DOMESTIC HOMICIDE REVIEW

SAFER WESTMINSTER PARTNERSHIP

Report into the murders of Elizabeth & Ash August 2021

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September 2023

From Elizabeth's daughter:

My Mum was a character, she was funny, incredibly loyal and generous. She was a good friend to Henry and others. She did what she needed to do for me to have a good life and she never tried to mess that up. In her own way - she did what she could for other people. She may have coloured outside the lines but ultimately, she was a good person who was loved by her family and friends.

In life you always think you have more time with loved ones and in this case, I thought I had more time with my Mum. I miss her deeply and the grief this has caused my family is immeasurable.

From Elizabeth's father:

For every parent this situation is their worst nightmare; no parent should have to bury their child, especially in these circumstances. The shock and horror I felt when I opened the door to the police to tell me this news will haunt me for the rest of my days. I still haven't quite recovered from losing my wife in 2019, so the news of losing my daughter only two years later in these tragic circumstances has left me numb. I have just been existing. It hasn't felt appropriate to celebrate any birthdays or Christmas, I haven't put my tree up since as it hasn't felt right to celebrate whilst my daughter wasn't at rest and had no peace…It has been a horrendous few years, losing my wife and daughter so close together. It doesn't feel real that Elizabeth is gone, as my mind will sometimes have me believe she will call. I will always miss her calls. I miss her more than words can describe.

From Ash's sister:

Ash was a pure soul, he was kind, he was gentle, and he was funny, a classy hippy and a precious human being. He was compassionate, he was empathetic, and he was intelligent but most of all he was loved. Just the mention of Ash's name touched that place in your heart and for that moment you only felt kindness and love.

To speak of him in the past tense makes my stomach churn. Goodness has gone. Ash had a great life; he was a qualified dietician chef; he had travelled and lived abroad using these skills. He met people from all over the world that loved him dearly and his unconditional love and kindness for people will be carved in their hearts forever. When he came back to the UK he worked hard and had good friends, then he finally settled down with his childhood sweetheart. Very sadly he recently lost a very dear friend with whom he had stood by through chemotherapy, and the Covid hit. Even then he was helping others by delivering food to the elderly. We will not allow the last year of our brother's life to define him.

He has no convictions and had led a crime free life. What was done to our beautiful brother and what our beautiful family has been put through is indescribable. No words can describe the pain caused, our world shattered and changed forever. We had to tell our elderly, frail mum that her son was dead. The worst thing you could ever tell a parent. We had to watch our mum bury her first born child.

…Ash touched so many lives in so many ways. He shone brightly in this world, but his light was cruelly put out by someone who gave no thought or care to the impact of his actions.

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Preface

The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the deaths of Elizabeth and Ash, and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity, and patience. The contribution of family members and friends has been invaluable in helping the Panel to understand the circumstances leading up to these horrific murders. That they were willing to do so in the middle of grieving their loved one is both humbling and inspiring.

1. Introduction

1.1 Domestic Homicide Reviews (DHRs) came into force in April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

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

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

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

The report uses the statutory definition of domestic abuse set out in the Domestic Abuse Act 2021. This can be found in full at Appendix B.

1.2 The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

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

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

[1] Not her real name
[2] Not his real name

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

f) highlight good practice[3].

1.3. In late August 2021, the Safer Westminster Partnership was notified by the Metropolitan Police of a murder which they believed met the definition of a domestic homicide under the Domestic Violence, Crime and Victims Act, 2004. The Chair of the Safer Westminster Partnership consulted with partners, including local specialist domestic abuse services, and in early September agreed that a DHR should be undertaken. The Home Office were duly notified.

1.4. There followed a significant delay in appointing a Chair and report author. Approaches to individuals and an advert circulated among relevant networks did not identify a suitably qualified and available person. An independent Chair was finally appointed in December 2022, the Home Office updated, and the victims' families informed.

1.5. The Panel met for the first time in February 2023. Further meetings of the Panel were held in April 2023, May, and June 2023. A draft copy of the final report was circulated over the summer and the Panel met for a final time in September to agree the wording of the final report.

1.6. At trial, Darren admitted to the double killing but claimed that Elizabeth's death was accidental, and Ash's was self-defence. The jury did not believe him. In January 2023, Darren was convicted of murder. The following month he was sentenced to a minimum term of 39 years. In his sentencing remarks, the Judge observed that this makes it very likely that he will die in prison.

1.7 After the trial, further contact was made with friends and family members. Some delays took place to accommodate their wishes.

1.8. The DHR process concluded in September 2023.

1.9. Domestic abuse is a key priority for the Safer Westminster Partnership who, alongside the Royal Borough of Kensington and Chelsea, have a joint VAWG Strategy 2021-2026.

It has four strategic objectives:

- providing support for victims
- interventions with perpetrators
- early intervention
- partnership working.

1.10. Domestic abuse is also a priority for Westminster City Council (WCC), and together with LB Hammersmith & Fulham and the Royal Borough of Kensington and Chelsea, commission domestic abuse support services. These include:

- the Angelou services[4], which comprises ten specialist 'by and for' agencies led by Advance

[3] Home Office, (2016) "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews", https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf
[4] https://www.angelou.org/our-services

- co-ordination of the MARAC via Standing Together Against Domestic Abuse[5]
- refuges delivered by Refuge[6]
- the Restart Service[7]
- For Baby's Sake[8]
- Safe and Together[9]
- The Freedom Programme[10]
- Some counselling via Women's Trust[11]
- two new perpetrator services which started in July 2023: the Drive Partnership[12] and the CIFA (Culturally Integrated Family Approach[13])

2. Overview

2.1. Persons involved in this DHR

Pseudonym used	Who	Age at the time of the incident	Ethnicity
Elizabeth	Victim	46	White British
Darren	Perpetrator / victim's partner	49	White British
Athena	Victim's daughter	-	Dual heritage: Jamaican & British
Henry	Victim's long-time friend and landlord	65	White British
Ash	Victim	59	White British

2.2. Summary of the incident

2.2.1. On a Thursday in August 2021, the police received a call from Darren's father at approximately 9.30pm. He told the call handler that his son had just left his house after confessing to killing three people. Police attended the father's home. Their arrival was observed by Darren, so he knew that his father had informed the police. Darren had arrived at his father's house with a black kitten in his backpack – a cat that would be later identified as belonging to Elizabeth.

2.2.2. Officers were dispatched to Elizabeth's address to check on the welfare of the occupants. Entry was forced to the property at approximately 10pm and the only occupant discovered at that time was Henry, the largely bed bound tenant. He confirmed that Elizabeth lived there as his lodger but said he hadn't seen her since Wednesday evening when her and Darren had had *'a big barny'*. He recalled Darren calling Elizabeth '*a lazy cow'* and Elizabeth shouting at him to '*Get out! Get out!*'. Darren had earlier been rolling cigarettes for Henry which he thought *'tasted funny'* and it is possible, although not proven, that he was deliberately drugged by Darren. Upon searching Henry's flat, police officers located a large amount of blood in the

[5] https://www.standingtogether.org.uk/
[6] https://refuge.org.uk/

[7] https://cranstoun.org/help-and-advice/domestic-abuse/restart/
[8] https://www.forbabyssake.org.uk/
[9] https://www.respect.uk.net/pages/147-work-with-safe-together
[10] https://www.freedomprogramme.co.uk/
[11] https://womanstrust.org.uk/
[12] https://drivepartnership.org.uk/
[13] https://www.rbkc.gov.uk/newsroom/ps15m-funding-help-encourage-abusers-domestic-abuse-change-their-behaviour-and-reduce-reoffending

room ordinarily occupied by Elizabeth. Her lifeless body was eventually located under the bed. Her throat had been cut.

2.2.3. A murder investigation commenced, and searches were completed at several other addresses to try and locate Darren.

2.2.4. At 2.15am, the police were contacted by London Ambulance Service (LAS) to say they were tending to a male (later identified as Ash). LAS had been contacted by a woman who had attended Ash's flat and found him with his throat cut. She stated that she had last seen Ash alive a few hours previously. Police quickly linked the two murders due to Darren's confession to his father the day before.[14]

2.2.5. A manhunt ensued. A week later, in response to intelligence received, police officers attended a houseboat on the Grand Union Canal in LB Ealing. Darren was located on this houseboat. He produced a blade and cut his neck before being restrained by officers. Emergency medical assistance was sought from LAS and Darren was transported to St Mary's Hospital where he underwent emergency surgery which he survived. Officers searched the houseboat and seized a number of items including several handwritten notes referencing the murders of Elizabeth and Ash.

2.3. Summary of agency contact.

All of the agencies listed below were asked to complete both a chronology and an IMR.

Service / Agency	Summary of Involvement
Westminster City Council (WCC) Adult Social Services	Darren was referred to Adult Social Services in 2016 following a head injury sustained after he fell down a lift shaft whilst committing a burglary. After an assessment, the case was closed as all his needs were being met. There was one telephone contact in with Ash in January 2021, regarding a foodbank referral. He reported a history of depression, which had worsened during lockdown, but his GP was aware and had prescribed anti-depressants. A befriending service referral was made. Elizabeth was known to be a carer for Henry and was supported in this role by ASC. She received carer's assessments in September 2018, August 2019 and March 2021 with other occasional contacts in person and by email/telephone to process Direct Payments.
Westminster City Council Housing Service	Henry was a tenant of WCC Housing Services and Elizabeth his lodger. Ash was also a tenant of WCC Housing Services.

[14] Darren confessed three murders to his father but at the time of the confession had only committed one. He would go on to commit this second murder in the immediate hours after leaving his parent's house. He had a plan in mind to murder more people but did not, in the end, manage to complete this.

