

**Safe in the city**

Brighton & Hove Community Safety Partnership

# **DOMESTIC HOMICIDE REVIEW**

**Brighton & Hove Safe in the  
City Partnership**

**Report into the murder of Alina (Adult H)**

**August 2016**

**Author: Davina James-Hanman OBE**

**September 2017**

## Glossary

CSP: Community Safety Partnership

DASH: Domestic Abuse, Stalking and 'Honour' Based Violence

DHR: Domestic Homicide Review

DVA – domestic violence / abuse

IMR: Individual Management Review

IPCC: Independent Police Complaints Commission, since renamed the IOPC: Independent Office for Police Conduct

MARAC: Multi-Agency Risk Assessment Conference

NICHE RMS: Police Report Management System

PIN: Police Information Notice

PND: Penalty Notice for Disorder

RISE: Refuge, Support, Information and Education

Scarf: Single Combined Assessment Referral Form

SPFT: Sussex Partnership NHS Foundation Trust

TSA: The Scout Association

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# DHR OVERVIEW REPORT INTO THE MURDER OF ALINA<sup>1</sup>, AUGUST 2016

## Preface

The Review Panel members and the Safe in the City Partnership (the Brighton & Hove Community Safety Partnership) offer their deepest sympathy to Alina's parents for the sudden loss of their daughter.

We further extend our condolences to all those who have been affected by the death of Alina, and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience. It is clear that Alina is greatly missed.

The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies. She is joined by the Review Panel in thanking James Rowlands for his efficient administration of the DHR.

## 1. Introduction

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

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

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

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

Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-Government definition as issued in March 2013. This can be found in full at Appendix B.

1.2 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

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<sup>1</sup> Not her real name

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 policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims (including stalking victims) and their children through improved intra- and inter-agency working.

1.3. This Domestic Homicide Review (DHR) examines the circumstances leading up to the death of Alina who was murdered in August 2016 by David<sup>2</sup>. The decision to undertake a DHR was made by the Safe in the City Partnership (Brighton & Hove's Community Safety Partnership) in consultation with local specialists. The Home Office was duly informed on 28th August 2016, with a further update provided in January 2017 regarding timescales. An independent Chair was appointed at the end of October 2016 and the Panel met for the first time in January 2017 where IMRs were commissioned and agencies advised to implement any early learning without delay. In consultation with the Senior Investigating Officer, it was decided to delay some aspects of the DHR, such as meeting with family members and other witnesses, until the criminal investigation had concluded. Three further meetings of the Panel were subsequently held in March, June and July 2017. The timing was arranged to reduce the burden on partners as there were other DHRs, commissioned by a neighbouring local authority area, which overlapped with this Review. This enabled attendance at Panel meetings.

1.4 The Executive Summary and Overview Report, as well as recommendations in response to the findings, were signed off by the Safe in the City Partnership Board in September 2017. They were submitted to the Home Office in October 2017 and were considered by the Home Office Quality Assurance Panel. The Home Office provided notification and approval for publication in August 2018.

1.5 Domestic violence and abuse, sexual violence and other forms of violence against women and girls are a key priority for the Safe in the City Partnership, and are included in the Community Safety and Crime Reduction Strategy 2017-20. The overarching aim is that *“local residents and communities are free from domestic violence and abuse, sexual violence and other forms of violence against women and girls by delivering the following outcomes:*

- *Increased social intolerance and reduced acceptance*
- *People have safe, equal and abuse free relationships*
- *Increased survivor safety and wellbeing*
- *Perpetrators are held to account and are required to change their behaviour*
- *A coordinated community response to violence and abuse.”*

Stalking has been identified as an area for development in the city, with a 'Talking Stalking Event' included for the first time as part of the 16 Days of Action Campaign in 2015 (<http://www.safeinthecity.info/16-days-2015>). This event was produced with Veritas Justice (a local organisation dedicated to support and advice for domestic abuse, child protection and stalking issues: <http://veritas-justice.co.uk/>). The current strategy includes ongoing development work around stalking and harassment, including:

- Raising awareness

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<sup>2</sup> Not his real name

- Develop proposals to further develop support for victim/survivors with a focus on Private Law Family Proceedings and those experiencing stalking and harassment
- Review interventions to challenge perpetrators, in particular repeat offenders and perpetrators of stalking and harassment.

Locally, specialist domestic abuse services are provided by The Portal (which is a partnership of leading Sussex Domestic and Sexual Abuse Charities including RISE, Survivors' Network and CGL: [www.theportal.org.uk](http://www.theportal.org.uk)) which provide a single point of access and helps victim/survivors of domestic and sexual violence and abuse to find advice and support in Brighton & Hove. Across The Portal in 2016/17, 10% of clients seeking support for current abuse reported experiencing stalking and harassment.

