of how to access such services<sup>19</sup>.

15.5.7 The Police and Crime Commissioner in Sussex has commissioned Hourglass to provide specialist IDVA provision in Sussex to support older victims of domestic abuse. Hourglass<sup>20</sup> is a national charity that focuses on the abuse and neglect of older people. It will be important that ESSCP raise awareness of this organisation in order to better support older victims who are experiencing domestic abuse.

### **15.6 To consider any agencies or wider community groups that had no contact with Grace and her family and whether helpful support could have been provided and if so, why this was not accessed.**

15.6.1 Grace had a range of support from several different agencies following the assault in **August 2017**, but what is clear is that Samay's life and his relationship with Grace was underpinned by his relationship and addiction to drugs. Following Samay's release from prison on licence, he stated to his probation manager that he was not participating in drugs but when drug tested on several occasions, his tests proved positive. There was concern over the drug testing equipment at the time and whether this influenced professionals not identifying additional support for Samay's drug habit is not known. Samay's family was very concerned that on his release from prison he was participating in drug use. Samay's father contacted the probation officer to highlight his concerns.

15.6.2 During the interview with Samay in prison with the Independent Chair and Panel member, there was a discussion around Samay's drug taking. Samay did not accept that his drug taking was a problem and that he was a recreational user only and therefore why would he seek support.

15.6.3 The correlation between domestic abuse and drug abuse by a perpetrator has been well documented and is explored further in section 15.9.6.

15.6.4 East Sussex has several drug and alcohol specialist services to support people with substance abuse issues. STAR Drug and Alcohol Service, managed by CGL, offers a range of support including drug treatment options, peer support, information and advice. East Sussex Recovery Alliance (ESRA) provides several recovery cafes for people who have substance

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<sup>19</sup> [www.safelives.org.uk](http://www.safelives.org.uk) Safe Later Lives; Older People and domestic abuse

<sup>20</sup> [www.wewrehourglass.org](http://www.wewrehourglass.org)

addiction. There is no evidence to suggest that Samay or his family was directed to any of the specialist drugs and alcohol services in the area by agencies.

**15.7 Identification of any training or awareness- raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.**

15.7.1 The employer IMR author identified that, although it did not impact on the employers' support and management of Grace, there was a broader issue for the employer in relation to DA awareness including:

- a) The need to review ways to improve manager's access to relevant information that enables them to be alert to signs of domestic abuse. To act in accordance with the employer policies and guidance and signpost colleagues to the most appropriate support.
- b) Review ways to improve current advice on domestic abuse and its content and accessibility as required.
- c) Review improvement of how colleagues in key roles are equipped with sufficient knowledge to enable them to advise others appropriately on domestic abuse.

15.7.2 These changes have been made already and include female, male and LGBT+ victims and some external links for male perpetrators. The Independent Chair and the Panel welcome the input of the employer in this review. In **2019**, the employer, employed approximately thirty-six thousand colleagues of which around 47% were female. The employer has an opportunity to highlight domestic abuse, what it is and what support is available. What is important is that managers have a full understanding of domestic abuse including controlling and coercive behaviour, stalking, harassment and emotional and economic abuse for all potential victims.

15.7.3 GPs have an important role in the identification of domestic abuse. The Domestic Homicide Review Case analysis by Sharp and Kelly 2016 for Standing Together against domestic violence identified that GPs are well placed to identify victims of domestic abuse for example injury, depression and substance misuse and also with perpetrators.

15.7.4 Very little evidence has been provided by the GP practice for this review as a letter stated that there was little evidence from the practice about Grace. A witness statement by the GP relating to the incident in **August 2017** details information about the assault but there is no evidence whether enquiries were made about the support Grace was getting or whether DA was explored further. What is concerning is that the employer provided a sick note for the DHR which was from Grace's GP dated **10 April 2019** which referred to broken ribs. There was no record relating to this within the GP notes that were provided although there is a record of multiple fractures of ribs in **June 2019**. Following an investigation with the GP, there was only the one incident in April 2019 and the second sick note was an extension of time off from work. Although Grace stated that she had fallen in the garden, there is no evidence the GP explored domestic abuse with Grace. Samay had been released from prison and there is evidence that Grace and Samay had continued contact throughout and the GP was aware of the previous domestic abuse/robbery incident and therefore good practice should be a routine enquiry about domestic abuse when Grace visited her GP.

15.7.5 GPs are mostly likely to be the one contact with a victim of DA. What is important is that they have the skills to enquire about DA and that GPs are reminded about the importance of

record keeping, ensuring a holistic picture can be established about the victim and the abuse that they may be experiencing.

**15.8 Whether Grace's welfare and needs were promoted and protected through timely and effective assessment including risk assessment and response to needs identified. (This to include information sharing, use of any assessment tools and timely interventions).**

15.8.1 The facts state that when Grace was assaulted in **August 2017**, the police arrested Samay, and he was detained in custody where he was interviewed. Samay was released under investigation as further information and evidence was required by the police, but the police instructed Samay not to contact Grace or visit her at home. The police met with Grace prior to Samay's release from custody to ensure that safeguarding plans were in place, including home security and advising Grace to keep her phone on all the time.

15.8.3 The Police referred the assault incident to Victim Support who contacted Grace and addressed her immediate needs, support, reassurance and safety planning. Victim Support contacted CGL to check whether Grace had been referred to them. (In 2017, all medium/high level domestic abuse referrals in East Sussex were also sent by SCARF to CGL. In **2020**, the duplication was addressed with Victim Support triaging the medium cases to ensure that victims are only contacted once).

15.8.4 CGL offered significant support to Grace following the assault in **August 2017** (KPE2 and KPE3), including professional contact, liaison and advocacy. Evidence displays that Grace was kept at the centre of support and intervention.

15.8.6 Grace appears to have been supported in a professional and compassionate way by practitioners within various agencies.

15.8.7 Grace was also supported by her employer. Grace was signed off sick by her GP and the employer did implement its absence policy to manage Grace's absence. Whether the formal absence procedure created extra pressures on Grace, there is no evidence to suggest it did. It is well recorded that Grace thanked the employer and the other agencies supporting her. The formal process did allow managers to ensure that Grace was accessing occupational health, Grace's employer Health Services (HS) and Help Direct<sup>21</sup> and Validium<sup>22</sup>.

15.8.8 The IMR author identified that although Grace was supported during the period of this review, the employer needed to review its support for victims of domestic abuse including further training on signposting of services available. This DHR Panel welcome the work that has already taken place within the employer, to support victims of domestic abuse.

15.8.9 Whilst Samay was in prison he was managed by an Offender Manager (OM-Probation Service) and Grace received support from a Victim Liaison Officer (VLO- Probation Service). It has been identified that there was a lack of information sharing between the OM and the VLO about the disclosure about contact between Grace and Samay. If this information had been shared, then further support and safety planning could have been provided to Grace and allowed the OM to have reassessed the risk assessment for Samay's release.

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<sup>21</sup> Help Direct 24 hr work force counselling service for employees to assist colleagues in resolving personal problems.

<sup>22</sup> Validium is the company offering the Help Direct Service.

15.8.10 Samay, on his release, was to be managed by a MAPPA (level one). Best practice by the Probation Service prior to the release of an offender is not only to share information internally e.g. OM and VLO (Probation Service) but also review information from other agencies involved with an offender e.g. Police, Specialist DA services and others. This did not happen with the release of Samay. If it had, then the ongoing contact and relationship between Grace and Samay should have been disclosed and the arrangements and management of the release of Samay would have reflected the ongoing contact between Grace and Samay.

15.8.11 Evidence has highlighted that the police and CGL were not aware in advance of the release date of Samay from prison. If the Police and CGL had been given prior notice of his release and the information shared that Grace and Samay were in communication, then Grace's support could have been increased and her risk assessment reviewed in advance and agencies could have been proactive in their support and not reactive.