Service / Agency	Summary of Involvement
Westminster City Council Housing Solutions	Homeless applications were made by Elizabeth. Darren was being housed in temporary accommodation at the time of the murders. There is no recorded contact with Ash.
National Probation Service	Darren has a long offending history of mostly acquisitive and dishonesty offences although he also had convictions for possession of a bladed article (2004), battery (2006) involving the assault on a hotel staff member, criminal damage (2007) and racially aggravated / threatening behaviour (2008). After 2008 he was convicted for 14 burglaries and on 12 counts of theft. His final conviction before the murders was in 2020 for burglary for which he received a sentence of 40 months. Darren was released early from prison on Home Detention Curfew in February 2021 but subsequently recalled for a breach in March 2021. His sentence ended in June 2021, and he was released and housed by WCC.
Westminster City Council Public Protection & Licensing	The property (address 1) where Elizabeth was discovered had been subject to numerous unsubstantiated complaints of anti-social behaviour (ASB) which were subject to ongoing investigations. In the course of managing these complaints, there were various interactions with Elizabeth and Darren, although neither were Westminster City Council tenants. There were 13 contacts with Elizabeth between June 2017 and August 2021 and three contacts with Darren between October 2018 and August 2021. There was contact with Ash on matters unrelated to those described above. He made various requests for repairs to his home address and an ASB report was made by him on 30 April 2019 regarding allegations of drug dealing near his property. This was closed on 20 May after interventions by the ASB team.
Westminster City Council Housing ASB Team	
Turning Point: Drug & Alcohol Wellbeing Service (DAWS)	Darren and Elizabeth were both known to DAWS since 2018 and Elizabeth was engaging regularly (every four weeks) with the Shared Care Scheme. This is when a Substance Misuse Provider (in this case Turning Point) works together with a GP to provide treatment; the GP prescribes, and Turning Point provides the additional wrap around support. Darren was referred through the prison release system into the same scheme, but his continuity of care was interrupted by his frequent returns to prison.
Metropolitan Police	Officers carried out weekly welfare visits to Henry's property, where Elizabeth was also living and attended to numerous reports of ASB. There was also extensive historical involvement with Elizabeth and Darren.

Service / Agency	Summary of Involvement
London Ambulance Service	Over the period of January 2019 to August 2021, the London Ambulance Service had eight contacts with the subjects of this DHR.
Integrated Care Board (GP's)	Elizabeth was registered with her GP for over 20 years. Elizabeth was on oral substitution therapy[15] and was managed under shared care arrangements by her GP and the allocated shared care worker employed by Turning Point.

2.3.1. It is worth noting that much of the recorded agency contact is tangential to this DHR.

2.3.2. There was extensive contact with Henry due to his personal care needs and as his lodger, glimpses of Elizabeth are occasionally evident in these records despite her not being the primary reason for agency contact. Nevertheless, Adult Social Care (ASC) worked closely with Elizabeth from September 2018 onwards. During that time, ASC completed three formal carer assessments and the outcome of those assessments led ASC to provide Elizabeth with carers personal budgets to support her role in caring for Henry. Due to the progressive nature of Henry's illness, Elizabeth's involvement as a hands-on carer decreased over this time, but Henry very much wanted her to remain involved as an informal carer. Henry often said he viewed Elizabeth like a daughter, so she continued to help with things such as domestic tasks, shopping and financial management.

2.3.3. The housing estate, and specifically Henry's flat and its occupants, forms the backdrop to a prolonged and escalating dispute between the block's Residents Association on the one hand and Westminster Housing and the police on the other. From 2018 onwards[16], there were escalating complaints, from the Resident's Association about activities they alleged were taking place at Henry's flat. These included the flat being used as a drugs den, leading to '*a never-ending stream'* of anti-social behaviour, including openly illegal drug dealing, prostitution, drug taking in bin rooms, and other criminal activity. Despite extensive and regular investigations, none of the complaints were substantiated and there is some evidence to suggest that at least some of the activities, whilst occurring, did not involve Henry's flat or its residents. These events provided useful context for the Panel but are not reported on here in any detail except where relevant to the circumstances surrounding the murders.

3. Parallel reviews

3.1. At the start of the DHR process, the coroner was notified that a DHR was taking place. An inquest was opened and then suspended pending the outcome of criminal investigations. It has not been resumed.

3.2. When police officers located Darren on the houseboat, he injured himself quite severely. As a consequence, the matter was referred to the Independent Office for Police Conduct. The investigation was solely around the actions and decision making

[15] OST involves substitution of injecting opioid drugs with oral medication that effectively minimises craving and withdrawals, and thereby enables Intravenous Drug Users to stop injecting drugs.
[16]The Resident's Association claimed this had been going on for ten years, but this is difficult to substantiate.

of officers involved in the manhunt and arrest. The IOPC concluded their findings in September 2021 which were:

- No criminal behaviour, misconduct or discipline was identified
- No organisational learning was identified

3.3. Two post-mortems were carried out. The cause of death for Elizabeth was a long and deep slash wound to the left side of her neck. The cause of death for Ash was also a long slash would to the left side of his neck.

3.4. A criminal trial took place concluding in February 2023.

3.5. The National Probation Service undertook a Serious Further Offending Review. The final report was submitted to the DHR Panel in lieu of an Independent Management Review[17] albeit that it was subjected to scrutiny to ensure that it met the DHR key lines of enquiry (see section 6 for more detail on these).

4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following:

Name	**Title**
Davina James-Hanman	Chair and Report Author
Grace Lauchlan	Minute taker
Amanda Gow	Head of Tamar, Tamar
Anna Robinson	Professional Safeguarding, Imperial College Healthcare Trust
Chris Shoubridge	Divisional Head of Housing Neighbourhoods, Westminster
Delyth Shaw	Strategic Safeguarding Adults Manager, Bi Borough
Hugh Constant	Safeguarding Operational Manager, Bi Borough
James Breed	Homelessness Commissioning Manager
Janet Durrant	Community Safety Manager, Westminster Housing
Jennifer Peckett	Operations Manager, Turning Point
Jessica Whittock	Domestic Abuse Coordinator, Chelsea & Westminster Hospital Trust
Julie Ryan	Substance Misuse Safeguarding Manager, Turning Point
Kathryn Hunt	Head of Service, Brent PDU, National Probation Service Probation Service
Kylie Rowsthorne	Service Manager, Advance Charity

[17] This is a single agency report, detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation.

Manju Lukhman	DHR Support Officer, Bi Borough Violence against Women and Girls Strategic Lead
Mark Dronfield	Operations manager, Turning Point
Musthafar Oladosu	Designated Professional for Safeguarding Adults, Bi Borough ICB
Natalia Croney	Safeguarding Specialist London Ambulance Service
Nicky Crouch	Director of Family Services, Westminster
Ross Harvey	Housing Needs, Westminster
Sally Jackson	Partnership Manager, Standing Together
Sally Pattison	Specialist Case Review Team, Metropolitan Police

4.1 DCI Wayne Jolley from the Specialist Crime Team (South), Metropolitan Police attended the first Panel meeting as the senior Investigating Officer in this case.

4.2. Expert advice was provided on domestic abuse by Advance and Standing Together. Expert advice was provided on the impacts of involvement in prostitution by Tamar.

4.3. The Panel met in February 2023, April, May and June. There was then a break to allow for the final report to be drafted and to take account of summer holidays. The Panel met for a final time in September 2023 to discuss the draft report. Although the Panel did not meet again after that, there was some email correspondence including the circulation of a revised final report to take account of Panel discussions.

5. Independence

5.1. The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. She has not previously undertaken any DHRs in Westminster City Council nor is she associated with any of the agencies there.

5.1.1. Davina is an experienced DHR Chair and is nationally recognised as an expert in domestic abuse having been active in this area of work for almost four decades. Further details are provided in appendix C.

5.2 All Panel members and IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact.

6. Terms of Reference and Scope

6.1. The full terms of reference can be found at appendix A. The key lines of inquiry were as follows:

1. Each agency's involvement with the following people between January 2019 and August 2021:

(a) Elizabeth, a lodger at address 1 (where Henry, the tenant, also lived)

(b) Ash, resident at address 2

(c) Darren, officially resident at address 3 but often staying at address 1

2. Whether any improvements are needed in communication and information sharing between services.

3. Whether responses to each of the subjects of this DHR were consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols.

4. The response of the relevant agencies to any referrals relating to the subjects of this review concerning domestic violence or other significant harm. This should include an analysis of any assessments, decision making, referrals and whether appropriate services were offered/provided and whether these responses were informed, professional, timely and effective. Were thresholds for intervention appropriately calibrated, and applied correctly? Are these adequate when a client is experiencing multiple issues?

5. Were there any missed opportunities to enquire about domestic abuse? Was your agency aware of the other issues facing the subjects of this DHR and if so, what actions did you take in relation to these?

6. Was the (alleged) perpetrator effectively managed and what forms did this take?

7. How accessible were services for the victims and the (alleged) perpetrator? What might have made a difference in terms of increasing their engagement with services?

8. Whether practices by all agencies were sensitive to the nine protected characteristics of the DHR subjects and whether any special needs or vulnerabilities were explored, shared appropriately and recorded. Please provide evidence for your assertions.

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

10. What learning can be identified from this case? What changes would you suggest to avoid such tragedies occurring in the future?

7. Confidentiality and dissemination

7.1. Throughout the process of undertaking the DHR, findings were restricted. Information was available only to participating officers/professionals and their line managers, until after the Review had been approved for publication by the Home Office Quality Assurance Panel. Members of the victims' families were offered sight of a copy of the report (see section 9 for more detail) and their feedback has been incorporated into this report.

7.2 As recommended within the '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* to protect the identities of those involved, pseudonyms – chosen or approved by family members - have been used and precise dates obscured.

7.3 The Executive Summary of this report has also been anonymised.

7.4 Subsequent to permission being granted by the Home Office to publish, this report and the executive summary will be widely disseminated to key local statutory and partnership boards including, but not limited to:

- Safer Westminster Partnership
- Bi-Borough VAWG Strategic Board
- Risk and Review Group
- Safeguarding Adults Case Review Group
- DHR Panel members
- Safeguarding Adults Board
- The coroner
- The Domestic Abuse Commissioner
- The Senior Investigating Officer for the criminal trial
- Friends and family who participated in this Review.

