OVERVIEW REPORT

of the

Domestic Homicide Review

relating to the death of Marie in 2019

on behalf of:

East Sussex Safer Communities Partnership Board

Report Author: **Liz Cooper- Borthwick**

Independent Chair

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GLOSSARY

ABBREVIATION	DEFINITION
ADHD	Attention deficit hyperactivity disorder
CGL	Change Grow Live
DASH	Domestic Abuse. Stalking, Harassment and honour-based violence check list
DHR	Domestic Homicide Review
ES CSC	East Sussex Children's Social Care
SCPB	Safer Communities Partnership Board
ESHT	East Sussex Healthcare NHS Trust
GBH	Grievous Bodily Harm
HBC	Hasting Borough Council
Health IDVA	Health Independent Domestic Abuse Advisor
Health in Mind DNA	Health in Mind - Did not attend
IDVA	Independent Domestic Abuse Advisor
MDMA	Methylenedioxymethamphetamine-commonly known as Ecstasy.
OCD	Obsessive Compulsive Disorder
OPA	Outpatients Admission
PNC	Police National Computer
RDC	Rother District Council
SCCG	Sussex Clinical Commissioning Group
SPFT	Sussex Partnership NHS Foundation Trust
VWD	Von Willebrand's disease (a bleeding disorder)

The East Sussex Safer Communities Partnership and the DHR Panel wish to express their sincere condolences to the family and friends of Marie. Also, following the death of Marie's mother during the review, we would like to extend our condolences to Marie's sister.

Pen Portrait

Marie was a sister, a daughter, a mum, an auntie, a friend and so much more. We miss her so much and wanted to share how wonderful she is.

Marie was fun, loving, and thoughtful. We've always been a close family; family is everything to us. We moved to the area as a three in 1995, my mum and her two daughters. Now there are only two of us and we have to learn to live without our Marie.

Since becoming a mum, she had so many plans for the future. She always treated others with respect and valued them; always had time for other people and always gave it. She wouldn't be able to walk past a homeless person without stopping and speaking to them, too kind not to stop. Marie cared about others and was forever putting others before herself. She gave everyone the time of day and paid attention to people that others ignored.

As a mother, Marie would do anything for her daughter. Marie wanted the best for her daughter. When Marie found out she was pregnant she was more than over the moon, her dreams had come true. Her daughter was her life, her world, her everything. Marie was always close to her sister, but the pregnancy brought us even closer together. She loved being pregnant as well as being a mum and she took to it so well.

My sister and I were the life of the party, we were a team and supported each other throughout our lives. We were very, very close and had each other's backs over everything. You could always tell what sort of mood she was in, as soon as I saw my sister, I could tell by the way she moved. Marie's unexpected departure has left a huge void in our hearts, homes, and lives. We will all miss her forever and are grateful for every moment we had her.

Marie's Sister, Mum and Family

1.0 PREFACE

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Marie and her family before Marie's death in July 2019. The East Sussex Safer Communities Partnership determined that the criteria for a DHR had been met under DHR Statutory Guidance 2016, in particular paras 13(a).[1] The review will identify any agency involvement and will also seek to understand the family dynamics in the build up to Marie's death, whether support was accessed within the community, whether there are identified gaps in provision and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2 **DHR:** Domestic Homicide Reviews became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.

1.2.1 The Domestic Abuse Act 2021 defines domestic abuse as:

- ***Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:***
  a. *A and B are each aged 16 or over and are personally connected to each other, and*
  b. *the behaviour is abusive.*
- ***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.

"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.*

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

1.2.2 Definition of "personally connected"

For the purposes of this Act, two people are **"personally connected"** to each other if any of the following applies:

[1] DHR-Statutory-Guidance-161206.pdf(publishing.service.gov.uk)

a. *they are, or have been, married to each other.*
b. *they are, or have been, civil partners of each other.*
c. *they have agreed to marry one another (whether or not the agreement has been terminated).*
d. *they have entered into a civil partnership agreement (whether or not the agreement has been terminated).*
e. *they are, or have been, in an intimate personal relationship with each other.*
f. *they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2)).*
g. *they are relatives.*[2]

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

1.3 **Time scales:** The review began in November 2020 and concluded with submission to the Home Office in February 2023.

The DHR timeline was extended (with Home Office approval) due to several reasons.

a. Appeal process by the perpetrator -James made several appeals and it was not possible to interview him until such time as the formal appeal process had concluded.
b. Impact of COVID-19 and the ability/time for professionals to produce IMRs under these circumstances.

In addition to the above, there were internal delays at both the CSP and the Home Office which led to submission in February 2023, receiving feedback late 2023 and publication in summer 2024.

1.4 **Incident summary:** The purpose of this review is to examine the circumstances surrounding Marie's tragic death in **July 2019** when she was murdered by James.

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

1.6 Dissemination: *The Overview Report, Recommendations and Executive Summary have* been redacted to ensure confidentiality, with pseudonyms used for the victim, child and family. The reports have been disseminated to the following groups.

- Sussex Police and Crime Commissioner
- East Sussex Safeguarding Adults Board

[2] Domestic Abuse Act 2021 www.legislation.gov.uk

- East Sussex Safeguarding Children's Partnership
- East Sussex Multi-Agency Domestic Homicide Review Oversight Group
- Domestic Abuse Commissioner

2.0 DETAILS OF THE INCIDENT

2.1 The police received a 999 call from James **late one evening in summer 2019** reporting that "Marie and I had an argument, she, Marie, had gone for me, she had a knife, I restrained her, think I did it too hard, she is not breathing". The police and an ambulance arrived and began cardiopulmonary resuscitation (CPR), but Marie could not be revived. Marie was pronounced dead at the scene and James was initially arrested for Grievous Bodily Harm (GBH) and then murder.

2.2 **Post-mortem:** The initial post-mortem which took place in **summer 2019** and concluded that Marie had died because of a compression to the neck. Following further examination, the Pathologist confirmed the findings relating to Marie's neck injuries which had led to her death. The samples were examined by a professor of pathology who was a consultant musculoskeletal pathologist. The pathologist confirmed the findings relating to Marie's neck injuries had been the cause, leading to Marie's death. A further observation was recorded by the pathologist stating,

"There is another finding which may be of significance, soft tissue haemorrhage in the right sternohyoid muscle (strap muscle at the front of the neck) with an established mesenchymal tissue response. The soft tissue reaction indicates that this intramuscular haemorrhage occurred more than two days prior to death and probably less than 7 days prior to death. This intramuscular haemorrhage would have been caused by direct blunt trauma of compressive force."

3.0 THE REVIEW

3.1 SCPB was notified of Marie's death in **July 2019** and the SCPB decided that the criteria for a DHR had been met and Liz Cooper- Borthwick was appointed as Independent Chair in September 2020.

3.2 The DHR was commissioned by SCPB in accordance with the revised Statutory Guidance for the conduct of Domestic Homicide Review[3] published by the Home Office in March 2016.

4.0 TERMS OF REFERENCE

4.1 Terms of Reference were agreed by the DHR Panel in November 2020 and were regularly reviewed and amended as further details of events in Marie's life emerged. The Terms of Reference are included in Appendix One.

5.0 PARALLEL INVESTIGATIONS AND RELATED PROCESSES

5.1 Criminal Investigation

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

Following Marie's death, James was charged with her murder. James was tried by a jury in a Crown Court early 2020, was convicted of Marie's murder and was sentenced to a term of life imprisonment.

James lodged an appeal against his conviction which was examined by the Court of Appeal in the summer of 2020. The examining Judge refused the application.

5.2 Inquest

An inquest was not held as criminal proceedings were instituted on a charge of murder. See 5.1 above.

6.0 PANEL MEMBERSHIP AND REPRESENTATIVES

The Panel consisted of senior representatives from the following agencies.

NAMED OFFICER	ORGANISATION	ROLE
Liz Cooper-Borthwick	LCB Consulting LTD	Independent Chair
Natasha Gamble	East Sussex Safer Communities Partnership	Strategy and Partnership Officer Domestic Abuse, Sexual Violence and Abuse and Violence against Women and Girls (VAWG) Joint Unit, Brighton and Hove and East Sussex.
Jane Wooderson	Sussex Police	DS Safeguarding Reviews, Strategic Safeguarding Team.
Gillian Field	Sussex CCG	Designated Nurse Adult Safeguarding, CCG[4]
Bryan Lynch	Sussex Partnership Foundation Trust	Deputy Director, Social Work
Gail Gowland	East Sussex Health Care Trust	Named Nurse Safeguarding Children (Acting Head of Safeguarding)
Jo Tomlinson	Sussex CCG	Assistant Head of Safeguarding Children and Designated Nurse.
Debbie King	Change, Grow, Live, (Specialist Domestic Abuse Service)	Service Manager
Richard Parker-Harding	Representing Rother and Hastings District Councils	Head of Environmental Health, Rother District Council

[4] Clinical Commissioning Groups have been replaced by Integrated Care Boards since this report was written https://www.eastsussexccg.nhs.uk/wp-content/uploads/sites/3/2022/06/3.2.1-Closedown-Report.pdf.

The panel met five times during the period November 2020 to December 2021 (all virtual meetings).

6.1 Independence of Chair

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

7.0 SUBJECTS OF THE REVIEW

The main subjects of this review are:

DHR subject	Age at death of Victim
Marie **(Victim of domestic abuse)**	**29 years old**
James **(Perpetrator of domestic abuse)**	**37 years old**
Bonnie **(Mother, Marie and Father, James)**	

Significant others:

Subject	Relationship
Marie's sister	Marie's sister
Susan	Marie's mother
Peter	Marie's husband
Glen	Friend
Rob	Friend

8.0 METHODOLOGY

Contributors to the Review

8.1. Statutory and Voluntary Agencies:

Each involved agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. Authors were independent of the incident and the reports were Quality Assured by the organisation. As the review progressed, additional agencies were identified who had contact with the family members and further information was requested. IMRs were received from:

i. Sussex Police (the Police)
ii. Sussex Clinical Commissioning Group (CCG on behalf of GPs)
iii. Sussex Partnership Foundation Trust (SPFT)
iv. East Sussex Health Care NHS Trust (ESHT)
v. Hasting Borough Council (HBC)
vi. Rother District Council (RDC)

The agencies were asked to review their contact with Marie, James, and Bonnie for the period **1 January 2016** up to Marie's death in the **summer of 2019.** If agencies had any significant information outside this timeframe, then they could include the information. The timeframe was chosen to reflect Marie's prior marriage to Peter, her desire to start a family and her relationship with James.

The Panel invited IMR authors to a panel meeting and have given detailed consideration and professional challenge to the IMRs submitted by these agencies. The final documents have contributed significantly to this report.

8.2 Involvement of Family and Friends

Marie's sister and mother participated fully in the review. They wanted Marie's story to be told. The Independent Chair met with the family and the family advocate on several occasions using virtual media and one face to face meeting to discuss the content of the draft report. The family were provided with the Home Office family information DHR leaflets. The family also had the opportunity to review the Terms of Reference, the final draft of the DHR Overview Report and they were regularly kept updated on progress of the DHR. The family chose the pseudonyms for Marie and Bonnie. The family would have liked to have used Marie's actual name but understood the need to protect Bonnie. The remaining pseudonyms were chosen by the DHR Panel.

The Independent Chair did try to speak with some of Marie's friends via Marie's sister, but contact was not possible as the friends had moved or contact details could not be found.

8.3 Contact with James

The Independent Chair, accompanied by a Panel Member, had a virtual meeting with James in July 2021. The meeting explored James's issues and behaviours and whether agencies could have supported him, especially around his substance abuse, mental health issues and his relationship with Marie. James's Prison Probation Officer was very supportive in arranging the meeting and the Independent Chair would like to thank her for her time and support.