### **15.9 To consider if all relevant civil (including workplace) or criminal interventions were considered and/or used. (Not already discussed.)**

Several interventions that Grace received have already been discussed but some warrant further comment.

#### **15.9.1 Mental Health interventions for Grace.**

15.9.1.a From information provided by Grace's GP, following the incident in August 2017, Grace complained to her GP that she was suffering from low mood and anxiety since the assault and that she was very scared to leave the house. The GP diagnosed an acute reaction to stress and Grace was prescribed a short course of Diazepam<sup>23</sup>. There is no further reference to any follow up by Grace's GP to see how Grace was coping and if her mood had improved.

15.9.1.b CGL offered substantial emotional support to Grace, especially around her attending the criminal trial as a witness. CGL also offered longer term support to Grace through the peer support programme, addressing healthy and unhealthy relationships and patterns of behaviours that keeps someone in an unhealthy relationship. Grace commented in her meetings with the employer manager that the specialist support she was receiving was helping her and she was very thankful.

15.9.1.c There were interventions to support Grace's mental health but due to the lack of information provided for the DHR by the GP, it is not clear whether the GP reviewed Grace's mental health needs on an ongoing basis. It is important that health professionals understand the trauma that a victim of domestic abuse may be experiencing, and a follow up consultation could/should be offered.

#### **15.9.2 Multi Agency Risk Assessment Conference (MARAC)**

15.9.2.a Following the incident in **August 2017** (KPE2), the police made a DASH assessment of medium as this was a first serious threat and violence that Samay made to Grace and as such it was not referred to a MARAC. A SCARF was forwarded to CGL and reviewed. CGL staff did have concerns around the severity of the assault on Grace and the IMR author states that due

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<sup>23</sup> Diazepam – commonly used to treat anxiety/insomnia and alcohol withdrawal symptoms.

to the severity of the assault, professional judgement should have re-assessed the risk as high and the case to have been referred to a MARAC.

15.9.2.b The MARAC would have provided a multi-agency discussion, shared information and ensured a coordinated approach to the safety planning for Grace.

### 15.9.3 Criminal Intervention

15.9.3.a Following the assault in August 2017 (KPE2), Samay was arrested and then Released Under Investigation (RUI). At the time in 2017, the Policing and Crime Act 2017 had been amended relating to the use of pre-charge bail set out in S47 of the police and Criminal Evidence Act 1984 PACE. The reforms which commenced in April 2017 introduced the following.

- I. A presumption against bail charges unless necessary and proportionate and
- II. Clear statutory timescales and processes for initial imposition and extension of bail.

15.9.3.b The strict timescales and complex process surrounding pre-charge bail encourage the police service to use the RUI process.

15.9.3.c This meant that Samay was released to wait for his trial. He was told not to contact Grace or intimidate the witness (Grace). The police investigation required a number of enquiries, and the case did not go to trial until **April 2018**, eight months after the assault. During this time Grace contacted Samay and Samay also turned up at Grace's home, "saying I will get three years for this, I am sorry."

15.9.3.d Although the Police and Crime Act 2021 still applies, the reforms were controversial and the government commissioned a consultation, which is now complete. In January 2021, the government published a response and made the undertaking to remove the presumption against bail to help support the police investigations.

15.9.4.e The Police IMR states that today, Samay would not have been RUI but would have been released on bail with conditions which will ensure victims of domestic abuse are safeguarded appropriately whilst under investigation.

### 15.9.4 Management of a perpetrator in prison.

15.9.4.a Whilst in prison, Samay had a sentence plan. The purpose of the plan was to identify objectives he had to work towards if he were to change the factors which led him to offending. Samay spent thirteen months in custody after he was sentenced. The OM at the time had three video links sessions with Samay. A meeting took between Samay and his OM in **September 2018** but the Risk Assessment, Offender Assessment System OASys assessment was not completed until **November 2018**. The OM submitted the OASys assessment, but this was not countersigned by the line manager. There was no record of why it was not countersigned. There were four objectives contained in Samay's sentence plan and they were as follows.

- 1) Victim awareness
- 2) Domestic abuse/attitudes
- 3) Drug misuse
- 4) Constructive use of time/positive behaviour in custody.

15.9.4.b A range of referrals were made for Samay including a referral to Resolve, a specific programme for domestic abusers as well as the completion of in cell work from drug treatment providers in prison. The IMR author noted that there is no evidence that Samay completed any of the objectives of his sentence plan.

15.9.4.c It was stated that Samay did not complete the Resolve programme nor the victim awareness course due to the length of his sentence. When a perpetrator has committed domestic abuse and is sentenced for this action, it should be paramount that they complete this specialist programme before release. If it is not possible for a perpetrator to complete a sentence plan then this should be factored into the risk assessments relating to the release including what extra safety measures the victim of domestic abuse may need.

### **15.9.5 Management of release of a perpetrator of domestic abuse.**

15.9.5.a Samay was released from prison under a Home Detention Curfew which involved Samay staying at his parents' home and not being allowed to leave the house between 19.00hrs and 7.00hrs. Non-contact and exclusion zones were put in place to protect Grace. Samay was tagged and required to take part in focussed work to address his drug/alcohol and offending behaviour. On his release the risk surrounding Samay was identified as medium. At the time of his release several protections had been put in place to try to protect Grace. What was not known by the OM was that Grace and Samay were in contact. The police were aware, the VLO was aware, but the OM was not and therefore this information would have allowed the OM to review the risk posed by Samay to high. This would have meant additional safeguarding actions to be implemented to safeguard Grace.

15.9.5.b As already described in paragraph 15.8, if the OM had followed best practice and reviewed what other information that partners had about Grace and Samay, Samay's release would have been managed in a different way.

### **15.9.6. The impact of substance misuse/mental health as a contributing factor in domestic abuse.**

15.9.6.a Samay's reliance on drugs and his views on his drug taking have already been documented. Research carried out in 2019 by Gadd, Henderson, Radcliffe, Stevens, Johnson and Gilchrist for the British Journal of Criminology<sup>24</sup> links the correlation between domestic abuse and substance misuse. It states that substance abuse featured in around half of all UK domestic homicides (Home Office 2016). The relationship between substance abuse and domestic abuse is not straight forward as different substances can have different effects. Cocaine can induce low levels of inhibition and self-regulation and alleviate anxiety.

15.9.6.b There were several opportunities to refer Samay to substance misuse services, especially when Samay's family voiced their concern that Samay was taking drugs following his release from prison. Professionals need to ensure that they understand the links between substance misuse and being a perpetrator of domestic abuse and that any prison release conditions relating to substance misuse are fully adhered to.

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<sup>24</sup> www.academic.oup.com The Dynamics of Domestic Abuse and Drug and Alcohol Dependency, Gadd, Henderson, Radcliffe, Stephens -Lewis, Johnson, Gilchrist. May 2019 Oxford academic -The British Journal of Criminology.

15.9.6.c The Domestic Abuse Act 2021 includes widening the scope of Domestic Abuse Protection Orders so that suspected perpetrators of domestic abuse can be compelled to attend drug and alcohol treatment. It will be imperative that agencies apply this condition. It will also be important that professionals have a full understanding of the Domestic Abuse Act 2021 and what sanctions are available to protect the victims of domestic abuse.<sup>25</sup>

### **15.9.7 Mental health and domestic abuse.**

15.9.7.a Information within the IMRs identified that Grace suffered loneliness, anxiety, feeling depressed over the assault by Samay and was prescribed medication by her GP. Domestic abuse and the links with mental health have been well documented. SafeLives “Safe and Well; Mental Health and Domestic Abuse May 2019” identify that people with mental health needs were more likely to have experienced each type of abuse, particularly sexual abuse. It states that having mental health issues can render a person more vulnerable to abuse.