7.5. The reports will also be shared with the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC).

7.6. Once permission is granted by the Home Office to publish, the recommendations will be owned by the commissioning body (Safer Westminster Partnership). They will be responsible for monitoring progress on implementing the action plan by the bi-Borough[18] VAWG Strategic Board.

7.7. A one-page learning summary will be created for professionals and used to aid learning across the partnership. Learning will be further incorporated into local VAWG training programmes.

7.8. All local DHRs are published on a permanent hyperlink on Domestic abuse and violence against women and girls | Westminster City Council

8. Methodology

8.1. An initial scoping exercise established that seven agencies had had significant contact with one or more of the subjects of the DHR. These agencies were asked to secure their records and to produce chronologies and an Individual Management Review (IMR) (see paragraph 2.3 for a list).

8.2. The flat where Elizabeth was residing was at the centre of a long running dispute between the Resident's Association and Westminster City Council Housing. Papers relating to this dispute were also made available to the Panel.

8.3. After the trial had concluded, permission was sought – and granted – for statements gathered in the course of the criminal investigation to be made available. Family members generously allowed the Panel access to their Victim Impact Statements. Extracts from these appear at the start of this report.

8.4. A rapid review was also undertaken to ensure that all participating agencies had relevant and up to date polices in place, that training was being provided to staff and that there was appropriate participation in local partnerships designed to address domestic abuse. The results of these 'spot checks' were compiled and circulated to the Panel and a copy of this is included at appendix D.

[18] This is a partnership between Westminster City Council and the Royal Borough of Kensington & Chelsea

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

- The reports detailed above
- The Police Senior Investigating Officer
- The criminal trial
- DHR Panel discussions, enhanced by expert input (see Panel membership above)
- Friends and family of the victim

9. Involvement of family and friends

9.1. The family of the victim were informed about the commencement of the DHR and invited to participate with a variety of options presented. As the criminal investigation was still on-going at this point, initial contact was made through the Victim Support Homicide Caseworkers. The family were sent a copy of the draft terms of reference and invited to comment on them. They were also provided with the relevant Home Office leaflet and information about AAFDA[19].

9.2. Once criminal proceedings had concluded, the Chair recontacted the families of the victims and invited their participation a second time. Ash's sister. Elizabeth's daughter, Elizabeth's brother and Elizabeth's father all participated.

9.3. The Chair also spoke to Henry, the tenant of the property in which Elizabeth lived as his unofficial carer.

9.4 Darren was offered the opportunity to participate but no response was received.

9.5. Darren's parents were contacted and asked if they would like to participate. They initially expressed interest but asked for a short delay. Follow up contacts did not generate a response.

9.6. A draft copy of the final report was provided to all family members listed above prior to submission to the Home Office.

10. NARRATIVE CHRONOLOGY

BACKGROUND

10.1. This case involves the double killing of Elizabeth and Ash at the hands of Darren, which took place over two days in August 2021.

10.2. Elizabeth was aged 46 when she died. She had a child, Athena, when she was 22 years old and moved to London with the child's father a couple of years later. They found it difficult to find suitable accommodation and employment and felt this wasn't a good environment for a child. When she was around three years old, they took her back to her grandparents in Yorkshire. This was initially intended to be a temporary arrangement but ended up being permanent, so Athena was raised by her grandparents into adulthood. Elizabeth visited her parents and her daughter in Yorkshire, and in turn, they would come to London several times a year to meet with Elizabeth. Elizabeth was particularly close to her mother who never gave up on her and always hoped that she would overcome her problems. Elizabeth's mother passed in

[19] AADAFA provide expert peer support to family members in the aftermath of a domestic homicide. www.aafda.org.uk

2019. Elizabeth was a user of class A drugs and had been involved in prostitution but her arrests for the latter ended in 2013 after she moved in with Henry. When Elizabeth moved in with Henry, her family thought this was a very positive move as it seemed to give her a degree of stability and he treated her like a daughter.

10.3. Elizabeth was an informal carer for Henry, a man who at the time of the murders was aged 65 and had Multiple Sclerosis. Henry has complex care and support needs and is wheelchair dependent, having to spent long periods of time resting in bed. Henry held a tenancy in a block of flats and Elizabeth had lived informally with him for approximately eight years, although she was not on the tenancy. Henry had a formal package of care commissioned by Westminster Adult Social Care (ASC) which consisted of multiple daily visits. The level of support ASC provided increased as Henry's condition deteriorated. This meant that in the last couple of years, Elizabeth provided less care but in line with Henry's wishes, continued to provide support with domestic tasks, meal preparation and financial management.

10.4. Henry and Elizabeth had originally met about 15 years previously near a hostel in Kings Cross. Over time they became friends, and she started doing odd jobs like cleaning for him. They both originated from Yorkshire which was part of their bond and Henry had a daughter of a similar age to Elizabeth. Henry considered Elizabeth his 'next of kin' and she looked after all his money. Henry had made a decision that he wanted Elizabeth to fully manage his finances. Social workers had discussions with Henry about this at reviews and one review had documented that the arrangement was 'chaotic' at times, but Henry clearly had capacity to make this decision even if unwise. There was no evidence in agency records, therefore, that Henry had ever been subjected to financial abuse by Elizabeth. After the homicides, however, Henry told police that Elizabeth took advantage of being in charge of his money, but he had not said anything as it was easier than having rows and he never went without.

10.5. Elizabeth's boyfriend, Darren, also lived there sometimes over this period. Henry didn't care for him very much but kept his counsel out of respect for Elizabeth. Darren kept offering people a place to stay in his flat (without Henry's knowledge or permission) so random people would turn up with an expectation they could stay.

10.6. Elizabeth and Darren met around 2007 when they were both in rehab and they went on to form a long-standing on/off relationship which was also interrupted by periods of Darren being incarcerated. Elizabeth would visit Darren in prison when he was serving a sentence[20] although this changed in 2021. After Elizabeth was murdered, lots of letters from Darren to Elizabeth were found among her belongings. These were often very toxic (*No-one will ever love you like I do* / *You can't live without me* etc) alongside lots of him begging her for forgiveness. This is very suggestive of coercive control[21] which is a form of entrapment whereby using a toxic mix of isolation, manufactured dependence, the threat of violence and intimidation, an abuser ensnares a victim in his clutches.

10.7. Both family and friends commented on how they experienced Darren as very manipulative and controlling although he could also be very charming. Athena described how sometimes when she visited her mother, Elizabeth would end the visit by saying '*I've got to go now, Darren will be waiting'*. If she didn't leave, her phone would blow up with constant texts and calls until she answered. Another example is that Elizabeth was a natural redhead and she used to have gorgeous long hair. After

[20] Obviously, this does not include periods when pandemic restrictions were in place.
[21] A specific criminal offence since 2015 carrying a maximum sentence of five years.

she met Darren, however, it was always short and blonde as *'Darren prefers it that way'*. Elizabeth often made positive progress when Darren was incarcerated, switching to methadone and vastly reducing her illegal drug intake. Both friends and family members commented that Elizabeth always looked much better – happier and healthier - when Darren was in prison.

10.8. Elizabeth's family members met Darren on a number of occasions. When Elizabeth's mother was dying, both her daughter and her brother described how Darren was promising her that he would take care of Elizabeth, but both felt this was a performance rather than genuine. Elizabeth's father never thought the relationship would last as Darren really dominated Elizabeth and he didn't think that was a good basis for a long-term relationship. Whilst Darren's coercive and controlling behaviour towards Elizabeth was evident to family and friends, it remained invisible to professionals with one even recording that in their view, it was a co-dependent relationship. Henry also claimed that Darren was physically abusive to Elizabeth. He never actually witnessed this, but Elizabeth would regularly show him bruises which she said had been caused by Darren. They were always on parts of the body where bruises don't show (e.g., back and kidneys). Like many domestic abuse perpetrators, he never touched her face[22].

10.9. Ash was 59 when he died. His friend Leah[23] had been staying with him for a couple of weeks as her granddaughter had appointments at a local hospital. She said that she and Ash '*had loads of things in common like travelling and food'* and that he was always nice to her. Ash was a qualified dietician and was very well travelled. He previously lived with his partner and his three stepchildren. He was a father figure to the family and was a stepfather for 15 years. In January 2021, Ash was referred to Octavia Older People Befriending service by Adult Social Care as he was experiencing low moods and depression, which had been exacerbated by the lockdown and a breakup with his partner. Leah said that Ash was a friendly person who disliked confrontation and even when he was on drugs, he *'never raised his voice at anyone'.*

10.10. When she stayed with him, she would help out with household chores like cooking and cleaning. She added that Ash lived quite a '*lonely life'* and did not have many other visitors or friends and family nearby, although he did call his mother every day. Leah said that Ash was a recovering alcoholic and she believed he had stopped drinking the previous Christmas. She said he took crack cocaine '*sporadically'*.

10.11. Ash's friend John[24], who discovered Ash's body with Leah, lived on the same landing as Ash for the previous five years. The two men had grown up together, attending the same schools and John regarded Ash as '*one of my best friends who I could always rely on'*. They saw each other '*on a daily basis'*, visiting each other's flats. Ash had been unemployed for nine months since he was involved in an accident which injured his back. John and Leah had known each other for ten years and also considered each other '*good friends*.' According to John, most of his friends were drug users. John had also known Darren for ten years, considered him a good friend and thought that he dealt drugs.

[22] Whilst injuries to the head and face are the strongest indicators of domestic violence, injuries to the arms and legs also present good opportunities for detection. These kinds of fractures are *more* common in domestic violence victims than facial or head injury but are more likely to be overlooked. See for example: https://doi.org/10.1148/radiol.2019180801

[23] Not her real name.
[24] Not his real name

10.12. Ash and Darren knew each other according to police reports as *'part of the same social group'* but the exact nature of their relationship was unclear. It seems likely, however, that it was drug related. Darren variously believed, seemingly without evidence, that Ash was a dealer, that he had introduced Elizabeth to dealing while Darren was in prison, and that Elizabeth and Ash had been having an affair. Ash's friend Leah, who knew all the parties concerned well, denied that there was any romantic involvement, despite Darren's apparent jealousy about their relationship. Leah maintained that Ash merely felt sorry for Elizabeth because of her circumstances and there is some suggestion that Elizabeth may have seen him as a possible solution to her housing problems, viewing him, like Henry, as a kind of father figure.

