Safer Rotherham Partnership

Domestic Homicide Review

Overview Report

'David'

Died: October 2021

Chair and Author: Ged McManus

Assisted by: Carol Ellwood-Clarke QPM

Date: April 2024

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1 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agencies' responses and support given to David, a resident of Rotherham, prior to his murder. The panel would like to offer its condolences to David's family on their tragic loss.

1.2 David was born in Rotherham and was the youngest of four siblings. He was described as a 'happy go lucky' child, and his nickname was 'smiler'

because he was always laughing and smiling. In his late teenage years, David told one of his siblings that there were no prospects for him in Rotherham and that he wanted to join the army.

1.3 David and Sarah met at around the time that David joined the army. Sarah already had a young child. Sarah and David married and went on to have two children together. Whilst David was in the army, the couple lived in army married quarters with their family. When David left the army, the couple moved back to Rotherham where they lived in social housing with their family. All three children were adults at the time of David's murder and no longer lived in the family home. David and Sarah had lived as a family in Rotherham for 19 years at the time of David's murder.

1.4 In October 2021, David was murdered by Sarah. She killed David by stamping on him repeatedly. Although the police and other emergency services were called immediately, Sarah was not arrested straight away because she had no visible injuries and there was white powder and tablets in the hallway and around the body of David, which was consistent with the account Sarah initially gave to the police. Sarah was arrested two days later and released on police bail. It was not until over a year later (in November 2022) that Sarah was charged with David's murder. The investigation was complicated by the fact that David had taken an overdose before being assaulted by Sarah; therefore, detailed medical evidence was required. The medical cause of David's death as recorded by the pathologist was. Polydrug toxicity (Lamotrigine, cocaine, zopiclone, buprenorphine, duloxetine and olanzapine) with blunt force trauma to the head, chest and abdomen.

1.5 David is a pseudonym chosen by his family. Sarah is a pseudonym chosen by the panel from a list of names, as her family had no preference. Alex is a pseudonym used for their youngest child: chosen from a list of names by the panel, as Alex had no preference.

1.6 Sarah pleaded not guilty to David's murder; however, on the third day of her trial, she changed her plea to guilty.

1.7 On sentencing Sarah to life imprisonment with a minimum term of seven years and three months (less the 170 days spent on remand), the judge made the following comments:

'Yesterday, on the third day of the trial, you pleaded guilty to the crime of murder.

You now fall for sentence for the murder of your husband. The circumstances of this case are both tragic and extremely unusual. First, the lives each of you led

together may only be characterised as comprehensively wretched. Your conduct was corrosive for both of you.

It was and has been described by family members as a toxic relationship. I accept that you and your husband loved each other, but you both abused the medication of each other. Second, the particularly unusual feature of this case is that regardless of what you did to the victim, he would have died in any event within a few minutes of you inflicting the physical injuries upon him.

It appears he had taken an overdose of an epilepsy drug. It was a fatal overdose. There is no evidence whatsoever that you administered that drug. There was in your relationship, a relentless avalanche of abusive conduct to each other and self-abuse.

It is very important to note your intention when you assaulted your husband was to inflict grievous bodily harm, it was not to kill your husband.

The backdrop to the circumstances of this case are as follows: Your husband was 43 at the time of his death, you had been married for over 22 years, you had three children. Your relationship was volatile, it was, as the prosecution assert, punctuated with frequent, almost daily arguments which involved low level violence inflicted by each of you on the other, you both habitually abused drugs and this conduct had gone on for many years prior to events on [date redacted].

Indeed, the events of that day were similar in respect to many other days. The deceased consumed a cocktail of drugs'.

The judge said one of the drugs, taken in the quantity consumed by David, "would have killed him in any event even if Sarah had done nothing". He added: "He would have succumbed and died. That is an important factor in this case. It is an extremely unusual situation".

1.8 In addition to agency involvement, this review will also: examine any relevant background of abuse before David's murder; whether support was accessed within the community; and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.9 The review considers agencies' contact and involvement with David and Sarah from 1 November 2017 until David's murder in October 2021. This time period was chosen because there was a significant domestic abuse incident in November 2017.

The panel acknowledged that David and Sarah had been in a relationship for many years before that but chose this time period because it was judged to be proportionate and capable of producing learning for current services in Rotherham. Information prior to that timeframe is used in the report as background and context, as the panel thought it was important to show a full picture. The panel also recognised that

some of the events were a considerable time before David's murder; therefore, it focussed its analysis on more recent events, which may be more capable of producing contemporary learning.

1.10 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.11 **Note:**
It is not the purpose of this DHR to enquire into how David died: that is a matter that has already been examined during Sarah's trial.

2 Timescales

2.1 This review began on 21 June 2023 and was concluded on 19 March 2024 – following consultation with David and Sarah's family.

More detailed information on timescales and decision-making is shown at paragraph 5.2.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including any support worker, during the review process.

3.2 Pseudonyms have been used in the report to protect the identity of the subjects of the review.

4 Terms of Reference

4.1 'The purpose of a DHR is to:

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

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

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

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

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice'.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] section 2 paragraph 7)

4.2 **Timeframe Under Review**

The review covers the period from 1 November 2017 until David's murder in October 2021.

4.3

Subjects of the DHR

Victim: David, aged 43 years

Perpetrator: Sarah, aged 44 years

Alex: Teenage child at the start of review period.

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[1] did your agency identify for David and Sarah?

[1] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act created an offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

2. How did your agency assess the level of risk faced by David and Sarah, and which risk assessment model did you use?

3. Did your agency consider that David or Sarah could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?

4. What consideration did your agency give to any mental health issues or substance misuse when identifying, assessing, and managing risks around domestic abuse?

5. What services did your agency provide for David and Sarah; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?

6. How did your agency ascertain the wishes and feelings of David and Sarah, and were their views considered when providing services or support?

7. How effective was inter-agency information sharing and cooperation in response to David and Sarah, and was information shared with those agencies who needed it?

8. Was there sufficient focus on reducing the impact of alleged abusive behaviour by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

9. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed? Are the procedures embedded in practice, and were any gaps identified?

10. What knowledge did family, friends, and employers have of domestic abuse in David and Sarah's relationship, and did they know what to do with that knowledge?

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11. Were there any examples of outstanding or innovative practice?

12. What learning did your agency identify in this case?

13. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Rotherham Community Safety Partnership?

14. Were there any resource issues, including during the Covid-19 pandemic, that affected the services your agency provided in this case?

5 Methodology

5.1 On 1 November 2022, Rotherham Community Safety Partnership held a Standing Group Meeting to consider multi-agency information held in relation to David and Sarah. They agreed that the circumstances of the case met the criteria for a Domestic Homicide Review and recommended one should be conducted. The Home Office was informed of the decision to undertake a review on 17 January 2023.

5.2 The start of the process was delayed pending Sarah's trial. However, in preparation for the DHR, the Independent Chair was appointed in January 2023 ahead of the scheduled trial. Following the conclusion of the trial, the DHR could start, and the first meeting of the DHR panel took place on 21 June 2023.

5.3 DHR panel meetings took place using Microsoft Teams video conferencing: the panel met six times. Outside of meetings, issues were resolved by email and the exchange of documents. The final panel meeting took place on 19 December 2023, after which minor amendments were made to the report: these were agreed with the panel by email. Consultation then took place with David and Sarah's family. David and Sarah's adult children pointed out minor factual inaccuracies, which were amended.

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

6.1 David and Sarah's children

6.1.1 The Independent Chair was introduced to Sarah and David's two youngest children by their Victim Support Homicide Worker. The Chair met them on two occasions. Sarah's oldest child did not wish to contribute to the review. Terms of reference for the review were discussed with them and they were content that the Terms of Reference were appropriate. The contribution of the two youngest children is contained within the report as appropriate (mainly in section 13.1). They were offered the opportunity to attend a DHR panel meeting but did not wish to do so. All of David and Sarah's children are now adults.

6.1.2 The Chair wrote to David's mum, enclosing an appropriate Home Office leaflet and inviting her to contribute to the review. The letter was given to her by her Victim Support Homicide Worker. As a result of the letter, David's mum expressed an intention to provide a written submission for the review to consider; however, she later felt unable to do so. The Chair had a telephone conversation with David's mum. During this call, she was supported by a close relative. The information provided by David's mum is attributed appropriately throughout the review. David's mum was provided with a copy of the report and did not wish to give any feedback.

6.2 Employer

6.2.1 Sarah had not worked for many years. David had periods of informal employment, but it was not possible to identify an employer who the DHR Chair could engage with.

6.3 Friends

6.3.1 The police investigation following David's murder, spoke to a number of friends and neighbours. The statements were disclosed by the police for the purposes of the DHR. These people have not been spoken to directly by the DHR.

6.4 Summary of friend's and neighbours' statements

6.4.1 Friend 1

Friend 1 stated that she was introduced to David and Sarah by a mutual friend. Friend 1 visited David and Sarah at home between January and July 2021, where they would all use crack cocaine. During a visit in July 2021, Sarah accused Friend 1 of having sexual relations with David, and Sarah assaulted Friend 1. David prevented the assault and called a taxi for Friend 1. As Friend 1 was leaving, Sarah shouted: "Don't let [gender redacted] get away, if you help [gender redacted] I'll kill you". This was not reported to the police until after David's death.

6.4.2 Neighbour 1

Neighbour 1 knew David and Sarah, as they had been neighbours for over 12 years. Neighbour 1 described how in the five years or so before David's murder, both his and Sarah's physical appearance had deteriorated. Neighbour 1 knew that David used drugs and said that he lost a lot of weight. Neighbour 1 said that David

and Sarah would often be heard arguing and had witnessed them fighting in the street.

6.4.3 Neighbour 2

Neighbour 2 knew David and Sarah, as they had been neighbours for nine years. During that time, Neighbour 2 had regularly witnessed Sarah and David arguing: at least one a week. It was usually worse in the summer when they were in the garden drinking. On a few occasions, Sarah knocked on Neighbour 2's door asking for help and was directed to call the police. Neighbour 2 said that Sarah never appeared injured and would not listen to what she was told. In Neighbour 2's opinion, no one would help because the disturbances were such a regular occurrence.

6.4.4 Neighbour 3

Neighbour 3 had lived near Sarah and David for about a year. Neighbour 3 would often see Sarah and David in the street, with both of them appearing to be intoxicated by alcohol or other substances. Sarah would sometimes walk around with a bottle of whisky, which she drank from. There were regular arguments between the couple, and Sarah would sometimes shout for someone to ring the police.

6.4.5 Neighbour 4

Neighbour 4 had lived near Sarah and David for about 10 years. Neighbour 4 said that Sarah and David would routinely be involved in arguments with each other in the street: about twice a week. Sarah, in particular, could often be heard shouting and screaming. On an unknown date in summer 2021, Neighbour 4 saw Sarah and David arguing in the street. David then punched Sarah in the face, knocking her to the floor. Neighbour 4 did not see any reason to call the police.

6.4.6 Neighbour 5 Neighbour 5 had lived near Sarah and David for around 10 years. Sarah and David were unpredictable and would give a friendly 'hello' one day but an aggressive stare the next. They had major arguments up to three times a week, which would often start in the evening and go on until the small hours of the morning. The arguments appeared to get worse after all three children had left home, and it was not unusual for Sarah or David to be in the street shouting that one had assaulted the other. Neighbour 5 never reported anything to the police, or any other agency, for fear of a backlash.

6.5 **Sarah**

6.5.1 The Chair of the review wrote to Sarah in prison, inviting her to contribute to the review. The letter was delivered and explained to her by her Probation Service prison offender manager. Sarah did not wish to contribute to the review.

7 Contributors to the Review / Agencies Submitting IMRs[2]

7.1	**Agency**	**Contribution**
	South Yorkshire Police	IMR
	NHS South Yorkshire ICB (Rotherham Place)	IMR
	Rotherham Metropolitan Borough Council Children's Services	IMR
	Rotherham Metropolitan Borough Council Adult Social Care and Domestic Abuse Services	IMR
	Rotherham Metropolitan Borough Council Housing	IMR
	Probation Service	IMR
	Rotherham Rise	IMR
	The Rotherham NHS Foundation Trust	IMR
	Rotherham Doncaster and South Humber NHS Foundation Trust	IMR
	Yorkshire Ambulance Service	IMR
	Change Grow Live / We Are With You	IMR

[2] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with David/Sarah/Alex

7.2 The Ministry of Defence Veterans Welfare Service was contacted to ask for any information held by them. David was not known to the service.

7.3 In addition to the IMRs, each agency provided a chronology of interaction with David, Sarah, and Alex, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective and to make recommendations where appropriate. Each IMR author had no previous knowledge of the subjects of the review, nor had any involvement in the provision of services to them.

7.4 The exception to this was The Probation Service. At the time of the events under review, the relevant service was the now defunct South Yorkshire Community Rehabilitation Company. The IMR author and panel member transferred from the CRC to The Probation Service on amalgamation, and at the time the IMR came to be completed, was the only senior member of staff working locally who had operational knowledge of the CRC procedures. He had met David on two occasions and had some involvement in supervising David's management by the CRC. The potential conflict was disclosed appropriately to the Independent Chair and the DHR panel. The Chair judged that, on balance, the potential conflict could be managed within the process.

7.5 It should be noted that during the timeframe of the events analysed, Change Grow Live was the organisation contracted to provide drugs and alcohol services. Change Grow Live therefore provided an IMR. We Are With You has now taken over the contract for drugs and alcohol services in Rotherham. Both organisations were represented on the DHR panel, and We Are With You has committed to taking forward any learning identified.

7.6 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to David, Sarah, and Alex; and any other action taken.

