EXECUTIVE SUMMARY of the DOMESTIC HOMICIDE REVIEW
relating to the death of Grace

FINAL

on behalf of:

East Sussex Safer Communities Partnership

Report author; Liz Cooper-Borthwick

Independent Chair

April 2022

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1. INTRODUCTION

This Executive Summary outlines the process and findings of a Domestic Homicide Review (DHR) undertaken by the East Sussex Safer Communities Partnership (ESSCP) into the death of Grace. All the names in this review have been anonymised for the purpose of confidentiality.

2. OUTLINE OF THE INCIDENT

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

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

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

3. DOMESTIC HOMICIDE REVIEW

The review considered the issues identified in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (DHRs)[1], issued under section 9(3) of the Domestic Violence, Crime and Victims Act (2004), and aims to:

a. Establish what lessons are to be learned from the domestic homicide regarding how effectively local professionals and organisations work individually and together to safeguard victims.
b. Identify clearly what those lessons are, how and within what timescales they will be acted upon, and what is expected to change as a result.
c. Apply these lessons to service responses including changes to policies and procedures as appropriate; and
d. Improving responses to all victims of domestic abuse.
e. Prevent future domestic violence homicides wherever possible, through intra and inter agency working.

4. TERMS OF REFERENCE

Terms of Reference (TOR) were agreed by the DHR Panel in January 2021 and were regularly reviewed and amended as further details of events in Grace's life emerged. The TOR is attached as Appendix One.

[1] www.Gov.uk DHR -statutory-guidance-

5. INDEPENDENCE

The Chair and author of the review is Liz Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council (Surrey). Liz has a wide range of expertise including services for vulnerable adults and children, housing and domestic violence. Liz has conducted Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy After Fatal Domestic Abuse (AAFDA). Liz has also been involved with several serious case reviews. Liz is also a member of the AAFDA DHR Chair Network. She has no connection with any of the agencies involved in this case.

6. PARALLEL AND RELATED PROCESSES

6.1 Criminal Investigation

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

6.2 Inquest

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

6.3 Her Majesty's Prison and Probation Service Serious Further Offence Review (SFOR)

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

7. METHODOLOGY

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

I. Sussex Police (the Police)
II. National Probation Service (NPS)

III. Sussex Clinical Commissioning Group (CCG on behalf of GP)
IV. Change Grow Live-Specialist Domestic Abuse Service (GCL)
V. Grace's employer
VI. Victim Support (VS)

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

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

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

7.5 The **Terms of Reference** detailed the specific areas of enquiry that an agency should consider in their IMR.

8. PANEL MEMBERSHIP AND REPRESENTATIVES

The Panel consisted of senior representatives from the following agencies.

NAMED OFFICER	ORGANISATION	ROLE
Liz Cooper-Borthwick	LCB Consulting LTD	Independent Chair
Natasha Gamble	East Sussex Safer Communities Partnership	Strategy and Partnership Officer Domestic Abuse, Sexual Violence and Abuse and Violence against Women and Girls (VAWG) Joint Unit, Brighton and Hove and East Sussex.
Jane Wooderson	Sussex Police	DS Safeguarding Reviews, Strategic Safeguarding Team.
David Satchell/Eleanor Gregory	Probation Service	Deputy Head East Sussex Probation Delivery Unit

NAMED OFFICER	ORGANISATION	ROLE
Alex Morris	Sussex CCG	Assistant Head of safeguarding Designated Nurse.
Gail Gowland	East Sussex Health Care Trust	Named Nurse Safeguarding Children (Acting Head of Safeguarding)
Debbie King	Change, Grow, Live, (Specialist DA Service)	Service Manager CGL
George Turner	Grace's employer	Head of Corporate Investigations and Protective Security
Stacey Criddle	East Sussex MARAC	MARAC Coordinator– shadowing the Review with the agreement of the Panel

Contact with family and friends

8.2 Involvement of Family and Friends

Chris, Mark, and Paul participated in the review. They wanted Grace's story to be told. The Independent Chair met with the family on several occasions using virtual media. The family were provided with the Home Office Family information leaflets about a DHR, and Mark had the support of a Victim Support Advocate. The family also had the opportunity to review and contribute to the Terms of Reference, the final draft of the DHR Overview report and they were regularly kept updated on progress of the DHR. The family chose the pseudonym for Grace and themselves.