15.9.7.b Grace had suffered several traumas in her life especially in the last six-eight years of her life:

- Breakdown of her relationship with Chris
- Her sons leaving for university thus creating an “empty nest”
- Her mother being ill in South America and Grace not being there
- Grace’s brother being a drug addict and her perceived inability of not being able to support him
- Grace being assaulted by Samay.

15.9.7.c Grace readily admitted to CGL that she was drinking and smoking more and was not keeping healthy. Women’s Aid highlights that domestic abuse has a considerable impact on a victim’s health and wellbeing. Domestic abuse can have an immediate physical effect including bruises, broken bones, lost teeth and hair. Domestic violence can also cause long term issues such as migraines, digestive problems and skin disorders. Domestic abuse also has an enormous effect on a victim’s mental health, and this can lead to an increased use of alcohol, smoking and drugs with Grace drinking and smoking more.<sup>26</sup>

15.9.7.d All the above would have impacted on Grace’s mental health and professionals need to understand the correlation between domestic abuse, mental health and the impact on physical health.

### **15.10 The impact of economic abuse in a relationship.**

15.10.1 The impact of economic abuse between Grace and Samay is described in KPE2. Surviving Economic Abuse states that one in eight adults in the UK have experienced economic abuse.<sup>27</sup>

15.10.2 A perpetrator of economic abuse restricts how a victim uses money and economic resources, for example dictating what they can buy. They can exploit the victim’s ability to

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<sup>25</sup> [Domestic Abuse Act 2021 \(legislation.gov.uk\)](https://legislation.gov.uk)

<sup>26</sup> [www.womensaid.org.uk](http://www.womensaid.org.uk) Women’s Aid Domestic Abuse and your physical health.

<sup>27</sup> [The Economic Abuse Threat Facing Girls & Women in the UK: New report reveals the six key life moments when women are most vulnerable to abuse - Surviving Economic Abuse](#)

maintain economic resources like stealing a victim's money. When Samay made Grace take money out of her account so he could buy drugs, he was abusing Grace.

15.10.3 Economic abuse has been included in the Domestic Abuse Act 2021 with a new statutory definition, which means any behaviour that has a substantial adverse effect on a victim's ability to-

- a) Acquire, use or maintain money or other property, or
- b) Obtain goods or services.

Section One of Domestic Abuse Act 2021 -Definition of Domestic Abuse (4)<sup>28</sup>

15.10.4 Although Grace could still financially support herself, Samay controlled Grace to seek money to fund his drug habits.

## 16 CONCLUSIONS

16.1 Information provided by the family states that up until **2012/2013**, Grace was the life and soul of the family and was well known and respected by neighbours. Following the breakup with Chris, both Mark and Paul leaving home permanently, following university and Grace's own family being thousands of miles away, Grace was very lonely and felt isolated. Grace met Samay through her work and was flattered by his attention and a relationship developed. Although the relationship appears to have been on and off and they never shared a home together, the relationship was intimate.

16.2 Grace and Samay encountered agencies from **2017** when Samay robbed and assaulted Grace. Following this incident, several agencies became involved with Grace, specialist domestic abuse services, the police, her workplace, and her GP. The criminal investigation by the police took around eight months and professionals have advised that this is a standard time for investigations. During this period there is evidence that Grace and Samay were in contact. Although this contact was known by the police, it was not shared with other agencies. Also, whilst Samay was in prison, the VLO supporting Grace knew that there was ongoing contact between Grace and Samay and again this information was not shared. If this information about the ongoing contact had been shared between agencies, then extra safety planning could have been put in place to protect Grace and additional restrictions could have been placed on Samay on his release from prison.

16.3 Grace was never referred to a MARAC. Following the assault and robbery in **2017**, the police rated DASH as medium although the assault was serious. CGL identified that Grace's case should have been escalated and that professionals should have the ability to use their professional judgement and challenge other agencies to achieve the best outcomes for victims of domestic abuse. If a MARAC had taken place, this would have provided a multi-agency response to support Grace.

16.4 Agencies working with Grace did not know that Samay was being released from prison in advance and therefore did not plan any additional safety measures. This lack of knowledge

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<sup>28</sup> [Domestic Abuse Act 2021 \(legislation.gov.uk\)](https://legislation.gov.uk)

was also compounded by the lack of understanding of the ongoing contact between Grace and Samay.

16.5 If victims of domestic abuse are to be protected when a perpetrator is being released from prison, then there needs to be an action to ensure all agencies working to support the victim are informed to ensure the most appropriate safety planning.

16.6 This DHR highlights the importance of GPs making routine enquires, being professionally curious and the need for robust record keeping. These issues are ongoing within DHRs and there needs to be a national response to create change.

16.7 This DHR has identified the value of an employer being involved in a DHR, not only in providing information but also as an active partner on the DHR Panel. The workplace can be a haven for victims of domestic abuse but also a place to share information with colleagues and managers and therefore the workplace provides an opportunity to support the victim.

16.8 Finally, Grace was described by her family as the life and soul of the family. Grace did experience a number of traumas in the last few years of her life, but she showed great strength when she was a witness in Samay's trial. Grace also sought support and worked with agencies to support her safety planning and she did want to help Samay stop taking drugs. The family feel that Grace felt she had let her sons down by continuing the relationship with Samay, but her family believe Grace wanted to do the best for everyone including trying to help Samay.

## 17 LESSONS LEARNT

17.1 This DHR has identified several lessons that that the East Sussex Safer Communities Partnership and agencies need to consider in responding to the death of Grace and some post-review learning.

### 17.2 Sharing of information between agencies

17.2.1 When Samay was arrested for the assault and robbery on Grace in August 2017 the police quickly shared information about the incident with Victim Support and CGL via a SCARF and DASH. This was to ensure that safeguarding measures could be put in place to support Grace, physical (practical safety measures for Grace's home) and emotional support for her appearance as a witness at Samay's trial.

17.2.2 Following the initial contact between the three agencies, there is evidence as highlighted in the IMRs that critical information was not shared both between different agencies and within agencies.

#### The Police

17.2.3 Grace told the police in late August that she had contacted Samay via WhatsApp asking why he had hurt her. Grace also admitted that she had text him on previous occasions. Grace was advised to cease contact. Later in November 2018, Samay contacted the police to say Grace had messaged him to wish him happy birthday.

17.2.4 It is apparent that police did not share this information with other agencies, namely CGL and the Prison Service.

### **Probation**

17.2.5 Whilst Samay was in prison, Grace had a VLO (Probation Service). Grace disclosed to the VLO that she and Samay had been in contact and that she still had feelings for Samay. What is clear from the Probation IMR and the SFOR is that this information was not disclosed to Samay's Offender Manager. If it had been, this information would have been used to review the risk assessment relating to Samay's release.

17.2.6 If the police and the Probation service had shared this information with each other but also CGL, further safeguarding support could have been provided for Grace and agencies may have been able to influence Grace's emotions about Samay.

17.2.7 The DHR Panel welcomed the significant progress that Sussex Police have made through a variety of initiatives to improve awareness of the importance of sharing information. Also, the Panel notes that the IMR author highlights that the findings in the investigation have been brought to the attention of Public Protection and will be included in future guidance to officers and staff.

17.2.8 The learning within the SFOR recommends that there needs to be formal communications between a prisoner's OM and the VLO and the DHR Panel welcome this to help safeguard victims of domestic abuse.

17.2.9 This DHR highlights the importance of sharing of relevant information between agencies and within agencies to ensure victims are safeguarded and that risks relating to a relationship can be fully assessed.

### **17.3 Importance of a perpetrator of domestic abuse fulfilling their conviction requirements**

17.3.1 As already described in section fourteen, Samay was required to have completed several offending behaviour programmes whilst in prison which should demonstrate a change in attitude and thinking. Samay was supposed to have completed four modules including offending behaviours, domestic abuse and to address his drug abuse. It was stated in the Probation Service IMR that there was insufficient time to complete the requirements due to the length of sentence.