7.7 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.8 In this case, the IMRs focussed on the issues facing David, Sarah, and Alex. Further elaboration by IMR authors during panel meetings was invaluable. The IMRs were quality assured by the original author, the respective agency, and by the Panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.9 **Information about agencies contributing to the review**

7.9.1 **South Yorkshire Police**

South Yorkshire Police is the territorial police force responsible for policing South Yorkshire in England.

7.9.2 **NHS South Yorkshire ICB**

NHS South Yorkshire – an Integrated Care Board – holds responsibility for planning NHS services, including primary care, community pharmacy, and those previously planned by clinical commissioning groups.

7.9.3 **Rotherham Metropolitan Borough Council Children's Social Care**

Children's Social Care works with children and their families in a restorative way, supporting them to reduce the need for social care intervention, and ensures that children and young people are safe and in education. Children's Social Care works with partners to make sure that children/young people and their families get the right support at the right time. Children's Social Care works with Rotherham's children, young people, and families to be resilient, successful, and safe.

7.9.4 **Rotherham Metropolitan Borough Council – Adult Social Care**

Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils, and providers of services to make sure that people who need care and support have the choice, flexibility, and control to live their lives as they wish.

7.9.5 **Rotherham Metropolitan Borough Council Housing** Rotherham Borough Council owns and manages a council housing stock of over 20,000 homes around the borough. The council's housing service is responsible for the management and delivery of all landlord related functions for its homes: tenancy and estate management, rent collection and income recovery, allocations and lettings; and repairs, maintenance, and investment. In addition to the traditional landlord functions, the housing service also provides

a range of advice and support services to its customers and tenants to help them attain, manage, and sustain a council home. The housing service is also responsible for setting and delivering the borough's housing strategy and the delivery of an ongoing programme of new council homes.

7.9.6 Probation Service

The Probation Service is a statutory criminal justice service that supervises offenders released into the community, while protecting the public. It is responsible for sentence management in both England and Wales, along with accredited programmes, unpaid work, and structured interventions. The Probation Service's priority is to protect the public by the effective rehabilitation of offenders – by reducing the causes that contribute to offending and enabling people on probation to turn their lives around.

7.9.7 Rotherham Rise

Rotherham Rise supports people of all genders who are affected by domestic abuse or sexual exploitation.

7.9.8 The Rotherham NHS Foundation Trust

The Rotherham NHS Foundation Trust is a combined acute and community Trust, providing services at Rotherham Hospital, and across the borough, to a population of more than 260,000 people.

7.9.9 Rotherham Doncaster and South Humber NHS Foundation Trust

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) provides extensive health services, including mental health across the South Yorkshire and North Lincolnshire area, as well as community nursing services in Doncaster for adults and universal services for children. RDaSH employs approximately 3,700 members of staff across the organisation. The Trust engages with a diverse population across three significant urban areas – Doncaster, Rotherham, and Scunthorpe. In the context of this review, RDaSH provided mental health services.

7.9.10 Yorkshire Ambulance Service (YAS)

YAS covers nearly 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline, and inner cities. YAS serves a population of over five million people across Yorkshire and the Humber and strives to ensure that patients receive the right response to their care needs as quickly as possible,

wherever they live. YAS employs more than 5,800 staff, who together with over 1,100 volunteers, provide a vital emergency and healthcare service – 24 hours a day, seven-days-a-week.

7.9.11 **Change Grow Live / We Are With You**

Both organisations are charitable organisations that provide alcohol and drugs services across England. These are commissioned by local authorities, who are required to procure services via competitive tender. Change Grow Live was the provider for Rotherham from 2017 to 2022, whilst We Are With You won the contract in 2021 and took over the services from 1st April 2022. Both services provide a range of interventions aimed to reduce harm from substance misuse, offer treatment and recovery services, and work with partner agencies to support work with individual cases.

8 The Review Panel Members

8.1	Ged McManus	Chair and Author
	Carol Ellwood-Clarke	Support to Chair and Author
	Jessica Mackintosh	South Yorkshire Police Case Review and Policy Officer
	Bonface Ndili	RDaSH Named Professional
	Anne Charlesworth	Head of Public Health Commissioning – RMBC Public Health
	Kayley Charlton	RMBC Community Safety Officer – Domestic Abuse and Sexual Violence
	Catherine Holiday	Yorkshire Ambulance Service – Named Professional for Safeguarding
	Emma Davison	Yorkshire Ambulance Service Safeguarding Team
	Deborah Gregory	We Are With You Team Leader
	Alex Goodier	RMBC Domestic Abuse Support Officer

Simon Fitter	Probation Service Senior Probation Officer/Team Manager
James Thurston	RMBC Service Manager – Children Services
Carol Sibley	RMBC Principal Children and Families Social Worker and MARAC Lead
Lee Wakefield	NHS South Yorkshire ICB Deputy Designated Professional for Safeguarding Adults
Sarah Taylor	Domestic Abuse Coordinated Community Response (DACCR) Service Manager – Rotherham Rise
Amanda Raven	RMBC Community Safety Officer – Domestic Abuse and Sexual Violence
Laura Sanderson	The Rotherham NHS Foundation Trust Adult Safeguarding Nurse Advisor
Lindsay Hood	The Rotherham NHS Foundation Trust MCA Lead and Named Nurse for Adult Safeguarding
Michaela Cox	RMBC Safeguarding Strategic Lead – Adult Care and Integration
Paul Walsh	RMBC Head of Housing Operational Services
Pamela Heydon	RMBC Technical Officer – Community Safety Unit

8.2 The Review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny. The exception was The Probation Service. [see paragraph 7.1.3].

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors. In this case, the Chair and Author was the same person.

9.2 Ged McManus was chosen as the Independent Chair and wrote the report. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He was judged to have the skills and experience for the role. He has experience as an Independent Chair of a Safeguarding Adult Board (not in South Yorkshire). Ged served for over 30 years in different police services in England. Between 1986 and 2005, he worked for South Yorkshire Police (a contributor to this review), before moving to another police service. The commissioners of the review were satisfied of his independence, given the length of time since he had any involvement with South Yorkshire Police. Ged has not worked for any other agency represented in the review and has not completed previous reviews for Safer Rotherham Partnership.

9.3 Carol Ellwood-Clarke supported the DHR Independent Chair. She retired from public service (British policing – not South Yorkshire) during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to safeguarding and family liaison. In addition, she is an Associate Trainer for SafeLives.[3] Carol has not worked for any other agency represented in the review and has not completed previous reviews for Safer Rotherham Partnership.

9.4 Between them, they have undertaken over seventy reviews, including the following: Child Serious Case Reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; and Domestic Homicide Reviews. They have also completed the Home Office online training for

[3] https://safelives.org.uk/

undertaking DHRs and have completed accredited training for DHR Chairs, provided by AAFDA.[4]

10 Parallel Reviews

10.1 The Rotherham coroner opened an inquest immediately after David's death. Following Sarah's trial and plea of guilty to murder, the inquest was closed without a hearing.

10.2 There are no other parallel reviews.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process. There has been no indication from any agency involved in the review that the circumstances of the case have engaged their disciplinary processes.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-today activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He

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starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].

- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
  (a) P has a physical or mental impairment, and
  (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 David was a 43-year-old white British male at the time of his death. He was heterosexual and had been married to Sarah for over 20 years. David was a drug user who was engaged with local drug and alcohol services. He also drank alcohol,

although there is little evidence to what extent. David had a history of mental health issues and suicidal ideation.

11.3 In 2003, David was diagnosed with anxiety. In February 2011, David was diagnosed with post-traumatic stress disorder (PTSD) and recurrent depressive disorder.

In February 2013, his medical record was coded as: 'Anxiety Disorder (E200.) – Anxiety States'. David complained of struggling to sleep at night-time.

Although David sometimes referred to himself as having mental health conditions, there is no other formal diagnosis recorded.

11.4 Between 2006 – 2013, David was engaged with the RDaSH community therapies team. In recent years, David did not engage with health services and had little contact with his GP. In June 2021, David's GP referred him to the local community mental health team, but David did not answer his phone for an arranged telephone appointment.

11.5 Sarah is a white British female. She is heterosexual and was married to David for over 20 years before his murder. Sarah had a history of mental health issues and suicidal ideation. She was diagnosed with epilepsy and was prescribed appropriate medication for that condition. There is evidence that Sarah abused drugs and drank alcohol; however, she was not engaged with any service (regarding substance misuse) before David's murder.

11.6 In March 2005, Sarah was diagnosed as having: 'Recurrent Depressive Episode with Severe Psychotic Symptoms'. In 2020, Sarah was referred to the local community mental health team due to the exacerbation of anxiety and memory problems.

Although Sarah sometimes told people that she had mental health conditions, there is no record of any formal mental health diagnosis after March 2005.

11.7 A report prepared by a consultant psychiatrist in March 2023, for the purposes of Sarah's trial, concluded that there was no evidence that Sarah was suffering serious mental illness such as severe depression, bipolar affective disorder, or schizophrenia. There was no evidence that Sarah suffered from a learning disability. There was no evidence that Sarah suffered from a mental disorder of a nature or degree as to impact on her capacity to enter a plea with understanding, follow proceedings, instruct counsel, or challenge a juror.

11.8 The Equality Act 2010 (Disability) Regulations 2010 [SI 2010/2128] specifically provide that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.9 There is nothing in agency records that indicated that any subjects of the review lacked capacity[5] in accordance with the Mental Capacity Act 2005. Professionals applied the principle of the Mental Capacity Act 2005:

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

11.10 The panel recognised that domestic abuse is a gendered crime, with women being more likely to be victims than men. Men are much more likely to be killed by a stranger than their partner.

[5] The Mental Capacity Act 2005 established the following principles:
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".
Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".
Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision". Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity. Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".
Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
(Mental Capacity Act Guidance, Social Care Institute for Excellence)

11.11 According to the Office for National Statistics (ONS) homicide report 2021/22,[6] there were 134 domestic homicides in the year ending March 2022.

Of the 134 domestic homicides: 78 victims were killed by a partner or ex-partner, 40 were killed by a parent, son, or daughter, and 16 were killed by another family member.

Almost half (46%) of adult female homicide victims were killed in a domestic homicide (84). Of the 84 female victims, 81 were killed by a male suspect.

Males were much less likely to be the victim of a domestic homicide, with only 11% (50) of male homicides being domestic related in the latest year.

11.12 According to the ONS domestic abuse in England and Wales overview: November 2023,[7] 26.5 % of domestic abuse victims were men. That equates to 751,000 male victims of domestic abuse in 2022/23.

11.13 In April 2021, Mankind Initiative published the document – 'Male victims of domestic abuse and partner abuse: 55 key facts'.[8] This included the following statistical data drawn from ONS figures:

- One in six/seven men and one in four women will be a victim of domestic abuse in their lifetime. In 2019/2020, 757,000 men and 1.56 million women said they were victims that year.
- From April 2015 to March 2020, on average 12 men per year had been killed by a partner or ex-partner (74 women per year).
- In 2019/20, 1.9% of men who were 60 – 74, stated that they had suffered domestic abuse (4.4% women), and 1.1% had suffered from partner abuse (3.4% women). The peak for men and women is 16 – 24.
- In 2019/20, 7.5% of men who were disabled, stated that they had suffered domestic abuse (14.7% women), and 5.1% had suffered from partner abuse (11.5% women). The rate of domestic/partner

[6] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022#the-relationship-between-victims-and-suspects

[7]

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2023#:~:text=The%20police%20recorded%20889%2C918%20domestic,the%20year%20ending%20March%202022

[8] https://www.mankind.org.uk/wp-content/uploads/2021/04/55-Key-Facts-about-Male-Victims-of-DomesticAbuse-and-Partner-Abuse-Final-Published-April-2021.pdf

abuse is double that of those who are not disabled.

11.14 The Review Panel took account of research in relation to the gender bias of male victims of domestic abuse. In 2021, Dr Elizabeth Bates, University of Cumbria, published a paper following a review of 22 Domestic Homicide Reviews.[5] The research identified that society still did not readily recognise male domestic abuse victims, and that some may have lost their lives as a result. The research looked at homicides featuring male victims of domestic abuse and found that opportunities to help them were missed due to gender bias and outdated stereotypes. The bias dually inhibited male victims from reporting their abuse, and public support services, such as police and health care, from recognising them as victims. Half of the reviews showed support services lacked guidance to help identify and treat male victims, and a considerable number of men's injuries from domestic abuse were dismissed by the police and other services, as well as friends and family.

11.15 The panel did not identify any of the protected characteristics which specifically inhibited David or Sarah from seeking help or inhibited the provision of services. Barriers to reporting are discussed at paragraphs 14.1.18 to 14.1.20.

12 Dissemination

12.1 Home Office
Rotherham Community Safety Partnership
South Yorkshire Police and Crime Commissioner
Domestic Abuse Commissioner
All agencies contributing to this review David
and Sarah's family

13 Background, Overview and Chronology

This section of the report combines the Background, Overview and Chronology sections of the Home Office DHR guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies and material gathered by the police during their investigation

[5] https://www.cumbria.ac.uk/about/news/articles/articles/homicide-research-reveals-society-blind-to-malevictims-of-domestic-violence-.php

following David's death, as well as information from his family. The information is presented in this section without comment. Analysis appears at section 14 of the report.

13.1 Relevant History Prior to the Timeframe of the Review

13.1.1 In 1995, David joined the army but dropped out after basic training. In 1997, David rejoined the army and successfully passed his basic training. He was discharged from the army in 2002 – recorded as medically unfit with posttraumatic stress disorder. David's children told the Chair of the review that although David sometimes spoke of the good times he'd had in the army, he did not engage with anything to do with the army after he left. He was not involved with any post military support service or charity. David's mum told the Chair that she was not sure what had happened to cause David to leave the army; however, it was known that he had self-harmed and caused damage to the family home.