8.3 Contact with Samay

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

8.4 Research and contacts by the Chair

The Independent Chair contacted Latin American Women's Rights Service[2] (based in London) and who support Latin American migrant women living in the United Kingdom to gather an insight into Latin American culture and the role of the female in the family. Information provided has been used to illuminate Grace's cultural background.

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[2] www.lawrs.org.uk

The Independent Chair carried out desk top research about the Hindu faith and spoke with the Sarvoday Hindu Association[3] to gain an understanding of the principles of the Hindu faith which has been used to inform the DHR.

9. SUMMARY OF THE CASE

9.1 The DHR Panel received extensive information from the agency IMRs and the DHR panel used the *Social Care Institute for Excellence* (SCIE) model "Learning Together"[4] to identify the key practice episodes (KPE) in the lives of Grace, Samay and their families.

KPE One: Break Up of Grace and Chris's Relationship (2012- 2015)

9.2 Grace came to England in early nineteen ninety, having met Chris in North America. They had two sons, Mark and David. Grace was a real homemaker and was the life and soul of the family.

Grace's relationship with Chris broke down in late 2012. This was followed by Mark and Paul going to university. Grace felt quite isolated as she was on her own. Grace's own family were in South America and during this time her father died, and her brother was suffering from drug addiction, and she felt there was nothing she could do to help him.

KPE Two: Relationship between Grace and Samay and assault and robbery on Grace by Samay (2015-2017)

9.3 The relationship between Grace and Samay started sometime during **2015/2016**. Although they had different employers, they both worked in the same location. In **August 2017**, one of Grace's neighbours phoned the police to say that Grace had been attacked. The police attended and Grace informed them that she had taken Samay to buy drugs. Whilst cleaning the kitchen, she had accidently thrown some drugs away and Samay became very angry, and he forced Grace to take give him her bank card to buy more drugs. Grace refused and Samay attacked Grace. Grace was fearful so following the incident she drove Samay to a cash point, she withdrew money, gave it to Samay and he drove away in a taxi to buy more drugs. The police completed a SCARF[5] and DASH[6] for Grace. Samay was arrested and warned not to contact Grace. There was evidence that Grace and Samay did continue to communicate with Samay turning up at Grace's home to apologise for what had happened.

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[5] SCARF- Single Combined Assessment for Risk- Enables police officers and staff to raise concerns and observations in relation to the needs and vulnerability of individuals.

[6] DASH -Domestic Abuse, Stalking and Honour Based Violence Risk, Identification, Assessment and Management Model 2009. www.dashchecklist.co.uk

9.4 Grace had a GP appointment, and her injuries were documented. The GP also noted Grace's anxiety and she was signed off from work. The employer also referred Grace to their employee Occupational Health Service.

KPE Three: Lead up to Court Case and involvement of agencies with Grace (2017-2018)

9.5 Following the assault and robbery, Grace was supported by several agencies, initially by Victim Support and then Change Grow Live (CGL), a specialist domestic abuse support service. CGL encouraged Grace not to contact Samay after she had admitted that she had contacted him. The police also advised Grace not to contact Samay. The Police carried out a DASH risk assessment which was rated as medium. CGL received the DASH and put in place a range of support for Grace including adaptations at Grace's house to make her feel safer and support around her emotional and wellbeing needs.

9.6 Grace also received further support from her employer and managed in accordance with the employer's absence policy.

9.7 Grace did contact the police as Samay arrived at Grace's house to say he was "sorry and that he would get three years". The police did arrive at the house, but Samay had left. Grace disclosed about her continued contact with Samay, and the police again advised Grace not to contact Samay.

9.8 Grace did return to work prior to Samay's court case in **2017/18**. Samay pleaded not guilty at his initial court appearance in **late 2017**. Samay's trial commenced spring **2018** and Grace gave evidence. Samay was convicted of assault and was sentenced to three years imprisonment.

KPE Four: Samay in Prison and continued contact between Grace and Samay (2018-2019)

9.9 Following Samay's conviction, the Court Desk Officer assessed that the case required management by the National Probation Service and that the nature of the case required a Multi-Agency Public Protection Arrangement (MAPPA) oversight and registration at level 1,2 or 3. Samay's level was registered a level 1.