10.13. Darren was 50 at the time of the homicides. He was a trained carpenter, a drug addict, had mental health difficulties and was a prolific burglar with 16 convictions for 52 offences. He had served several prison sentences and committed a significant number of offences while out on bail. He was incarcerated for 20 out of 32 months of the review period.

CHRONOLOGY OF EVENTS FROM JANUARY 2019 ONWARDS

10.14. As mentioned above, there was a background of continuing allegations of anti-social behaviour (ASB), largely unproven, centred on the flat for which Henry held the tenancy but shared his residence with Elizabeth, and also occasionally Darren, throughout the period covered by this review. Throughout these allegations, the ASB Team undertook a number of in-depth investigations and implemented a number of risk mitigation actions which largely failed to satisfy the Resident's Association. Henry, who was deemed vulnerable and a possible victim of cuckooing[25], was warned about ASB and twice offered alternative accommodation, which he refused as he did not want to make Elizabeth homeless. Concerns about cuckooing were thoroughly explored and were eventually ruled out. Housing ASB staff had a total of 13 direct contacts with Elizabeth. There were no disclosures of domestic abuse.

10.15. In early 2019 Elizabeth was complaining to her GP about the way Darren was treating her, saying he was verbally abusive. She appeared 'very underweight' and admitted to taking both heroin and crack, often together. When she attended an appointment with Darren (they often seemed to go around together), her GP noted: '*not good consultation wise as I feel that she wants to talk more but holding things back'.* Elizabeth was offered further support with her relationship, but this was declined. She was also offered – but declined - residential rehab treatment.

10.16. in March, following renewed complaints of ASB involving the flat, the police attended. Henry told police that whilst Elizabeth and Darren supported him, he felt '*uneasy'* about the situation and wanted to live on his own. At the same time, he maintained that he did not want to make Elizabeth homeless. He stated that '*many people'* visited Elizabeth throughout the day and he believed them to be friends; he added that he was '*not bothered*' by the people who visited and that the visits did not last long. Later Henry and Elizabeth would deny that strangers were coming to the flat, attributing disturbances to people, possibly rough sleepers, always trying to access the building.

10.17. In early April 2019, Darren was arrested for an alleged theft and recalled to prison for breaching conditions. He was released on license a couple of weeks later but

[25] Cuckooing is a term used to describe a situation where the home of a vulnerable person is taken over by a criminal in order to use it to deal, store or take drugs/ stolen property, facilitate sex work, as a place for them to live, or to financially abuse the tenant. It takes the name from cuckoos who take over the nests of other birds.

rearrested in the summer for an alleged burglary. After a police interview, no further action was taken due to '*conflicting evidence'*.

10.18. The father of Athena made contact around this time. He had been a victim of the Windrush scandal and was deported to Jamaica in 2013. He made contact asking for money and Elizabeth sent him some. When Darren found the receipt, he flew into a rage, exhibiting extreme jealousy even though Elizabeth hadn't seen him for six years at this point and he wasn't even in the same country.

10.19. In the summer of 2019, Elizabeth was taken to hospital after taking an 'impulsive' overdose of antidepressants; she expressed 'regret' soon afterwards and discharged herself. Elizabeth's mother was dying around this time and Elizabeth travelled back to Yorkshire for her final days, with Darren as described above (paragraph 10.8), and then the funeral. Henry's condition also deteriorated at this time, and he had to be hospitalised. Elizabeth feared becoming homeless if Henry had to be institutionalised and worried that if she was put into a hostel, she would '*revert to old habits'*.

10.20. In August 2019, Elizabeth reported to her GP that she was stressed dealing with both Henry and Darren (who suffered from epilepsy) and coping with her mother's recent death.

10.21. Following escalating complaints, and on police advice, the Residents' Association applied for a community trigger review[26] in September 2019. The complaints centred on Henry's flat, which residents claimed was being used as a drugs den, leading to '*a never-ending stream'* of anti-social behaviour, including openly illegal drug dealing, prostitution, drug taking in bin rooms, and other criminal activity. Whilst these allegations were investigated, they were never substantiated. Police also pointed to a different potential source of unwanted visitors entering the building as the block backed onto a carpark which was regularly used by rough sleepers. Nevertheless, the increased pressure from the Residents' Association seemed to galvanise a more robust and coordinated housing/police response. This led to Henry being issued with a formal warning in October 2019 regarding ASB and moves were initiated to create a housing pathway for Elizabeth. However, despite several meetings, she did not follow the necessary application process and little progress was made. At this time Darren was back in prison.

10.22. In early December, Elizabeth spoke to her GP about her partner being in jail and how *'she is really worried for him, because he has fits all the time'.* She talked about them both going to rehab as she was '*fed up'* with the life she had been leading and wanted to make changes.

10.23. In late April 2020 Darren was sentenced to 40 months in prison for various burglary-related offences.

10.24. By mid-2020 renewed efforts were being made to rehouse Elizabeth but an application on medical grounds was rejected. This was because it is not simply a case of whether there are medical needs or not, but rather how these needs are impacted or affected by the home, such as not being able to manage stairs and living in a property with stairs. Elizabeth's application did not meet this threshold. She reported phoning Darren in prison daily over this period; she was concerned for him as he was locked up 23 hours a day due to the pandemic. Elizabeth admitted smoking crack every day to her doctor but no other illegal drugs (apart from smoking marijuana).

[26] A community trigger review allows repeat victims of anti-social behaviour (ASB) to have a greater say in how their complaints are handled - allowing those who have made three separate complaints about anti-social behaviour in the last six months to have their cases reviewed.

10.25. In a two-month period between June and August 2020 there were eight incidents recorded by the police relating to Elizabeth / Henry and disturbances in or in the vicinity of the flat, all of which seemed to involve drink or drug-fuelled disputes. No further action was taken in any case, although the police did attend on five occasions. Then in September, police completed a welfare check following a report that Elizabeth had left Henry's front door open whilst intoxicated, leading to someone coming into the flat.

10.26. Throughout the autumn, ongoing attempts were made to find Elizabeth a housing pathway so that Henry could move to more suitable accommodation. The flat was visited regularly by police, ASC and housing throughout 2020 and into 2021. Additional security was arranged to patrol the estate from late September to February 2021 in an attempt to reassure residents. This service did not report any issues relating to the property again, suggesting that residents may have been mistaken about the source of at least some of the ASB.

10.27. Probation was also gathering information from the police ahead of Darren's planned release in 2021, when he proposed returning to live at the flat. When they learned of the ASB complaints, as well as the concerns that Elizabeth was potentially taking advantage of a disabled resident (Henry), alternative accommodation options were sought.

10.28. Elizabeth was assaulted, possibly with a screwdriver, at the flat in early 2021 by another woman who then left the scene. She was treated by the ambulance service for head and facial injuries but refused to go to hospital or give a statement.

10.29. Two weeks later, in early February 2021, Darren was released from prison to a bail hostel in Edmonton on a Home Detention Curfew[27]. He expressed unhappiness at being so far away from Elizabeth and other family members. Within five days he was issued a warning letter for having Elizabeth stay overnight at his hostel. Two weeks later he was taken to hospital having had a seizure. A week later he was returned to prison as he had breached hostel rules again by spending two nights at Elizabeth's. He claimed he had been having more seizures, but there was no evidence of this.

10.30. From this point on, Elizabeth started to vocalise her dissatisfaction with Darren more openly and to more people, albeit to friends and family members rather than professionals. She stopped visiting Darren in prison and complained about how Darren was always claiming to be on the verge of change – of getting clean, of getting a job or a flat - but that nothing ever in fact changes and here he is, in prison, again. She told friends that she was always much happier when Darren was incarcerated as she could '*do what she wants.'* Despite this shift in attitude, Elizabeth still reported to housing staff that she wanted to get a flat together with Darren. This apparent indecision is not uncommon for women leaving abusive and controlling partners[28]. Part of it may have been Elizabeth feeling sorry for Darren, but she may also have had a keen sense of how dangerous Darren may be once he felt he had lost everything. Survivor assessment of the risk they face has been repeatedly proven to be the most reliable assessment of dangerousness[29]. He already had no job and no home. Elizabeth –

[27] Home Detention Curfew is a scheme whereby fixed-term offenders serving between three months and four years in prison may be released between 15 days and 180 days (depending on sentence length) earlier than their 'normal' release date to allow them to integrate back into society. Typically, prisoners under HDC are required to remain in their designated home between 7 pm. and 7 am.

[28] https://www.thehotline.org/resources/supporting-someone-who-keeps-returning-to-an-abusive-relationship/

[29] '*Domestic Abuse Risk Assessment Rationale'* (2022) National College of Policing

correctly as it turned out – probably sensed that the ending of their relationship might be a critical tipping point.

10.31. In March 2021, a notice of possession proceedings (NSP) was served on Henry as a tenant because of the complaints of ongoing anti-social behaviour and nuisance involved with the property. Details were given of the complaints, including drug misuse and ASB incidents. Later that month, a telephone care assessment by ASC noted that Darren was now back in prison and thus no longer involved in 'supporting' Elizabeth and Henry. The social worker was informed by Elizabeth that Darren was due to be released from prison in early June and that both of them wanted him to return to live with them. Elizabeth spoke of finding Henry '*demanding*' and that she experienced carer stress. She was advised to seek support from her GP with stress management.

10.32. During spring, there were a number of incidents suggesting ASB in or around the flat, but no further action was taken albeit that the police were informed or attended each time.

10.33. Darren was released from prison again as scheduled in early June[30]; this was about two and half months before the murders. He had a broken foot at the time. Although initially placed in multi-occupancy temporary accommodation outside the borough, within a week he was in temporary accommodation inside the borough.

10.34. Shortly afterwards, the ASB team began exploring options to remove or prohibit Elizabeth from residing at or even visiting Henry's address, given the ongoing complaints about her ASB. Concern was again expressed about Henry being potentially exploited. Complaints about ASB involving drug taking / dealing and prostitution continued throughout June and July, but housing struggled to contact either Elizabeth or Henry over this period. Elizabeth and Darren, separately and together, repeatedly expressed their desire to live together.