13.1.2 On his discharge from the army, David, Sarah, and their family returned to Rotherham, where they lived in social housing. David's mum told the Chair that David had a lump sum from the army and used part of it to pay for cosmetic surgery for Sarah. David obtained work in a distribution warehouse, where he worked until around 2008. The reason for the end of his employment is unknown. David's mum told the Chair that Sarah would ring David very often at work and ask him to come home and that this gradually wore him down. David and Sarah's children recall that during this time, they were treated generously, for example, receiving nice Christmas and birthday presents.

13.1.3 There is a history of domestic abuse between David and Sarah dating back to 2006. Between 2006 and 2011, there were five allegations of domestic abuse when the couple's children were present. In 2008, the couple's case was referred to MARAC.

13.1.4 David and Sarah's children told the Chair of the review that their parents showed them love and care and provided the necessities when they were growing up. This included taking the children on happy holidays to the seaside.

13.1.5 David and Sarah's children also told the Chair that they had witnessed David and Sarah abusing drugs on a daily basis. This would take the form of overuse of prescription medication and supplementing that with other drugs bought illegally. If they had a prescription on Monday, then they would take it all on that day. David often took Sarah's drugs, which caused arguments. David took steroids for several years, which caused him to have anger issues.

13.1.6 The children said that the influence of drugs would often result in arguments. Sarah was very vocal whilst David was quieter, but he was unpredictable when intoxicated by drugs. David smashed the house up on numerous occasions and often broke the television. The children estimated that David had broken around a hundred televisions over the years.

13.1.7 David and Sarah's children say that, as children, they witnessed David attack Sarah around once a month. They did call the police on several occasions but more often would hide in their bedrooms. They genuinely feared that David would kill Sarah.

13.1.8 The panel acknowledges that the children's views can be seen as victim blaming. However, the panel thought that the views should be incorporated into the report in order to provide a full context. The panel also noted that the views of the children are corroborated by historical information about calls to the police.

13.1.9 David's mum told the Chair that as the children were growing up, they were often provided with things that they needed by members of the extended family, as well as going on holiday with other family members. At the same time, Sarah was often witnessed to have new possessions and clothing. There were many times when David and Sarah were supported practically and financially by David's extended family.

13.1.10 David was involved in providing practical care and support to his father, along with other family members, until his father's death in 2017. David's father also provided financial support to David. David and Sarah would regularly split up, with David staying at his father's house. During times when the couple were not together, other family members witnessed regular phone calls from Sarah asking David to go back home. The death of David's father had a considerable and emotional effect on David. Furthermore, on a practical level, this was the end of the caring responsibilities that had kept David busy.

13.2 Events within Timeframe of Review

13.2.1 Throughout the period of the review, David was engaged with Change Grow Live, which was contracted as the local drugs and alcohol service. He had many regular appointments that are not listed in the below chronology – so as to avoid repetition. David continued to be reliant on various drugs, including amphetamine, diazepam, buprenorphine, and admitted occasional cocaine use. He was prescribed opioid substitute treatment drugs.

Sarah had many GP appointments. Only those judged to be relevant are included in this combined chronology. Both David and Sarah also missed many appointments.

13.2.2 On 23 November 2017, David and Sarah's youngest child, Alex, (secondary school age at the time) called the police following a violent incident when David assaulted Sarah. On police arrival, David emerged from the house wearing a mask and goggles whilst carrying a long pole and a fire extinguisher, which he discharged towards the officers. David was arrested by use of a Taser.

Sarah later said that she could not remember the incident but thought that David must have hit her with a bottle. Sarah did not wish to make a statement and did not consent to her injuries being photographed or the house being photographed. A DASH risk assessment was conducted but was incomplete: it was graded as high risk on professional judgement. Referrals were made to MARAC, domestic abuse services, and children's services.

The Crown Prosecution Service (CSP) reviewed the evidence and concluded that there was insufficient evidence to charge David with assault on Sarah. David was charged with a public order offence, for which he later appeared at court.

13.2.3 On 24 November 2017, David and Sarah's case was discussed at the daily multiagency domestic abuse (MADA) meeting. Actions were agreed for Children's Social Care assistance, and the allocation of an IDVA to support Sarah.

13.2.4 On 24 November 2017, Alex was placed in the care of a family member and became a looked after child from 28 November 2017 (under Section 20 of the Children Act 1989), after Sarah and David consented to the arrangement.

13.2.5 On 1 December 2017, after many attempts, an IDVA contacted Sarah. Sarah declined any service or further contact from domestic abuse services, stating that she and David had sorted things out and were back on track.

13.2.6 On 7 December 2017, Sarah and David's case was heard at MARAC. It was noted that Sarah was minimising the situation. An action was recorded for the police to consider a Domestic Violence Protection Notice/Domestic Violence Protection Order (DVPN/DVPO)[6] if there were further instances of domestic abuse, and for children's services to give an update on the progress of their investigation.

13.2.7 On 15 December 2017, a short format pre-sentence report was written for court by a probation officer. The report involved an interview with David and a conversation with Sarah. The assessment used evidence from the CPS, previous police call-outs,

[6] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violenceprotection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-andsecurity-act-2010

and an interview with David. David was assessed as posing a medium risk of serious harm to Sarah.

13.2.8 On 18 December 2017, David was sentenced to a twelve-month community order by the court in relation to an offence of threatening behaviour. This related to his conduct towards police officers on 23 November 2017. The order was for 25 Rehabilitation Activity Requirement Days. As David was assessed as medium risk of serious harm, the case was allocated to South Yorkshire Community Rehabilitation Company (SYCRC). SYCRC was aware that the background to the case was domestic abuse; therefore, the focus was around addressing domestic abuse.

13.2.9 On 28 December 2017, a strategy meeting took place regarding Alex. The outcome was for the case to proceed to a single agency investigation under Section 47 of The Children Act 1989.

13.2.10 In February and March 2018, David had a number of appointments with a mentor from Inspiring Intelligence [this organisation, contracted by SYCRC, no longer exists, and full details are not available]. Work included support on benefits, outstanding debt, and a referral to the British Legion.

13.2.11 Over the following months, Sarah and David attended several meetings with children's services regarding their youngest child. Children's services commenced the Public Law Outline (PLO),[7] and David and Sarah were invited to the initial meeting that took place on 20 March 2018. It was at this meeting that David and Sarah made the decision that it would be in Alex's best interests to remain in the care of their aunt. Sarah and David had legal representation at the meeting.

13.2.12 On 24 January 2018, children's services made a referral for Sarah to Rotherham Rise. The referral requested that Rotherham Rise work with Sarah around understanding healthy relationships, the impact of domestic abuse, risk assessment and safety planning, and to provide emotional support. They also requested that support be provided to Alex to explore their wishes and feelings. A confidentiality and information sharing agreement was completed with Sarah on 26 January, and the first session was booked for 6 February. Sarah did not attend this appointment, and during a telephone call that same date, she declined any further support from the service. The case was subsequently closed to Rotherham Rise.

[7] The Public Law Outline (PLO) is a framework used in the family court in England and Wales to manage cases involving children. It was introduced in 2008 as part of the Children and Adoption Act 2006.

A separate process took place to engage with Alex. On 5 June 2020, after several contacts, Alex declined any involvement with the service.

13.2.13 On 9 April 2018, David attended the first session of the Respectful Relationships Programme (mandated by SYCRC). He attended 11 sessions, and records state that he engaged well. The programme concluded on 2 July 2018.

13.2.14 On 6 August 2018, Alex's case was closed to children's services.

13.2.15 On 14 December 2018, David had his last appointment with the South Yorkshire Community Rehabilitation Company – prior to conclusion of the community order on 18 December 2018.

13.2.16 On 8 April 2019, a Notice Seeking Possession (NSP) was served on Sarah: it related to rent arrears of £446. This prompted payments to reduce the arrears. Sarah was the sole tenant named on the tenancy.

13.2.17 On 31 May 2019, Sarah was supported by the RDaSH crisis team – following the suicide of a close family member.

13.2.18 On 22 November 2019, David called the police following an argument with Sarah in which items had been thrown around the house. On police arrival, both David and Sarah agreed that that there had been a verbal argument and no assault. A DASH risk assessment was completed, which showed a standard risk. A vulnerable adult form was submitted, as it was stated that Sarah had mental health issues and had not taken her medication: the form did not reference domestic abuse. On receipt of the referral, Adult Social Care discussed the case with RDaSH; consequently, a decision was made that no further action was required by Adult Social Care.

13.2.19 On 4 June 2020, Sarah's GP referred her to RDaSH community mental health team. The concerns were around memory problems and that her mood and anxiety had become worse. She had also been diagnosed with epilepsy. The team tried to contact Sarah on four occasions before successfully contacting her on 3 September 2020. [See paragraph 13.2.23].

13.2.20 On 23 July 2020, a relative rang the police on behalf of Sarah. On police attendance, Sarah said that David had been taking amphetamines for two weeks, and the previous night had been saying to her: "I'm having bad thoughts". During

the night, David had put his hand over her mouth and punched her to the head multiple times. When completing the DASH risk assessment, Sarah disclosed that around seven weeks prior to this incident, David had grabbed her by the head, put her into the bath, dragged her around, and punched her in the head before taking a mirror from the wall and smashing it over her head: this was previously unreported, as she was too scared. It was noted within the DASH that Sarah was dependent on David for money, and this was the main reason that she was reluctant to leave the relationship. David was arrested for assault and coercive and controlling behaviour. He was interviewed and made no reply to any question. Consideration was given to a DVPN; however, as Sarah provided a statement to the police, David was instead bailed with conditions to not contact Sarah or return to the family home. This was to allow officers time to obtain the relevant statements and to prevent David from interfering with witnesses or otherwise obstructing the course of justice.

Sarah went on to retract her statement. Sarah stated that she was not prepared to go to court because she thought that David needed help rather than prosecution. A police decision was made to file this investigation because the police were unable to prove the offence without Sarah's support. Furthermore, this did not meet the criteria for evidence-led prosecution. There were no witnesses to the assaults in question and no medical evidence. Controlling and coercive behaviour was considered; however, there was no evidence from Sarah, and no supporting evidence. The DASH was completed. DARA completed a secondary risk assessment and assessed the incident as high risk. Referrals were made to IDVA, MARAC, and Adult Social Care.

13.2.21 On 23 July 2020, Sarah was contacted by an IDVA. Sarah was offered a refuge placement but declined. She was staying at her mother's house but was going back to her own house later that day. Safety planning was carried out. Furthermore, offers of support from, and referral to, other agencies were made but declined. Sarah said that she did not want to resume the relationship with David, as she had had enough.

13.2.22 On 27 July 2020, David and Sarah's case was discussed at the multi-agency domestic abuse meeting. The meeting was assured that David was on bail with conditions not to contact Sarah. An action was agreed for Sarah's mother's address (where she was staying temporarily) to be flagged on the police computer system. An IDVA spoke to Sarah on the telephone and completed safety planning. A range of options, including the offer of a refuge placement, were discussed. Sarah declined this. Sarah was also offered referrals to Change Grow Live and Improving Access to Psychological Therapies. She declined any assistance.

13.2.23 On 6 August 2020, Sarah and David's case was heard at MARAC. David was residing away from the family home, with bail conditions not to attend. Alternative telephone numbers for Sarah were shared because the IDVA had been unable to contact Sarah after the initial call. The case was closed to the IDVA service on 27 August, as Sarah did not reply to further letters or telephone calls.

13.2.24 On 17 August 2020, a police superintendent granted an authorisation for an extension of David's police bail. Due to an administration error, this was not formally recorded, and as a result, the bail lapsed on 29 August when David was released under investigation with no bail conditions.

13.2.25 On 19 August 2020, David told his drugs worker that he was starting a job that week.

13.2.26 On 3 September 2020, Sarah was contacted by the RDaSH community mental health team: this was to follow up on the GP referral of 4 June 2020. Sarah did not feel that she needed support from mental health services. Her only concern was a bad memory, and she was advised to see her GP regarding this. Sarah said that David had left the family home.

13.2.27 On 15 September 2020, Sarah told her GP that she could not remember declining mental health services. The GP referred Sarah back to RDaSH, as she was experiencing hallucinations and mood fluctuation. The GP also referred Sarah to the memory clinic.

13.2.28 On 24 September 2020, David told his drugs worker that he had returned to live in the family home.

13.2.29 On 2 October 2020, David and Sarah's youngest child (who was by then an adult) made a 999 call to the police, stating that they were outside their parent's house and were too scared to go back in. They reported that David was irate and was making threats to smash the house up. They were afraid for Sarah's safety, stating that David had hit her before and that this was a regular occurrence. Officers arrived and spoke with both parties. Sarah disclosed that David had returned home from work annoyed that she hadn't contacted him all day. He had come home with a kebab, which he threw on the floor. Sarah was taken to her mum's address by the police to avoid any escalation. This was recorded as a non-crime domestic. As no offences were disclosed, and Sarah confirmed it had been a verbal argument only, it was filed 'no further action'. The DASH questionnaire was completed, with Sarah recorded as the victim. She stated that David was taking Subutex[8] for previous drug

[8] Buprenorphine, sold under the brand name Subutex among others, is an opioid used to treat opioid use disorder, acute pain, and chronic pain.

abuse. Risk indicators were identified, as Sarah was back living with David after a period of separation following an assault. The incident was assessed as medium risk from the DASH and by DARA. Sarah agreed to support from Helpline regarding domestic abuse, and a referral was made to Adult Social Care because both parties presented with potential mental health issues. The DASH included a comment that Sarah was the aggressor.

13.2.30 On 5 October 2020, Sarah was referred to Rotherham Rise by South Yorkshire Police (arising from the incident of 2 October). Several attempts were made to contact Sarah to offer support, but they were all unsuccessful. On 13 October, Sarah's case was closed because the service had been unable to contact her.