8.4 Contact with Bonnie

Bonnie was a baby when Marie died. Her aunt, Marie's sister, now has a Special Guardianship Order (SGO) for Bonnie. Bonnie was present at a virtual meeting between the Independent

Chair and the family and she appeared to be vibrant and thriving with the support of Marie's sister and Marie's mother.

8.5 Research and contacts by the Chair

8.5.1 The Police provided the Independent Chair and the Panel members with two diaries that Marie had kept over several years. The diaries gave a detailed account of what Marie was experiencing both physically and emotionally. The diaries also gave an insight into Marie's intelligent understanding of what she was experiencing and her practicality in trying to get on with life and do the best for Bonnie.

8.5.2 James also made available a considerable amount of documentation, although this was not requested. The Independent Chair reviewed only the documentation that she had requested.

8.5.3 As Marie and her family did not engage with any specialist domestic abuse service, the Independent Chair engaged with Change Grow Live (CGL), outside of the DHR Panel meetings. This enabled the Independent Chair to fully understand the services provided by CGL and how victims of domestic abuse and / or their families access their services. This information has been included in the report.

9.0 EQUALITIES

9.1 Marie was a 29 -year-old heterosexual white British woman. Marie met James in 2017 and their relationship was on/off until Marie's death.

9.2 James is a heterosexual white British man who was 36 years old when Marie died.

9.3 The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Two of these characteristics are considered by the review to have had an impact – sex/gender and pregnancy and maternity. These characteristics are considered later within this report (Section 15.3).

10.0 KEY PRACTICE EPISODES (KPEs):

Social Care Institute for Excellence (SCIE)-Learning Together [5]

10.1 Significant information has been made available for this review and the DHR Independent Chair has utilised the SCIE model "Learning together" to identify the key episodes in the lives of Marie, James and Bonnie in the lead up to Marie's murder.

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

- **KPE One:** Marie's early life
- **KPE Two:** Marie experiencing mental health issues
- **KPE Three:** James and his arrest for drug use and violence towards females
- **KPE Four:** Marie's relationship with Peter and escalation in Marie's mental health issues

[5] https://www.scie.org.uk/children/learningtogether/

- **KPE Five:** Relationship between Marie and James
- **KPE Six:** Marie and housing issues
- **KPE Seven:** Birth of Bonnie and on/off relationship with James
- **KPE Eight:** Marie's death

10.3 Examples of domestic abuse including controlling coercive behaviour and the homicide timeline (Dr Jane Monckton Smith 2020)[6] are highlighted within the analysis.

11.0 BACKGROUND INFORMATION (THE FACTS) OVERVIEW OF FAMILY LIFE

11.1 Marie and James met in a nightclub and they, according to family, "hit it off." James appeared to be a "real charmer" and pursued Marie through Facebook. They started their on /off relationship in 2017 which continued until Marie's murder in mid-2019. James stayed at Marie's flat most evenings, but he also had his own flat in the area. Marie and James had their daughter, Bonnie, in late 2018.

12.0 VOICE OF THE VICTIM

Based on information provided by Marie's family, the IMRs, and contact with agencies.

12.1 Marie was a vibrant young woman. Marie's diaries identify how organised she was and always wanting to do the best for Bonnie. Marie had great strength; when she was struggling with her housing needs, she approached a local councillor and a Member of Parliament. Not only did this show how strong Marie was, but also how she worked through any problems she may have had to achieve the best for her and Bonnie.

12.2 Although Marie suffered intermittently with her mental health, she sought support to ensure she remained in good health. Evidence indicates that Marie's voice was not always heard, as James used Marie's mental health issues to undermine her and to stop her seeking help from agencies about the abuse she was living with. James would say "*you are mad, they will not believe you and they will take Bonnie away,"* (example of emotional abuse).

12.3 Bonnie was the child that Marie struggled to conceive, and it is likely that the fear of losing Bonnie meant that Marie did not seek support that could have helped her and agencies were unaware of her situation.

13.0 CHRONOLOGY

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

13.1 Key Practice Episode One: Marie's early life

13.1.1 Marie's family were originally from the southwest of England. Marie's mother, Marie and Marie's sister moved to the south coast for a holiday in the late 1990s and never returned to the family home.

[6] Intimate Partner Femicide Timeline; Dr Jane Monckton-Smith University of Gloucester www.womensaid.ie

13.1.2 Marie had several health issues when she was young, including asthma and a burst inner ear which impacted on her ability to hear. Marie also had to have her jaw broken and reset.

13.1.3 When Marie went to her secondary school she started to suffer with anxiety, and from year nine (aged about 14 years old) she was home-schooled. Marie would stay in her own room and would write about her emotions.

13.1.4 Once Marie had completed her education, she started work in a shop where she remained for 5 years before becoming a care worker in a home.

13.2 Key Practice Episode Two: Marie experiencing mental health issues (2011-2013)

13.2.1 In **January 2011**, Marie was referred to Health in Mind (SPFT). The risk screening tool stated that Marie believed that she could intentionally cause harm to others and was at significant risk of causing harm to others because of her mental health difficulties. An assessment took place in **June 2011** and Marie was provided with a self-help guide. The apparent delay in assessment related to difficulties in engaging with Marie (*Source: SPFT IMR).*

13.2.2 In **September 2011** Marie was offered a follow up appointment with Health in Mind[7] and guided self-help prior to being discharged from the counselling services on **29 September 2011.**

13.2.3 Marie was again referred to Health in Mind on **16 April 2013**. A triage was completed within the allocated timeframe (2 days). Marie accepted the treatment with the Primary Care Mental Health Worker and a review was booked for **14 May 2013**. Marie did not attend the planned appointment and the Health in Mind and the Did Not Attend (DNA) policy was followed. An “opt in” letter was sent to Marie on **7 June 2013** which Marie did respond to. However, Marie did not attend the next arranged appointment on **9 July 2013** and was then discharged back to her GP for further support (*Source: SPFT IMR*).

13.3 Key Practice Episode Three: James and his arrest for drug use and violent crime (2015-2016)

13.3.1 In **June 2015** the Police were called to a bar as James was found in possession of a brown crystalline substance. James was intoxicated and denied being in possession of the substance and was arrested. The drug was field tested and was found to be class A drug Methylenedioxymethamphetamine (MDMA)[8]. James was interviewed and made a full admission to possessing the substance, stating it was for his personal use. The quantity of drug found reinforced this and coupled with James’s admission and previous good character, he received a simple adult caution. This caution was the appropriate action by the police in accordance with Sussex Police Drug policy and was recorded on the police national computer (PNC) *(Source: Police IMR).*

[7] Health in Mind -www.health-in-mind.org.uk

[8] Methylenedioxymethamphetamine (MDMA) commonly known as Ecstasy. Psychoactive drug primarily used for recreational purposes.

13.3.2 **April 2016** James was in a bar and became very intoxicated and the bar staff refused to serve him. James left the bar with a female known to him and went with her to her adult daughter's house. James collapsed, with friends believing he was under the influence of not just drink but also drugs. The two females arranged for a taxi to collect James and take him home. As the two females tried to get James to the front door, he became very aggressive and grabbed the younger female by the throat to such an extent that the younger female was struggling to breathe. The mother of the younger female tried to intervene, but James started to pull her hair. The situation was eventually diffused by others in the flat at the time, pulling James away.

13.3.3 Both females made a statement to the police but one stated that she had spoken with James, and he was very remorseful and apologised. The two females stated they did not want to pursue the matter further and it was agreed to close the incident by a Community Resolution[9]. A community resolution is a nationally recognised out of court disposal option for lower risk crimes and anti-social incidents which forms part of the National Police Chief Council's (NPCC) Justice Outcome Framework[10]. It is a tool designed to enable the police to use their professional discretion and judgement on how to deal with lower risk crime.[11] It is aimed at first time offenders where it is believed genuine remorse has been expressed. Whilst the Community Resolution is an informal non-recordable Out of Court Disposal, it is disclosable as part of any enhanced Disclosure and Barring Service (DBS)[12] check *(Source; Police IMR).*

13.3.4 Witness evidence gathered by the Police as part of the criminal investigation into the death of Marie indicates that James was manipulative and aggressive in a previous relationship. The female in this relationship states that James would put her down and accuse her of cheating on him.

(This behaviour by James is an example of Stage One of the Homicide Timeline - pre relationship history of abuse).

13.4 Key Practice Episode Four: Marie's relationship with Peter and escalation with Marie's mental health issues (2016- 2017)

13.4.1 In 2016 Marie and Peter got married and Marie was desperate to have a baby, but they struggled to conceive. **In 2016 to 2017**, Marie was seen by the Gynaecology and Haematology services provided by East Sussex Healthcare to investigate her fertility *(Source: ESHT IMR).*

13.4.2 **In January 2017**, Marie was admitted to the Early Pregnancy Unit at East Sussex Healthcare, having suffered a miscarriage. In the words of Marie's family, "Marie was devastated." Following the miscarriage, the relationship between Marie and Peter began to break down. Marie's family described the breakdown of the relationship being due to Marie and Peter wanting different things in life. Despite the break-up of the marriage, Marie and Peter remained living in the same house *(Source: ESHT IMR)*.

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[9] Community Resolution: www.justiceinnovation.org
[10] NPCC Justice Outcome Framework www.npcc.police.uk
[11] However, ACPO guidance is clear that community resolutions should not be used in connection with offences of serious violence and never in cases of domestic violence.
[12] Disclosure and Barring Service Check: A check carried out of your criminal record carried out by the DBS. It is used for employment in certain sectors and professions and volunteering. www.gov.uk/DBS

13.4.3 Following the breakdown of Marie and Peter's relationship, Marie met James sometime in **February/March 2017** in a nightclub. James pursued Marie on social media and was very persistent but according to Marie's family he presented as a "charmer."

13.4.4 **March 2017**: Marie met Rob and Marie told him that James was controlling and had knocked her about. Marie went on to explain that James went with other women and was a drug user who physically and mentally controlled her.

13.4.5 **May 2017,** Marie, her sister, James and Glen had gone out together and on returning to Marie and James's address, a row erupted between Marie and James. Marie left the house and James "turned" on Glen, grabbing him by the throat and restricting his beathing for around twenty seconds. When James released Glen, he left the house quickly. *(Source: Police IMR).*

13.4.6 **24 August 2017** Health in Mind received a further referral from Marie's GP. Following a triage of the information, an initial phone contact was made to book an appointment for Marie but there was no answer, and a message was left. Marie responded sometime after, and an initial appointment was arranged for **22 September 2017** when the initial assessment was completed.

13.4.7 Based on the assessment, a referral was made to secondary mental health services for an outpatient appointment and medical review with a psychiatrist. At this meeting Marie reported that she had called 111 "due to feeling panicky" and that she was "advised to take an extra half a tablet and drink alcohol". (*Source: SPFT and CCG IMR*)

The statement from Marie as detailed in the SPFT IMR cannot be verified and 111 was contacted but they could not confirm any contact as detailed above.