17.3.2 Prison Services may need to react to changing circumstances such as staff shortages and in the last eighteen months, the Covid Pandemic which may impact on the inability to ensure that perpetrators of domestic abuse comply with their sentencing programme. If this does happen (and the DHR Panel understand and acknowledge the pressure on such services) then there is the need to ensure that this inability to review behaviours of the perpetrator is reflected in any risk assessment that is prepared for a release of a perpetrator of domestic abuse. Safety planning for a victim should also be reviewed if the perpetrator has not concluded the requirements of offending behaviour programme.

#### **17.4 Understanding by professionals of the link between substance misuse and domestic abuse by a perpetrator**

17.4.1 Samay had been arrested for drugs prior to the assault on Grace in 2017. The assault and robbery on Grace were motivated by the need of Samay to get drugs. He made Grace get money out of her bank account so he could buy drugs to replace what Grace had inadvertently thrown away.

17.4.2 On Samay's release from prison, he was required to undertake regular drug tests. Despite Samay saying he had not taken drugs, most of the tests came back positive. Samay's family became so concerned about his behaviour following his release that they contacted Samay's Probation Officer to highlight their concerns about his drug habit.

17.4.3 At the time when Samay was being drugs tested, there was concern by the Probation Service about the reliability of the drug testing equipment. It would appear this impacted on any review of the risk assessment relating to Samay. A second test should have been carried out by an outside agency to ensure the risk relating to Samay showing negative behaviours was known and managed in respect of further risks to Grace.

17.4.4 The Addiction Centre states that nearly 80% of domestic violence crimes are related to the use of drugs<sup>29</sup>. All types of domestic violence originate from one person's desire for control and power over another. When a person abuses drugs, as Samay did, the chemicals in his brain would have been rewired to seek out substances despite any future consequences of behaviour. This can result in irrational, violent or controlling behaviours within a relationship.

17.4.5 The assault in August 2017 identifies such behaviours by Samay. He was so angry that Grace had accidentally thrown the drugs away, he beat her, he made her get money to fund his drug habit and made her drive him to buy further drugs.

17.4.6 Professionals and the wider community need to understand the relationship between drugs and domestic abuse in order to best protect victims. Drug testing as part of being released under licence (RUL) should be robust and acted upon if a perpetrator proves positive with the inclusion of extra safety planning for a victim.

#### **17.5 Effective record keeping by agencies of information about a victim and perpetrator of domestic abuse**

17.5.1 Very little information was provided by Grace's GP despite a request for an IMR. The only information provided was a statement by the GP as part of the criminal investigation relating to the incident in August 2017 and a list of dates of when Grace visited for various ailments, including the deterioration of mental health following the incident in August 2017. From information provided it is not possible to identify if there was any enquiry around the support that Grace was receiving from other agencies and whether there were any further routine enquiries about how Grace was coping.

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<sup>29</sup> [www.addictioncenter.com](http://www.addictioncenter.com)

17.5.2 Domestic Homicide Review (DHR) Case Analysis 2016 (on behalf of Standing Together, Sharps-Jeffs and Kelly)<sup>30</sup> identified GPs are sometimes the only stakeholder group that a victim and perpetrator were involved with.

17.5.3 GPs need to be reminded of the importance of good record keeping and also that it is good practice for a GP to make a routine enquiry about domestic abuse. This was identified as a recommendation in ESSCP DHR Marie 2024 and therefore should be already being implemented.

17.5.4 The Probation IMR author also identified that record keeping by various OMs was not as thorough as it should have been. There was no structured approach to the recording of information and hence critical issues relating to Samay may have been omitted, which may have affected risk management planning relating to his release.

17.5.5 Robust and structured record keeping by agencies is required to ensure appropriate information can be reviewed and shared to provide a holistic overview of the issues a victim may be experiencing or to ensure appropriate management of a perpetrator.

17.5.6 If agencies are also needing to learn from such as tragedy as Grace, then information needs to be readily available so all agencies can respond to such learning.

### **17.6 Professionals to have the tools and confidence to use professional judgment when assessing risk**

17.6.1 Professional judgment can be defined as:

“Applying knowledge, skills and experience, in a way that is informed by professional standards /knowledge and ethical principles, to develop an opinion or decision that should be done to best service someone, a victim or client.”<sup>31</sup>

The judgment allows professionals to utilise their understanding of the context the situation, the victim, their professional knowledge, and training to identify concerns and take relevant action.

The key aspects of professional judgement are:

- Knowledge: training, academic knowledge, practical experience, evidence-based practice.
- Professional obligation: assessing the risk and Ethics
- Victim’s input
- Experience: Professionals using their knowledge, skills, and values of which little can be taught.

17.6.2 The CGL IMR author identified that when the agency received the SCARF referral which had been assessed as medium, then on reviewing the violence towards Grace, this should have been assessed as high and referred to a MARAC to reflect the severity of the incident. This would have enabled a multi-agency discussion and shared information.

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<sup>30</sup> [www.standingtogether.org.uk](http://www.standingtogether.org.uk) DHR Case Analysis Sharps-Jeff and Kelly 2016.

<sup>31</sup> [equation.org.uk](http://equation.org.uk) Briefing note on the use of Professional Judgement when completing the DASH RIC.

17.6.3 Professionals should be emboldened by agencies to use their professional judgment to safeguard victims. All agencies should be respectful of each's others decision making but they should also welcome challenge to ensure the best support for victims of domestic abuse.

### **17.7 Ensure that existing mechanisms for a multi- agency response to support and safeguard a victim are used or consider an updated community response model**

17.7.1 A MARAC provides the mechanism for a multi-agency response in supporting a victim of domestic abuse. The DHR has already identified that Grace's case was not referred to a MARAC as the DASH was rated medium and therefore did not meet the required threshold. The CGL IMR author identified that practitioners should be able to use their professional judgement to refer Grace's case to a MARAC if they view the risk to a victim as high. In the case of Grace, the risk should have been challenged considering the severity of the assault with robbery and the lack of a protective order following the assault/robbery, including no bail conditions and no civil orders in place to protect Grace.

17.7.2 A MARAC would have provided an opportunity for a multi- agency response to support Grace in a holistic way, understanding her needs and what was happening including ongoing contact between Grace and Samay.

17.7.3 Several Community Safety Partnerships have developed a coordinated community response (CCR) to domestic abuse which brings services together to ensure local systems keep survivors safe and hold abusers to account and prevent domestic abuse. A CCR is designed to bring services together including housing, health, social care, education, criminal justice, and communities together to ensure local systems keep survivors safe, hold abusers to account and prevent domestic abuse. Standing Together Against Domestic Abuse, who pioneered the CCR model, updated guidance in 2020 "In Search of Excellence" and have highlighted that domestic abuse is every agency's business and that every agency who has a responsibility for working with domestic abuse must work effectively with other agencies to support victims and their children and hold perpetrators to account. A CCR should be developed locally and locally owned so it reflects the community it serves, a CCR should be more than just a crisis response, it should have good governance and be trauma informed.

17.7.4 East Sussex's model for multi-agency support for victims of domestic abuse is the MARAC. To ensure victims of domestic abuse are referred to a MARAC and therefore supported appropriately, there is the need to remind agencies that professionals should be encouraged to use professional judgement in referring cases to MARAC that have been assessed as medium risk and are confident in doing so.