13.2.31 On 7 October 2020, Sarah had an appointment for a mental health assessment. A plan was agreed for her to self-refer to Talking Therapies, attend a memory clinic assessment, attend an epilepsy assessment, and visit her GP for health checks.

13.2.32 On 7 October 2020, the investigation resulting from the incident of 23 July 2020 was finalised. An Inspire to Change referral was made for David. Inspire to Change is a voluntary perpetrator programme commissioned by Rotherham Borough Council. The provider of the programme has changed since 2020, and records of the previous provider were unavailable to the review. It is therefore unknown whether David engaged with Inspire to Change.

13.2.33 On 6 November 2020, a third party made a call to the police to report an ongoing domestic incident involving Sarah and David. Officers were dispatched as an emergency, and upon attendance, they had to force entry into the address because Sarah was unresponsive on the settee due to alcohol intoxication. When officers spoke to Sarah, she confirmed that there had been a verbal argument over David taking steroids, and no offences had taken place. Both parties were spoken to, and the DASH was completed. In the DASH, Sarah mentioned that over the last couple of weeks, she and David had been consuming more alcohol, but she could not explain why. She stated that the argument was due to David taking steroids.

Officers transported David to a friend's address to prevent any further incidents. No offences were disclosed, and the incident was filed no further action and recorded as a non-crime domestic. The incident was secondary risk assessed by DARA and was assessed as medium risk. This was based on the previous high-risk incident between the parties. It was noted that the risk factors were that both parties had consumed alcohol and that Sarah had declined domestic abuse advice – as she did not consent within the DASH to being referred on to any partner agencies for support. It was agreed for the critical marker to remain in place, and a referral was made to IDVA due to the previous high-risk incident.

13.2.34 On 4 December 2020, David's drugs worker received a telephone call from him. David stated that he did not have any medication. He appeared to sound under the influence of substances. David stated that he was no longer working and denied any substance misuse.

13.2.35 On 11 December 2020, a third party called the police on Sarah's behalf to report that following an argument, David had left the house and taken Sarah keys, locking her in the house. When officers attended, David had returned, and Sarah clarified that there had been a verbal argument. Safeguarding advice was given, and the DASH was completed. Sarah did not consent to working with partner agencies regarding domestic abuse. A secondary risk assessment was completed by DARA, and they assessed the incident as medium risk. A referral was made to IDVA due to Sarah being a recent high-risk victim. This was recorded as a noncrime domestic and was filed.

13.2.36 In the early hours of 12 December 2020, a third party called the police on behalf of Sarah. It was reported that David had driven off and was planning to take an overdose. Officers located David, who was safe. David confirmed that he was safe, and the indicated medication was found back at the home address.

13.2.37 On 14 January 2021, Sarah was visited at home by the Young Onset Dementia team. David was present. Sarah had no concerns regarding her mood, although she had sleep problems. Sarah said that she smoked 20 – 30 cigarettes a day, rarely drank alcohol, and did not abuse drugs. Sarah said that domestic abuse in her relationship with David was historic. The practitioner discussed Sarah's case with a doctor and wrote to Sarah's GP to ask for a sleep medication review. A further appointment was to be arranged after a CT scan. The panel was told that a CT scan did take place in October 2021 and showed no abnormalities.

13.2.38 On 9 February 2021, David told his drugs worker that he was caring for Sarah fulltime. Over the next several months, David repeated that he was finding caring for Sarah stressful.

13.2.39 On 21 February 2021, Sarah made a 999 call to the police. She was crying and stated that someone was not being nice to her. Officers were dispatched to the address and found that there had been a verbal argument between Sarah and David. No offences were disclosed. The DASH risk assessment was completed and there was mention of David's mental health issues. Sarah did not consent to working with partner agencies for domestic abuse support. Both parties were given safeguarding advice, and the officers left the scene. This was secondary risk assessed by DARA, and a referral was made to IDVA due to the high-risk incident in July 2020. At that time, the IDVA service only responded to medium- or high-risk

incidents for those currently at high risk, so no response was made to this standard-risk referral. At that time, Rotherham Rise was commissioned to provide a service to standard-risk victims. This was a 'with consent service', and as Sarah did not give her consent, then it was not possible for Rotherham Rise to respond. Since 1 October 2022, all referrals are made to Rotherham Rise as a single 'front door' for domestic abuse referrals.

13.2.40 On 2 April 2021, a Notice Seeking Possession (NSP) was again served on Sarah. On this occasion, the rent arrears were £412. The main issues identified in the rent recovery history (as impacting payments) were:

- Changes in benefit entitlement, arising from changes in circumstances.
- Family members leaving and returning to the property, including son, daughter, and at one point, David, affecting non-dependant charges and under-occupancy charges, thereby impacting benefit entitlement.
- Residual rent payments (arising from the above) not being paid.
- Payment agreements not being sustained, leading to rent arrears increasing.

13.2.41 On 22 June 2021, David was referred by his GP to the RDaSH community mental health team regarding worsening of his mood and perceived carer stress. A telephone appointment was arranged for 20 September, but David did not answer his phone. A further appointment was to be arranged, but this did not take place before his death.

13.2.42 On 3 September 2021, David contacted his drugs worker (by text) and asked for help: this resulted in a telephone call. David said that he had left the family home after Sarah accused him of having an affair with one of her friends, and he was feeling suicidal. He was given contact details for the homelessness service and mental health crisis line. David did not answer numerous further calls to him, and the police were asked to check on his welfare. He was seen later the same day – safe and well at the home address.

13.2.43 On 16 September 2021, David attended a face-to-face meeting with his drugs worker at his GP surgery. David declared cocaine and amphetamine use and that he had drunk a few cans of alcohol at Sarah's birthday party.

13.2.44 On 28 September 2021, Sarah's GP referred her to RDaSH community mental health team regarding worsening of her mood, hallucinations, and being tearful all the time. The referral noted that she was prescribed olanzapine[13], duloxetine[14], and zopiclone[15].

13.2.45 On 30 September 2021, David's drugs worker telephoned him. David sounded intoxicated. He denied any drug use that day, but he said that he had taken diazepam two days earlier.

13.2.46 In October 2021, David's drugs worker telephoned him. David stated that he had refrained from any illicit drug use, and home life was more settled.

13.2.47 In October 2021, the community mental health team contacted Sarah to offer an assessment. An arrangement was made for Sarah to attend for a cognitive assessment. This had not taken place at the time of David's death.

13.2.48 On a day in October 2021, David was murdered.

14 Analysis

14.1 What indicators of domestic abuse, including coercive and controlling behaviour,[9] did your agency identify for David and Sarah?

14.1.1 Within the time period of this review, the police received seven domestic abuse related calls to David and Sarah's address prior to David's murder.

14.1.2 The first incident in the review timeframe – on 23 November 2017 – led to David being convicted of threatening behaviour. A DASH risk assessment showed Sarah

[13] Olanzapine helps to manage symptoms of mental health conditions such as: seeing, hearing, feeling or believing things that others do not, feeling unusually suspicious or having muddled thoughts (schizophrenia); feeling agitated or hyperactive, very excited, elated, or impulsive (mania symptoms of bipolar disorder)

[14] Duloxetine is a type of antidepressant medicine known as a serotonin-noradrenaline reuptake inhibitor (SNRI). SNRIs are thought to work by increasing the amount of mood-enhancing chemicals, serotonin and noradrenaline, in the brain. It's used to treat depression and anxiety. It's also used to treat nerve pain, such as fibromyalgia, and can be used to treat stress urinary incontinence in women.

[15] Zopiclone is a type of sleeping pill that can be taken for short-term treatment of severe insomnia.

[9] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act created a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

as a high-risk victim. Although there was no prosecution in relation to offences against Sarah, this incident, combined with historical events that are not analysed here, clearly identified that Sarah was a victim of domestic abuse.

14.1.3 David's subsequent conviction for threatening behaviour resulted in a twelvemonth community order. During which, he was supervised by Probation (South Yorkshire Community Rehabilitation Company). Although the conviction was for threatening behaviour, it was recognised that the background was domestic abuse, and David was mandated to attend the Respectful Relationships Programme. This was a non-accredited domestic abuse perpetrator programme that was then in use by the CRC. David's attendance at, and engagement in, the programme was said to be good. The panel thought that ensuring David attended such a programme was good practice, given that his conviction was not for domestic abuse.

14.1.4 Arising from the incident of 23 November 2017, referrals were made to MARAC and the IDVA service. The IDVA service was unable to engage with Sarah. Information about the incident was shared at MARAC, with all relevant agencies.

14.1.5 Following this incident, David and Sarah's youngest child moved out of the family home to live with an extended family member and became a looked after child (under Section 20 of the Children Act 1989).

14.1.6 In January 2019, children's services made a referral to Rotherham Rise to seek support for Sarah and her youngest child in relation to domestic abuse. After initially engaging, Sarah did not attend an arranged appointment and then declined any further support.

14.1.7 After this time, domestic abuse in David and Sarah's relationship was widely known to agencies.

14.1.8 There were a further six domestic abuse incidents reported to the police prior to David's murder. The police attended all six incidents. In five of them, David was recorded as the perpetrator. The panel thought that two of the incidents were particularly significant.

14.1.9 On 23 February 2020, David was arrested for grievous bodily harm and coercive and controlling behaviour after a report of assault from Sarah. In addition to providing information about the assault, Sarah stated that she was dependent on David for money, and this was the main reason she was reluctant to leave the relationship. Sarah later retracted her statement, and a police decision was made to file the case without charge. Although other potential witnesses had been spoken to, it was considered that there was insufficient evidence to put the case to

the Crown Prosecution Service without Sarah's involvement. There is no record of an evidence-led prosecution being considered, although in hindsight, South Yorkshire Police do not think it would have been possible due to a lack of corroborating evidence of Sarah's initial complaint. David was referred by the police to Inspire to Change. This is a voluntary domestic abuse perpetrator programme commissioned by Rotherham Borough Council. The provider of the programme has changed since these events, and records of the previous provider were not available to the review. It is therefore unknown if David engaged with Inspire to Change.

14.1.10 On 11 December 2020, Sarah reported that David had taken her house keys and locked her in the house. When the police attended, David had returned with the keys. On 12 December 2020, it was reported that David had left the house and intended to take an overdose. In fact, he was found safe and well, and the medication that he intended to use was found in the house. Both behaviours can be interpreted as coercive and controlling behaviour.

14.1.11 The panel reflected on whether, in hindsight, there was evidence of coercive and controlling behaviour in David and Sarah's relationship. In doing so, it referred to the Crown Prosecution Service guidance.

14.1.12 The Crown Prosecution Service Guidance on coercive control (updated 23 April 2023) states:[10]

'Building on examples within the Statutory Guidance Framework, relevant behaviour of the suspect can include:

- isolating a person from their friends and family
- depriving them of their basic needs
- monitoring their time
- monitoring a person via online communication tools or using spyware
- using digital systems such as smart devices or social media to coerce, control, or upset the victim including posting triggering material
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep – this can be intertwined with the suspect saying it is in their best interests, and 'rewarding' 'good behaviour' e.g. with gifts

[10] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-familyrelationship

- depriving them of access to support services, such as specialist support or medical services
- repeatedly putting them down such as telling them they are worthless
- enforcing rules and activity which humiliate, degrade or dehumanise the victim
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- economic abuse including coerced debt, controlling spending/bank accounts/investments/mortgages/benefit payments
- controlling the ability to go to school or place of study
- taking wages, benefits or allowances
- threatening to hurt or kill
- threatening to harm a child
- threatening to reveal or publish private information
- threatening to hurt or physically harming a family pet
- assault
- physical intimidation e.g. blocking doors, clenching or shaking fists
- criminal damage (such as destruction of household goods)
- preventing a person from having access to transport or from working
- preventing a person from learning or using a language or making friends outside of their ethnic or cultural background
- family 'dishonour'
- reputational damage
- sexual assault or threats of sexual assault
- reproductive coercion, including restricting a victim's access to birth control, refusing to use a birth control method, forced pregnancy, forcing a victim to get an abortion, to undergo in vitro fertilisation (IVF) or other procedure, or denying access to such a procedure
- using substances such as alcohol or drugs to control a victim through dependency, or controlling their access to substances
- disclosure of sexual orientation
- disclosure of HIV status or other medical condition without consent
- limiting access to family, friends and finances
- withholding and/or destruction of the victim's immigration documents, e.g. passports and visas
- threatening to place the victim in an institution against the victim's will, e.g. care home, supported living facility, mental health facility, etc (particularly for disabled or elderly victims'.

This is not an exhaustive list, and prosecutors should be aware that a suspect will often tailor the conduct to the victim, and this conduct can vary to a high degree from one person to the next. Prosecutors should consider the conduct of the suspect (in each individual case) to assess whether it discloses controlling or coercive behaviour. There is plainly overlap with stalking and harassment.

There might be confusion about where the 'appropriate' dynamic of a relationship ends and where unlawful behaviour begins. One way of considering this is described by The College of Policing Authorised Professional Practice on Domestic Abuse,[11] which sets out that: 'In many relationships, there are occasions when one person makes a decision on behalf of another, or when one partner takes control of a situation and the other has to compromise. The difference in an abusive relationship is that decisions by a dominant partner can become rules that, when broken, lead to consequences for the victim'.

Prosecutors should consider, within the wider context of the relationship, the impact on the victim of following, or not following, rules imposed upon them, especially where this type of behaviour has occurred within the relationship. It is not necessary for the prosecutor to prove that consequences follow: not least because the fear of consequences is just as powerful. This is intended as a tool by which to recognise a controlling or coercive relationship, rather than a 'point to prove'.