10.35. Henry reported that there was a man who had come into Elizabeth's life in the past year whilst Darren was in prison. Neither he nor Athena thought this was anything more than a friendship, despite what Darren would later allege.

10.36. A tense meeting took place at the flat in the first week in August with Elizabeth, Henry and Darren. Also present were officials from housing, ASC and a police officer. Darren claimed to be only visiting as Elizabeth '*wanted him there for support'*. The case officer said that they had had problems with engagement in the case and said that a male had been answering the phone and then putting it down. Darren admitted that this was him. He also said that neither Elizabeth nor Henry wanted to answer the phone but said that he had encouraged them to do so. Darren and Elizabeth told the officer that they wanted to get '*their own place'* – and were advised to approach Shelter, Citizen's Advice Bureau or the Council One Stop Service for impartial advice and also to seek assistance with letters. Elizabeth said that she had applied for housing, but her medical grounds were refused earlier in the year, and she had not applied since.

10.37. The housing officer noted that Elizabeth denied there was any nuisance, and that no one came to the flat apart from the carers for the tenant. Elizabeth and Darren insinuated that the officials present were 'deliberately scaring Henry'. Both also

[30] Darren was released in June as this was the halfway point of his most recent sentence and thus when he became eligible for a Conditional Release Date (CRD). He was scheduled to remain on licence until February 2023. In practice, this meant he was required to abide by the standard license conditions (see here for a complete list: https://www.gov.uk/government/news/licence-conditions-and-how-the-parole-board-use-them) No additional conditions were attached.

interrupted the meeting several times when the ASC officer was speaking with Henry. Eventually Elizabeth walked out the room and the police officer went to speak with her.

10.38. It was noted that Henry was *'visibly upset and shaking'* and they tried to reassure him that he was not going to get kicked out on the streets. Henry refused a verbal offer again of Management Transfer and said he was happy there. The housing officer also noted that when Darren was on his own, he told her that Elizabeth had got into debt with some drug dealers and that she had to repay the debt by '*holding onto things in the flat'*. He said that he had '*tried to keep these people away but Elizabeth had got in over her head and that they were bad people'*. This information was immediately relayed to the police and ASC. This is the last note recorded on the ASB case. No evidence has come to light to support these allegations.

10.39. Around about this time, Elizabeth's complaints about Darren started to increase. She claimed he was constantly harassing her and wouldn't leave her alone and told others that she had much more freedom when Darren was in prison. She started to talk about a future that didn't involve Daren and unable to accept that this might be her choice, Darren blamed her new friends, made whilst he was in prison, for '*corrupting'* her.

10.40. Just over a week later, in the early hours of the morning, Elizabeth sent Darren 22 furious texts within less than an hour, indicating that she had thrown his stuff out and never wanted to see him again. The messages are interspersed with a large number of calls so it isn't always easy to make sense of the texts but there is a strong suggestion that Elizabeth had discovered that Darren had been cheating on her. At one point she asserts that '*we both know it's over and [we've] been done for long time'* and '*There no going back now u will never hurt me again'.*

10.41. Four days later, Darren killed Elizabeth and Ash. Examination of Darren's text messages would suggest that Elizabeth was killed in the early morning (between 6am and 7.30 am). These text messages were attempts by Darren to make contact with his mother and sister, trying to obtain money and making comments about how he will end up in prison for the rest of his life for what he has done.

10.42. He then went to see his father who had not seen him for almost three years. Darren originally confessed to him that he had killed three people, although no evidence of a third murder was ever uncovered. It seems likely that after killing Elizabeth, his intention was to go on and kill the two dealers (one of whom was Leah) that he believed had led her astray. After Darren left, his father called the police. Elizabeth's body was found in her room at Henry's flat; Ash's body was discovered in the early hours of the following day at a separate address. Both had had their throats cut. Henry later told police that the night before her body was found, Elizabeth and Darren had a 'big barney' which may have lasted into the early hours of the following day so despite the text messages referenced above, Darren and Elizabeth were at least talking again prior to the 'big barney'. Darren had come to his room 'wired and agitated' but Henry had not seen Elizabeth again. Darren would later state in his police interview that Elizabeth laughed at him after he said he was going to kill those involving her in drug supply – she did not think he would do anything about it. He became angry with her and slashed her throat.

10.43. Later on the same day after confessing to his father, Darren was seen talking to Ash by a mutual friend, Leah, who had spent several hours that evening at Ash's flat. CCTV would also show that Darren was in the company of Ash between 11:45pm and midnight.

10.44. Darren said he originally planned to kill Leah and another man, who he believed were the dealers who had got Elizabeth involved in the supply of drugs. Darren would

claim he had not in the end killed Leah because she was with her 12-year-old granddaughter. Ash had been killed, Darren claimed, because he was Leah's 'right hand man' and it was 'bad luck' that he was there.

10.45. When Leah returned to the flat and tried Ash's doorbell soon after midnight, she initially got no reply. She eventually gained entry to the block of flats through another resident, John. She told him that she thought Ash was ignoring her calls as they had had a bit of a falling out earlier that evening. At first John thought little of this as '*both Leah and Ash are always behaving like this, so nothing was out of the ordinary'.* Eventually Leah went to investigate and found Ash's door unlocked. She saw blood all over the door and screamed. John came running down the landing from his own flat and together they entered, discovering Ash's body.

10.46. Darren went on the run after the deaths were discovered. The police announced a £20,000 reward and, after a five-day manhunt, he was discovered staying in a houseboat on the Grand Union canal. The houseboat was owned by someone Darren knew but he was there without their consent or knowledge. Darren had attempted to cut his own throat and, after some resistance, was arrested.

10.47. During the trial, Darren stated that he hadn't meant to kill Elizabeth and her murder had been an accident. Darren stated that Elizabeth had laughed at him, and he lashed out with the knife in his hand and slashed her throat. However, the wounds were not indicative of an accident as they were around 4cm deep. Both Darren's father and sister gave evidence against him at the trial. In his statement to the police, his father described how Darren would go into '*a mode where he, I think he tries to unsettle people… he kind of tries to destabilise people'*.

10.48. At trial, Darren was found guilty and sentenced to 39 years. The judge concluded that Elizabeth's murder was not premeditated but that Ash's showed a *'significant level of premeditation and planning'.*

11. Analysis: Equality and Diversity

11.1 The nine protected characteristics[31] under the Equality Act 2010 were reviewed and due consideration given to each, as to whether or not they were applicable.

11.2. Disability and sex were found to be relevant.

11.3. There was no evidence to suggest that age, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and sexual orientation were relevant to the circumstances of this case.

11.4. Disability was relevant because Darren had had two serious head injuries. The first of these was as a child in a road traffic accident and then another as an adult when he slipped down a shaft on a building site during the course of a burglary in 2016. Both instances appear to have contributed to his condition of epilepsy. Darren had regular seizures although he was prescribed medication to manage his condition. Elizabeth helped him to manage his condition and it may have been a factor in her feeling unable to terminate the relationship.

11.5 Disability was also relevant in that Henry had multiple sclerosis which, by the time under scrutiny in this DHR, had rendered him mostly bedridden. This meant that he was not able to fully control who came and went in his flat or what they did when they

[31] These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

were there. It is very strongly suspected – although ultimately unproven – that this was a situation which Darren - and possibly others - exploited.

11.6. Disability in the form of enduring mental ill-health may also have been relevant for Elizabeth. Her diagnosis of depression was monitored in psychosocial interventions and GP appointments, but it is difficult to unpick whether this impacted on her day-to-day activities when assessed alongside her drug taking. Even if her enduring mental ill-health did not meet the threshold to 'count' as a disability, it certainly increased her vulnerability.

11.7 Sex was also found to be relevant as it is a significant risk factor for being a victim of domestic abuse; women are more likely than men to be subjected to abuse. Women are around twice as likely to experience domestic abuse and men are far more likely to be perpetrators. The majority of domestic homicide victims are women, killed by men[32]. On average, three women are killed every two weeks by their current or former partner in the UK, a figure that has changed relatively little in recent years. It impacts women's health and independence, and their broader inequality limits women's ability to escape from abusive relationships. Women remain more likely to be threatened, raped, assaulted and murdered by men they know and, in particular, by men with whom they are having, or have had, a romantic relationship.[33]

11.8. Despite well-established under-reporting, and not every reported incident of domestic abuse being a crime, the recently published VAWG statistical bulletin identified that at least 507,827 offences against women and girls were recorded in a six-month period (1 October 2021 - 31 March 2022) in England and Wales. This equates to just under 117 crimes recorded by police, per hour or two crimes per minute.[34]

11.9. In addition to the protected characteristics as defined under the 2010 Equality Act, the Panel also considered the likely impact of other vulnerabilities. Both Elizabeth and Darren were drug addicts. Whilst the precise nature of all of their drug intake is not known, both are on record confirming their use of both heroin and crack cocaine. Evidence would suggest that Darren encouraged Elizabeth to join him in drug binges that she felt more able to resist in his absence. During his periods of incarceration, Elizabeth seemed to switch to methadone and reduce her intake of any other illicit drugs. The positive changes in her appearance when Darren was absent were commented on by several different people. Darren's efforts to manage and reduce his drug intake were significantly less impressive.

11.10. Although falling outside of the period under review, Elizabeth had a long history of involvement in prostitution[35]. This changed when she moved into Henry's flat. Henry was adamant that despite the allegations made by the Resident's Association that Elizabeth had '*put all that behind her*' and never used his flat to '*turn tricks'*. Elizabeth herself reported that something had '*scared her off'* further involvement in prostitution although it has not proven possible to determine exactly what this was.