### **17.8 Trauma-based approach by professionals to supporting victims of domestic abuse**

17.8.1 An accepted definition of trauma is an event, series of events or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening and can have lasting adverse effects on an individual's functioning, (mental health, physical, social and

emotional).<sup>32</sup> Domestic abuse is a form of trauma and often overlaps with mental health issues, as in the case of Grace she experienced a number of traumas including:

- Break up of her relationship with Chris, her husband and father of Mark and Paul.
- Mark and Paul leaving home for university (Grace was on her own)
- Grace's family still in South America
- Grace's mother being ill and dying in South America and Grace's inability to see her before she died
- Grace's brother being a drug addict and Grace feeling she was unable to help him, a feeling of helplessness.

17.8.2 Research by Safe Lives identifies that when practitioners' approach shifts from "what's wrong with this person (victim)" to "what had happened to this person" helps to understand the behaviour, needs and what support a victim may need.<sup>33</sup>

17.8.3 It is not clear whether agencies developed an overview of what was happening or had happened in Grace's life to understand why Grace remained in contact with Samay (including affection for him), despite what he did to her. Grace was very lonely, she wanted to help Samay with his drug addiction as she could not help her brother and her life events had placed Grace into a very vulnerable position.

17.8.4 Agencies need to understand the impact of trauma on a victim of domestic abuse and how it could adversely impact on their behaviour.

### **17.9 Safe management of release of a perpetrator of domestic abuse**

17.9.1 Samay was released from custody in **May 2019**. The police and CGL were not notified in advance and therefore no pre-planning could be made to support Grace in advance. If information about Samay's release had been provided in advance, this may have provided an opportunity for agencies to review safety planning in advance and shared information around the continued contact between Grace and Samay.

17.9.2 Information provided identified that Grace was contacting Samay whilst in prison and during his RUL. Samay did report the contact made by Grace to the police and Grace was advised not to contact Samay by CGL, the VLO and the police but it would appear that contact still happened. In discussion with Samay, the issue of contact by Grace was highlighted. Samay stated that there were protocols in place to stop him contacting Grace but there were no reciprocal arrangements to stop Grace contacting him.

17.9.3 Also, it has been highlighted that when Samay was released from custody, the police may not have identified Samay as a perpetrator of domestic abuse. Samay's crime would have been recorded as robbery and assault. Grace and Samay, although not living together at the time of the robbery, were in an intimate relationship (Samay did confirm this in the meeting with the independent chair and the Panel member) and therefore such violence should have been

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<sup>32</sup> [www.samhsa.gov/trauma-violence](http://www.samhsa.gov/trauma-violence)

<sup>33</sup> [www.safelives.org.uk](http://www.safelives.org.uk)

identified as Intimate Partner Violence (IPV) and therefore appropriate measures could have been taken to support Grace.

17.9.4 The Panel have welcomed the information that the East Sussex Strategic DA Board have identified the need to have protocols in place to manage the release of a perpetrator of domestic abuse to provide the most appropriate support for a victim. To reinforce and ensure this action takes place, it has been included as a recommendation within this report.

17.9.5 The National Probation Service identified within its IMR and SFOR that it should review its policy and procedure relating to being lead for MAPPAs one cases and the DHR Panel welcomes this. The DHR would also want to remind other agencies who could be the lead agency for a MAPPAs one case, that they should also review their procedures to ensure that their information sharing with other agencies is robust in order to best manage a perpetrator and best protect a victim.

### **17.10 The need for professionals to understand why a victim of domestic abuse stays with a perpetrator**

16.10.1 Grace was viciously assaulted and robbed by Samay and yet she remained in contact and still had feelings for him, resulting in them seeing each other following his release from prison. Professionals may ask why. If professionals are to support victims, they need to understand why a victim may stay in an abusive relationship.

17.10.2 Women's Aid<sup>34</sup> identifies several reasons why victims remain in a relationship with a perpetrator:

- Danger and fear of leaving
- Isolation- perpetrator weakens connections with family. Although Grace remained close to Mark and Paul, they disapproved of the relationship with Samay and therefore she did not speak to them about it. Grace thought she was letting her sons down.
- Shame, embarrassment, or denial
- Trauma and low confidence- Grace had experienced several traumas in her life, she was lonely, and this may have impacted on her confidence.
- Practical reasons- job/finance immigration status.

17.10.3 Although not all the above are applicable to Grace, her sense of loneliness, being flattered, to have attention by someone younger and the need to help and be needed seem to have played a part in Grace continuing in a relationship with Samay. Samay used Grace's loneliness and vulnerabilities to control the situation to ensure he could support his drug addiction.

### **17.11 Understanding by professionals and the wider community of the Domestic Abuse Act 2021**

17.11.1 The Domestic Abuse Bill 2020 was enacted in April 2021, thus becoming the Domestic Abuse Act 2021. The DA Act 2021 provided legislation which better protects a victim of domestic abuse and gives the police and the courts more power to hold perpetrators to account. Although

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<sup>34</sup>[www.womensaid.org.uk/relationships](http://www.womensaid.org.uk/relationships)

the new legislation cannot help Grace, it could help victims in the future. Samay did grab Grace by the throat during the robbery and assault in August 2017. The DA Act 2021 creates a new criminal offence of non-fatal strangulation or suffocation including in cases of domestic abuse. The DA Act 2021 amends the Serious Crime Act 2015, introducing two new sections 75A and 75B, which create the new and specific criminal offence of non-fatal strangulation and suffocation. The courts can now sentence a perpetrator for up to five years in prison for such an offence.<sup>35</sup>

16.11.2 It is imperative that not only professionals and practitioners understand and utilise the new legislation within the Domestic Abuse Act 2021, but also that the wider community have an understanding of what new protections the DA Act 2021 provides to victim of domestic abuse.

### **17.12 Post-review learning**

#### **17.12. 1 Inclusion of Grace's workplace on the DHR Panel**

17.12.1.a The employer was able to provide significant information about Grace and how she was supported in the workplace. The employer also provided information that should have been included in other agency information. As the employer is a multinational company, an employer of significant numbers of staff across many countries, it can highlight domestic abuse in all its forms, provide support to victims of domestic abuse and signpost to relevant agencies. When DHR Panels are being established, they will include the statutory agencies such as the police, health and social care but there is also a benefit to include the victim's employer as they can bring a fresh perspective and challenge to a DHR and, more importantly, review their practices to better support a victim of domestic abuse.

17.12.1.b The Department for Business, Energy and Industrial Strategy launched a review into workplace support for victims of domestic abuse in 2020, with the report being published in January 2021. The report focuses on what best practice looks like and the positive role that employers can play. The report is of benefit to large and small employers, describing how they can best support victims of domestic abuse.<sup>36</sup>

#### **17.12.2 Lack of routine enquiry by GPs**

17.12.2.a. There appears to have been no routine enquiry by the GP in their contact with Grace. Although the GP did support Grace following the assault and robbery by Samay, including preparing a report for the criminal trial, there appears or there are no records of any routine enquiry relating to Grace's broken ribs. As already stated, research has identified that health services, especially GPs, often have the most consistent engagement with victims and perpetrators. In accordance with NICE guidance<sup>37</sup> and CAADA (Safe Lives)<sup>38</sup>, GPs should ask about abuse when a patient presents with accidental injuries (Grace and her broken ribs), a

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<sup>35</sup> [www.gov.uk](http://www.gov.uk) Strangulation and Suffocation Policy Paper- updated 28 July 2021

<sup>36</sup> Department for Business, Energy and Industrial Strategy; Workplace support for victims of domestic abuse January 2021.

<sup>37</sup> NICE National Institute for Health Care Excellence. [www.nice.org.uk](http://www.nice.org.uk)

<sup>38</sup> [www.safelives.org.uk](http://www.safelives.org.uk)

history of psychiatric illness, alcohol or drug dependence, and a history of depression and anxiety.