9.10 Grace continued to receive support from CGL, but she did miss a number of appointments. Grace also received support from the Probation Service Victim Liaison Officer (VLO). Grace disclosed to the VLO that she was still in contact with Samay. A report was prepared by the VLO which detailed the ongoing contact between Grace and Samay but at no stage was this shared with Samay's Offender Manager. Grace also had continued support from her employer.

9.11 Although Samay initially appeared to be keen to participate in some of the intervention programmes as required under his sentencing requirements, this keenness changed due to an allegation that he was being victimised by other prisoners as his father had a role in the criminal justice system. Samay was moved to another location in the prison, and this curtailed his participation in intervention programmes.

KPE Five: Release of Samay from prison and ongoing contact with Grace and Samay (2019)

9.12 Late **spring 2019**, Samay was released from prison with certain conditions, including, wearing an electronic tag, not to approach Grace or enter the specific area of her home or work. Following Samay's release, Grace found a dead sheep's head in her garden. Grace thought it was about retribution by Samay as she had identified that such an action was related to a Hindu custom.

9.13 Grace continued with support from CGL and her workplace. Samay visited his probation officer following his release and was trying to find work. His parents did contact the probation office as they were concerned that he was taking drugs again. Samay was required to take drug test and despite stating that he was no longer involved in drugs he failed several drug tests. At the time the Probation Service were concerned about the accuracy of the drug test and therefore it was never clear whether Samey was challenged.

KPE Six: Death of Grace (late 2019)

9.14 As detailed in paragraph 2.1, following concern from Mark as he was unable to contact his mother **late 2019** the Police forced entry and Grace was found deceased in the hallway of her home. It was clear that Grace's death was unnatural and Samay was arrested whilst at his probation office.

10. CONCLUSIONS AND KEY ISSUES ARISING FROM THIS REVIEW

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

10.2 Grace and Samay encountered agencies from **2017** when Samay robbed and assaulted Grace. Following this incident, several agencies became involved with Grace, specialist domestic abuse services, the police, her workplace and her GP. The criminal investigation by the police took around eight months and professionals

have advised that this is a standard time for investigations. During this period there is evidence that Grace and Samay were in contact. Although this contact was known by the police, it was not shared with other agencies. Also, whilst Samay was in prison, the VLO supporting Grace knew that there was ongoing contact between Grace and Samay and again this information was not shared. If this information about the ongoing contact had been shared between agencies, then extra safety planning could have been put in place to protect Grace and additional restrictions could have been placed on Samay on his release from prison.

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

10.4 Agencies working with Grace did not know that Samay was being released from prison in advance and therefore did not plan any additional safety measure. This lack of knowledge was also compounded by the lack of understanding of the ongoing contact between Grace and Samay.

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

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

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

10.8 Finally, the DHR Panel wanted to reflect that Grace, despite enduring several traumas in the last few years of her life, showed great strength when she was a witness in Samay's trial. Grace also sought support and worked with agencies to support her safety planning and she did want to help Samay stop taking drugs. Grace's family felt that they thought Grace felt she had let her son's down by continuing the relationship with Samay, but her family believe Grace wanted to do the best for everyone including trying to help Samay.

11. LESSONS TO BE LEARNT

The review identified several instances which may have contributed to Grace's death.

11.1. Sharing of Information between agencies

11.1.1 When Samay was arrested for the assault and robbery on Grace the police quickly shared information with Victim Support and CGL to ensure that Grace's physical and emotional need were supported. Following the initial contact between the agencies, there was evidence that information was not shared.

11.1.2 The police were aware that Grace was contacting Samay, and Grace was advised by the police to cease contact. This information was not share with CGL. Whilst in prison, Grace received support from the VLO and again she disclosed contact with Samay. This information was not shared within the prison, nor with other agencies.

11.1.3 If this information had been shared internally and externally then Grace's risk relating to Samay's release would have been reviewed and Grace's risk and safety plan could have been adjusted accordingly.

11.2. Importance of a perpetrator of domestic abuse fulfilling their conviction requirements.

11.2.1 Sammy was required to fulfil several offending behaviour programmes whilst in prison including behaviours to address domestic abuse and drug use. Evidence stated that there was not sufficient time to complete the requirements.