13.4.7 **September 2017:** Marie told a friend that James and she had had a fight and that James had hit her. James had accused Marie of being "slutty" and she told the friend that she had not been to the police as James would "wriggle out of it." (*Example of James undermining and humiliating Marie*) (*Source: Police IMR).*

13.4.8 **9 October 2017**: Marie attended an appointment with a psychiatrist and was accompanied by her sister. Marie reported she had been struggling with her mood and had been feeling very anxious and depressed. Marie also said that she had been focussing on her health anxieties and was worried about death because of illness. Marie explained she had been under a lot of stress due to a build-up of various things in her life. Marie reported her anxiety symptoms as heart racing, feeling sweaty, hot, becoming sick and wetting herself. Marie stated she had difficulty in focussing or thinking and that only professionals could reassure her. Marie stated that she had become verbally and occasionally physically aggressive. Marie added that her moods were up and down and felt balanced on some days but that certain life events could affect her mood and that she relied on her family for help and support.

13.4.9 The psychiatrist noted that Marie was coherent and relevant, her mood was up and down but that she was not severely depressed, with no active suicidal thoughts. It was also noted that Marie had an insight into her condition and had the capacity to make decisions regarding treatment. The completed risk assessment stated the following.

- Suicide/self-harm-low

- Neglect- low
- Violence-low

13.4.10 Marie informed the psychiatrist that she had decided to move from her home with Peter. The psychiatrist considered whether Marie was suitable for Cognitive Behaviour Treatment[13] (CBT) which they did and Marie was placed on a waiting list for CBT.

13.4.11 Marie attended her first CBT session on **16 November 2017**. The main presenting problem by Marie was Obsessive Compulsive Disorder (OCD)[14]. Marie stated that she had been previously diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)[15] following an outpatient appointment (OPA).

13.4.12 Marie had a further CBT session on **23 November 2017**. Marie reported she had had a miscarriage on her birthday in 2016 and how she had saved her mother from dying when she was in hospital. Marie had a further appointment on **30 November 2017** which she did not attend as she was unwell. (S*ource: SPFT IMR*).

13.4.13 The following day Marie attended accident and emergency at her local hospital with left sided flank pains (*Source: ESHT IMR*).

13.5 Key Practice Episode Five: Relationship between Marie and James (2017-2018)

13.5.4 As above, Marie and James met in 2017 in a nightclub. Marie became pregnant in **April 2018** (James being the father) and she attended an antenatal clinic appointment in **June 2018** when she was 14 weeks pregnant along with her mother. The professional noted that Marie had a condition known as Von Willebrand Disease (VWD) which is a common inherited condition that can make you bleed more easily than normal.[16] As a result, Marie was referred to a haematologist and monitored throughout the pregnancy. Marie went on to explain that this was her third pregnancy, that she had had an ectopic pregnancy in **early 2017** and a second miscarriage later the same year. Marie explained that she felt depressed after each miscarriage. Marie also informed professionals that she had separated from her husband and the father was James. Marie explained she had severe anxiety about Human Immunodeficiency Virus (HIV) infection but would not divulge the reason behind this. During the consultation, the midwife asked Marie's mum to leave the room and a general question was asked about domestic abuse (standard policy). Marie did not disclose any past or current domestic abuse to the midwife *(Source: ESHT IMR).*

13.6 Key Practice Episode Six: Marie and housing issues (2018)

13.6.1 **1 October 2018:** Marie presented as homeless to Hastings Borough Council (BC) Housing department. Marie explained that she had been sofa surfing at her sister's house after she had left her property which she had been sharing with her estranged husband. Marie explained that she had had a break down in her mental health and that she was pregnant and

[13] Cognitive Behaviour Treatment- Using behavioural and cognitive techniques for treating depression
[14] Obsessive Compulsive Disorder-A personality disorder characterised by excessive orderliness, perfectionism to details, and a need to control others.
[15] Attention Deficit Hyperactivity Disorder- Is a mental health disorder that includes a combination of persistent problems such as difficulty paying attention, hyperactivity and impulsive behaviour.
[16] Von Willebrand disease. - www.nhs.uk/condtions/von-willebrand-disease.

that she had been overwhelmed with being in the property and decided to move out *(Source: Hastings BC IMR).*

13.6.2 **2 October 2018:** The health visitor met with Marie at her sister's house with both Marie's sister and Marie's mother present. The health visitor discussed domestic abuse and Marie disclosed physical abuse which she described as a "slap." Marie told the health visitor that she was no longer in the relationship with James and she was not sure if he would be involved in the birth.

13.6.3 **11 October 2018:** Marie visited her GP and was diagnosed with gestational diabetes which continued throughout her pregnancy. On the same day James attended A&E stating he was having difficulties breathing and the impression was that it was a chest infection *(Source: CCG and ESHT IMR).*

13.6.4 **25 October 2018:** Marie contacted Rother District Council (DC) saying she was staying with her sister; the house was overcrowded and she was 31 weeks pregnant. Marie also went on to explain that she had mental health issues and that she was in treatment. Marie continued to liaise with the housing department, and she finally secured a two-bed property six-month tenancy on which she paid the deposit and rent in early **December 2018**. It was explained by the Housing Needs manager that the council would only consider funding a one-bed property. Marie made the decision to write to her local Member of Parliament (MP) about the service she received from Rother DC Housing department (*Source Rother DC IMR*).

13.7 Key Practice Episode Seven: Birth of Bonnie and on/off relationship with James (2018)

13.7.1 Late **December 2018** Bonnie was born. (*Source: CCG IMR*) The midwife visited Marie and Bonnie five days and ten days after the birth at Marie's sister's house (*Source: ESHT IMR)*.

13.7.2 **4 February 2019:** The health visitor met with Marie, Marie's mother and Marie's sister for a six-eight-week review. At this meeting Marie stated that James was a good father and that she was considering resuming the relationship (*Source: ESHT IMR).*

13.7.3 **19 February 2019:** SPFT Health in Mind received a referral from Marie saying she noticed she was becoming irritated or upset or slightly snappy, more than normal, that she did not feel at risk to herself or anybody else, but that she was experiencing anxiety and low mood swings since giving birth, and not feeling herself *(Source: SPFT IMR).*

13.7.4 SPFT triaged the referral and Marie was referred into Step Three CBT treatment. The referral was prioritised as Marie was perinatal.[17]

13.7.5 Marie attended her first CBT session in early **March 2019,** and it was agreed between the clinician and Marie that the focus should be around her low self-esteem (*Source: SPFT IMR).*

13.7.6 **8 March 2019:** Marie took Bonnie to A&E as Bonnie had a history of being sniffly and Bonnie was discharged home for a review with the GP. Bonnie was admitted to a Specialist

[17] Perinatal relating to time, usually number of weeks, immediately before and after birth.

Care baby unit four days later, having been diagnosed with a viral illness and was discharged the following day *(Source: ESHT IMR).*

13.7.7 Marie attended her second CBT appointment on **27 March 2019**. The clinician noted that Marie's anxiety appeared to be the primary issue and that she was struggling to bond with Bonnie due to returning OCD thoughts *(Source: SPFT IMR).*

13.7.8 **4 April 2019:** Marie cancelled her CBT appointment as there was a family emergency and a further appointment was booked for **11 April 2019** which Marie did not attend.

13.7.9 The health visitor met with Marie and Bonnie on **16 April 2019**. Marie expressed her concerns to health visitor about her "ex-partner" James' possible use of cocaine. Marie told the health visitor that if James did not comply with drug testing, then she would not permit James to see Bonnie.

(This would indicate that the relationship had broken down between Marie and James and potentially a threat to James's control when the relationship was "off." Example of Stage Four of the Homicide Timeline).

13.7.10 During the period between **mid-May 2019 and July 2019**, Marie made several phone calls to the health visitor to discuss several issues relating to Bonnie including teething and weaning.

13.7.11 **10 July 2019:** Marie contacted her local councillor to complain about damp in her rented flat and the antisocial behaviour of her neighbour. The local Councillor referred the complaint to the housing department at Rother DC. Rother DC reviewed the complaint but on **19 July 2019**, Marie informed her local Councillor that she did not want to pursue the complaint any further as she wanted to remain on good terms with the landlord. (*Source: Rother DC IMR)*

13.7.12 **23 July 2019**: Marie attended A&E in an ambulance as she had abdominal pain and nausea. Evidence recorded by the Ambulance service suggested that James and Marie had resumed their relationship. *(This information again gives an indication about the on/off relationship between Marie and James).*

13.7.13 **18 July 2019:** James attended Health in Mind due to pressure of work. He had been signed off work by his GP, but he reported that he was fragile and volatile (in and out of work). James was asked if he had thoughts of harming himself or anyone else. James explained he had had a caution for affray many years ago and the clinician assessed James as not being a risk to others in relation to harm *(Source: CCG IMR*).

13.8 Key Practice Episode Eight: Marie's death (2019)

13.8.1 Late **July 2019**, Marie, James and Bonnie spent the day together including a visit to Marie's sister's house. Marie saw Rob in the street and chatted with him before entering Marie's sister's house. James went straight into the house. From IMR information, Marie and James were getting on well, but on returning to Marie's house later that day, James's mood had changed and he became abusive and obsessive. Shortly before midnight, Rob received a Facebook message from Marie asking if he and she had ever had an affair. The message was followed up with a phone call from Marie which Rob did not answer. Rob assumed Marie's

message and call was instigated by James. Rob sent back a message saying they had not had an affair and the friend saw that the message was read straight away.

13.8.2 Late in the evening, James phoned the police to say there had been an argument and that Marie had stopped breathing. (*Source: Police IMR*)

14.0 OVERVIEW-ENGAGEMENT WITH OTHER AGENCIES AND IMR FEEDBACK

This section has been compiled from the Individual Management Reviews (IMRs) submitted by the agencies involved in this case. The IMRs aimed to provide an accurate account of an agency's involvement with Marie, James and Bonnie up until the date of Marie's murder. All IMRs have been challenged robustly by the panel and, where appropriate, have been subject to review and revision.

Some IMR comments have been included under the relevant KPEs in the main body of the report, to provide a clearer, chronological overview. Where this is the case, the IMR source is clearly referenced.

14.1 Sussex Police

14.1.1 Sussex Police (the Police) had no contact with Marie and James in relation to domestic abuse prior to Marie's death. Sussex Police had contact with James in **June 2015** when he was arrested for being in possession of a Class A drug. There was a further occasion in April 2016 when James assaulted two women, grabbing one by the throat and pulling the hair of another whilst under the influence of drugs /alcohol. The two females involved did not wish to pursue the matter to court as James was a friend. It was agreed that the incident would be closed by a Community Resolution (CR) (see page 14).

14.1.2 The IMR author noted that this issuing of a CR was appropriate, and that the method of disposal accorded with Approved Professional Practice (APP) Guidance and with the Terms of the Sussex Police Community Resolution (current policy no 1091/2019).[18]

14.1.3 ***Lessons Identified:*** *None*
14.1.4 ***Recommendations and implementation: None***

14.2 East Sussex Clinical Commissioning Group (GPs)

14.2.1 Marie consulted fairly frequently with her GP practice about her mental and physical health problems. It was noted that Marie came across as someone well engaged, wanting to make positive changes for herself. The GP stated that Marie experienced intermittent episodes of anxiety which featured health anxieties and worry about physical symptoms. It was also noted that Marie's sister was very supportive of Marie, often attending appointments with her.

14.2.2 When Marie presented with mental health issues in June 2017, following the breakup of her marriage with Peter, her ectopic pregnancy and the death of her pet dog, she was

[18] Policy at time of writing was 1091/2019 but at the time of publication, the policy number was 1091/2022.

prescribed Sertraline and referred to Health in Mind (HiM) to access emotional and psychological support.

14.2.3 In **August 2017** when Marie presented to her GP in crisis, she was again referred to the secondary care mental health team and was seen by Health in Mind (HiM).