17.12.2.b. Although CCGs can advise and offer guidance to GP practices about making a routine enquiry with a patient about domestic abuse due to the nature of the health landscape, they have no role in enforcing GPs to make such enquiries. GP practices are small to medium sized businesses whose services are contracted by National Health Services commissioners to provide medical services in a geographical or population area.<sup>39</sup>

17.12.2.c. Lack of routine enquiry by GP practices is a common thread in many DHRs and if there is to be change then this needs to be reviewed at a national and not a local level as CCGs cannot enforce such an action. Evidence identifies that a GP is the best placed professional to make a routine enquiry around domestic abuse and therefore to make significant change, then there should national guidance/legislation to ensure routine enquiry is part of a GP's consultation with a patient.

17.12.2.d. GPs should also be reminded that best practice includes good patient record keeping. The GP information provided for this DHR was very scant and the DHR Panel was informed by the GP that they had very little information relating to Grace. GPs should be reminded that information about a patient may be required for criminal trials, reviews such as DHRs, Safeguarding Adult Reviews and Child Practice Reviews to learn and improve services and support to those who are vulnerable. The DHR Panel understand that GPs, like other professionals, are working in a very pressurised environment but if practitioners are to learn and improve their support for victims of domestic abuse, then information and facts are key to improve support for victims of domestic abuse.

### **17.12.3 Support for professionals involved in domestic homicides**

17.12.3.a. The death of Grace did impact on professionals, especially members of staff in the Probation Service who were directly dealing with Grace and Samay. It is important that agencies consider their duty of care to staff following such a tragedy as the death of Grace. Professionals can feel guilt around the death of a victim and ask if decisions made by the professional impact on the death of a victim, and such experiences are often referred to as vicarious trauma.<sup>40</sup> Agencies need to ensure that they have procedures in place to support professionals and practitioners either through reflective supervision or counselling.

## **18 RECOMMENDATIONS**

The recommendations have been developed in response to the issues identified in this DHR.

### **Local**

### **Communication**

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<sup>39</sup> What are general practices [www.kingsfund.org](http://www.kingsfund.org)

<sup>40</sup> [www.BMA vicariously trauma](http://www.BMAvicariouslytrauma)

### **Recommendation One**

ESSCP to review and update its communication strategy for the wider community to raise awareness about domestic abuse in all its forms including, controlling coercive behaviour, stalking, emotional abuse, and economic abuse. Information also to include the behaviours of a victim and a perpetrator and what is new for the community in the Domestic Abuse Act 2021 and what local support is available.

**Ownership: ESSCP**

### **Recommendation Two**

ESSCP raise awareness with the local community about domestic abuse and older people and to include information about services available for older people.

**Ownership: ESSCP**

### **Recommendation Three**

ESSCP to raise awareness with local businesses about domestic abuse, what it is, how it impacts on employees, what support there is in the local area and how an employer can support a victim of domestic abuse.

**Ownership: ESSCP**

## **Policy and Procedures**

### **Recommendation Four**

The police, probation, and specialist domestic abuse services to review the release process convicted perpetrator of domestic abuse to ensure appropriate safety planning can be put in place by agencies for a victim of domestic abuse. This to include a review of completion of sentencing requirements.

**Ownership: ESSCP, Police, Probation and specialist DA services**

## **Training**

### **Recommendation Five**

For all professionals to participate in training to ensure a full understanding of the Domestic Abuse Act 2021 including legislation which will protect victims of domestic abuse, e.g. non-fatal strangulation.

**Ownership: ESSCP**

### **Recommendation Six**

ESSCP seeks assurance from agencies that professionals/practitioners are provided with the skills/tools/ to use professional judgement and critical challenge to challenge partner agencies in a constructive manner relating to a DASH rating to enable a MARAC referral and therefore a multi-agency response to the needs of a victim of domestic abuse.

**Ownership: ESSCP and agencies involved in the DHR**

## **Multi Agency Response to Domestic Abuse- MARAC**

### **Recommendation Seven**

ESSCP to be assured that agencies are utilising professional judgement for referrals of cases assessed as medium risk into MARAC to ensure that identification of support and multi-agency safety planning is offered to victims of domestic abuse.

**Ownership; ESSCP**

**Other**

### **Recommendation Eight**

All agencies to implement recommendations as detailed in section fourteen and to report only to ESSCP if the agency cannot deliver the action.

**Ownership: ESSCP and all agencies involved in this DHR.**

**National**

### **Recommendation Nine**

The Home Office and the Department of Health to engage with the Primary Care named GP network to promote and embed routine domestic abuse enquiry into GP working culture.

**Ownership: Home Office**

### **Recommendation Ten**

The Home Office with the Department of Business, Energy and Industrial Strategy to deliver a national campaign to promote “Workplace support for victims of domestic abuse” to all businesses and to encourage businesses to have workplace policies to support victims of domestic abuse.

**Ownership: Home Office Department of Business, Energy and Industrial Strategy.**

### **Recommendation Eleven**

The Home Office to consider including in any new updated DHR guidance the benefits (where appropriate) of including the employer of a domestic abuse victim as part of DHR Panel to complement statutory agency responses to domestic abuse.

**Ownership: Home Office**

**Appendix One: Terms of Reference**  
**EAST SUSSEX SAFER COMMUNITIES PARTNERSHIP (ESSCP)**  
**DOMESTIC HOMICIDE REVIEW**  
**DHR Grace**  
**January 2021**

**TERMS OF REFERENCE**

1. This Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.
2. This legislation places a statutory responsibility on organisations to securely share confidential information, which will remain confidential until the panel agrees the level of detail required in the final report for publication.
3. The DHR will strictly follow the ESSCP DHR protocol, which is based on Home Office DHR guidance<sup>41</sup>.
4. The statutory purpose of the DHR is to:
  - I. Establish what lessons can be learned from the domestic homicide regarding how the local professionals, agencies and organisations worked individually and together to safeguard the victims of domestic abuse.
  - II. Identify clearly what those lessons are, both within and between agencies and organisations, how they will be acted on, and what will change as a result through a detailed Action Plan.
  - III. Apply these lessons to service responses including changes to policies and procedures as appropriate.
  - IV. Improving responses to all victims of domestic abuse.
  - V. Prevent domestic homicides where possible in future through improved intra and inter-agency responses for all domestic abuse victims and their children.
5. The agreed timeframe for information to be secured and reviewed is for **from August 2017 to late 2019 (Date of incident)**, unless there have been significant events prior to this. Significant events will include engagement with agencies due to noteworthy medical issues, reports of domestic abuse and other wellbeing issues.
6. The DHR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures (e.g. SCR, SAR? IOPC<sup>42</sup>

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<sup>41</sup> <https://www.gov.uk/government/publications/reviced-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>

<sup>42</sup> *Independent Office for Police Conduct* <https://policeconduct.gov.uk/>

referral, and internal agency disciplinary) may use information from the DHR process to support their investigations.

7. The Panel notes that the DHR process may be suspended as necessary to avoid the risk of activities prejudicial to criminal proceedings. (Criminal proceedings completed Dec 2020, perpetrator guilty of murder, sentence 27 years)
8. In addition, the following areas will be addressed in the Individual Management Reviews (IMRs) and through wider enquiries:
  - a) Awareness and understanding of professionals and the wider community of the potential presence of **coercive and controlling behaviour** and how this may have impacted on the behaviour of the victim and perpetrator.
  - b) Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator e.g. Femicide,<sup>43</sup> men/ women's roles in society, **culture and religion**.
  - c) Whether there were any barriers experienced by Grace or her family /friends and colleagues in seeking support and engaging with professional service providers.
  - d) To consider any agencies or wider community groups that could have had contact with Grace and her family and whether helpful support could have been provided and if so, why this was not accessed?
  - e) Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.
  - f) Whether Grace's welfare and needs were promoted and protected through timely and effective assessment including risk assessment and response to needs identified (this to include information sharing and timely interventions).
  - g) To consider if all relevant civil (including workplace) or criminal interventions were considered and/or used.
  - h) The impact of substance misuse/mental health as a contributing factor in domestic abuse.
  - i) The use of economic abuse by a perpetrator to control a victim.
9. The Panel will critically evaluate and approve the Overview Report, Executive Summary and Action Plan produced by the Independent Chair at the end of investigation prior to it being passed to the chair of ESSCP, which will own the Report and implementation of the Action Plan.
10. As actions and lessons are identified, the Chair will notify the relevant agencies/ local safeguarding boards so that the implementation, monitoring, and review of actions can be commenced as soon as possible.
11. These Terms of Reference may be varied by the DHR Panel as new information emerges.