11.2.2 The inability for Samay to fulfil the sentencing requirements should have been considered in any risk assessment relating to his release and safety planning for Grace.

11.3 Understanding by professionals of the link between substance misuse and domestic abuse by a perpetrator

11.3.1 Samay had been arrested for drug use prior to the assault on Grace. The assault on Grace was drug-related and there was evidence identified that Samay continued to take drugs on his release from prison. Professionals need to be aware that substance misuse by perpetrators of domestic abuse is a common theme. The Addiction Centre states that nearly 80% of domestic violence crimes are related to the use of drugs[7].

11.3.2 It is imperative that professionals and the wider community understand the relationship between domestic abuse and drug use to better protect and support victims of domestic abuse.

[7] www.addictioncenter.com

11.4 Effective record keeping by agencies of information about a victim of and perpetrator of domestic abuse

11.4.1 Little information was provided by Grace's GP practice for this review despite Grace visiting on numerous occasions and the GP practice being aware of the assault on Grace by Samay. This did create gaps in information for this DHR, resulting in Grace's employer providing additional health information such as sickness certificates.

11.4.2 The Probation Service also identified that record keeping by managers was not as thorough as it should have been.

11.4.3 Robust record keeping by agencies is important to ensure appropriate information about a victim of DA or a perpetrator can be shared and therefore enabling better safety planning for the victim.

11.5 Professionals to have the tools and confidence to use professional judgement

11.5.1 Professional judgement is about applying knowledge, skills and experience which is informed by professional standards/knowledge and ethical principles to develop a decision on what should be done to protect a victim or client.

11.5.2 CGL identified that the SCARF referral forwarded by the police relating to the assault on Grace by Samay should have been professionally challenged and rated high and not medium which would have enabled a referral to a Multi-Agency Risk Assessment Conference (MARAC).

11.5.3 Professionals need to be supported by agencies to use their professional judgement to better support a victim of domestic abuse.

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

11.6.1 As Grace's DASH was rated medium, there was no referral made to a MARAC. As stated in 10.5, this rating was not challenged. If it had been, and in hindsight, CGL felt it should have been rated high a referral to a MARAC would have taken place. Even with the risk assessment rated medium, a referral could have been made into MARAC on the basis of professional judgement. This would have enabled a multi-agency conference relating to the risks Grace was facing including the sharing of information about the continued contact between Grace and Samey. The safety planning for Grace could have been more appropriately managed in the knowledge of comprehensive information.

11.7 Trauma-based approach by professionals to supporting victims of domestic abuse.

11.7.1 Grace had suffered several traumas in the last few years of her life, the break down in the relationship with Chris, her sons leaving home for university, the death of her father in South America and her brother suffering from drug misuse also in South America.

11.7.2 Although CGL developed an overview of Grace's life and what she had been through, it is not apparent other agencies did. If agencies had known about some of the traumas in Grace's life, it may have helped agencies to understand her ongoing contact with Samay. Grace was lonely and she wanted to help Samay with his drug abuse as she could not help her brother.

11.7.3 If agencies can understand what traumas have happened in a victim of DA life, then they may be able to provide better safety planning and support for that person.

11.8 Safe management of release of a perpetrator of domestic abuse

11.8.1 When Samay was released from prison, the police and CGL received the information on the day of his release. This did not enable any advance safety planning for Grace which would have included sharing the knowledge of the ongoing contact between Grace and Samay.

11.8.2 It was also noted that when Samay was released from custody, he was not identified as a perpetrator of domestic abuse as the crime was recorded as robbery and assault.

11.8.3 East Sussex agencies have identified that protocols to manage the safe release of perpetrators need to be reviewed and updated to ensure more appropriate support for victims of DA.

11.8.4 The DHR Panel also want to request that all agencies who are a lead agency for the Multi-Agency Public Protection Arrangements (MAPPA) review their procedures for information sharing to ensure the most appropriate management of a perpetrator and better support for victims.

11.9 The need for professionals to understand why a victim of domestic abuse stays with a perpetrator

11.9.1 Grace was assaulted and robbed by Samay, but she continued to stay in contact with Samay and admitted to professionals that she still had feelings for him. Professionals do need to understand why a victim of domestic abuse may stay with a

perpetrator. There can be several reasons, fear, shame, isolation, trauma and low confidence and practical reasons.