14.2.4 The GP supported Marie through her pregnancy and in **June 2018** she was referred to HiM for additional support.

14.2.5 Following the birth of Bonnie, the GP continued to support Marie. On several occasions Marie contacted the GP about her anxiety of not being able to protect Bonnie and the GP advised booking CBT again if her anxiety deteriorated further.

14.2.6 The GP saw Bonnie for her immunisations at 2,3 and 4 months. **In March 2019**, the GP sent Bonnie to hospital for an assessment as she had a viral infection.

14.2.7 ***Lesson Identified:*** There were 24 contacts between Marie and a clinician at the practice over a period of the review of which the majority were relating to Marie's mental health. There is evidence of appropriate referrals to secondary mental health services and there appears to have been good dialogue with Marie. Despite the level of contact, at no time did Marie disclose domestic abuse to anyone at the practice.

*14.2.8****Actions to be Implemented****:* Consideration of whether a safeguarding prompt on the six-week check template or a postnatal check template would be helpful for clinicians. This would provide an opportunity for a patient to disclose.

14.3 Sussex Partnership NHS Foundation Trust (SPFT)

14.3.1 SPFT had four referrals to Health in Mind for Marie between 2011 and 2019. Marie received a total of 25 appointments and received two episodes of NICE guided evidence-based CBT for OCD/anxiety. Domestic violence was not identified from any contact and James was not known or disclosed to be known to SPFT Health in Mind during Marie's last episode of care.

14.3.2 Did Not Attend (DNA) was a theme in each episode of Marie's care but no evidence of safeguarding concerns was noted through the contact.

14.3.3 James was referred to Health in Mind in 2013 and had an initial assessment with his presentation due to work stress and moods and that he felt fragile and volatile in and out of work. James had a follow up session and then did not attend a further session and was discharged for no attendance.

14.3.4 ***Lessons Identified:*** Following the review within this IMR, there is a requirement for SPFT Health in Mind to review its DNA policy. All professionals working in Health in Mind to receive specialist domestic abuse training for primary care.

14.3.5 ***Actions to be implemented:***

Local Working Group to review and update the DNA policy.

Update: *Health in Mind (HiM) (SPFT service involved) has reviewed and updated their DNA policy, via a working group. HiM is having a Domestic Abuse Theme for the next Report and Learn Forum in December 2021 which will include learning from this DHR.*

BONNIE BARTA[19] updated training module to be delivered to all staff.

Update: *BARTA Domestic Abuse training has been offered in July and September 2021 to staff (primary care mental health team practitioners). Primary Care Mental Health practitioners are the "front door" for services and see people in crisis before they are ready for treatment. Further dates for training are being added.*

14.4 East Sussex Heath Care NHS Trust (ESHT)

14.4.1 During the period 1 January 2016 up until Marie's death, ESHT had contact with Marie on 31 occasions. The contacts with Marie were predominately centred on gynaecological investigations and treatment and review of her existing Von Willebrand haematological condition. The IMR author noted whilst reviewing the records that there were no unusual features in the contact with Marie. Much of the involvement was about ante-natal care prior to Bonnie's birth and post-natal support through the local delivery of the Health Child Programme.[20] Within the framework some families can be assessed as requiring enhanced support, but the IMR author noted that Marie and Bonnie received universal services.

14.4.2. The IMR author interviewed many of the ESHT professionals who met Marie, Bonnie and the family, including Obstetric Registrars, Diabetic specialists, midwives, and health visitors.

14.4.3 ***Lessons Identified:*** The IMR identified that it is embedded in practice that midwives will discuss domestic abuse at a woman's initial booking contact and at an early-stage Marie was identified to have additional needs and raised a support form (Von Willebrand Condition). However, the IMR author states that domestic abuse is not addressed at every contact within the service. Clinical staff identified that in a busy clinic there is not always the time to discuss such issues and therefore evidence suggests that routine enquiry about domestic abuse is not embedded for all staff.

Staff interaction with Marie was predominately focussed on her health needs and therefore domestic abuse was not always appropriate. Staff also had limited contact with Marie and James as a couple and therefore there was no understanding of how they functioned together.

14.4.4 ***Actions to be implemented:***

i. Women need to be spoken to privately; and a private area at the maternity day unit should be made available to speak with women alone.

[19] Against Violence and Abuse Be Aware and Respond to Abuse Support and advice for Mental Health Trusts wanting to improve their responses to domestic and sexual abuse. www.Bonnieproject.org.uk

[20] Evidence based framework of public health services to families with a child between conception and age 5. www.eif.org

ii. All obstetrics and gynaecological staff to routinely enquire about domestic abuse, to develop a culture of routine enquiry and 'prevent inappropriate to ask.' All staff to attend 'Think Family Training and Domestic Abuse' workshop.

iii. Raise awareness of links between domestic abuse and physical mental presentation. Domestic abuse workshop to be accessible to all staff via Learning and Development.

iv. Embed questions about domestic abuse as part of pre-clerking procedures for surgery. Domestic abuse workshop and implementation of a rapid assessment tool within the organisation.

The DHR Panel recommends that Health professionals should be instructed to record the reasons why it is not possible to make a routine enquiry about domestic abuse on a patient's case file.

14.5 Hastings Borough Council (Hastings BC)

14.5.1 Marie presented to Hastings BC in October 2019 as she was sofa surfing at Marie's sister (her sister's) house. Marie explained she had left her privately rented flat due to the deterioration in her mental health. Marie explained to the housing team that she was pregnant, she suffered OCD and ADHD, anxiety and depression and had gestational diabetes. During the only interview with the housing team, Marie explained she had not been a victim of domestic abuse.

14.5.2 Hastings BC carried out a vulnerability risk assessment which included questions relating to domestic abuse in all its forms, physical, emotional, economic. Although Marie could have been deemed to have made herself intentionally homeless as she had left her private rented accommodation prior to the lease ending, Hastings BC accepted a 'Duty of Care' in accordance with section 189B (2) Duty[21]. Marie was expected to provide documentary evidence of her pregnancy, bank details and tenancy agreement. Hastings BC closed the case after 56 days as Marie had not presented the documentary evidence as required by the housing team.

14.5.3 ***Lessons Identified:*** The handling of Marie's case by the Housing Service Team was deemed good practice as the decisions were based on professional judgement and consideration of all the evidence as provided by Marie.

14.5.4 ***Actions to be implemented*:**
Housing Team to undertake domestic abuse training in all its forms annually. The DHR Panel would want to ensure that this is mandatory training for all housing staff.

As Hastings BC had no contact with other agencies, they could only make decisions around Marie based on their own intelligence. The IMR author identified that a review should be taken by the relevant Safeguarding Boards about what should be communicated and when.

[21] Section 189 B of the 1996 Housing Act Chapter 13 Relief Duty -Guidance on duties owed to applicants who are homeless, to try and relieve their homelessness. www.gov.uk

14.6 Rother District Council (Rother DC)

14.6.1 Marie first contacted Rother DC on 25 October 2018 when she was staying with Marie's sister and was 31 weeks pregnant. Marie did not mention James or domestic abuse to the housing officer.

Marie made two complaints involving Rother DC, one to her MP relating to what she felt was not good service from Rother DC and the second (June 2019) to a local councillor relating to a complaint about her landlord and noisy neighbours. Both complaints were reviewed, and the latter complaint was dropped by Marie, as she wanted to remain on good terms with her landlord.

14.6.2 ***Lessons Identified:*** As contact was limited with Marie, no lessons have been identified at this stage.

14.6.3 ***Actions to be implemented.*** Following completion of this DHR, the Panel would suggest that the final overview report is utilised in DA training for housing staff.

15.0 ANALYSIS

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

15.1.2 From information provided, only close family and friends were aware of the abuse that Marie was experiencing from James. Despite Marie being asked about domestic abuse during her contact with health professionals during her pregnancy, there was no disclosure and therefore health professionals focused on Marie's mental and physical health. At no time did Marie or her family seek any specialist domestic abuse support.

15.1.3 Key themes were identified through the IMRs and discussion with professionals involved with the family:

- Domestic abuse: physical and coercive and controlling behaviour.
- Mental health issues relating to Marie.
- Lack of professional curiosity around domestic abuse
- Understanding by professionals of the relationship between domestic abuse and mental health
- Understanding by professionals and the wider community of the behaviours of a perpetrator including the crime of non-fatal strangulation.
- Impact of substance abuse on a perpetrator of domestic abuse.
- Impact of housing needs for a victim of domestic abuse.

15.2 Awareness and understanding of professionals and the wider community, of the potential presence of coercive control and how it may have impacted on the behaviour of the victim and perpetrator.

15.2.1 It is clear from the information provided by Marie through her diary, the family and evidence detailed in the IMRs that Marie experienced domestic abuse, both physical and emotional, in her on / off relationship with James.

15.2.2 Marie messaged a friend in late **September 2017** that there had been a fight and James had hit her *(Physical abuse).* The friend stated that Marie had a bruise on her jaw. Allegedly, James had accused Marie of being "slutty" during a night out and then hit her. Marie said she did not go to the police as "James would wriggle out of it." *(Example of physical abuse and coercive control).*

15.2.3 Marie met another friend in **2017** and she disclosed to the friend that James was controlling and that he had "knocked her about." *(Further example of physical abuse).* Marie went on to inform the friend that James was seeing other women, was a drug user and he would go off for weeks and blame her including how she dressed, her appearance, how she kept the flat and he made her feel that she was always wrong, and constantly put her down. (*Examples of emotional abuse by James and the relationship becoming dominated by coercive control, Stage Three Homicide Timeline, Dr Jane Monckton Smith).*

15.2.4 There was an incident in **July 2019** when the friend saw James and Marie, and Marie stopped to chat, but James went straight into the house they were visiting. Later that evening, the friend received a message from Marie asking if they (the friend and Marie) had ever had an affair. The friend then received a phone call from Marie which he did not answer. The friend responded to the message by saying no they had never had an affair. The message was read straight away, and the friend believed that James had instigated the message. *(Example of control by James)*

15.2.5 Marie's sister and Marie were close, and Marie would disclose what was happening between James and her, the arguments, the physical abuse (against which on occasions Marie had to use violent resistance to protect herself). (*Retaliatory violence or violent resistance can mean that when a victim has been abused by their partner, they can retaliate to protect themselves. Boxall, Dowling, Morgan 2020)*.[22] Marie's sister recalled that most of the arguments were about dishonesty and ex-partners and Marie would accuse James of having affairs.

15.2.6 Marie's sister also described an incident when she was with Marie, James and some friends at James's flat. James told Marie to get on her knees and tell him she loved him. Marie did carry out this action. This incident was also detailed in Marie's diary. (*Example of a perpetrator showing power over his victim, humiliation of the victim.)*

15.2.7 In Marie's mobile phone diary (examined as part of the criminal investigation) Marie made a reference to James "strangling her" and a further entry speaks of James whispering

[22] www.aic.gov.au Female perpetrated domestic violence; Prevalence of self-defensive and retaliatory violence. Boxall, Dowling &Morgan 28-01-2020

an apology in her ear for strangling her, but that if she called the police no one would listen to her because she was mad. *(Example of escalation of control tactics by a perpetrator including control, manipulation, emotional abuse. Stage four of the Homicide Timeline).*

15.2.8 Coercive control is not primarily a crime of violence but, as Evan Stark (2007)[23]describes, it is a 'liberty crime'. Stark provides a breakdown of coercive controls, e.g., degradation and shaming. James stated that Marie was mad, his behaviour was also intimidating, manipulative and degrading of Marie.

15.2.9 What is clear in this DHR is that only one health visitor was aware that James had "slapped Marie" but that the relationship had now ended. Marie was asked by other midwives about domestic abuse, and she would state that there was no domestic abuse happening to her.