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<sup>43</sup> [www.womensaid.org.uk/femicide](http://www.womensaid.org.uk/femicide)

## Appendix Two: Serious Further Offence Review

### SERIOUS FURTHER OFFENCE REVIEW

Serious Further Offence reviews are undertaken when an individual who being supervised by either the National Probation Service (NPS) or a Community Rehabilitation Company (CRC) commits a specified serious offence.

In undertaking a serious further offence (SFO) review, the NPS or the CRC must transparently and rigorously review their work and provide an understanding of what happened. The purpose of the SFO review is to:

- review whether all action had been taken as far as could reasonably be expected to manage the risk of harm posed to others by the individual
- identify what – if anything - could or should have been done differently
- analyse why things were done in the way they were done
- establish whether there is learning from the review of the case that requires actions at local or national levels
- ensure that areas for improvement are clearly identified along with how and within what timescale action will be taken and what will be expected to improve as a result
- provide victims with relevant information on how the offender was supervised and where there were shortcomings, how action to drive improvements will be taken
- inform Ministers, HMPPS Chief executive and other HMPPS senior officials and the wider MoJ of noteworthy cases of alleged SFOs.

#### SFO reviews:

- are conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame
- identify and report on systemic, organisational or individual failures, particularly where these may be relevant to the outcome
- highlight notable good practice, recognising that those involved may have taken all reasonable action to manage the offender
- contribute to the continuous improvement of the management of offenders by the MoJ, HMPPS, NPS and CRCs; and
- are undertaken by reviewing managers who are independent of the line management of the case.

## Appendix Three: Multi-agency action plan

### GLOSSARY

<b>Sussex Clinical Commissioning Group</b>	<b>CCG</b>
<b>Domestic Abuse</b>	<b>DA</b>
<b>East Sussex Safer Communities Partnership</b>	<b>ESSCP</b>
<b>Home Office</b>	<b>HO</b>
<b>Sussex Probation Service</b>	<b>PS</b>
<b>Multi-Agency Risk Assessment Conference</b>	<b>MARAC</b>
<b>Department for Business, Energy and Industrial Strategy</b>	<b>BEIS</b>

East Sussex Safer Communities Partnership

	Recommendation	Scope	Action	Lead Agency	Outcomes	Target Date	Completion date	RAG Rating
1	<b>ESSCP to review and update its communication strategy for the wider community to raise awareness about domestic abuse in all its forms including, controlling coercive behaviour, stalking, emotional abuse, and economic abuse. Information also to include the behaviours of a victim and a perpetrator and what is new for the community in the Domestic Abuse Act 2021 and what local support is available.</b>	Local	<ol style="list-style-type: none"> <li>1. ESSCP to review its DA communication strategy and to identify any gaps in information relating to the definitions as detailed in the DA Act 2021 e.g. controlling, coercive behaviour, economic abuse</li> <li>2. ESSCP to review its DA communication strategy and ensure that information about the forms of domestic abuse as detailed in the recommendation are included, ensuring information about perpetrator tactics is incorporated</li> <li>3. Update Communication Strategy as required.</li> <li>4. To include perpetrator tactics and include within multi-agency DVA training inc. coercive control.</li> </ol>	<b>ESSCP</b>	An increase in self-referrals of victims of DA services to specialist DA services and the Police, resulting in increased support and safety for victims of domestic abuse	Sept 22	November 2022 in line with 16 Days of Activism campaign	

**East Sussex Safer Communities Partnership**

	<b>Recommendation</b>	<b>Scope</b>	<b>Action</b>	<b>Lead Agency</b>	<b>Outcomes</b>	<b>Target Date</b>	<b>Completion date</b>	<b>RAG Rating</b>
<b>2</b>	<b>ESSCP to raise awareness with the local community about domestic abuse and older people and to include information about services available for older people.</b>	Local	<ol style="list-style-type: none"> <li>1. ESSCP to develop social media and internal and external communications during key campaigns including 16 Days of Activism, Carers' Week and Safer Ageing Week.</li> <li>2. ESSCP to hold dedicated information sessions for professionals on Hourglass and domestic abuse amongst older people.</li> <li>3. ESSCP to hold public awareness raising events of services available for older people experiencing domestic abuse.</li> <li>4. ESSCP to arrange communications materials on public transport</li> <li>5. ESSCP to raise awareness of Hourglass annual conference and encourage partners to attend and share learning following the event.</li> </ol>	<b>ESSCP</b>	<p>Increased awareness of domestic abuse amongst older people</p> <p>Increased specialist support for older people experiencing domestic abuse</p> <p>Improved safety and reduction in risk to victims of domestic abuse</p>	Dec 2023	<p>December 2023</p> <p>Hourglass conference held on 19<sup>th</sup> March 2024</p>	

## East Sussex Safer Communities Partnership

	Recommendation	Scope	Action	Lead Agency	Outcomes	Target Date	Completion date	RAG Rating
3	<b>ESSCP to raise awareness with local businesses about domestic abuse, what it is, how it effects employees. what support there is in the local area and how an employer can support victims of domestic abuse.</b>	Local	<ol style="list-style-type: none"> <li>1. ESSCP to include in its DA Communication Strategy, awareness rising about domestic abuse with local businesses and to include information about local support available to victims of domestic abuse.</li> <li>2. ESSCP to work with the Sussex Chamber of Commerce and D&amp;B Chambers of Commerce in East Sussex to raise awareness and link businesses to support.</li> </ol>	<b>ESSCP</b>	<p>Increased protective factors for victims of domestic abuse</p> <p>Indicators of abuse are noticed earlier and support offered in a more timely way.</p>	Dec 22 and review Dec 23		
4	<b>The police, probation, and specialist domestic abuse services to review the release process for convicted perpetrators of DA to ensure appropriate safety planning can be put in place by agencies for victims of domestic abuse. This to include a review of completion of sentencing requirements.</b>	Local	<ol style="list-style-type: none"> <li>1. Sussex Police, Probation and CGL Domestic Abuse Service to review present arrangements for release of a perpetrator of domestic abuse and recommend improvements where required.</li> <li>2. Sussex Police, Probation and CGL Domestic Abuse Service to update procedure to include advanced notice of release</li> </ol>	<b>ESSCP</b>	Improved safety and reduction in risk to victims of domestic abuse	Dec 22	December 2022	

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	Recommendation	Scope	Action	Lead Agency	Outcomes	Target Date	Completion date	RAG Rating
			<p>of perpetrator of DA (even where this is not the primary charge), intelligence to be shared about perpetrator/victim of DA.</p> <p>3. Sussex Police and Probation to ensure known perpetrators of DVA are flagged on pre-release data.</p>					
5	<p><b>For relevant professionals identified by agencies involved in this DHR to participate in training to ensure a full understanding of the DA Act 2021, including legislation which will protect victims of DA, e.g. non-fatal strangulation.</b></p>	Local	<ol style="list-style-type: none"> <li>1. Review training programme offered by ESSCP.</li> <li>2. Update training programme to include definitions of all forms of domestic abuse as detailed in the DA Act 2021</li> <li>3. Agencies who provide their own DA Training, to review and update as required to comply with above.</li> <li>4. Update ESSCP as appropriate of changes to individual agency DA training.</li> <li>5. Perpetrator tactics to be included within DVA training package</li> </ol>	<b>ESSCP</b>	<p>Victims are receiving effective support and intervention</p> <p>Professionals will be better equipped to identify and support victims</p>	Jan 23	Jan 2023 – briefings and communications on the DA Act delivered through 2022 and subsequent years	