11.11. Elizabeth kept a diary in which she expressed her innermost thoughts. According to her daughter, they were full of self-loathing about her time in prostitution and how much she hated herself and didn't feel worthy of love or affection. Working in

[32] Office for National Statistics. 'Homicide in England and Wales 2021.
[33] *'Long-term partners – Reflections on the shifts in partnership responses to domestic violence'* Kirsty Welsh, International Review of Victimology March 2022
[34] Violence Against Women and Girls Strategic Threat Risk Assessment 2023
[35] The terminology used here has been deliberately chosen; to use 'sex work' implies a free choice that the Panel are not convinced existed.

a trauma informed way was undoubtedly essential for services to engage and maintain engagement with Elizabeth. This would include the provision of female staff, women-only spaces and flexibility regarding appointments and making contact. These issues are explored further in the following section.

12. Analysis: Terms of Reference

Information provided to the Panel was analysed against each of the key lines of enquiry set out in the terms of reference.

12.1. Each agency's involvement with the following people between January 2019 and August 2021

(a) Elizabeth, a lodger at address 1 (where Henry, the tenant, also lived)

(b) Ash, resident at address 2

(c) Darren, officially resident at address 3 but often staying at address 1

12.1.1. This is set out in section 10 above.

12.2. Whether any improvements are needed in communication and information sharing between services.

12.2.1. There were some examples of excellent multi-agency work involving good communication and information sharing albeit that these related to the care of Henry and the management of anti-social behaviour complaints rather than in relation to domestic abuse. Despite the general high standard however, it was identified that involving the care workers in the multi-agency meetings might have been helpful given their daily contact with Henry.

12.2.2. Similarly, the GP and Turning Point had good information sharing practices in place and also made referrals to other agencies. However, with the benefit of hindsight, it has been identified that Elizabeth's primary need was to resolve her housing situation. Had this been addressed, more progress may have been made on other areas, in particular her substance use issues, but potentially she may have also been more open to addressing her relationship with Darren.

12.3. Whether responses to each of the subjects of this DHR were consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols.

12.3.1. Only the GP was aware of any abuse, and he received a single disclosure in early 2019. He recorded that Elizabeth was '*quite distressed about the way her partner has been treating her. She doesn't want any help at this stage saying that he is verbally abusive'.* This information was shared with Turning Point. Good practice would have been to revisit this at future appointments, particularly those when Elizabeth was saying she wanted to change her circumstances but the focus in the GP records seems to have been solely on her housing situation and her drug intake. Elizabeth's key worker at Turning Point did try to open up a conversation with Elizabeth about her relationship but was unsuccessful in doing so (see 12.5 below).

12.3.2. In 2021, the GP surgery underwent IRIS[36] domestic abuse training.

12.3.3. No other agencies were aware of any domestic abuse and thus there were no responses to this issue to assess.

12.3.4. With respect to other issues that agencies dealt with, professional standards were met.

12. 4. The response of the relevant agencies to any referrals relating to the subjects of this review concerning domestic violence or other significant harm. This should include an analysis of any assessments, decision making, referrals and whether appropriate services were offered/provided and whether these responses were informed, professional, timely and effective. Were thresholds for intervention appropriately calibrated, and applied correctly? Are these adequate when a client is experiencing multiple issues?

12.4.1. For most agencies involved with the subjects of this DHR, the significant harm related to issues other than domestic abuse.

12.4.2. For Adult Social Care, for example, the significant harms to which they responded concerned Henry with Elizabeth and Darren being potentially the source of that harm. There was good multiagency work with the Police and Housing ASB Team to investigate concerns including speaking to Henry on his own to ascertain his wishes.

12.4.3. The Community Rehabilitation Company[37] assessed Darren as low risk in 2016 and this did not change, even when a further risk assessment was undertaken in March 2021. This assessment failed to take into account that Darren's offending had escalated and in his most recent burglary, he had threatened the homeowner with a crowbar. A further assessment was undertaken in July 2021 when the Probation Service was renationalised and at this point, Darren's risk rating was increased to medium. As the CRC has now been disbanded, no recommendations are made here.

12.5. Were there any missed opportunities to enquire about domestic abuse? Was your agency aware of the other issues facing the subjects of this DHR and if so, what actions did you take in relation to these?

12.5.1. With the exceptions of the GP and Turning Point as noted above, there were limited opportunities to enquire about domestic abuse as there were few professionals that identified any indicators of domestic abuse. However, we do now know that there was a long history of coercive control and Elizabeth did allege to Henry that Darren was physically abusive to her as well.

12.5.2. With the benefit of hindsight, it has been possible to identify that there were some missed opportunities to enquire about domestic abuse, even if the 'clues' were not the usual indicators. For example, there were several agencies that knew about

[36] This is an evidence-based model of domestic abuse good practice for primary care. More detail can be found here: https://irisi.org/

[37] Community Rehabilitation Company (CRC) was the term given to private-sector suppliers of Probation and Prison-based rehabilitative services for offenders in England and Wales. A number of CRCs were established in 2015 as part of the Ministry of Justice's (MoJ) Transforming Rehabilitation (TR) strategy for the reform of offender rehabilitation. In June 2020 the government announced it would terminate all CRC contracts by June 2021 and services would be transferred to the renationalised National Probation Service.

Elizabeth's drug addiction, others also knew about her history of involvement in prostitution, and some were additionally aware of her insecure housing situation. All of these issues, both separately and in combination, are strongly correlated with domestic abuse and should have prompted a routine enquiry.

12.5.3. There is no guarantee, however, that this would have made a difference in this particular case as evidenced by Elzabeth's response when the worker from Turning Point attempted to probe whether she had any additional needs that were not being met by them. There were occasions where Elizabeth disclosed concerns regarding her relationship, but these were vague, and Eizabeth was evasive when the worker tried to explore this further and declined the support services which were offered. The Panel noted that Elizabet's key worker was male and considered that this may have been a barrier to a fuller disclosure.

12.5.4. In recognition of this potential barrier, Turning Point are currently developing their Women's Service which includes the allocation of a female worker and the creation of 'women safe spaces' within certain services. Trauma informed approaches, led by a clinical psychologist, are also being embedded across the organisation.

12.5.5. There were, however, missed opportunities in relation to other matters.
In terms of Elizabeth's substance misuse, ASC acknowledged that there were potentially missed opportunities for them to have direct conversations with her around whether she wanted to change her life or whether ASC could support her to access rehab. By only seeing Elizabeth one-dimensionally, that is as an informal carer for Henry, opportunities were missed to signpost her to support with other issues in her life. In mitigation, however, ASC were aware that Elizabeth was linked in with support from Turning Point and was accessing support from her GP. Moreover, in the early part of 2020, there was extensive communication and joint work primarily between ASC, the ASB team, Housing, and Turning Point to seek more settled housing for Elizabeth, albeit without success. ASC have also reflected on the role that the care agency played. Overall, there was excellent multi-agency work, and the Social Worker for Henry did seek feedback from the carer agency, but they weren't invited to the professionals' meetings or safeguarding meetings to give their input in person.
ASC have now implemented some changes in their training and created a bi-monthly safeguarding practice forum (see single agency recommendations below).

12.5.6. There was a single occasion in October 2019 when Housing staff visited address 1 regarding some complaints of ASB. It was recorded that '…*staff did not feel safe to enter the flat and asked Elizabeth to speak to them alone. Darren would not allow this and followed them out*'. This could potentially have indicated some degree of coercive and controlling behaviour by Darren. In mitigation, however, this is the only entry that suggests such behaviour and indeed, one of only three contacts that Housing had with Darren over the course of managing the ASB. To be clear, the feelings of unsafety that staff experienced related to the very intoxicated state that both Elizabeth and Darren were in. A year later, a housing officer did specifically ask Elizabeth if she feared for her safety, and she said no. At the same interview, Elizabeth said that she was no longer taking drugs, just drinking beer.

12.6. Was the (alleged) perpetrator effectively managed and what forms did this take?

12.6.1. There were three agencies involved with Darren: Housing Solutions, Turning Point and the Community Rehabilitation Company although arguably, only one of these (CRC) was able to exert any authority over Darren.

12.6.2. Housing Solutions intervention with Darren was focused on finding him suitable housing when he left prison. There was appropriate and effective communication between St Mungo's prison-leaver service and Housing Solutions, resulting in the co-ordination of a homelessness assessment taking place on the day of his release and provision of temporary accommodation.

12.6.3. Darren was known to Turning Point sporadically from 2016 to 2021, most often via the criminal justice system. He did not engage with their main services choosing only to engage with the psychosocial interventions and prescribing of opiate substitute prescribing.

12.6.4. As noted above (paragraph 12.4) CRC's risk assessment of Darren should have been elevated as indeed it was when Probation re-assessed him in July 2021. Despite this, effective steps were taken in March 2021 when Darren proved unable to abide by the conditions of his Home Detention Curfew and he was recalled to prison until June 2021.

12.7. How accessible were services for the victims and the (alleged) perpetrator? What might have made a difference in terms of increasing their engagement with services?

12.7.1. Ash did seek some assistance from ASC, but he ended up addressing his issues before ASC made contact. Darren did not seek or access services from ASC. Elizabeth sought, and received, assistance in her carer role, and was granted carer's personal budgets. Henry's package of care was increased to address the pressures she faced as a carer.

12.7.2. ASC had a number of discussions with Elizabth about making an application for housing, and many of these revolved around her not having made the application. When a housing application was made in 2020, it was made on medical grounds and rejected as Elizabeth did not meet the criteria. With hindsight, it is easy to see that the provision of more detailed guidance to Elizabeth about making an application would have been useful given that alternative housing would have solved a number of issues. Instead, she was signposted eight times to Housing Solutions for this advice, but she only made contact a couple of times and did not respond when contact was made with her.

12.7.3. Overall, therefore, services were mostly accessible to all concerned but were not always taken up when offered or when follow-up contact was made. This is not unusual for people who are dealing with multiple issues. Had Elizabeth been subjected to criminal justice system procedures, she may well have ended up with a referral to a Women's Centre[38] where a single key worker would have had a holistic overview of all of the issues she was dealing with. Sadly, Elizabeth's ability to avoid criminal justice system sanctions meant she was on her own in navigating multiple systems.