15.2.10 Professor E Gracia in a report for the *Journal of Epidemiology & Community Health*[24] stated that victims of domestic abuse do not seek help for several reasons.

- Embarrassment
- Fear of retaliation. (Evidence suggested that Marie did fear retaliation)
- Economic dependency
- Imbalanced power relationship for men and women in society
- Privacy of the family
- Victim blaming attitudes

15.2.11 Although agencies have training programmes including domestic abuse, professionals clearly understand physical abuse but controlling, coercive behaviour is still more difficult to understand. It takes skill such as professional curiosity to try to understand what a victim of domestic abuse may be experiencing.

15.2.12 Despite the family identifying Marie as a victim of domestic abuse, there appears to have been concern about retaliation from James if anything was reported. Marie details in her diary that "James physically and mentally and gaslighted[25] me all the way through our relationship."

15.2.13 Marie knew she was being abused but she did not seek help. There is no doubt that Marie was fearful of retribution if she reported James. James also put doubt in Marie's mind about whether she would be believed, due to her mental health issues, James would say, "the police would not believe you; you are mad, and Bonnie could be taken away" *(A further example of controlling, coercive behaviour).*

15.2.14 On asking Marie's sister why Marie and the family did not seek support, it was confirmed that there was concern about James's retribution on Marie and the family. The family also stated that they were not aware of any specialist domestic abuse services in the locality.

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[23] Stark. E Coercive control. The entrapment of women in personal life. 2007
[24] www.jech.bmj.com- Unreported cases of domestic abuse against women; towards an epidemiology of social silence, tolerance, and inhibition 2004 Enrique Gracia
[25] Gaslighting is a form of psychological abuse here a person or group makes someone question their sanity, perception of reality. www.medicalnewstoday 14 July 2020

CGL could have supported Marie in not only her safety planning but also in her approach to reporting the domestic abuse to the police.

15.2.15 Change Grow Live (CGL)[26] provides the community-based domestic abuse service in East Sussex for medium and high-risk incidents of domestic abuse. Pathways into the service are referrals from professionals or self-referrals. Services offered include assessment, full support (medium high-risk incidents or safeguarding needs) which could include allocation of an Independent Domestic Abuse Advisor (IDVA), safety planning and other support, or an advice/information/referral or signposting service.

15.2.16 The Independent Chair also discussed with the family whether Marie may have had any childhood memories of the abuse her mother suffered and whether this may have impacted on what behaviour/abuse Marie may have "accepted as normal." Marie's sister and Marie's mother stated that Marie was very young when the relationship between her mother and father broke down and she would have no real recollection of what was happening in the relationship.

15.2.17 There is evidence that James tried to strangle a previous partner, he tried to strangle a male friend and a female friend's daughter and from information within Marie's diary and from police evidence, he tried to strangle her on several occasions. At the time of these incidents, if the police had been aware, they could have only acted under common assault regulations but now with the Domestic Abuse Act 2021, non-fatal strangulation is a specific crime and perpetrators could now face up to five years in jail[27]. (Domestic Abuse Act2021- Part 6 – point 70 and 75A Strangulation of Suffocation).

15.2.18 It will be important that all agencies understand the requirements in the Domestic Abuse Act 2021, whether it be the Police, Social Care, Health, local authorities, or other providers in the voluntary / community sector in order to provide the best possible protection to victims of domestic abuse.

15.2.19 Prior to Marie's death, her main agency support was provided by health, primary and secondary, and therefore it is imperative that all professionals have a thorough understanding of all aspects of controlling coercive behaviour to support a victim of domestic abuse.

15.2.20 This DHR also identifies those professionals and the wider community need to understand the behaviour patterns of a perpetrator of domestic abuse in all its forms. Following extensive research *Jane Monckton Smith* has developed the '*Intimate Partner Femicide Timeline'* which includes the following stages[28].

1. *Pre relationship history; criminal records, allegations*
2. *Early relationship behaviours /early commitment*
3. *Relationship behaviours; risk markers*
4. *Potential homicide triggers; separation, ill health, threats, or rumours*
5. *Escalation; frequency, seriousness, stalking*
6. *Change in thinking*

[26] Change Grow Live www.changegrowlive.org
[27] www.independent.co.uk 11 January 2021 non-fatal strangulation to become a criminal offence after calls from domestic abuse campaigners. Maya Oppenheim
[28] Intimate Partner Femicide Timeline; Dr Jane Monckton-Smith University of Gloucester www.womensaid.ie

7. *Planning; buying weapons*
8. *Homicide*

To note; examples have been highlighted within the Chronology section.

15.2.21 As documented, James had a history of violence, including to women. Evidence shows how James pursued Marie and a relationship appears to have commenced quite quickly. Early in the relationship James was "telling" Marie to move from the home she shared with her husband who she had separated from but had remained friends. Marie's diaries explain the relationship behaviours of James being in control of Marie, gas lighting her, undermining her in addition to physical violence. The behaviour by James identifies significant risk.

15.2.22 The relationship between James and Marie was very on / off and when Marie did disclose to a health worker that she had been hit by James, but they had since separated, this should have raised further questions. Professionals often assume that if the victim and the perpetrator have separated then the risk of domestic abuse is decreased whereas it should identify heightened risk. The perpetrator has lost control and will feel the need to regain it.

15.2.23 Marie's diaries highlighted the increased risk of James trying to control what she should wear, what she should do and the violence in their relationship. The post-mortem highlighted that the violence was increasing as there was evidence of a previous attempted strangulation three days before the homicide.

15.2.24 Professionals and the wider community need to have knowledge and an understanding of the homicide timeline as it identifies heightened risk and will help inform safety planning for a victim.

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

15.3.1 Two characteristics seem pertinent to consider when reviewing why Marie was killed.

- *Sex/Gender*
- *Pregnancy/maternity*

15.3.2 **Sex and Gender**

Marie was more likely to have suffered domestic abuse because she was a female. Research by the Office for National Statistics, (year ending March 2020) stated that 2.3 million adults aged 16-74 experienced domestic abuse in the last year, of which 1.6 million were women and 757,000 men [29]. There are important differences between male violence against women and female violence against men, namely the severity, amount and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby and Towers, 2017) or killed than male victims of domestic abuse (Office for National Statistics 2020). Also, women are more likely to experience higher levels of fear and be subject to controlling coercive behaviour[30].

Evidence identified that James was controlling Marie and using violence against her.

[29] Domestic Abuse in England and Wales Overview 2020 www.ons.gov.uk
[30] www.womensaid.org.uk Domestic Abuse is a gendered crime

15.3.3 **Pregnancy/Maternity**

Although Marie was not pregnant at the time of her death, Bonnie was only several months old when Marie died. Information provided identified that Marie and James continued to have an on/off relationship through her pregnancy and beyond. During her pregnancy and following Bonnie's birth, Marie's mental health deteriorated, with her having concerns about keeping the baby secure. This would have impacted on Marie's vulnerabilities. Marie was desperate for a child, and this may have been a reason for her to continue to be with James. Family members have indicated, and documentation provided by James confirms, that he was starting to consult a solicitor about custody of Bonnie, and this also may have added to Marie's need to be with James.

Pregnancy can be a trigger for domestic abuse and existing abuse may get worst during pregnancy or after giving birth. Domestic abuse during pregnancy can put an unborn child at risk and it can cause mental health and emotional problems such as anxiety and stress which can impact on the development of a child.[31]

The domestic abuse that Marie was experiencing during her pregnancy and following the birth did impact on Marie's mental health and it is important that professionals understand the impact of a victim experiencing domestic abuse during pregnancy.

15.4 Whether there were any barriers experienced by Marie or her family /friends and colleagues in seeking support from professional service providers.

15.4.1 Although Marie never reported or disclosed the domestic abuse she was experiencing fully, evidence would indicate that Marie was proactive in seeking support for her mental health and housing.

15.4.2 The information provided within the IMRs from her GP, SPFT and ESHT highlighted the fact that Marie would engage and was proactive in seeking help for her mental health and physical health. The GP made a comment that "*Marie consulted fairly frequently at the practice about mental and physical health problems and came across as someone who was well engaged, wanting to make positive changes for herself."*

15.4.3 In 2013, Marie was referred to Health in Mind, but she did not attend her planned appointment. The Did Not Attend (DNA) policy was followed with Marie receiving a letter. A further appointment was arranged which again Marie did not attend. Marie was then referred back to her GP.

15.4.4 Marie was referred again to Health in Mind in **2017** and she had several CBT sessions and good engagement with the service.

15.4.5 Following the birth of Bonnie, Marie was again referred to Health in Mind as she appeared to be struggling with anxiety about not bonding with Bonnie and OCD thoughts returning. Marie cancelled her next two appointments with Health in Mind and due to the non-attendance, was discharged from the SPFT.

[31] www.nhs.uk Domestic Abuse and pregnancy

15.4.6 Marie was vulnerable, and evidence identified that she was experiencing domestic abuse. At the time there was no follow up from the service as to why Marie could not attend. The DHR panel noted that the IMR author identified that a recurring theme in reviewing Marie's support was the DNA policy. The DHR Panel is supportive of the SPFT reviewing its DNA policy which should allow for more professional curiosity about non-attendance and to probe what further issues that a victim like Marie could be experiencing, such as domestic abuse and therefore offer further support or signposting.

15.4.7 Information provided by family and agencies would indicate that in the last few months of Marie's life, she was experiencing several traumas, recurring mental health issues, trying to find somewhere to live and being abused physically and emotionally by James.

15.4.8 James was emotionally abusing Marie by saying that "she was mad and that Bonnie would be taken away from her" which may have created a further barrier for Marie to seek support. It is well documented that children are a protective barrier for mothers and the potential loss of a child would have been an added trauma for Marie. The University of Warwick and Refuge in their research, 'Domestic Abuse and Suicide,' (Ruth Aitken and Vanessa Munro 2018)[32] identified in the research that children appeared to be a positive, protective factor for many clients involved with Refuge. For many mothers who felt suicidal, children were the main reason they did not act upon the suicidal thoughts. This research identifies the strength of the bond between mothers and their child and if Marie thought that Bonnie could have been removed from her care, it may have impacted on what she disclosed to professionals.

15.4.9 A generally accepted definition of trauma is an event, series of events or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening and can have lasting adverse effects on an individual's functioning (mental health, physical, social and emotional)[33]. Domestic abuse is a form of trauma and often overlaps with mental health issues, as it did in the case of Marie.

15.4.10 Research by Safe Lives identifies that when practitioners' approach shifts from "what's wrong with this person (victim)" to "what had happened to this person," it helps to understand the behaviour, needs and support a victim may need[34].

15.4.11 In reviewing and updating the SPFT DNA Policy, professionals should understand the need to consider a trauma-based approach in developing and implementing an updated policy.

15.4.12 When Marie and Peter's relationship broke down, she continued to live in the same house but eventually moved out and lived with Marie's sister for a short while sofa surfing. Marie sought housing support from Hastings BC in **2018** and Rother DC in **2019.** Information provided within the IMRs show that housing professionals used their professional judgement to support Marie's housing needs.

15.4.13 Kelda Henderson (in research around the role of housing in a coordinated response to domestic abuse, 2019) states that housing is often overlooked in favour of the criminal justice

[32] Domestic Abuse and Suicide -Exploring the links with Refuge's client base and work force-Ruth Aitken and Vanessa E. Munro 2018 http://wrap.warwick.ac.uk/103609
[33] www.samhsa.gov/tauma-violence
[34] www.safelives.org.uk

dominance within a community response to domestic abuse. This is changing with increasing attention on the role of housing[35].