14.1.13 The Review Panel took cognisance of the following definitions, as detailed by the UK charity Surviving Economic Abuse:[12]

Economic abuse is a legally recognised form of domestic abuse and is defined in the Domestic Abuse Act. It often occurs in the context of intimate partner violence and involves the control of a partner or ex-partner's money and finances, as well as the things that money can buy. Economic abuse can include exerting control over income, spending, bank accounts, bills, and borrowing. It can also include controlling access to and use of things like transport and technology, to allow an individual to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.

[11] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse

[12] https://survivingeconomicabuse.org/about-us/what-we-do/
Surviving Economic Abuse (SEA) is the only UK charity dedicated to raising awareness of economic abuse and transforming responses to it.

Financial abuse is controlling finances, stealing money, or coercing someone into debt. Economic abuse and financial abuse involve similar behaviours, but it is helpful to think of financial abuse as a subcategory of economic abuse.

14.1.14 David and Sarah were largely reliant on benefits in recent years. The panel therefore asked for information from the Department for Work and Pensions in relation to David and Sarah's benefit payments.

Prior to July 2020, David was in receipt of Personal Independence Payment (PIP) and Employment and Support Allowance (ESA), which was paid into a bank account in Sarah's name.

From July 2020, David and Sarah had separate benefit claims. Sarah was paid Universal Credit into her account. David was paid Employment and Support Allowance by bank giro credit, which he would then need to cash at a post office. The change in arrangements appears to coincide with the domestic abuse incident in July 2020, for which David was arrested.

14.1.15 In considering whether there were indicators of coercive and controlling behaviour, the panel was clear that David was the ultimate victim in this case when he was murdered by Sarah.

14.1.16 During the timeframe of the review, the panel saw evidence that David had assaulted Sarah, locked her in the house, and threatened to take his own life. There is evidence that he sometimes took Sarah's medication, thereby depriving her of it. Panel members noted that most calls to the police were made by others on Sarah's behalf and wondered if she had access to a phone. On balance, the panel thought it more likely than not that David had subjected Sarah to coercive and controlling behaviour. That view has to be balanced by the information from David's mum of Sarah's behaviour, including constant phone calls to David asking him to come home, which had a wearing effect on David. The panel was also aware that prior to July 2020, benefit payments were made into a bank account in Sarah's name, which may have restricted David's access to money. Sarah was the sole person named on the tenancy agreement for the family home. David paid for cosmetic surgery for Sarah when he left the army. It is possible that both David and Sarah exhibited coercive and controlling behaviours to each other.

14.1.17 The panel also noted information from David and Sarah's children of events in their childhood of regular violent incidents and smashed televisions. Although that behaviour would not have amounted to coercive and controlling behaviour because it was before the legislation was enacted on 29 December 2015, the panel thought it was relevant in showing that there were long-running issues of domestic abuse.

14.1.18 The panel was aware that many domestic abuse incidents are not reported and thought that given the information from neighbours about regular arguments, it was likely that a number of domestic abuse incidents had not been reported. The panel noted information from ONS data [paragraph 11.12] that 26.5% of domestic abuse victims are men.

14.1.19 There are several surveys that outline why victims may not report abuse. The report by Victim Support – 'Surviving justice' (2017) – contains the following information:

14.1.20 **Barriers to reporting – as cited by Victim Support Caseworkers**

Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear they would not be believed or taken seriously	42%
Fear, dislike, or distrust of the police/CJS	25%
Concern about their children and/or the involvement of social services	23%
Poor previous experience of police/CJS	22%
Abuse normalised, not understood, or believed to be deserved	15%
Wanting to protect the perpetrator / wanting to stay in relationship / not wanting to punish perpetrator	14%
Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

14.1.21 The review has seen evidence that information about domestic abuse in David and Sarah's relationship was shared with Adult Social Care, RDaSH, Change Grow Live, primary care, Rotherham IDVA service, and Rotherham Rise. On some occasions,

information was shared by direct referral to agencies, for example, Adult Social Care, IDVA, and Rotherham Rise. Other agencies had information shared through the MARAC process.

14.1.22 Sarah was the sole person named on the tenancy of the family home, which was rented from Rotherham Borough Council. There were no reports of anti-social behaviour from the property. Twice during the timeframe of the review, a Notice Seeking Possession of the property was served on Sarah due to rent arrears.

On 2 April 2021, a Notice Seeking Possession (NSP) was again served on Sarah. On this occasion, the rent arrears were £412. The main issues identified in the rent recovery history (as impacting payments) were:

- Changes in benefit entitlement, arising from changes in circumstances.
- Family members leaving the property, including David at one point, affecting non-dependant charges and under-occupancy charges, thereby impacting benefit entitlement.
- Residual rent payments (arising from the above) not being paid.
- Payment agreements not being sustained, leading to rent arrears increasing.

The housing service made ongoing contacts with Sarah to discuss her rent payments and understand what was impacting payments. They provided advice to help maximise benefit take-up and income maximisation. They also established reasonable and affordable rent payment plans. Notices were served when all reasonable attempts to reduce the debt and establish regular payments had been unsuccessful. Once served, a NSP remains in force for a period of 12 months. At any time during the 12 months, the housing service would be entitled to commence legal proceedings for possession of the property if the arrears were not reducing. After 12 months, the NSP expires, and a new NSP must be served – if the circumstances warrant it. The housing service was aware of domestic abuse, as a representative attends MARAC and was present at the MARAC meeting on 6 August 2020.

14.1.23 On 9 April 2021, during a conversation with a housing income recovery officer, Sarah expressed a desire to move from the then family home to a bungalow. A move to a smaller property was likely to be helpful because there would then be less chance of recurring under occupancy charges. In May 2021, a discretionary housing payment was made, which cleared the arrears. The panel thought that the actions taken by the housing service to reduce rent arrears, whilst providing support to Sarah, were reasonable and proportionate.

14.1.24 The panel was told that it is very common for a tenancy to be in one person's name, including married couples, and there was nothing unusual in the tenancy

being solely in Sarah's name. This is a common arrangement and not something that would draw any attention from housing officers.

14.2 **How did your agency assess the level of risk faced by David and Sarah, and which risk assessment model did you use?**

14.2.1 The police used the DASH risk assessment in order to assess risk at each domestic abuse incident attended. South Yorkshire Police have a secondary risk assessment process in place, known as DARA. The secondary DASH is a specialist, independent risk assessment that follows the initial risk assessment (DASH). It ensures risk factors are identified and are part of a management plan that is designed to consider all relevant information, including the current incident and research of police systems. Referrals may be made to partner agencies following the risk assessments.

14.2.2 The below table shows details of all the DASH risk assessments completed by the police.

14.2.3

Date	Victim	Initial risk Assessment	Secondary Risk Assessment
23 November 2017	Sarah	High	High
22 November 2019	David	Standard	Standard
23 July 2020	Sarah	Medium	High
2 October 2020	Sarah	Medium	Medium
6 November 2020	Sarah	Standard	Medium
11 December 2020	Sarah	Standard	Medium
21 February 2021	Sarah	Standard	Standard

14.2.4 The DASH risk assessments were shared with Adult Social Care and the IDVA service, as well as Rotherham Rise where appropriate.

14.2.5 The DASH risk assessment completed for the incident of 2 October 2020, contained a comment that Sarah was the aggressor. Despite this, Sarah was shown as the victim in all other aspects of the risk assessments. The panel noted that where two parties to a domestic abuse incident are both

considered as victims, then two DASH risk assessments should be completed. This is a learning point for South Yorkshire Police.

14.2.6 Following his conviction for threatening behaviour in 2017, Probation (South Yorkshire Rehabilitation Company) assessed David using the OASys[13] risk assessment tool. This assessed that David posed a medium risk of serious harm to Sarah (this harm being both physical harm and emotional harm as a result of domestic abuse), his youngest child (the risk being from witnessing domestic abuse), and the public/police, should they attempt to intervene in future domestic abuse offences (this harm was likely to be physical harm). It was also highlighted that David had the potential to cause a risk of harm to himself. The OASys risk assessment tool defines 'serious harm' as: 'an event which is life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be "difficult or impossible".

Risk of serious harm has two important dimensions:

- the relative likelihood that an offence will occur and
- the relative impact or harm of the offence – what exactly might happen, to what or whom, under what circumstances, and why'.

14.2.7 David was engaged with Change Grow Live throughout the timeframe of the review. Change Grow Live reviews risk using a dynamic risk assessment model in line with clinical and National Institute for Clinical Excellence (NICE) guidelines. Risk is reviewed in conjunction with the service user's recovery plan – every 6 to 12 weeks depending on influencing factors. The last risk review was completed on 14 Oct 2021. The risks highlighted were David's use of illicit diazepam and alcohol. Appropriate harm reduction advice was given. David understood the risks of his substance misuse and stated that his home life was stable, and he had no concerns.

14.2.8 RDaSH did not see David during the timeframe of the review; therefore, no risk assessment was possible. RDaSH used a FACE (Functional Analysis of Care

Environments) risk assessment to assess Sarah's risk – on 7 October 2020 and 21 January 2021. The FACE provides a framework to record a risk assessment, formulation and risk management plan. No risks were identified, although historical domestic abuse was disclosed. The RDaSH IMR author considered that the risk

[13] OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the Probation Service (nationally from 2002) to measure the risks and needs of criminal offenders under their supervision.

assessments were of the appropriate standard, with all questions asked and completed.

14.3 **Did your agency consider that David or Sarah could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?**

14.3.1 Section 42 of the Care Act 2014 requires consideration of the following criteria under Section 42 (1) and (2) of the Care Act (2014):

'S42 (1)
Whether there is "reasonable cause to suspect" that an adult

i. has needs for care and support
ii. is experiencing, or is at risk abuse or neglect, and
iii. as a result of their needs is unable to protect themselves

S42 (2)

iv. Making (or causing to be made) whatever enquiries are necessary
v. Deciding whether action is necessary and if so what and by whom'.

The three points of Section 42 [1] are often known to professionals as 'the three stage test'.

14.3.2 David was engaged with Change Grow Live and was referred to RDaSH by his GP (although he was never seen or spoken to by RDaSH). There was nothing in his presentation to suggest that he met the three criteria under Section 42 of the Care Act.

14.3.3 Sarah was referred to Adult Social Care by the police on three occasions:

November 2019 – A vulnerable adult form was submitted, as it was stated that Sarah had mental health issues and had not taken her medication. The form did not reference domestic abuse. On receipt of the referral, Adult Social Care discussed the case with RDaSH, and a decision was made that no further action was required by Adult Social Care.

July 2020 – Sarah was awaiting a mental health assessment, and the information was passed to RDaSH. The concern was also passed to the IDVA service.

October 2020 – Sarah was awaiting a mental health assessment, and the information was passed to RDaSH. The concern was also passed to Rotherham Rise.
Expected practice would have been to assess the information, make relevant enquiries, and pass the concerns to an agency that was already engaged with Sarah.

14.3.4 No agency that engaged in the review, held information that signified that Sarah met the three criteria under Section 42 of the Care Act.

14.4 **What consideration did your agency give to any mental health issues or substance misuse when identifying, assessing, and managing risks around domestic abuse?**

14.4.1 South Yorkshire Police consider mental health issues and substance misuse when identifying, assessing, and managing risks around domestic abuse, by including consideration of them (directly) in the DASH questionnaire. Appropriate referrals are made following information from the DASH or from wider information received. The DASH asks a series of questions relating to mental health and substance issues: this forms part of the risk assessment that is then subject to a secondary risk assessment by DARA (Domestic Abuse Risk Assessment). DARA staff have undergone specialist training. They include any substance misuse or mental health in their risk assessments and highlight them as key risk indicators where identified.

14.4.2 After the incident of 23 November 2017, it was noted that there had been mention of David taking amphetamines and sleeping tablets: this was picked up by DARA in their risk assessment, as well as mention of David's mental health. The information around David taking amphetamines and sleeping tablets was provided by Sarah. David denied being under the influence of alcohol, drugs, or prescription drugs in interview. Sarah told the officers that David suffered with PTSD. David confirmed this in custody as well as stating that he suffered with paranoid schizophrenia. The appropriate actions were taken in custody, as David was assessed by the force psychiatrist.

14.4.3 The DASH risk assessment following the incident of 22 November 2019, noted that Sarah may have bipolar disorder and paranoid schizophrenia. A vulnerable adult form was submitted to Adult Social Care, which contained details of this. The information around Sarah's mental health issues was provided by David in this instance.

14.4.4 The DASH risk assessment following the incident of 23 July 2020, recorded that Sarah told officers that David had been taking amphetamines and had been

diagnosed with psychosis. DARA used knowledge of previous incidents to consider information that both David and Sarah may have mental health issues. DARA identified David's mental health, drug use, and a previous assault (whilst under the influence of drugs) as key risk indicators. David was arrested following this incident and taken into custody. It was noted in custody that David suffered with asthma, PTSD, COPD, and he was dependent on buprenorphine[14] (also known as Subutex). David said that he had previously self-harmed via overdose and cutting, but it was confirmed that he had no such thoughts. David was assessed by healthcare professionals whilst in custody, and there was no evidence that a secondary referral to mental health services was required.

14.4.5 The DASH questionnaire completed as a result of the incident of 2 October 2020, stated that David was taking Subutex, and following the risk assessment by DARA, an Adult Social Care referral was made for both parties – as they were presenting with potential mental health issues.

14.4.6 Information shared at MARAC in 2017, indicated concerns in terms of Sarah's mental health and possible issues pertaining to alcohol: indicating possible dual diagnosis issues. Sarah had previously been under mental health services but was discharged in February 2017 due to lack of engagement. The IDVA service offered Sarah a referral to Change Grow Live for support around her alcohol misuse; however, she declined this. Information was also provided about IAPT.[15] The IDVA tried to connect Sarah to services to help her address her alcohol and mental health issues. As Sarah disengaged from the service, these attempts were unsuccessful.