12.8. Whether practices by all agencies were sensitive to the nine protected characteristics of the DHR subjects and whether any special needs or

[38] These are community-based alternatives to prison whereby women can access a one-stop-shop that delivers a woman-centred, holistic package of support in a safe and women only environment so that the issues that gave rise to women's offending are resolved.

vulnerabilities were explored, shared appropriately and recorded. <u>Please provide evidence for your assertions.</u>

12.8.1. This is addressed in section 9 above.

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

12.9.1. There were no individual organisational changes that were relevant to this DHR, and the services delivered.

12.9.2. However, all agencies were impacted by the covid pandemic, and the subsequent restrictions that were imposed on freedom of movement. For example, Elizabeth received a carer's assessment via telephone in March 2021 when this would usually have been done face to face. Turning Point delivered its case work appointments via telephone albeit that risk was monitored throughout.

12.9.3. Despite these changes in ways of working, no agency felt that the quality of service they delivered was significantly impacted.

12.10. What learning can be identified from this case? What changes would you suggest to avoid such tragedies occurring in the future?

12.10.1. Responses to this key line of enquiry formed the basis of Panel discussions and are reflected in the key findings and recommendations below.

13. Good practice

13.1. Although there was nothing in their encounters with the subjects of this DHR to suggest that domestic abuse may have been a factor, London Ambulance Service (LAS) identified some practices which are worthy of note. For example, during COVID, the National Domestic Abuse helpline number was visible to patients via stickers on clinicians' iPads and on paramedics' infection suits and mindful of the possibility of an abuser overhearing in person or via hidden recording devices, as a matter of routine practice, LAS staff now move the patient on their own to the ambulance to ask questions in a safe place. Additionally, the content of their Level 3 Safeguarding training has been updated to focus on upskilling knowledge of the Domestic Abuse Act 2021, understanding coercive control and raising awareness that substance use, and mental ill-health can often be a survivor's way of coping with abuse to encourage greater professional curiosity over this and other ways in which survivors may present to LAS staff.

13.2. This case provides clear evidence of joined up working between Westminster CC Housing, their ASB team, ASC and the Police. This ensured that there was joint problem-solving, regular monitoring visits and the offer to both Henry and Elizabeth of locating alternative accommodation.

13.3. Adult Social Care identified that Henry received regular reviews in which he was spoken to in private to ascertain his views and allow him the opportunity to discuss how he felt in relation to the concerns raised. His formal package of care was closely

monitored and increased as required during the period under review. The provision of this package also created a way to monitor the situation in Henry's home on a daily basis.

13.4. There was also good practice in relation to the application of the Mental Capacity Act 2005. Concerns in relation to potential coercion and control were assessed and there was no indication that Henry was under any duress. He had the mental capacity to make decisions about his living arrangements and was clear that he wanted Elizabeth to live with him and continue to provide support. ASCs work was in line with supporting positive risk taking and respecting Henry's rights to make choices.

13.5. Separately from the specifics of this case, ASC have worked closely with the Violence Against Women and Girls (VAWG) Board and Safer Community Partnership in recent years to strengthen joint working across services to ensure more effective and coordinated responses. This has led to the creation of a dedicated Safeguarding Operational Team in June 2021. This team is made up of a Safeguarding Operational Manager and five Safeguarding Adults Managers, who oversee Section 42(2) enquiries and work to provide advice and support to ASC operational teams and external partners regarding adult safeguarding. The new service has increased safeguarding expertise and also plays a key role in supporting best practice around domestic abuse and strengthening responses to adults who experience insecure housing.

13.6. Turning Point was able to offer consistent engagement with Elizabeth in the form of both appointments and prescription collection along with continuity of care with a consistent keyworker.

13.7. The GP surgery identified that they had protected clinical time set aside each week for patients with substance use issues which gives ease of access to a GP if needed.

13.8. Housing Solutions identified that the process for ensuring that Darren did not leave prison into homelessness worked well. Offenders leaving prison with nowhere to live is a notoriously difficult set of circumstances to navigate. There are lots of agencies at play and usually there is a small timeframe to act within with limited preparation. Therefore, this can sometimes mean that the support someone gets for housing isn't in place for someone leaving prison who is homeless. Those who become homeless straight away following prison release have increased chances of falling back into offending behaviours. Although this case ended in tragic circumstances, Darren received a good service regarding accommodation. In turn, of course, this meant that Elizabeth and Henry were not accommodating Darren and this created space in which Elizabeth could further imagine a future without Darren.

13.9. It should also be noted that Housing Solutions have done a huge amount of work in the last few years, namely achieving accreditation from the Domestic Abuse Housing Alliance. This involved undertaking an extensive programme of work to get them to a standard of excellence around their responses to domestic abuse. Amongst other measures, this has included locating an Independent Domestic Abuse Adviser (IDVA) provided by a third party into the Housing Solutions office and all staff now attend domestic abuse training as a mandatory course.

14. Key findings by the DHR Panel and recommendations

14.1. This section addresses the overarching lessons that have been learned from this DHR. Each agency who provided an IMR to this process identified their own lessons and these single agency recommendations can be found in the action plan at appendix E.

14.2. The DHR process has yielded few lessons that are domestic abuse specific.

14.2.1. Despite considerable agency involvement in the lives of those around them, in particular with Henry few agencies were aware of any domestic abuse between the couple. Darren had a long offending history but almost all of his convictions were for dishonesty and theft. Elizabeth did occasionally mention relationship issues with those she trusted – her GP and her Turning Point worker – but was evasive if further questions were asked.

14.2.2. Whilst there is no direct evidence of physical abuse from Darren prior to Elizabeth's murder, information provided by friends and family suggests there may have been coercive and controlling behaviour, jealousy, a probable sense of entitlement, possible use of financial control, manipulation, and harassment by Darren. At the time, none of these behaviours were recognised as abusive by Elizabeth or those closest to her, which highlights that not all abuse is easily identifiable or considered abusive in the moment.

14.2.3. Elizabeth's family acknowledge they had felt uncomfortable with some of Darren's behaviours but had not identified his behaviour as threatening to Elizabeth's safety. Behaviours he displayed may be understood as common relationship difficulties that can be ignored or taken in one's stride, which makes it difficult to identify if the relationship is abusive. This is in no way to assign blame to anyone, instead it highlights the need to be able to raise awareness in being able to identify behaviours, patterns, risks factors and how to support those who are subjected to this form of what Johnson has termed intimate terrorism.[39] It also serves to highlight how common it is when imparting information about what 'counts' as domestic abuse, that extreme examples are used where there is already little debate (eg kicking and punching) rather than using more subtle and nuanced examples.

14.2.4. Despite the lack of professional knowledge of domestic abuse, the DHR process has afforded an opportunity for each participating agency to reflect on its current practice, including in relation to domestic abuse where relevant. It has also highlighted how professionals may need to be more holistic in their consideration of domestic abuse indicators. Whilst it is often stated that anyone can experience domestic abuse, it is also the case that some groups are more likely to be victimised than others either in terms of individual characteristics such as disability, or in terms of life experiences such as drug addiction. Of course, not every member of these groups is, or will be, a victim of domestic abuse but the higher prevalence rates of some groups justify routine enquiry.[40] In this particular case, the co-existence of depression, addiction, a history of involvement in prostitution and insecure housing should all have prompted a routine enquiry.

Recommendation 1: Review local domestic abuse training to ensure that routine enquiry is advocated for high-risk groups.

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[39] '*Typology of Domestic Violence: Intimate, Terrorism, Violent Resistance, and Situational Couple Violence'* Michael P. Johnson, 2008

[40] See, for example, NICE guidance which recommends that health and social care staff 'Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.' https://www.nice.org.uk/guidance/ph50/chapter/1-Recommendations#recommendation-5-create-an-environment-for-disclosing-domestic-violence-and-abuse

Recommendation 2: Undertake a dip sample of relevant services to ensure that routine enquiry has been embedded.

Recommendation 3: Review local domestic abuse materials to ensure that the focus is on giving examples of behaviours where some people still have doubts rather on those that are widely accepted as abusive.

14.3 Review the role of informal carers.

14.3.1. Elizabeth was seen through the lens of being an informal carer for Henry who was the actual client of Adult Social Care. Subsequent to this DHR, ASC has embarked upon a programme of work to ensure that ASC practitioners are supported to develop their practice and confidence. This is with the aim of enabling them to explore what may be 'difficult conversations' with informal carers, who may have their own vulnerabilities, for example, in relation to substance misuse. The aim is to have conversations to support the person to reflect on how this may impact on their caring role, and what additional support may be required.

14.3.2. As this work is already underway, there are no recommendations made here.

14.4. Family and social networks are critical in gaining a 360◦ understanding.

14.4.1. The Panel is indebted to family members and friends who provided their knowledge to this DHR. Through sharing their experiences and insights, the Panel was able to gain a much richer understanding of the circumstances surrounding these murders and thus able to think more creatively about solutions (see above for details). It is also a timely reminder to agencies that they tend to get a snapshot rather than a full picture and thus maintaining an active professional curiosity is essential to understanding what the problems are, and how interventions might be made more effective. This is especially true for clients with multiple needs.

Recommendation 4: Review local domestic abuse training to ensure that the practical application of professional curiosity is included within the content.

Recommendation 5: Publicise pathways for friends and family to follow if they have concerns about someone. This should include more than making an official report and also encompass gaining guidance on ways to respond.

14.5. The centrality of housing to resolving issues faced by residents with multiple and longstanding needs.

14.5.1. Westminster CC adopted a Housing First approach in 2018. This is a recovery-oriented, evidence-based philosophy and approach that recognizes that housing is a basic human right, and that people are better equipped to make progress in their lives if they have a safe and stable place to live. Housing First recognizes that homelessness is, first and foremost, a housing crisis, which can be addressed and resolved by providing safe, affordable housing. This approach prioritises people's basic needs, like food and shelter, above less critical necessities such as employment, income, or sobriety that are not required of a typical renter.