15.4.14 The Domestic Abuse Act 2021[36] provides that all eligible homeless victims of domestic abuse (as Marie was) have "priority" needs for homelessness assistance. The DA Act will also ensure that where a local authority, for reasons connected to domestic abuse, grants a new secure tenancy to a social tenant who had or has a secure lifetime or assured tenancy, this must be a secure lifetime tenancy *(Domestic Abuse Act 2021-Part 4 Local Authority Support Section 57).*

15.4.15 At a local level, the DHR Panel welcome the implementation of the Pan Sussex Domestic Abuse Accommodation and Support Strategy 2021-2024[37] which will ensure that victims and survivors are able to access the high-quality services they need. The support provided will include work to allow victims and survivors to remain safely in their own homes or in safe accommodation.

15.5 To consider any agencies or wider community groups that had no contact with Marie and her family and whether helpful support could have been provided e.g., specialist domestic abuse services and if so, why this was not accessed.

15.5.1 Marie and her family were not able to access any specialist domestic abuse support service as in discussion with the family and the Independent Chair, they highlighted that they were not aware of such a service in the local area.

It is important that agencies advertise their services to the wider community, so individuals know how to get support.

15.5.2 Change Grow Live (CGL) offers a range of information and advice services in Sussex. The services provided are well-marketed under the branding of the Portal.[38] Services include Independent Domestic Abuse Violence Advisors (IDVAs) in the local hospital, posters and leaflets in hospitals, training and literature to designated staff and GPs. If Marie and her family had engaged with CGL then support around risk management and safety planning could have been discussed with Marie.

15.5.3 The wider community does not always understand how to navigate information around specialist domestic abuse services, whether it be local or national. Marie could have self-referred to CGL without the need to go to the police in the first instance and support about safety planning and risk management could have been provided.

15.5.4 This apparent lack of knowledge by the wider community about specialist domestic abuse services should be reviewed by the Safer Communities Partnership Board and an information campaign about domestic abuse, including elements of the Domestic Abuse Act

[35] Henderson. Kelda the role of housing in a coordinated community response to domestic abuse 2019 Kelda_Henderson_Thesis_2018_December_Formatted_2019.pdf (dur.ac.uk)
[36] Domestic Abuse Act 2021 - GOV.UK (www.gov.uk)
[37] www.safeineastsussex.org.uk Strategy for Domestic Abuse Accommodation and Support
[38] This was correct at the time of Marie's death, however at the time of the publication, CGL delivers the East Sussex Domestic Abuse Service (ESDAS) with no reference to the Portal.

2021 e.g., non-fatal strangulation/housing support and the specialist local support services via marketing should be considered.

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

15.6.1 ESHT identified within its IMR that midwives have a good understanding of domestic abuse and routinely enquire with a client as to whether they are experiencing abuse in all its forms, but this in not embedded across the service. SPFT also identified that mental health practitioners routinely ask about domestic abuse as part of an assessment, however some initial triage and assessment (screening for eligibility) will not ask specific question about domestic abuse. Hastings BC identified that they routinely ask about domestic abuse if a person is seeking housing support.

15.6.2 There is no reference to the GP making a routine enquiry about domestic abuse with Marie, with the focus being on Marie's mental and physical health needs. The GP is often the one professional that a victim of domestic abuse will encounter. *Sharp-Jeffs and Kelly June 2016 Domestic Homicide Review Case Analysis* (Standing Together Against Domestic Violence *(STADV) and London Metropolitan University)*[39] highlighted that GP surgery staff have a crucial role in preventing homicide as they often engage with both a victim and a perpetrator. In their research of DHRs it was identified that just over 50% reports note that GPs missed opportunities to ask a victim about domestic abuse. Most frequently observed was a lack of professional curiosity about relationships with partners and children's fathers.

15.6.3 Mental health services were recorded as the second most common health-related theme in DHR reports and that mental health problems may increase vulnerability to domestic abuse. The same was also identified about perpetrators who had a history of mental health issues.

15.6.4 ESHT and SPFT have identified the need to embed domestic abuse routine enquiry by all professionals within the service. The DHR Panel also recommend that the GPs introduce routine enquiry about domestic abuse at the six-week check-up following the birth of a child.

(A GP must offer a six-week postnatal check-up for all new mothers and birthing parents and in 2020, the NHS introduced a six week mental health check-up for all new mothers to ensure they have the support they need and to see if they are struggling with their mental health. This provides an opportunity to make a routine enquiry about domestic abuse)[40]*.*

15.6.5 Any training now provided for professionals should focus on all forms of domestic abuse including physical, emotional, controlling and coercive behaviour, stalking and economic abuse. It will also be critical to include relevant aspects of the new duties within the Domestic Abuse Act 2021, especially in reference to this review; housing and the new crime of non - fatal strangulation.

[39] Domestic Homicide Review Case Analysis -Nicola Sharp-Jeffs and Liz Kelly June 2016 (STADV and London Metropolitan University) www.static1sqaurespace.com
[40] www.healthwatch.co.uk Six week postnatal check-up for Mums

15.6.6 Professionals should also have training and guidance provided about the Domestic Abuse Homicide Timeline. An understanding of the perpetrator's behaviour would allow more appropriate risk assessment and safety planning. The Homicide Timeline training may need to be refined and proportionate to the role and responsibility of the professional but key elements such as separation, breakdown of a relationship and the associated escalation of risk related to separation should be understood by all professionals.

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

15.7.1 Marie was only known to primary and secondary health services. The contact was based around her physical and mental health needs. Information provided within the IMRs indicates, on balance, an effective referral process between the GP and Health in Mind. Marie's mental health assessments appear to have followed in a timely manner. During the period 2017/18 when Marie was receiving CBT, there was good engagement between Marie and SPFT. Marie identified within her diary about how well she felt supported by one of the clinicians she was working with. Professionals identified that some positive work took place with Marie around her mental health issues. This provided Marie with the confidence to seek help again during her pregnancy.

15.7.2 The risk assessments carried out by health professionals focussed on Marie's physical and mental health needs. Although certain professionals and midwives did make routine enquiries about domestic abuse, Marie only disclosed to one midwife that James had slapped her but that the relationship had ended. It is not known if any signposting was offered by the midwife to Marie.

15.7.3 Although agencies carried out their own individual risk assessments there was no evidence that information gathered was shared between agencies. Despite a disclosure of domestic abuse to a midwife, it was taken at face value that the relationship had ended but it could have been an opportunity to complete a Domestic Abuse, Stalking and Honour Based Violence Risk Identification checklist (DASH). Many professionals still identify that a DASH is a tool for the police when in reality it is a tool for any professional.

(The DHR Panel request that agencies involved in this DHR remind their frontline practitioners that a DASH is a checklist for victims of domestic abuse which can be shared with other agencies and better protect victims of domestic abuse).

15.7.4. Agencies also described that there were pressures on services due to reorganisation, reduction in staff which may have impacted on the sharing of information relating to Marie and having a holistic approach to identifying and supporting Marie's needs. If professionals/practitioners are aware and use established, universal tools to share information, such as using the DASH checklist, then this can better help them support victims of domestic abuse despite there being pressures on services.

15.7.5 Marie needed housing support in 2018 and 2019 and Hastings BC and Rother DC assessed Marie housing needs in a timely manner. Although it was identified that Marie had

made herself intentionally homeless by leaving a property which still had several months left on the lease, housing officers used their professional judgment and considered the risks relating to Marie and supportive in a proactive manner.

15.7.6 Professional judgement is built on four building blocks,

- Knowledge
- Professional obligation (e.g., legislation /policy)
- Client Input
- Experience.

15.7.7 It is about a professional, whether it be the police, housing officer, or GP applying the above to develop an opinion or decision which should be done to best serve the client.[41]

15.7.8 Such judgements allow professionals to utilise their knowledge and their training to identify concerns and take relevant action.

15.7.9 The Domestic Abuse Act 2021 will provide duties on local authority housing services to ensure victims and their children are supported. Housing duties will include.

- *Proving all eligible homeless victims of domestic abuse to automatically have a priority need for homelessness assistance.*
- *Ensuring that where a local authority, for reasons connected with domestic abuse, grants a new secure tenancy who had or has a secure lifetime or assured tenancy (other than an assured shorthold tenancy) this must be a secure lifetime tenancy.*
- *The new duty will cover the provision of support to victims and their children residing in: * refuge accommodation; * specialist safe accommodation; * dispersed accommodation; * sanctuary schemes; and * move-on or second stage accommodation.*
- *B&B or homeless hostels or other generic temporary accommodation will not be considered 'safe.' Only accommodation dedicated to DA victims can be included in commissioned support.*
- *All support provided under the duty must be provided to victims of domestic abuse, and their children, who reside in relevant accommodation as set out above and should meet Women's Aid National Quality Standards and / or Imkaan Accredited Quality Standards.* [42]

15.7.10 In future, victims of domestic abuse such as Marie will have access to housing and support services.

16.0 CONCLUSIONS

16.1 Up until Marie's death in 2019, there was no contact with agencies relating to the domestic abuse, physical, controlling and coercive behaviour that Marie was experiencing in her relationship with James. Marie's contact with health professionals was around her mental health and the birth of Bonnie. Marie was very proactive in seeking help around her mental

[41] www.collegeofdietitJamess.org/resouces/professional-practice/what-is-judgement-(2015)
[42] www.gov.uk domestic abuse act 2021

health and was very attentive to her physical health whilst pregnant with Bonnie. The GP, mental health services and midwife services indicate positive engagement with Marie. With this positive engagement professionals did have opportunities to make a routine enquiry about domestic abuse. Marie did on one occasion make a disclosure to a midwife but there is no evidence to suggest whether any advice was given around the disclosure. There may have been an assumption as Marie and James were no longer together, that the risk of domestic abuse had been reduced. This review does highlight how important health professionals are in making routine enquiries about domestic abuse and they are often the only agencies that a victim may liaise with.

16.2 The DHR Panel acknowledge that health professional and other practitioners were under severe pressures (shortages of staff) prior to Marie's death and such pressures have only intensified following the Covid Pandemic with recruitment being a major difficulty. Such difficulties within agencies often meant that professionals/practitioners were "firefighting" and not also able to make that valuable routine enquiry. The DHR Panel is encouraged that this is being addressed through GP and health professional training around domestic abuse and its impact on health.

16.3 When an abusive relationship is breaking down, as it was with Marie and James, there is an increased risk of serious harm. The Homicide Timeline identifies separation as a key stage and all professionals need to understand the concept of the timeline as it will help identify risk and safety planning for a victim.

16.4 The Review highlights that James had tried to strangle female victims before meeting Marie and there is evidence that he tried to strangle Marie three days before she died. The Domestic Abuse Act 2021 will provide the police with greater powers to convict perpetrators of such actions, and also the wider community and victims of non-fatal strangulation will have recourse to seek action from the police.

16.5 It is important that the Domestic Abuse Act 2021 is communicated to the wider community in national and local campaigns. At a local level, the communication/information should include details of access to local specialist domestic abuse services.

16.6 This review has highlighted the tragic cost of domestic abuse in all its forms, physical, control, coercion, manipulation, and humiliation. It also highlights how the mental health of a victim can be used by a perpetrator to manipulate and emotionally abuse a victim. James used Marie's mental health to stoke fear in her mind that if she ever reported domestic abuse, no one would believe her, and that Bonnie could be taken away. Professionals need to understand domestic abuse in all its forms and the impact of mental health on a victim.

16.7 All Marie ever wanted was to be a mother. When Bonnie was born, she would do anything to protect that relationship with Bonnie and the fear of losing her will have meant that Marie did not seek help from agencies who could have supported her.