14.4.7 Information shared at MARAC in 2017, indicated that David had been under the RDaSH community therapies team from 2006 – 2013; however, he was not known to secondary mental health services in 2017.

14.4.8 Research shows that substance use and addiction is commonly connected to cooccurring disorders like PTSD, depression, and anxiety.[16] People seeking treatment for PTSD are 14 times more likely to also be diagnosed with a substance use disorder. Attempting to self-medicate can be a cause to why many people with

[14] Buprenorphine is a long-acting opioid drug used to replace the shorter-acting opioids that someone may be addicted to, such as heroin, oxycodone, fentanyl, or hydromorphone. Long-acting means that the drug acts more slowly in the body, for a longer period of time. The effects of buprenorphine last for 24 to 36 hours. In contrast, a person who uses short-acting opioids to avoid withdrawal must use three to four times a day.

[15] The NHS Talking Therapies programme, for anxiety and depression (formerly known as Improving Access to Psychological Therapies, IAPT), was developed to improve the delivery of, and access to, evidence-based, NICE recommended, psychological therapies for depression and anxiety disorders within the NHS.

[16] Teeters, J.B., Lancaster, C.L., Brown, D.G., & Back, S.E. (2017). Substance use disorders in military veterans: prevalence and treatment challenges. Substance Abuse and Rehabilitation.8, 69-77.

PTSD also misuse substances.[17] The thought is that by using substances, a person with PTSD will null or avoid PTSD symptoms.

14.4.9 Children's services was mindful of the increased risk and prevalence of domestic abuse when associated alongside substance misuse and poor mental health. With both parents experiencing long-standing mental health and substance misuse difficulties, this increased the likelihood of further incidents, thereby placing Alex at risk of significant harm. This risk assessment informed children's services' decisionmaking – made in partnership with David, Sarah, and Alex. It was decided that it would not be safe for Alex to remain in David and Sarah's care. Children's services worked closely with David's probation officer, who was aware of the difficulties that David experienced with mental health and substance misuse, and the role these issues may play in increasing risks around domestic abuse. The OASys risk assessment completed by Probation (SYCRC) was informed by the known risks of poor mental health and substance misuse.

14.4.10 David's substance misuse risks were managed by David and Change Grow Live. These were in terms of harm reduction and overdose advice, psychosocial interventions, and liaison with his GP regarding prescribed medication. David disclosed that the incident of domestic abuse in August 2020 was affected by a combination of his increased use of amphetamines and the side effects of a lack of sleep and escalating agitation. Change Grow Live and David's GP were closely linked. David's face-to-face appointments with Change Grow Live were held at the GP surgery, and notes of his meetings with Change Grow Live were visible to GPs at the surgery on their computer system.

14.4.11 In June 2021, David was referred to the RDaSH community mental health team by his GP. He was not seen or assessed before his death. David was not engaged with secondary mental health services during the timeframe of the review.

14.4.12 Sarah was also referred to the RDaSH community mental health team in 2020. Sarah did not disclose any issues around substance misuse when asked. RDaSH consider that Sarah's mental health was assessed and managed appropriately.

14.5 **What services did your agency provide for David and Sarah; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?**

[17] McCauley, J. L., Killeen, T., Gros, D. F., Brady, K. T., & Back, S. E. (2012). Posttraumatic Stress Disorder and Co-Occurring Substance Use Disorders: Advances in Assessment and Treatment. Clinical psychology: a

14.5.1 The police responded in a timely and proportionate manner to all of the incidents reported to them. All domestic abuse incidents had a DASH questionnaire completed, which then went on to be secondary risk assessed by DARA. This led to the appropriate referrals being made. Furthermore, high-risk markers were added

publication of the Division of Clinical Psychology of the American Psychological Association, 19(3), 10.1111/cpsp.12006.

to individuals and addresses where appropriate, to manage the ongoing risk. All incidents were investigated and filed appropriately after all lines of enquiries were carried out. Where a power of arrest existed, this was used. In December 2020, when it was reported that David had driven off and was planning to take an overdose, officers responded to the call, found David, and then established that the medication (that he was said to be planning to take) was at the home address.

14.5.2 Yorkshire Ambulance Service had a total of five contacts with David and Sarah during the timeframe of the review. Only one of these contacts resulted in an attendance at David and Sarah's address – for a medical, which is not considered in the chronology. Other contacts resulted in a referral to the GP out of hours service or were closed after being advised by the police that an ambulance was not required. The Yorkshire Ambulance Service IMR author stated that upon review of all contacts with both David and Sarah throughout the timeframe, it was clear that policies and procedures were followed – with the appropriate outcomes achieved.

14.5.3 David was seen at his GP surgery by his allocated Change Grow Live worker on a monthly basis. The restrictions brought in, as a response to the Covid-19 pandemic, resulted in changes to the service. Extended face-to-face contact was not possible, and as a result, David was offered fortnightly telephone calls to review his substance misuse and recovery goals. On occasions when contact was not made, further attempts would follow, and text messages were sent to him to make contact. Sarah was also on his contact list and was sometimes involved in appointments and supporting David to attend. On the occasion in September 2021 when David stated that he felt suicidal, measures were put in place to support him, including a welfare check by the police when he failed to respond to calls back to him on the same day.

14.5.4 David was managed on a community order by Probation (SYCRC) from December 2017 to December 2018. He was referred into Restorative Justice, Victim Awareness Programme, and Respectful Relationships Programme. In addition to this, he was referred into Inspiring Intelligence for a mentor that would offer emotional wellbeing support and support in relation to benefits / getting support from the British Legion. [Note: Inspiring Intelligence no longer exists]. The British Legion sent out paperwork for David to complete, but it was never returned. All

referrals were timely and fit for purpose. There is no evidence of liaison with substance misuse services throughout his time on probation: this would have been helpful to understand David's situation and progress holistically. David did not consent to Probation sharing information with the substance misuse team. The panel was told that significant changes have been made to services since the time that David was supervised by SYCRC in 2017. For example, probation and substance misuse services are now co-located, resulting in significant improvements in information sharing. No recommendation is therefore made on this point.

14.5.5 RDaSH provides mental health services in Rotherham.

In May 2019, Sarah was briefly involved with the mental health crisis team following a family bereavement. In June 2020, Sarah was referred by her GP to the community mental health team. It was not until the fifth telephone contact that Sarah answered her phone. At that point, she declined support and was signposted back to her GP. Sarah was later referred to the Young Onset Dementia team and received a home visit assessment in January 2021.

14.5.6 In June 2021, David was referred by his GP to the community mental health team due to worsening of his mood and carer stress. He did not answer his phone for the arranged appointment, and a further appointment was to be arranged; however, he sadly passed away prior to this.

14.5.7 The RDaSH IMR author assessed that the services provided by RDaSH were proportionate and appropriate to David and Sarah's needs, with no concerns around the services provided.

14.5.8 In February 2021, David told his Change Grow Live worker that he was finding caring for Sarah stressful, as he was unable to leave her on her own. Concerns may have been alleviated in March 2021, when the worker called and spoke to Sarah whilst David was out.

14.5.9 There were indicators, to Change Grow Live and to the GP, of potential carer stress. The review has seen no evidence of a referral for a carer's assessment, which could potentially have helped to manage the situation. There is no evidence that David was registered as Sarah's carer, for example, there was no active claim for carer's allowance. This is a learning point for all services to consider making a referral to the local authority for a carer's assessment in appropriate circumstances.

14.5.10 Following domestic abuse incidents and high-risk DASH assessments, Sarah was contacted within the IDVA policy timescales. In 2017, the IDVA service was unable to engage with Sarah, and Sarah declined IDVA support. Sarah did agree to the service sending contact details should she change her mind or in case she wanted

help in the future. Given the concerns/risks, a GP alert was left with her GP practice to request that domestic abuse was discussed should she attend.

14.5.11 In 2020, the allocated IDVA contacted Sarah (in line with policy). Sarah was spoken to, and the IDVA tried to connect Sarah to services that could provide support in terms of both her mental health and alcohol use. A refuge place was offered but declined; however, Sarah did agree to target hardening, and safety planning was provided. The contacts with Sarah were within the IDVA service policy.

14.5.12 Rotherham Rise had two periods of involvement. In 2018, after initial contact and safety planning, Sarah did not attend an appointment and then declined any further contact. In 2020, Rotherham Rise was unable to contact Sarah at all.

14.5.13 No contact to either the IDVA service or Rotherham Rise, identified David as the victim of domestic abuse. Sarah was identified as the victim in all referrals to them.

14.6 **How did your agency ascertain the wishes and feelings of David and Sarah, and were their views considered when providing services or support?**

14.6.1 Children's services made considerable efforts to ensure that David and Sarah's wishes and feelings were captured during the period of involvement. The social work team completed home visits to David and Sarah on five occasions in the timeframe that Alex's case was open. These were to obtain their wishes and feelings, to inform the assessment that was being undertaken on Alex, and to discuss future care planning for Alex. David and Sarah attended Alex's Looked After Child Review on 24 January 2018.

14.6.2 David and Sarah attended Alex's Personal Education Planning meeting on 1 February 2018.

David and Sarah attended a meeting (dated 7 February 2018) where the plan for Alex was reviewed with other professionals in attendance.

David and Sarah were contacted by phone (on several occasions) to keep them updated and to obtain their views at key decision points.

14.6.3 Children's services commenced Public Law Outline (PLO), and David and Sarah were invited to the initial meeting that took place on 20 March 2018. It was at this meeting that David and Sarah made the decision that it would be in Alex's best interests for them to remain in the care of their aunt, with the view of a child arrangement order being granted. David and Sarah were legally represented at the

PLO meeting – giving them the opportunity for independent legal advice to support their decision-making. Alex was provided with an advocate. Alex informed their advocate that they wanted to remain living with their aunt and did not want Children's Social Care involvement. Alex stated that they wanted to have overnight contact with their mum and dad when they wished.

14.6.4 Probation (SYCRC) managed David and was not directly involved with Sarah. The Justice Star[18] assessment was completed with him – allowing him to articulate his views and experiences. The OASys risk assessment included the sentence plan objectives. These were shared with him, and he stated that he agreed with them.

14.6.5 In relation to contact with their GPs, both David and Sarah were involved in their care decisions in a person-centred approach to their healthcare. Decisions were discussed, and informed choices were made regarding all aspects of their healthcare. Both David and Sarah often attended each other's appointment in a support role, and both were open regarding any issues they were facing.

14.6.6 The police ascertained the wishes and feelings of David and Sarah primarily by speaking with them both and ensuring their wishes and feelings were recorded within the investigation. Police officers completed the DASH risk assessment for all domestic incidents. Within these assessments, it was captured whether the victim consented to referrals to partner agencies. The police followed all lines of enquiry in their investigations into the offences disclosed by the victim, and they actioned the investigations accordingly.

14.6.7 Following the incident of 23 July 2020, a statement was taken from Sarah. However, when she decided to retract her statement, the investigation was filed with no further action, as no corroborating evidence was found. The wishes and feelings of the parties are recorded in statements, pocket notebook entries, and the investigation itself. So far as reasonably practicable, referrals were made in line with the party's wishes and feelings. There are some exceptions where referrals were made regardless of David and Sarah's wishes, for example, high-risk incidents, standard- or medium-risk incidents where there had been a previous high-risk incident, and children's services referrals.

14.6.8 David was engaged with Change Grow Live throughout the review timeframe. There is evidence contained within the treatment outcome profile (which is completed alongside the risk and recovery plan) that David felt involved in his treatment options.

14.6.9 Rotherham Rise was asked to provide support for Alex when they became a looked after child. After several calls with Alex's guardian, Rotherham Rise was told that

[18] The Justice Star is a version of the Outcomes Star developed for individuals in the criminal justice system, and specifically those in the community, on short custodial sentences or approaching release from custody. All versions of the Outcomes Star have a number of five- or ten-point scales arranged in a star shape.

Alex did not require support from them, and the case was closed. Alex told the Chair of the review that they were fully aware of the service that Rotherham Rise had offered, but at that time, they were not interested in speaking to anyone and simply wanted to get on with their life. There was nothing that anyone could have done to engage with them.

14.7 **How effective was inter-agency information sharing and co-operation in response to David and Sarah, and was information shared with those agencies who needed it?**

14.7.1 Following the first domestic abuse incident covered by the review on 23 November 2017, the multi-agency working and information sharing was effective, and the relevant professionals co-operated and contributed to the overall plan for the family.

14.7.2 Children's services chaired a multi-agency domestic abuse (MADA) meeting on 24 November 2017 because of the high-risk domestic abuse incident that was reported. Partners present included health representative, education, police, and Rotherham Rise. This demonstrates services for both children and adults working together. Subsequently, there was a strategy meeting that took place on 28 December 2017 that was attended by police, health, and Children's Social Care. This is a statutory requirement.

14.7.3 A professionals' meeting took place on 7 February 2018 to discuss and review Alex's plan. This included professionals from Probation, fostering and children services, as well as David and Sarah. Again, this shows that services supporting adults were included in the information sharing and decision-making for the child.

14.7.4 Children's services shared and obtained information from a range of agencies: adult mental health services, who were supporting David; RDaSH drug and alcohol service (service provider prior to Change Grow Live), who had worked with both David and Sarah; Rotherham Rise; David's probation officer; school nurse; and David and Sarah's general practitioner. This is good practice and ensures a holistic understanding of the family.

14.7.5 Although, overall, the partnership working on this occasion was effective, the delay in the strategy meeting taking place prolonged the opportunity to bring all professionals together from the outset to share information and make decisions. The incident took place on 23 November 2017, and the strategy meeting took place on 28 December 2017. Only the police, school nurse, and children's services were

in attendance. This is in line with statutory requirements. However, in these circumstances, it would have been good practice to have included other key professionals supporting the family, including David's mental health worker, RDaSH drugs and alcohol service, David's probation officer, and Rotherham Rise. The panel was assured that since this time, practice has changed significantly in Rotherham. There has been a partnership focus on working together, particularly around strategy meetings being attended by the relevant partners and taking place in a timely way.