11.9.2 Grace was lonely and may have been flattered by the attention of someone younger than herself and she wanted to help that person with their drug addiction.

11.9.3 Professionals do need to understand why a victim stays with a perpetrator to provide better support and protect a victim.

11.10 Understanding by professionals and the wider community of the Domestic Abuse act 2021

11.10.1 The Domestic Abuse Act 2021 gives legal powers to better protect a victim of domestic abuse and hold perpetrators to account. Samay did grab Grace by the throat during the assault and robbery. This would now be seen as non-fatal strangulation which could result in a prison sentence for up to five years for the perpetrator.

11.10.2 It is imperative that not only professionals but also the wider community understand what the Domestic Abuse Act 2021 means and what support it provides to a victim.

Post Review Learning

11.11 Inclusion of Grace's workplace on the DHR Panel

11.11.1 Having Grace's employer on the DHR Panel provided significant additional information and challenge to the review. Also, the employer (a multi-national company) reviewed and updated its support for victims of domestic abuse for its extensive workforce***.***

11.12 Lack of routine enquiry by GPs

11.12.1 There was no information provided by the GP to indicate whether a routine enquiry about DA was made with Grace on her continued visits to her GP. GPs are well places to make a routine enquiry and therefore they should be reminded about best practice relating to DA.

11.13 Support for professionals involves in a domestic homicide.

11.13.1 The death of Grace did impact on several professionals who were dealing with Grace and Samay. It is important that agencies understand that professionals may also need additional emotional support following such a tragedy.

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12 RECOMMENDATIONS

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

Local Communication

Recommendation One

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

Ownership: ESSCP

Recommendation Two

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

Ownership: ESSCP

Recommendation Three

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

Ownership: ESSCP

Policy and Procedures

Recommendation Four

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

Ownership: ESSCP, Police, Probation and specialist DA services

Training

Recommendation Five

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

Ownership: ESSCP

Recommendation Six

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

Ownership: ESSCP and agencies involved in the DHR

Multi Agency Response to Domestic Abuse - MARAC

Recommendation Seven

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

Ownership: ESSCP

Other

Recommendation Eight

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

Ownership: ESSCP and all agencies involved in this DHR.

National

Recommendation Nine

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

Ownership: Home Office

Recommendation Ten

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

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

Recommendation Eleven

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

Ownership: Home Office

Appendix One
EAST SUSSEX SAFER COMMUNITIES PARTNERSHIP (ESSCP)
DOMESTIC HOMICIDE REVIEW
DHR Grace
January 2021

TERMS OF REFERENCE vrs 3

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

2. This legislation places a statutory responsibility on organisations to securely share confidential information, which will remain confidential until the panel agrees the level of detail required in the final report for publication.

3. The DHR will strictly follow the ESSCP DHR protocol, which is based on Home Office DHR guidance[8].
4. The statutory purpose of the DHR is to:

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

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

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

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

5. The agreed timeframe for information to be secured and reviewed is for **from August 2017 to December 2019**, unless there have been significant events prior to this. Significant events will include engagement with agencies due to noteworthy medical issues, reports of domestic abuse and other wellbeing issues.

6. The DHR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures

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

(e.g. SCR, SAR, IOPC[9] referral, and internal agency disciplinaries) may use information from the DHR process to support their investigations.

7. The Panel notes that the DHR process may be suspended as necessary to avoid the risk of activities prejudicial to criminal proceedings (Criminal proceedings completed Dec 2020, perpetrator guilty of murder, sentence 27 years)

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

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

*b) Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator e.g., Femicide,[10] men/ women's roles in society, **culture and religion.***

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

d) To consider any agencies or wider community groups that could have had contact with Grace and her family and whether helpful support could have been provided and if so, why this was not accessed?

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

f) Whether Grace's welfare and needs were promoted and protected through timely and effective assessment including risk assessment and response to needs identified (this to include information sharing and timely interventions).

g) To consider if all relevant civil (including workplace) or criminal interventions were considered and/or used.

h) The impact of substance misuse/mental health as a contributing factor in domestic abuse.

i) The use of economic abuse by a perpetrator to control a victim.

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

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[9] *Independent Office for Police Conduct https://policeconduct.gov.uk/*
[10] *www.womensaid.org.uk/femicide*

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

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