16.8 Finally, the DHR Panel believe that Marie showed great strength in her life. Marie sought help and engaged with health professionals to try to support her mental health, she navigated local authorities to ensure she could seek housing and her diaries identify how practical and

orderly she was. Marie wanted to be the best mother she could and provide for Bonnie and to ensure Bonnie's safety, potentially at the cost of her safety.

17.0 LESSONS LEARNT

17.1 This DHR has identified several lessons that that East Sussex Safer Community Partnership and agencies need to consider in responding to the death of Marie and some post review learning following discussions with the family.

17.2 Lack of routine enquiry about domestic abuse

17.2.1 Despite Marie having very few contacts with agencies before her murder, there were several contacts with health agencies including Marie's GP and mental health service over several years, mainly relating to Marie's mental health (From 2012 onwards). Marie also had contact with ESHT from 2016 including ante-natal and post-natal involvement during her pregnancy and following the birth of Bonnie.

17.2.2 During her pregnancy in 2018, Marie was asked by the midwife about domestic abuse but only one disclosure was made. ESHT have an electronic prompt on their case recording system and at a further meeting between Marie and the midwives, the records show that it was "inappropriate to ask" but with no further explanation as to why.

17.2.3 There appears to have been no routine enquiry by the GP or mental health professionals during their contact with Marie. The contact concentrated predominantly around Marie's mental health. As already stated, research has identified that health services, especially GPs, often have the most consistent engagement with victims and perpetrators. In accordance with NICE guidance[43] and CAADA (Safe Lives)[44], GPs should ask about abuse when a patient presents with accidental injuries, a history of psychiatric illness, alcohol or drug dependence, and a history of depression, anxiety. Marie did have mental health issues, and this should have provided a prompt for a GP to enquire about DA. Also, there was a missed opportunity to enquire about DA when Marie visited her GP following the birth of Bonnie, at her six-week check-up.

17.2.4 Although CCGs can advise and offer guidance to GP practices about making a routine enquiry with a patient about domestic abuse, due to the nature of the health landscape they have no role in enforcing GPs to make such enquiries.[45] GP practices are small to medium sized businesses whose services are contracted by National Health Services commissioners to provide medical services in a geographical or population area.[46]

17.2.5 Lack of routine enquiry by GP practices is a common thread in many DHRs and if there is to be change then this needs to be reviewed at a national and not a local level as CCGs cannot enforce such an action. Evidence identifies that a GP is the best placed professional to

[43] NICE National Institute for Health Care Excellence. www.nice.org.uk
[44] www.safelives.org.uk
[45] The Clinical Commissioning Groups have have now been renamed replaced by as the Integrated Care Boards since this report was written https://www.eastsussexccg.nhs.uk/wp-content/uploads/sites/3/2022/06/3.2.1-Closedown-Report.pdf.
[46] What are general practices www.kingsfund.org

make a routine enquiry around domestic abuse and therefore to make significant change there should national guidance/legislation to ensure routine enquiry is part of a GP's consultation with a patient.

17.2.6 In Sussex there have been several CCG funded initiatives relating to domestic abuse which have or are taking place. In 2017, prior to Marie's death, an Identification and Referral to Improve Safety, (IRIS)[47] pilot took place. A further project was funded by the CCG for the year 2018-2019 which supported CGL to provide a Health IDVA / GP IDVA pilot. Further CCG funding was awarded in 2020 for CGL to provide a Health IDVA based within ESHT covering the two main general hospitals in East Sussex. Training was delivered to doctors, nurses and midwives on the hospital site. In 2021, a training package was developed in partnership with the CCG and CGL entitled *'Domestic Abuse and the impact on health'*. A training package is co-delivered with the CCG, CGL Health IDVA, the police, GPs, Adult Safeguarding and Worth Domestic Abuse Services, aimed at all primary care staff.

17.2.7 Research also identifies that second most common health related theme in DHR reports are mental health issues, both victim and perpetrator. There is no evidence to suggest that Marie was asked about domestic abuse at any of her sessions with SPFT services.

17.2.8 Mental health professionals should be expected to enquire about domestic abuse and should have training on identifying, risk assessing and safety planning responding to domestic abuse. The DHR Panel welcomes the work that SPFT is implementing following this review to update its domestic abuse training and reviewing policy and procedures.

17.3 Access to domestic abuse services by victims of domestic abuse

17.3.1 In her diaries, Marie identifies as someone who knew she was being abused. She used terms such as 'gaslighting, controlling, intimidating, undermining' to describe what she was experiencing. In speaking with her family, they too were clear that Marie was experiencing abuse by James but on speaking with the family it is evident that they were not fully aware of the domestic abuse services availability in the area. As already described, CGL provides a wide range of services and there is the ability for a victim to self-refer.

17.3.2 East Sussex Safer Communities Partnership Board (SCPB) has a key role in providing and promoting information about the specialist DA services availability via promotional and information campaigns. SCPB should not just provide information about services but what domestic abuse is, the new legislation and what other support there is availability, such as housing.

17.3.3 Forensic evidence came to light in this review that James tried to strangle Marie three days before she died. Non-fatal strangulation is now a crime in the Domestic Abuse Act 2021 with a possible sentence of up to five years for a perpetrator. It is imperative that not just professionals are aware of this but that victims of domestic abuse and the wider community know that there are strong actions that can now be taken by the police and the justice system for such an offence.

[47] www.irisi.org IRIS Interventions.

17.3.4 The Domestic Abuse Act 2021 also provides legislation which will provide stronger housing support for victims of domestic abuse. One of Marie's issues in the last year of her life was to find accommodation for her and Bonnie and now with the new legislation, victims of domestic abuse should be better supported in gaining accommodation.

17.4 Professional curiosity and the understanding to know a victim better

17.4.1 Marie was known to several health services: SPFT, ESHC and her GP. Evidence identifies that Marie suffered from mental health issues from a young age and this continued right up to her death. During her pregnancy, Marie had contact with a further number of health professionals such as midwives and consultants. Marie disclosed that she was concerned about her personal health as she was concerned that James was seeing other women. The midwife asked why but when Marie responded that it was just anxiety and there was no further probing. Although it was well recorded by midwives that the relationship between James and Marie seemed very on/off and that Marie identified James's drug taking with them, and further professional curiosity around the family dynamics were not explored.

17.4.2 When Marie did disclose that she was a victim of domestic abuse to the midwife there is no written evidence to suggest whether this was explored further with Marie or whether the assumption that as the relationship appeared to have finished, the risk had "gone away."

17.4.3 Marie's diaries highlight her concerns that James was seeing another woman, and this perhaps explains why Marie was concerned about her own personal health. The IMRs suggest that there was very little understanding of the family dynamics by health professionals including any questions about James as Bonnie's father. In interviewing James, he did say he felt that he was "omitted" from the contact with the midwives. This may have been due to Marie not wanting James to be present, but James did identify that he felt that the professional focus was all on the mother and that the father was excluded.

17.4.4 Professional curiosity (or lack of) is a theme running through many published Domestic Homicide Reviews. It could be argued that professionals are not doing their job unless they are professionally curious. Professional curiosity is the capacity and communication skill to explore and understand what is happening to someone rather than making assumptions.

17.4.5 What is important is that professionals are provided with training and tools to be professionally curious. It is also important that agencies ensure that professional curiosity is embedded in professional practice through reflective supervision and case reviews.

17.4.6 At a national level, the *Annual Review of Local Child Safeguarding Practice Reviews and Rapid Reviews 2021(LCSPR)*[48] highlights that many reviews are critical of practitioners for not being professionally curious. Although professional curiosity is extensively used in Child Practice Reviews, the same could be said of DHRs. The *LCSPR* states that the challenge for front line practitioners is to develop authentic relationships with children and families to effect positive change. It was also highlighted that at times, practitioners were not suitably curious or challenging. When professionals are supporting victims of domestic abuse, there is not always

[48] Annual Review of LCSPRs and Rapid reviews- The Child Safeguarding Practice Review Panel March 2021 www.assets.publishing.service.gov.uk

the asking of a "second question," for example "how often are you slapped." The report goes on to describe that organisations need a culture of openness to allow practitioners to ask for support when needed and that practitioners must feel safe to admit their concerns about a family a child, or it could be a victim of domestic abuse, knowing that these will be taken seriously and acted upon.

17.4.7 Manchester Safeguarding Partnership offers some good guidance which highlights that professionals are more likely to be professionally curious and more likely to flourish when practitioners:

- Are supported by good quality training to help them develop
- Have access to good management, support and supervision
- "Walk in the shoes" (have empathy) of the adult/child and consider the situation from their lived experience
- Remain diligent in working with the family and developing the professional relationships to understand what has happened and its impact on all family members
- Always try to see all parties separately.

17.4.8 The guidance also identifies that when professionals are working with families where there is domestic violence and abuse, it can be very challenging and that practitioners should not take everything they are told on face value[49].

17.4.9 Such guidance and support for practitioners will give them the tools to understand the family dynamics, better identify victims and perpetrator of domestic abuse and therefore can signpost a victim to appropriate support.

17.5 Trauma-based approach to domestic abuse

17.5.1 A generally accepted definition of trauma is an event, series of events or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening and can have lasting adverse effects on an individual's functioning; mental health, physical, social and emotional[50]. Domestic abuse is a form of trauma and often overlaps with mental health issues, as in the case of Marie, along with being pregnant with Bonnie, trying to find a home and the on/off relationship with James.

17.5.2 Research by Safe Lives identifies that when practitioners' approach shifts from "what's wrong with this person (victim)" to "what had happened to this person" helps to understand the behaviour, needs and what support a victim may need[51].

17.5.3 Although there were a few agencies involved with Marie and her family, there does not appear to have been a complete overview of the issues and traumas that Marie was facing e.g., housing knew about housing, health knew about health issues, but no agency had an overall picture of what was happening in Marie's life. Agencies and practitioners need processes and training to understand and implement a trauma-based approach to supporting victims who may be experiencing domestic abuse.

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[49] Manchester Safeguarding Partnership- Professional curiosity & challenge-resources for practioners.www.manchestersafeguardingpartnership.co.uk
[50] www.samhsa.gov/tauma-violence
[51] www.safelives.org.uk

17.6 Access to services and lack of engagement

17.6.1 Marie missed several appointments with SPFT Health in Mind services and due to the policy that SPFT have, Marie was discharged back to her GP which meant she received no further treatment at that time. Whilst it is recognised that there needs to be a degree of personal motivation to engage with services, there can be a tendency for too much onus on the service user to take responsibility for this. When an individual is suffering from mental health issues and domestic abuse such as that experienced by Marie, then the effort to go to appointments, return phone calls and communicate can be too much. Agencies need to review how to improve the engagement processes with people who struggle to engage.

The DHR Panel welcomes the recommendation by SPFT to review their Did Not Attend policy.

17.7 Understanding by professionals and the wider community of the behaviour of a perpetrator of domestic abuse.

17.7.1 James did have some contact with SPFT in 2013, mainly relating to pressure from running his own business, when he was fragile and volatile. Despite James reporting he had a caution for affray several years ago, and his reported mood, the Health of the Nation Outcome Score (HoNOS)[52] score was 0 with the clinic assessing that James was not a risk to others.

17.7.2 The Police had engagement with James in 2015 relating to a drug offence and in 2016 relating to a violent crime when, in an intoxicated state, he attacked a female friend by grabbing her by the throat. This was dealt with by a Community Resolution as the two female friends did not wish to pursue the case.