14.7.6 The panel was told that all relevant agencies are party to a domestic abuse information sharing agreement, attend MARAC, and either attend or provide information to daily MADA meetings. Adult Social Care, which manages the processes, considers that information was shared with all agencies that needed it. There is evidence of information from MARAC being shared. For example, following the MARAC held in 2020, information was recorded in The Rotherham NHS Trust (Rotherham Hospital) Meditech record for Sarah.

14.7.7 Change Grow Live, which was engaged with David throughout the review period, was involved with a looked after child meeting for Alex; therefore, it was aware of the domestic abuse background at that time in 2018. There is little other evidence of information sharing with Change Grow Live regarding domestic abuse, including from Probation (SYCRC) – despite the fact that David was supervised by Probation for a year. Information from MARAC was not shared with Change Grow Live. The panel was informed that the current drugs and alcohol service provider, We Are With You, attends MARAC meetings and are party to the domestic abuse information sharing agreement. No recommendation is therefore made on this point.

14.7.8 RMBC Housing, the social landlord for David and Sarah, was aware of domestic abuse because a manager had attended a MARAC meeting when David and Sarah's case was discussed. Housing had no other indicators of domestic abuse. There were no reports of anti-social behaviour. This behaviour can often be mistaken for domestic abuse – as has been seen by the Chair in other Domestic Homicides Reviews. There was no pattern of housing repairs: indicative of domestic abuse. For example, on 6 November 2020, when the police forced entry to the family home, neither David nor Sarah reported the need for a repair to RMBC Housing.

14.7.9 David and Sarah's GP utilises SystmOne for the recording of medical information. This occurs both during consultations with clinicians, and retrospectively where secondary care communication has been received by the practice after an event such as a hospital appointment. The drug and alcohol service, and community mental health team both record directly into the patient's records; therefore, information is available to all parties instantaneously. This is known locally as

'shared care'. No problems were reported by the GP regarding the sharing of relevant information.

14.8 **Was there sufficient focus on reducing the impact of alleged abusive behaviour by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?**

14.8.1 During the review period, David was arrested on two occasions when there was a clear power of arrest. From the information available to the review, the panel did not identify any occasion when there was a clear power of arrest for a domestic abuse incident that could have applied to Sarah prior to David's murder.

14.8.2 The first incident in November 2017, could have given rise to the consideration of a DVPN/DVPO. This was prior to the creation of South Yorkshire Police's dedicated DVPO unit in 2020. The panel was told that should this incident occur today, consideration regarding the application for a Domestic Violence Protection Notice would be documented and progressed. As there was insufficient evidence to charge him with a domestic abuse assault, David was charged with an alternative offence of using threatening, abusive, insulting words or behaviour with intent to cause fear or provocation of violence. David pleaded guilty to this at court and was given a community order with a rehabilitation requirement.

14.8.3 During the community order, the main intervention delivered by Probation was the Respectful Relationships programme that addressed David's behaviour as a perpetrator of domestic abuse. David's engagement with Probation was positive, and he completed the interventions that were expected of him, including the 25 Rehabilitation Activity Requirement Days. Enforcement action was not required.

14.8.4 David was arrested again after the incident of 23 July 2020. On this occasion, he was released on police bail with conditions not to contact Sarah or attend at the home address. As a result of the police bail conditions, a DVPN/DVPO was not considered appropriate. When Sarah stated that she wished to retract her statement for this incident, one of the reasons was that she would rather David received help than prosecution. A referral to Inspire to Change was made; however, as previously highlighted at paragraph 14.1.9, the provider of the programme has changed since these events, and records of the previous provider were not available to the review. It is therefore unknown if David engaged with Inspire to Change.

14.8.5 Sarah was recorded as the perpetrator of domestic abuse on only one occasion during the timeframe of the review prior to David's murder. This was a verbal argument on 22 November 2019, which David reported to the police. Therefore, no

sanctions were, or could be, applied to her. The IDVA service and Rotherham Rise were unable to engage with her beyond initial contact.

14.8.6 The panel discussed the couple's relationship in the context of Johnson's[19] typology of intimate partner violence. This divides domestic abuse (intimate partner violence) into four categories:

Intimate terrorism, or coercive controlling violence, occurs when one partner in a relationship, typically a man, uses coercive control and power over the other partner – using threats, intimidation, and isolation. Coercive, controlling violence relies on severe psychological abuse for controlling purposes: when physical abuse occurs, it too is severe. In such cases, one partner, usually a man, controls virtually every aspect of the victim's life, usually a woman's. Johnson reported in 2001 that 97% of the perpetrators of intimate terrorism were men.

Violent resistance, a form of self-defence, is violence perpetrated by victims against their partners who have exerted intimate terrorism against them. Within relationships of intimate terrorism and violent resistance, 96% of the violent resisters are women.

Situational couple violence, also called common couple violence, is not connected to general control behaviour, but arises in a single argument where one or both partners physically lash out at the other. This is the most common form of intimate partner violence, particularly in the western world and among young couples, and involves members of both sexes nearly equally. Among college students, Johnson found it to be perpetrated about 44% of the time by women and 56% of the time by men.

Mutual violent control, is a rare type of intimate partner violence occurring when both partners act in a violent manner – battling for control.

14.8.7 The panel thought that whilst it was possible that there had been intimate terrorism/violent resistance, it was also equally possible that, in hindsight, the relationship was characterised by the rarer form of mutual violent control. The panel did not think that situational couple violence was a likely explanation. The true nature of the relationship between David and Sarah was not easy to understand, and there remained many grey areas.

14.8.8 The main barrier to understanding what was going on in the couple's relationship was the inability of agencies to engage with them beyond statutory or medical interventions. Both David and Sarah had multiple disadvantages and a complex

[19] Michael Paul Johnson is Emeritus Professor of Sociology, Women's Studies and African and African American Studies at Penn State university, USA, having taught there for over 30 years.

presentation. Both had suffered previous trauma, which may have affected how they were able to accept support. A trauma-informed approach that recognised this and sought to engage both David and Sarah may have meant that engagement could have improved.

14.8.9 The panel was informed that significant work has been progressed in Rotherham in relation to trauma-informed working. The public health commissioning strategy for domestic abuse and substance misuse services now references the need for trauma-informed approaches in all services.

14.8.10 A new domestic abuse pathway has been established with one 'front door'. All domestic abuse incidents are now referred to Rotherham Rise. The approach to victims is led in a trauma-informed way, and all staff have received traumainformed training.

14.8.11 Regular trauma-informed working training sessions – provided by the Community Safety Partnership for all partners – are scheduled throughout 2024.

14.8.12 Therefore, no recommendation is made regarding trauma-informed approaches.

14.8.13 The panel was informed of changes to the commissioning of domestic abuse services in Rotherham from October 2022. One of the changes has been to develop an assertive outreach service (DAAOS) to try to improve engagement with victims who struggle to accept support. The panel thought that such a service may have been helpful to David and Sarah. As the service has now been established, no recommendation is made.

14.9 **Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed? Are the procedures embedded in practice, and were any gaps identified?**

14.9.1 Partners in Rotherham hold daily multi-agency domestic abuse (MADA) meetings where high-risk cases are discussed. The aim of the meetings is to address any immediate risk and safeguarding issues and bridge a potential gap prior to fortnightly MARAC meetings. Immediate safety plans are made in live time. David and Sarah's case was discussed at MADA on 24 November 2017 and 27 July 2020 – in response to domestic abuse incidents that were assessed as high risk. The review has seen evidence of immediate actions taking place as a result of the meetings, for example, allocation of an IDVA and flagging of addresses on the police computer system.

14.9.2 David and Sarah's case was discussed at MARAC on 7 December 2017. An action was recorded for the police to consider a DVPN/DVPO if there were further

instances of domestic abuse, and for children's services to give an update on the progress of their investigation.

14.9.3 David and Sarah's case was discussed again at MARAC on 6 August 2020. Actions were recorded for the police to provide feedback on the progress of the case. Secondly, for an IDVA to attempt contact with Sarah and send a letter if contact by telephone was not possible.

14.9.4 Following a domestic abuse incident on 2 October 2020, which was assessed as medium risk, the case should have been referred back to MARAC. This was as per the then Rotherham MARAC protocol to refer any repeat incidents within 12 months of the last high-risk incident. This did not happen. A referral was made to Rotherham Rise, who was unable to contact Sarah. The panel noted that although the case was not referred back to MARAC, positive action was taken by the referral to Rotherham Rise. The panel did not think that MARAC would have generated further actions. In July 2021, the MARAC protocol was changed so that a repeat medium-risk incident does not now automatically generate a repeat referral to MARAC. Other options, including a direct referral to an IDVA, are considered. No recommendation is therefore made on this point.

14.9.5 The main action on both occasions was for Sarah to be provided with support around domestic abuse. The IDVA service and Rotherham Rise were unable to engage with Sarah. As a result, the MARAC process did not directly contribute to David or Sarah's safety. Individual agencies, for example RDaSH, ensured that David and Sarah's records were flagged to record a domestic abuse risk. David was recorded as the perpetrator.

14.9.6 The panel was told that MARAC policies and procedures are embedded, and there were no gaps in the process.

14.9.7 David did not meet the criteria for MAPPA as a statutory case. Whilst it may have been possible for any agency to make a referral to MAPPA at level 3,[20] there is no information to suggest that such a referral was appropriate. Had such a referral been made, it is highly likely that it would have been screened out – given that the case was discussed in another multi-agency forum, together with the volume and seriousness of other referrals. Sarah was not convicted of any offence during the timeframe of the review; therefore, she could not be referred to MAPAA.

[20] Category 3 offenders are those offenders who, by reason of offences committed by them and which they have been convicted for, are considered by the Responsible Authority to be persons who may cause serious harm to the public.

14.10 **What knowledge did family, friends, and employers have of domestic abuse in David and Sarah's relationship, and did they know what to do with that knowledge?**

14.10.1 Following the domestic abuse incident of November 2017, which resulted in Alex becoming a looked after child, their aunt showed a good insight into the concerns around domestic abuse, the impact this was having on Alex, and what her role was to ensure that Alex was able to have safe contact with their parents. As she provided care for Alex, information was shared with her appropriately, and on a 'need to know' basis by children's services.

14.10.2 It is apparent from agency records that family were aware of domestic abuse within David and Sarah's relationship, and to an extent, they knew what to do with that knowledge – as four calls to the police (within the scope of this review) were made by family members. Family members were spoken to following incidents, but it is not clear what advice they were given by officers regarding domestic abuse. There appear to be instances where accounts could have been taken from family members but were not.

This is a learning point for South Yorkshire Police and leads to an appropriate single agency recommendation to engage with third parties who are witnessing or around domestic abuse, to ensure that they are correctly informed on what to do in situations of domestic abuse.

14.10.3 Information from neighbours is included in the report at section 6.4 and is not repeated here. In summary, neighbours were aware of repeated domestic abuse. It seems that over the years, neighbours had become desensitised to the situation and did not consider that calling the police, or other authorities, would be an appropriate solution.

14.10.4 Information from family members is included in the report at section 13.1. Their lived experience was that David was largely the perpetrator of domestic abuse, and Sarah was the victim.

14.10.5 David's mum told the Chair that people in the neighbourhood were frightened of Sarah due to her volatile reaction to situations, and that this contributed to the situation – where little was reported by third parties.

14.10.6 A statement from one of David and Sarah's children was read to the court. The panel thought it was helpful to include it in the overview report.

'Throughout our childhoods we lived in the family home and witnessed their relationship first hand and it can be described as toxic. They loved each other and I would say they loved each other too much.

They both used to abuse medications they had been prescribed. They enjoyed the highs this gave them. If they were prescribed a week's worth of medication on a Monday, they would take it all that day. They would also illegally buy more of this medication to take. Under the influence of drugs, they would have aggressive and verbal arguments.

I have never seen my mum attack my dad. I wish to add they both suffer from mental health issues.

When I heard someone in the house had died, I assumed my dad had died from an overdose, or he had killed my mum.

While I accept she has done this, I do think the drug abuse would have played a part. I feel the death of one of them was inevitable'.

14.11 **Were there any examples of outstanding or innovative practice?**

14.11.1 The panel did not identify any outstanding innovative practice. However, there were a number of areas of good practice exhibited. Examples include.

A Change Grow Live worker being based at the GP practice and entering records directly onto the same clinical system that the practice uses.

After the incident of 23 July 2020, Sarah initially declined to provide a statement to the police; however, follow-up by the domestic abuse team, encouraged her to provide a statement so the investigation could be progressed. This led to a period of David being subject to bail conditions. Although this gave Sarah space for reflection; ultimately, she then retracted her statement.

14.12 **What learning did your agency identify in this case?**

14.12.1 **The Rotherham NHS Trust**

Continue to reinforce the importance of recording names and relationships in patient records. This has particular importance when reviewing risks and actions relating to safeguarding practice.

14.12.2 **Change Grow Live**

CGL could have sought further clarification on domestic abuse from external agencies, such as social care, Probation, and police. A risk assessment from The Probation Service in 2018 could have provided information on the risk factors and previous issues prior to CGL becoming the lead substance misuse service.

Discussion on driving whilst under the influence and/or using substances. David should have been advised to contact DVLA and should have been noted on CGL management system. If David had refused, a CGL doctor or the GP could have informed the DVLA of any concerns and drug use. There is no evidence that this discussion took place between 2018 and David's death.