14.5.2. Had Elizabeth's housing situation been more critical, that is if she had been roofless rather than 'just' in an insecure housing situation, she may well have been given a greater degree of assistance. Elizabeth's own efforts to secure alternative accommodation should Henry be rehoused were somewhat half-hearted, perhaps due to the apparent lack of urgency. She may also have felt ambivalent about moving in with Darren.

14.5.3. In August 2019, the Westminster VAWG Housing First Project became operational. This project was specifically designed for women who have experienced

any form of violence against women and girls. It currently supports 30 women. There is no evidence that Elizabeth was ever offered this housing option as no agency perceived Elizabeth as being subjected to abuse.

14.6. Problematic substance use

14.6.1. All three subjects of this DHR were users of illicit substances. We do not know much of Ash's drug taking as he was never arrested and never sought assistance for his drug use. The only information we have comes from his friend Leah who told police officers that he was a 'sporadic user' of crack cocaine and the toxicology report.

14.6.2. We know much more about Darren and Elizabeth's drug use. Their drug use started separately becoming more entwined once a relationship formed between them. We do know that Elizabeth's drug use seemed more under control when Darren was incarcerated, albeit that it did not stop entirely. Other than the fact that Darren met Elizabeth in rehab, he seemed to make very few efforts otherwise to address his addiction. In part this is because any efforts to stabilise kept being interrupted by spells of incarceration. During these times, despite the availability of drugs inside prison, it is likely that his drug use diminished. Darren did not take this opportunity to address his addiction and there were obvious signs of an immediate increase again once he was released. Addressing addiction is not easy and there needs to be a degree of willingness on the part of the addict to address the issue; forcing it on someone is doomed to failure. Help and opportunities were available to Darren if he had chosen to take them.

14.6.3. The Panel discussed at length whether professionals who came into contact with Elizabeth viewed her as a drug addicted woman who was involved in prostitution, accused of ASB and treated as such, or as a woman who wanted to change her life and offered opportunities to do that? In other words, was a trauma informed approach taken that focused on her strengths or was the gaze firmly clamped on her (perceived) deficits? At times, it seemed as if the focus was only on keeping Elizabeth in treatment rather than seeing that she had a range of issues which needed addressing and that treatment was bound to fail if these were not also in focus. As detailed above, Turning Point have been expanding their 'offer' to female clients and the Westminster VAWG Housing First Project is now fully operational.

Recommendation 6: Learning to be shared from these two local models regarding engagement with women with multiple needs

14.7. Impact of covid

14.7.1. In many homicides which occurred during the pandemic lockdowns, service delivery was negatively affected. Whilst it is the case that Elizabeth had some services (Turning Point, Carer's Assessment, etc) move online, there is no evidence that this had a negative impact. Rather, the lockdowns may have acted as a catalyst for Elizabeth to start reimagining her life. Records of her calls, prison visits and letters prior to the pandemic show that even when he was incarcerated, interacting with Darren still shaped her daily life. When the lockdown restrictions began, although some contact was still possible it wasn't so all-encompassing leaving Elizabeth free to form new friendships and 'practice' what having a life without Darren might feel like. When he was initially released in February, she was glad to see him and to start planning a new life again but within a matter of days, he was found to be in breach of his conditions and was once again in prison. Although the lockdown restrictions had ceased by this time, it is from this point on that Elizabeth seemed to be more seriously contemplating a Darren-less future.

14.8. Ending abusive relationships is fraught with risk

14.8.1. It is a well-established fact that leaving an abuser, especially one who is adept in coercive control, significantly raises the risk of homicide. Although Elizabeth had voiced dissatisfaction with her relationship before, from around March 2021 onwards her resolve seemed to harden and grow albeit not instant and immediate. Unable to believe that Elizabeth might be rejecting him, Darren concocted imaginary affairs / reasons which raised the risk still further. Exhibiting sexual jealousy – even in the absence of any evidence - is a common behaviour exhibited by abusers - especially those who are homicidal. For many years, this afforded abusers additional protection under the law, and it is not surprising that it has yet to die out. It is, after all, relatively recently that the law has not excused men who kill their female partners if they suspected her of having an affair[41].

15. Conclusion

This case involved a long-standing intimate relationship that at its best was unhealthy and at its worst was outright abusive. Due to the multiple illegal activities of both victim and perpetrator, both led lives in the shadows, away from the notice of most official agencies. Aware that his control over Elizabeth was slipping, Darren went on his murderous rampage which also claimed the life of Ash.

The Panel sincerely hopes that the lessons learned from this Review will be a significant contribution to the changes needed to try and avoid a recurrence in the future.

[41] The so-called 'nagging and shagging' defence was changed in 2010 to prevent men who had killed their female partners from being able to reduce a murder charge to manslaughter on the grounds that she had either nagged him or slept with someone else.

Appendix A: Terms of reference

DOMESTIC HOMICIDE REVIEW (DHR)
INTO THE DEATHS OF ELIZABETH AND ASH

TERMS OF REFERENCE

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible

Key lines of enquiry

Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with the following people between January 2019 and August 2021

(a) Elizabeth, a lodger at address 1 (where Henry, the tenant, also lived)

(b) Ash, resident at address 2

(c) Darren, officially resident at address 3 but often staying at address 1

2. Whether any improvements are needed in communication and information sharing between services.

3. Whether responses to each of the subjects of this DHR were consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols.

4. The response of the relevant agencies to any referrals relating to the subjects of this review concerning domestic violence or other significant harm. This should include an analysis of any assessments, decision making, referrals and whether appropriate services were offered/provided and whether these responses were informed, professional, timely and effective. Were thresholds for intervention appropriately calibrated, and applied correctly? Are these adequate when a client is experiencing multiple issues?

5. Were there any missed opportunities to enquire about domestic abuse? Was your agency aware of the other issues facing the subjects of this DHR and if so, what actions did you take in relation to these?

6. Was the (alleged) perpetrator effectively managed and what forms did this take?

7. How accessible were services for the victims and the (alleged) perpetrator? What might have made a difference in terms of increasing their engagement with services?

8. Whether practices by all agencies were sensitive to the nine protected characteristics of the DHR subjects and whether any special needs or vulnerabilities were explored, shared appropriately and recorded. Please provide evidence for your assertions.

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

10. What learning can be identified from this case? What changes would you suggest to avoid such tragedies occurring in the future?

Panel Membership

The following agencies have been invited to sit on the Panel:

- Advance
- Drug and Alcohol Wellbeing Service
- London Ambulance Service
- Metropolitan Police
- National Probation Service
- NHS (local hospital, Mental Health Trust and GPs)
- Standing Together Against Domestic Violence
- Tamar
- Turning Point
- Westminster City Council (Housing, Public Health, Adult Social Care & Community Safety)

Family involvement

The review will seek to involve the family of both the victim and the (alleged) perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Contact with the family and other members of their social networks will be led by the Chair.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by a pseudonym. Panel members, however, will be named.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

Subject to criminal proceedings, the Review will aim to conclude within six months in line with the statutory guidance.

Media strategy

- Up until the report is signed off, media enquiries should be directed to the Chair
- Once the final report has been signed off, any media enquiries should be directed to the CSP.

Panel members should be mindful that:

- They are representing their agency and as such, no-one from their agency should be commenting to the media on this case
- This also applies to self-generated publicity e.g., tweets, Facebook posts etc. if unsure, please check with the Chair.

Appendix B: Statutory definition of domestic violence

This statutory definition was introduced via the Domestic Abuse Act 2021 and is taken from the statutory guidance[42].

Definition of "domestic abuse"

(1) This section defines "domestic abuse" for the purposes of this Act.

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

(a) A and B are each aged 16 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).

(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.

Section 2: Definition of "personally connected"

(1) 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); Domestic Abuse Act 2021 Statutory Guidance 22

(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;

[42] Domestic Abuse Statutory Guidance (publishing.service.gov.uk)

(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.

(2) For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if —

(a) the person is a parent of the child, or;

(b) the person has parental responsibility for the child.

(3) In this section — "child" means a person under the age of 18 years; "civil partnership agreement" has the meaning given by section 73 of the Civil Partnership Act 2004; "parental responsibility" has the same meaning as in the Children Act 1989; "relative" has the meaning given by section 63(1) of the Family Law Act 1996.

Section 3: Children as victims of domestic abuse

(1) This section applies where behaviour of a person ("A") towards another person ("B") is domestic abuse.

(2) Any reference in this Act to a victim of domestic abuse includes a reference to a child who –

(a) sees or hears, or experiences the effect of, the abuse, and

(b) is related to A or B.

(3) A child is related to a person for the purposes of subsection (2) if –

(a) the person is a parent of, or has parental responsibility for, the child, or

(b) the child and the person are relatives.

(4) In this section – "child" means person under the age of 18 years; "parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act); "relative" has the meaning given by section 63(1) of the Family Law Act 1996.

Appendix C: Further information about the chair and report author

Davina James-Hanman has been an independent Violence Against Women Consultant since 2015. She was formerly the Director of AVA (Against Violence & Abuse) for 17 years (1997-2014), which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK (1992-97). From 2000-08, she had responsibility for developing and implementing the first London Domestic Violence Strategy for the Mayor of London. A key outcome of this was a reduction in domestic violence homicides of 57%.

She has worked in the field of violence against women for almost four decades in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and three book chapters and formerly acted as the Department of Health policy lead on domestic violence (2002-03). She was also a Lay Inspector for HM Crown Prosecution Service Inspectorate (2005-10).

Davina has authored a wide variety of original resources for survivors and is particularly known for pioneering work on the intersections of domestic violence and alcohol/drugs, domestic violence and mental health, child to parent violence, developing the response from faith communities and primary prevention work.

She acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence, forced marriage and 'honour' based violence (2007-08) and Chairs the Accreditation Panel for Respect, the national body for domestic violence perpetrator programmes. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. Davina was also a member of the National Institute of Health & Care Excellence group which developed the domestic violence recommendations and subsequent Quality Standards. She remains an Expert Adviser to NICE.

Davina is a Special Adviser to Women in Prison and a Trustee of the Centre for Women's Justice. She has chaired and authored over 50 DHRs.

Appendix D: Merged spot check report (see separate document)

Appendix E: Action Plan (see separate document)