17.7.3 The crime of grabbing a female by the throat was seen in 2015 as a minor offence. With the Domestic Abuse Act 2021, it is likely that this crime would be considered much more severe and could be considered under part 6 section 70, 75A and 75B Non-Fatal Strangulation/suffocation which could result in a prison term for up to five years.

17.7.4 When identifying characteristics of a perpetrator of domestic abuse, James's character and behaviour certainly conformed to such behaviours including.

- Extreme jealousy: James checking whether Marie had had an affair with a friend
- Possessiveness: James challenging Marie about her relationship with male friends
- Controlling behaviour: James breaking down the relationship with Marie's family
- Embarrassment or humiliation of the victim: Making Marie kneel in front of him to ask for forgiveness and saying how much she loved him in front of friends
- Antiquated beliefs about roles of women and men in relationships: telling Marie off for not ironing his shirts.

17.7.5 There are also strong links between substance misuse being a catalyst for being a perpetrator of abuse but by no means the cause (*as identified by Gilchrist in 2015*). The research identified that domestic abuse perpetration was common among men attending

[52] Health of the Nation Outcome Scale HoNOS- Developed in the early 90's by Royal College of Psychiatrists as a measure of the functioning of people with severe mental illness. www.mentalhealthpartnerships.com

treatment for substance abuse. Although substance misuse is not the only factor impacting on a perpetrator of domestic abuse (others include lower socio- economic status, adverse childhood experience, psychological problems), men receiving substance abuse treatment reported a higher rate of abuse- perpetration compared to men in the general population. Alcohol, cocaine and methamphetamine use is associated with domestic abuse- perpetration as it can impair cognitive processing as a result of the pharmacological properties of substances or may be the mechanism for reducing the threshold at which a provocation results.[53]

17.7.6 It is important that professionals and the wider community understand the behaviours of a perpetrator including the links between substance abuse and domestic abuse. James was arrested for substance abuse and a violent crime against a female and during the police investigation into Marie's death, there was evidence that James had tried to strangle a previous partner. The professional and the community needs to understand that these actions are not acceptable, and victims need to be encouraged to seek help.

17.8 Understanding of why a victim of domestic abuse may not disclose abuse to a professional

17.8.1 Although Marie was asked if she was experiencing domestic abuse, she only disclosed once to a professional. Research has identified that reasons for staying with an abuser are very complex and, in many cases, are based on a reality that an abuser may follow through with threats.

Additional barriers which are relevant to this review are as follows

a) The victim's feeling that the relationship is a mix of good and bad
Marie's diary certainly identifies her love for James and that some days are good, and some days are bad.

b) Fear of losing custody of a child
Marie loved Bonnie and so desperately wanted a child. Evidence provided identifies that James was seeking custody of Bonnie through a solicitor. Marie would have been distraught about this happening.

c) The lack of knowledge of access to safety and support.
Marie did not seek support, and details from the family describe that they did not know how to seek support.

d) Emotional abuse by a perpetrator
Following a domestic abuse incident, James would sometimes say sorry but that if Marie reported it "no one would believe her because she was mad" or that "Bonnie would be taken away."[54]

[53] Gilchrist, Radcliffe Drug and alcohol review. 2017 The prevalence and factors associated with ever penetrating intimate partner violence by men receiving substance use treatment. www.onlinelibray .wiley.com
[54] National Coalition Against Domestic Violence- Why do Victims stay www. ncadv.org

17.8.2 Professionals need to understand the reasons why a victim of domestic abuse may not disclose and use their curiosity to build up a picture of what is happening in a victim's life which could be an indicator of domestic abuse. For example, at the time of the relationship breakdown during Marie's pregnancy, why she was so concerned about her personal health, why she did not attend consultations? The ability to have a fuller picture of what is happening in a victim's life will allow professionals to assess the risk for a victim of domestic abuse and what support may help, whether this be signposting/referral to a specialist domestic abuse service or the police.

17.9 Post Review Learning

a) Support for family member (s) assuming Special Guardianship Order for child of a Victim of domestic Homicide

16.9.1 Marie's sister was appointed under a Special Guardianship Order (SGO) forBonnie following Marie's death in 2019. An SGO is an order appointing one or more individuals to be a child's special guardian. It is a private law order made under the Children Act 1989 and is intended for those who cannot live with their birth parents and who would benefit from a legally secure placement.[55] Marie's sister felt that as soon as the SGO was finalised then East Sussex Children's Social Care (CSC) "left her alone to get on with it". There was no guidance about how to manage the relationship between James, Marie's sister and Bonnie, nor was there any follow up by CSC as to how the SGO was operating and Marie's sister was coping. Marie's sister felt that James was trying to control her in phone call communications from prison, and she struggled to understand how to manage the situation to ensure that Bonnie was supported to have access to James (her father). When these issues were identified, the Independent Chair notified the SCPB, and Marie's sister's advocate spoke with the East Sussex Safeguarding Team. Marie's sister's situation did not meet the threshold for any interventions or support. The Advocate has continued to support Marie's sister and provide guidance around Marie's sister's emotional safety.

17.9.2 When Marie's sister was awarded the SGO for Bonnie she, along with her mother, would have been suffering the loss of Marie and experiencing many emotions, grief, anger, confusion, and how to support Bonnie in the best possible way. Professionals in CSC need to understand the needs of the family who have lost a family member to a domestic homicide and need to ensure that there are policies and procedures in place to ensure that a Special Guardianship is supported, their wellbeing is promoted and that they have the tools to manage the ongoing relationship between the SGO, the child, and the perpetrator.

The DHR Panel also request that East Sussex CSC place a copy of the Domestic Homicide Review Marie within Bonnie's Children's Social Care file for future reference. Also, at the appropriate time in Bonnie's life, support is provided to Bonnie and her family when Bonnie is ready to read a copy of the report.

b) Ongoing Support and Information for Families of Victims of Domestic Homicide.

16.9.3 Following the death of a victim of domestic homicide, the victim's family will receive support from the police via a Family Liaison Officer who will support the family and help

[55] www.familylives.org.uk

navigate the family through the criminal process. The family will also have access to support from Victim Support.[56]

16.9.4 On completion of a criminal investigation and criminal trial, the support often ceases but for several years a family of a victim of a domestic homicide may need to navigate ongoing issues for example when a child of a victim of a domestic homicide can meet their father (the perpetrator). Other issues identified by Marie's family include not being notified of the change of prison of Bonnie's father, and not knowing which avenues to pursue to find out. These are just two examples and families will have many more. Dame Louise Casey (CB) in the Review into the Needs of Families Bereaved by Homicide (2011) states *"The passage through the (criminal justice) system is often cited as being as traumatic as the bereavement itself"*[57] For many families of the victims of domestic homicide, the criminal trial is not the end of the need for support and information. The Home Office should consider a review of the ongoing challenges that victims' families face and identify possible support and how this can be made available to families.

18.0 RECOMMENDATIONS

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

Ownership: Safer Communities Partnership Board

Recommendation Two (Training)
SCPB to continue to seek assurance from agencies that professionals are accessing training, including domestic abuse training delivered by the specialist domestic abuse service provided by CGL, to include an understanding of DA, including controlling, coercive behaviour, a trauma-based approach of supporting victims suffering from DA, understanding the links between mental health issues and domestic abuse, professional curiosity, timeliness of interventions, the Homicide Timeline and the impact of the Domestic Abuse Act 2021. This to include a further assurance from agencies that the success/or not of training is reviewed and updated as required.

Ownership: Safer Communities Partnership Board

[56] www.victimsupport.org.uk
[57] http://www.justice.gov.uk/downloads/news/press-releases/victims-com/review-needsof-families-bereaved-by-homicide.pdf

Recommendation Three (Policy and Procedures)

All agencies to continue to review how they embed professional curiosity and critical challenge within their organisation, including support and training for managers and supervisors to have the confidence to support and challenge professional through reflective supervision.

Ownership: All agencies

Recommendation Four (Policy and Procedures)

SCPB to seek assurance that all agencies have actions to address non engagement within their polices and Do Not Attend Policies, where applicable. (DNA)

Ownership – Safer Communities Partnership Board and Agencies.

Recommendation Five (Policy and Procedures)

SCPB seek assurance from agencies in this review that professionals and practitioners in their organisation understand and utilise the DASH checklist to better support victims of domestic abuse.

Ownership: Safer Communities Partnership Board and all agencies included in this report.

Recommendation Six (Other local)

Agencies to implement the recommendations identified within their IMRs and provide updates to the East Sussex Safer Communities Partnership Board if an agency's recommendation cannot be implemented

Ownership: All agencies

Recommendation Seven (National)

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

Ownership; Home Office

Recommendation Eight (National)

The Home Office to review what support is available at present to support families of victims of domestic abuse (both short term and long term) and what is required in the future. This to include support for families through the criminal justice process and long-term support to help families of a domestic homicide victim, especially family members who are awarded Special Guardianship Orders including legal advice, signposting for further support and information.

Ownership; Home Office

Appendix One.
EAST SUSSEX SAFER COMMUNITIES PARTNERSHIP (SCPB)
DOMESTIC HOMICIDE REVIEW Marie
November 2020

TERMS OF REFERENCE vs. 2

1. This Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

2. This legislation places a statutory responsibility on organisations to securely share confidential information, which will remain confidential until the panel agrees the level of detail required in the final report for publication. The DHR will strictly follow the ESSCP DHR protocol, which is based on Home Office DHR guidance[58].

3. The statutory purpose of the DHR is to:

a) Establish what lessons can learned from the domestic homicide regarding how the local professionals, agencies and organisations worked individually and together to safeguard the victims of domestic abuse.

b) Identify clearly what those lessons are, both within and between agencies and organisations, how they will be acted on, and what will change as a result through a detailed Action Plan.

c) Apply these lessons to service responses including changes to policies and procedures as appropriate.

d) Prevent domestic homicides where possible in future through improved intra and inter-agency responses for all domestic abuse victims and their children.

4. The agreed timeframe for information to be secured and reviewed is for three **years** prior to the event **i.e., from January 2016 to July 2019**, unless there have been significant events prior to this. Significant events will include engagement due to mental health, other noteworthy medical issues and other wellbeing issues.

5. The DHR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures (e.g., SCR, SAR, IOPC[59] referral, and internal agency disciplinaries) may use information from the DHR process to support their investigations.

6. The Panel notes that the DHR process may be suspended as necessary to avoid the risk of activities prejudicial to criminal proceedings.

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[58] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

[59] *Independent Office for Police Conduct https://policeconduct.gov.uk/*

7. In addition, the following areas will be addressed in the Individual Management Reviews (IMRs) and through wider enquiries:

*a) Awareness and understanding of professionals and the wider community of the potential presence of **coercive control** and how this may have impacted on the behaviour of the victim and perpetrator.*

b) Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator e.g., Femicide[60], men and women's roles in society

c) Whether there were any barriers experienced by Marie or her family / friends and colleagues in seeking support from professional service providers.

d) To consider any agencies or wider community groups that had no contact with Marie and her family and whether helpful support could have been provided e.g., specialist domestic abuse services and if so, why this was not accessed?

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

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

8. The Panel will critically evaluate and approve the Overview Report, Executive Summary and Action Plan produced by the Independent Chair at the end of investigation prior to it being passed to the Chair of SCPB**,** which will own the Report and implementation of the Action Plan.

9. As actions and lessons are identified, the Chair will notify the relevant agencies/ local safeguarding boards so that the implementation, monitoring and review of actions can be commenced as soon as possible.

10. These Terms of Reference may be varied by the DHR Panel as new information emerges.

[60] *www.womensaid.org.uk/femicide*