14.12.3 Children's Services

On reflection, the strategy meeting (in relation to the risks posed to Alex) should have taken place within 72 hours of the incident referred in on 23 November 2017. This would have led to a s47 investigation. Although there was a MADA meeting on 24 November 2017, this was primarily to share information, safety plan for survivors and perpetrators, and offer IDVA support. It's likely at the time that a strategy meeting didn't take place due to the MADA process being used. This was an oversight at the time and is not reflective of current practice. Over recent years, there has been focused partnership work within Rotherham to improve the timeliness and partner input into strategy meetings. The improvement is formally recognised within Ofsted inspection reports, as well as the HMICFR inspection of South Yorkshire Police and Care Quality Commission inspection of the Hospital Trust services. Whilst it is appropriate that this is highlighted as a learning point, this relates to practice six years ago, and it is not a current learning point requiring future action.

Although children's services had information from the MADA that Sarah was previously considered a vulnerable adult, a referral was not made to Adult Safeguarding. Children's services did liaise with adult mental health and substance misuse professionals, but on reflection, a safeguarding referral to adult services could have been made.

14.12.4 Rotherham Rise

The incident on 2 October 2020 was the only occasion where Sarah was named as the aggressor; however, she was still not listed as the suspect/perpetrator on the DASH. If Rotherham Rise had shared this information with MARAC, it could have been discussed further and potentially have highlighted more incidents where Sarah was abusive towards David.

Rotherham Rise could have liaised with Adult Social Care when Sarah was referred to the service and when she subsequently disengaged and/or declined support. However, Rotherham Rise had minimal contact with Sarah so ultimately did not have significant information on any issues that she may have had at the time.

There was no contact with David due to him never being identified as a victim during that time.

14.12.5 **Probation**

More regular requests to the police for domestic abuse call-out information would have been useful to support whether David had made meaningful change prior to the end of his time on probation. Probation offered less appointments towards the end of his supervision, which was to be expected (to a degree), as he had completed the interventions expected of him. However, additional appointments with Probation could have allowed him to disclose any ongoing issues at home. He moved between four different probation officers during his 12 months of supervision, which may have been a barrier for him opening up if there had been issues in the family home.

14.12.6 **Police**

People who have knowledge of the abuse should be advised accordingly on what to do when they are made aware of, or witness, any further acts of abuse.

To ensure that all documentation is uploaded to investigations on policing systems.

To ensure that all options are considered when concluding an investigation, and that consideration of these options are documented with appropriate rationale, such as considerations surrounding an evidence-led prosecution.

When obtaining a retraction statement, it must be clarified whether they are still confirming the incident occurred but are retracting for another reason, or whether they are now stating the incident did not occur.

Where the DASH questionnaire has been left incomplete for any reason, it should be revisited when the victim is able to answer the questions.

Action Taken

Since the incidents involving David and Sarah the force has introduced a domestic abuse handbook which guides officers as to how to effectively deal with all incidents where there is a report of domestic related matters. There is also guidance on domestic abuse arrest policy.

CPD events have been held around the implementation of the changes which have come into effect within the DA Act 2021.

Further Domestic Abuse Matters training is taking place within force to capture officers who did not attend this initially or have joined the force since the initial role out. This will increase officers' knowledge of domestic abuse with a specific focus on Coercive and Controlling Behaviour.

14.13 **Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Rotherham Community Safety Partnership?**

14.13.1 A review of previous DHRs commissioned by The Safer Rotherham Partnership has shown that the review for Adult Z (completed in 2013) recommended a programme of public awareness raising around DHRs. The findings of the DHR for David reinforce that further work on this important area is required.

14.14 **Were there any resource issues, including during the Covid-19 pandemic, that affected the services your agency provided in this case?**

14.14.1 No agency has reported that resource issues had any negative impact on their interactions with David and Sarah. The panel was, however, keen to understand whether the impact of Covid-19, and the restrictions because of it, had any impact in this case.

14.14.2 On 16 March, the Prime Minister Boris Johnson made a televised statement saying: "now is the time for everyone to stop non-essential contact", referring to it both as "advice" and a "very draconian measure".

It was not until 23 March 2020 that Mr Johnson told people they "must" stay at home, and said that "we will immediately" close some businesses.

This had been referred to as the start of lockdown by Government ministers, including Messrs Hancock and Johnson.

Legally, the main restrictions in England actually began at 1 pm on 26 March, when The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 came into force.

14.14.3 All services involved in the review adapted their service to some extent because of the Covid-19 pandemic. Change Grow Live moved from seeing David once a month to fortnightly telephone appointments. There was undoubtedly an impact, as engagement over the telephone can't convey everything that can be seen in person. However, services were maintained. On the occasions that David did not engage in a prearranged appointment, these were followed up in a variety of ways,

for example, by contacting Sarah or checking with the pharmacy whether David had collected his prescriptions.

14.14.4 The police response to domestic abuse incidents was unaffected – as seen by David's arrest and the investigation that followed the incident of July 2020.

14.14.5 Contact from domestic abuse agencies with Sarah was by telephone. After initial contact, the agencies were unable to engage with Sarah. This was also the case prior to the pandemic – after the 2017 domestic abuse incident.

14.14.6 David and Sarah were no doubt impacted by the Covid-19 pandemic, along with the rest of the population. There was one incident of domestic abuse in July 2020, where some Covid-19 restrictions were in place. However, to put that into context, the 'Eat out to help out' scheme that encouraged people to visit restaurants and cafes began on 3 August 2020.

14.14.7 Relating to the year of David's murder, The Office for National Statistics homicide report 2021/22 [footnote 6] states:

- Homicide returned to pre-coronavirus (COVID-19) pandemic levels, with 696 victims in the latest year – this was 130 more (a 23% increase) than the year ending March 2021 when Government restrictions meant there was less social contact.
- There were 134 domestic homicides in the year ending March 2022, 18 more than the previous year, and a similar number to the average over the last decade (129).

15 Conclusions

15.1 The panel wished to restate that David was the victim of domestic abuse when he was murdered by Sarah. David and Sarah had been married for over 22 years and had brought up their three children together in Rotherham. It seems that for much of that time, domestic abuse was a constant presence complicated by their poor mental health and substance misuse.

15.2 Although David is the victim of murder in this case, almost all of the information seen by the review suggests that David was the primary perpetrator of domestic abuse in the relationship prior to his murder.

15.3 David engaged with a domestic abuse perpetrator programme when supervised by SYCRC, and he engaged with drugs and alcohol services voluntarily. Sarah was not engaged with drugs and alcohol services during the timeframe of the review; however, there is evidence that she regularly abused prescription and illicit drugs. Domestic abuse services were unable to engage with Sarah, who declined their services on each occasion they were able to contact her.

15.4 On the day of David's murder, he had taken an overdose of medication that was prescribed to Sarah. The panel thought it likely that David's vulnerability, whilst impacted by the overdose, caused a change in the power balance of the relationship. If that was the case, then Sarah took advantage of the changed dynamic and stamped David to death.

16 LEARNING

This multi-agency learning arises following debate within the DHR panel.

16.1 Narrative

The homicide investigation identified that many people knew of the domestic abuse featured in this report. This finding is consistent with many other DHRs. The panel felt that additional publicity is required so that people who know or suspect someone is a victim of domestic abuse, know what they can do and should not do.

Learning

The absence of clear guidance on what members of the public can do when they know or suspect that someone is a victim of domestic abuse, could contribute to the abuse enduring and/or placing the victim in greater danger. The panel felt that the

level of knowledge within the community – of the domestic abuse featured in the report – illustrated a cultural acceptance of domestic abuse within some neighbourhoods of Rotherham, and that action was required in order to address the cultural issue.

Panel recommendations 1 and 2

16.2 **Narrative**

David told agencies that he was struggling because of his caring responsibilities for Sarah.

Learning

The opportunity for a carer's assessment may assist a family by providing the potential for additional support. In doing so, stressful situations in the home may be reduced.

Panel recommendation 3

17 RECOMMENDATIONS

DHR Panel

17.1 Rotherham CSP should review and strengthen, if necessary, the effectiveness of information provided to family, friends, neighbours, and diverse communities about recognising the signs of domestic abuse. Furthermore, where they can go, anonymously if necessary, with such information.

17.2 The Rotherham domestic abuse strategy should set out how agencies in Rotherham can challenge cultural acceptance of domestic abuse in some neighbourhoods. An action plan should be developed to support the strategic aim.

17.3 Rotherham CSP, in conjunction with Rotherham Safeguarding Adults Board, should ensure that the availability of a carer's assessment, and the pathway to achieve it, is widely understood amongst statutory and voluntary sector agencies in Rotherham. This could be achieved, for example, by a '7-minute briefing' to provide information on a carer's assessment and referral.

17.4 **Single Agency Recommendations**

South Yorkshire Police

To engage with third parties who are witnessing or around domestic abuse, to ensure they are correctly informed on what to do in situations of domestic abuse.

GP Practice

Review DNA policy at next in-house staff meeting to ascertain if and where improvements can be made.

Feedback any process improvement to the whole team.

Discuss with drug and alcohol worker, the importance of sharing information between teams.

Implement a way for any critical information to be passed to the on-call GP, by the above worker.

Implement a safeguard to ensure the follow-up of any shared information – i.e., task to admin at same time.

Discuss with TPP SystemOne whether a flag exists to highlight patients that have a history of domestic abuse.

Review and audit any implemented new process, from the above, to ensure effectiveness.

Appendix A Action Plan – David DHR – Rotherham Community Safety Partnership

No	Recommendation	Scope i.e., Local/ National	Action to Take	Lead Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of Completion & Outcome
Community Safety Partnership							
1	Rotherham CSP should review and strengthen, if necessary, the effectiveness of information provided to family, friends, neighbours, and diverse communities about recognising the signs of domestic abuse. Furthermore, where they can go, anonymously if necessary, with such information.	Local					
2	The Rotherham domestic abuse strategy should set out how agencies in Rotherham can challenge cultural acceptance of domestic abuse in some neighbourhoods. An action plan should be developed to support the strategic aim.						

3	Rotherham CSP, in conjunction with Rotherham Safeguarding Adults Board, should ensure that						

No	Recommendation	Scope i.e., Local/ National	Action to Take	Lead Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of Completion & Outcome
	the availability of a carer's assessment, and the pathway to achieve it, is widely understood amongst statutory and voluntary sector agencies in Rotherham. This could be achieved, for example, by a '7-minute briefing' to provide information on a carer's assessment and referral.						
Single Agency Recommendations							
South Yorkshire Police							
1	To engage with third parties who are witnessing or around domestic abuse, to ensure they are correctly informed on what to do in situations of domestic abuse.	Local					

GP Practice							
1	Review DNA policy at next in-house staff meeting to ascertain if and where improvements can be made.	Local	Update policy.	GP Practice	Policy updated.	12.10.2023	27.10.2023

No	Recommendation	Scope i.e., Local/ National	Action to Take	Lead Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of Completion & Outcome
2	Feed back any process improvement to the whole team.	Local	Update the team regarding any changes to policy.	GP Practice		Next in-house meeting 14.12.2023	
3	Discuss with drug and alcohol worker, the importance of sharing information between teams.	Local	Advise shared care worker regarding contacting on-call GP with any issues around safeguarding/DV/FGM, etc.	GP Practice	Shared Care Worker Amanda Richardson reminded of this.	31.08.2023	23.11.2023
4	Implement a way for any critical information to be passed to the oncall GP, by the above worker.	Local	To advise regarding use of the on-call task list at the surgery, f2f conversation with oncall GP, or inform management.	GP Practice	Shared Care Worker Amanda Richardson reminded of this.	19.09.2023	23.11.2023

5	Implement a safeguard to ensure the follow-up of any shared information – i.e., task to admin at same time.	Local	Task list monitored every day to ensure all messages are dealt with. Frequent check on received messages.	GP Practice	No tasks missed.	19.09.2023	20.10.2023
6	Discuss with TPP SystemOne whether a flag exists to highlight patients that have a history of domestic abuse.	Local	Check with TPP regarding this.	GP Practice	Victim of/at risk of domestic abuse icon is on patient records on TPP.	31.08.2023	20.10.2023 Shared this information with clinical staff.
No	**Recommendation**	**Scope i.e., Local/ National**	**Action to Take**	**Lead Agency**	**Key Milestones Achieved in Enacting Recommendation**	**Target Date**	**Date of Completion & Outcome**
7	Review and audit any implemented new process, from the above, to ensure effectiveness.	Local	Spot check the DNAs recorded on S1 to ensure they are accurate and that letters have been sent out.	GP Practice		20.02.2024	

Appendix B Home Office Letter– David DHR – Rotherham Community Safety Partnership



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Amanda Raven
Domestic Abuse and Sexual Abuse Lead
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Regeneration & Environment Services Directorate
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Rotherham
S60 1AE

23rd April 2025

Dear Amanda,

Thank you for submitting the Domestic Homicide Review (DHR) report (David) for Rotherham Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered in March 2025. I apologise for the delay in responding to you

This was noted as a comprehensive DHR which identifies some useful learning. There is a suitable range of sources used, and the family has contributed. The evidence provided via police statements, neighbours and friends is also helpful.

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

Areas for final development:

- For future reviews, the Chair and Author need to make clear their independence of all agencies.

- Paragraphs 13.2.46 to 13.2.48 narrow the date of death down to a date in October after the 15th. This should be avoided by removing the specific October dates and removing the word "*later*" from paragraph 13.2.48.

- The cause of death as per the post-mortem is not provided. Please include this.

- The police only have one recommendation, despite Section 14.12 identifying five learning points. It would be helpful to clarify how this learning has been taken forward.

- It is not currently explained why the family was not consulted on the Terms of Reference. Please provide some additional information on this.

- No conclusion is made in the Equality and Diversity section regarding barriers to either seeking or providing services. This should be included.

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

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

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

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

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

Yours sincerely,

Home Office DHR Team