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	<b>Recommendation</b>	<b>Scope</b>	<b>Action</b>	<b>Lead Agency</b>	<b>Outcomes</b>	<b>Target Date</b>	<b>Completion date</b>	<b>RAG Rating</b>
<b>6</b>	<b>ESSCP seeks assurance from agencies that professionals/practitioners are provided with the skills/tools/ to use professional judgement and critical challenge to challenge partner agencies in a constructive manner relating to a DASH rating to enable a MARAC referral and therefore a multi-agency response to the needs of a victim of DA.</b>	Local	<ol style="list-style-type: none"> <li>1. DA training programmes to include professional judgment and critical challenge in assessing domestic abuse incidents/cases.</li> <li>2. Professionals within ESSCP agencies to be given guidance and training on how to challenge assumptions made by other agencies and how to use their professional expertise to challenge</li> <li>3. Agencies to complete Case Review Audits to consider how professionals are using their professional judgement to ensure best support for a victim of domestic abuse.</li> <li>4. Managers/supervisors to review with practitioners the use of professional judgement and critical challenge in domestic abuse cases in reflective supervision and other appropriate line management mechanisms.</li> </ol>	<b>ESSCP</b>	Increase in effective risk management and safety planning for victims at the earliest opportunity	October 2022	December 2022	

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	<b>Recommendation</b>	<b>Scope</b>	<b>Action</b>	<b>Lead Agency</b>	<b>Outcomes</b>	<b>Target Date</b>	<b>Completion date</b>	<b>RAG Rating</b>
<b>7</b>	<b>ESSCP to be assured that agencies are utilising professional judgement for referrals of cases assessed as medium risk into MARAC to ensure that identification of support and multi-agency safety planning is offered to victims of domestic abuse.</b>	Local	<ol style="list-style-type: none"> <li>ESSCP to review referrals into MARAC via professional judgment within the multi-agency MARAC audit.</li> <li>If appropriate, following the review, make appropriate changes following best practice.</li> <li>Agencies to support professionals in referring cases to the MARAC based on professional judgement through briefings and communications.</li> </ol>	<b>ESSCP</b>	<p>Increased number of referrals via professional judgement</p> <p>Holistic support for Victims of domestic abuse through a partnership approach</p>	April 23	July 2023 upon completion of MARAC audit.	
<b>8</b>	<b>All agencies to implement recommendations as detailed in section fourteen and to report only to ESSCP if the agency cannot deliver the action.</b>	Local	<ol style="list-style-type: none"> <li>Agencies to review their recommendations and report to ESSCP six months after completion of the DHR.</li> <li>Feedback to include how agency recommendations have been implemented, how the actions have been monitored and the outcome/improved support for victims of domestic abuse identified.</li> </ol>	<b>All agencies involved in this DHR</b>	Increased support, safety and reduced risk to victims of domestic abuse	6 months after publication of DHR		

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	<b>Recommendation</b>	<b>Scope</b>	<b>Action</b>	<b>Lead Agency</b>	<b>Outcomes</b>	<b>Target Date</b>	<b>Completion date</b>	<b>RAG Rating</b>
<b>9</b>	<b>The Home Office to consult with the Department of Health on a statutory requirement for GPs to make routine enquiries about domestic abuse when in a consultation with a patient.</b>	National	1. Home Office to discuss with the relevant department the statutory requirement for GP's to make a routine enquiry about DA with adult patients.	<b>Home Office</b>	Improved support and safety for victims of domestic abuse at an earlier stage	2023		
<b>10</b>	<b>The Home Office with the Department of Business, Energy and Industrial Strategy (BEIS) to have a national campaign to promote "Workplace support for victims of domestic abuse" to all businesses and to encourage businesses to have workplace policies to support victims of domestic abuse.</b>	National	1. Home Office and Department of BEIS to consider developing a joint national campaign to promote workplace support for victims of domestic abuse.	<b>Home Office</b> <b>Dept. of BEIS</b>	Improved protective factors for victims of domestic abuse and increased support	2023		
<b>11</b>	<b>The Home Office consider including in any new updated DHR guidance the benefits (where appropriate) of including a domestic homicide employer as part of DHR Panel to complement statutory agency responses to DA.</b>	National	1. Review DHR Statutory guidance to include where appropriate, employers being involved in DHRs including as a Panel Members.	<b>Home Office</b>	Improved learning from DHRs to reduce risk of future DHRs	2022/23		

## East Sussex Safer Communities Partnership

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

RAG rating key:

NOT PROGRESSED

IN PROGRESS

COMPLETE

## Appendix Four: Home Office feedback letter

Interpersonal Abuse Unit  
2 Marsham Street  
London  
SW1P 4DF  
Tel: 020 7035 4848  
[www.homeoffice.gov.uk](http://www.homeoffice.gov.uk)

18 October 2023

Strategic Commissioner for Domestic Abuse  
Sexual Abuse/Violence & VAWG  
County Hall  
North Block, Floor B  
St Anne's Crescent  
Lewes, East Sussex  
BN7 1UE

Thank you for submitting the Domestic Homicide Review (DHR) report (Grace) for East Sussex Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 6<sup>th</sup> September 2023. I apologise for the delay in responding to you.

The QA Panel commended the engagement with Grace's family and the input from wider family and work colleagues, which contributed to reader getting a good sense of Grace throughout the review. The QA Panel also praised the input from third-sector organisations regarding South American women and cultural barriers to disclosing domestic abuse, as well as the inclusion of employer engagement, citing this as an example of good practice.

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 Action Plan would benefit from being more outcome-focused and including review dates. Moreover, the QA panel recommends greater consistency in the Action Plan's numbering system. The QA panel noted there are 10 recommendations in the Action Plan, but the numbering system used looks like there are 11. This is because the Action Plan does not use the number 6 but jumps from 5 to 7.
- The Equality and Diversity sections should consider barriers from all perspectives. The QA panel notes that paragraph 15.5 asks if the victim and her family experienced any barriers to reporting abuse but does not ask if the agencies had barriers to providing services based on protected characteristics.
- The report does not engage with the protected characteristic of age. The victim was 58 and the perpetrator 35, which the QA panel felt was a significant age difference. A consideration of age is important here in terms of accessing any support that the victim might have needed.

## East Sussex Safer Communities Partnership

- The QA Panel suggested amending the Terms of Reference and Section 3 of the Executive Summary to highlight a DHR's role in improving responses to all victims of domestic abuse alongside preventing domestic homicides.
- Paragraph 5 of the Terms of Reference breaches anonymity requirements by revealing the exact date the victim's body was found.
- The QA panel notes the poor record-keeping by GP/primary care. The victim presented to the GP with significant injuries and the Panel notes a routine enquiry regarding domestic abuse was not explored.
- There was a missed opportunity for police to refer to the multi-agency risk assessment conference (MARAC) following Grace's assault and robbery.
- There were missed opportunities to refer the perpetrator on to drug/substance misuse services.
- There was a lack of information sharing between agencies, in particular police and probation.
- There are typographical and spacing mistakes within the report that need to be reviewed.
- The following acronyms are not explained in the body of the report although they are explained in the glossary:
  - "ESFRS", shown as "ESFR" in the Glossary.
  - "HDC"
- The acronym "RUI" is not explained in the body of the report but presents as "RUL" in the Glossary.
- The term "EG300" is not explained in the body of the report or the Glossary.

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](mailto: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](mailto: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,



**Lynne Abrams**

Chair of the Home Office DHR Quality Assurance Panel