- 1.6 Brighton & Hove City Council and East Sussex County Council have brought together commissioning and partnership activity in relation to domestic violence and abuse, sexual violence and other forms of violence against women and girls. This has made it easier to identify shared learning, including from other reviews. Of relevance to this review is the 2017 DHR completed by the East Sussex Safer Communities Partnership into the death of Pamela, which identified significant learning in relation to both victims/survivors, the wider community and professionals and their understanding of domestic violence, as well as awareness and identification of harassment and stalking. That review can be accessed at <http://www.safeineastsussex.org.uk/our-publications.html>.
- 1.7 In July 2017, a pan-Sussex Stalking and Harassment Working Group was established. The terms of reference for this group can be found at appendix D.

## 2. Overview

### 2.1. Persons involved in this DHR

Name	Gender	Age at the time of the murder	Relationship with victim	Ethnicity
Alina	F	19	Victim	White UK
David	M	27	Perpetrator / on-off boyfriend	White UK
Andy	M		Occasional intimate partner	
Simon	M		Boyfriend	
Kevin	M		Work colleague and close friend	
Jane	F		David's mother	
Alison			Previous victim of the perpetrator	
Barbara			Previous victim of the perpetrator	

Carla			Previous victim of the perpetrator	
Daphne			Previous victim of the perpetrator	
Elsa			Former girlfriend and victim of the perpetrator	
Fiona			Previous victim of the perpetrator	
Gail			Previous victim of the perpetrator	
Harriet			Neighbour and former victim of the perpetrator	
Ingrid			Previous victim of the perpetrator	
Julie			Previous victim of the perpetrator	
Karen			Previous victim of the perpetrator	
Lorraine			Previous victim of the perpetrator	

2.1.1. Neither Alina nor David had children.

2.1.2. Initially this case was known as Adult H in Brighton & Hove but subsequently the name 'Alina' was chosen as a pseudonym. The family were offered the option of choosing a name but decided not to do so.

2.1.3. This report also includes examination of a number of instances where David was reported to the police by women and girls although it should be noted that almost all of these were not reported to any professional until after the murder of Alina. To preserve their privacy, pseudonyms – in alphabetical order - have also been used for them.

## 2.2. Summary of the case

2.2.1. Alina was 19 years old and shared a bungalow with two friends near Brighton. Alina's bedroom was on the ground floor at the rear of the property.

2.2.2. Alina had a boyfriend called Simon. They had been seeing each other for about four years but after Alina started a new job in July 2015, she was approached by an older work colleague called David who took an immediate interest in her. Within weeks they began seeing each other. Approximately ten weeks before the murder, Alina and Simon split up but got back together again about a month later. Alina continued to see David throughout this period.

2.2.3. Between 8 February 2016 and 12 July 2016, Sussex Police were contacted five times by Alina and other members of the public, with concerns about David's behaviour towards Alina. Simon also reported damage to his car and a note that had been left on his windscreen stating "Dear Simon, Alina has and always will cheat on you. Happy New Year."

2.2.4. From the outset, Alina said that she believed that David was stalking her, and that she felt frightened of him. On the first occasion, David was spoken to by police officers; on the second he was interviewed and on the third occasion he was arrested. Throughout their

contact with Alina, Sussex Police consistently assessed that Alina was at 'medium' risk of serious harm, using the DASH RIC.<sup>3</sup>

- 2.2.5. At 09.43am towards the end of August 2016, Sussex Police received a call from Simon's sister. She stated that she had been asked by Simon to go to Alina's address to check on her as Simon had been contacted by Alina's manager to say that she had not turned up for work that morning. On arriving at the address she saw there was a bloody footprint on the doorstep of the property. Simon's sister was extremely concerned as she knew that Alina had reported in the past that she was being stalked by David.
- 2.2.6. Simon's sister phoned the police as well as her father. She was too scared to go into the property or knock on the door. Her father was in the local area and arrived at the address within a matter of minutes. He began banging on the doors and windows calling Alina's name.
- 2.2.7. He attempted to gain entry by going to the back of the property but failed (he assumed the front door would be locked). He returned to the front of the house and opened the letter box to see in. At this point he could smell smoke. Neighbours heard the commotion and tried to help gain access. They also went to the back of the property and were discussing breaking a window but felt that this could cause an explosion with the fire.
- 2.2.8. Simon's father tried the handle of the front door and it opened. He entered the property and became aware of the extent of the smoke. He was struggling to breathe and had to come back out of the house.
- 2.2.9. On exiting the house he became aware that his sister in law had arrived to help. Both of them entered the bungalow and managed to get to Alina's bedroom. Through the hazy smoke they were able to see a body lying face down on the bed. Although they could not see the person's face they were able to see long blond hair that looked like Alina's. It was apparent to them that she was dead. They ran from the bungalow to find that the police and ambulance had arrived. A paramedic pronounced Alina dead at 10.03am.
- 2.2.10. David was subsequently arrested and interviewed. Throughout seven interviews, he either gave no comment responses or protested his innocence, although changing his story each time evidence proved that he was lying. In early March 2017 he was convicted of murder and sentenced to a minimum tariff of 25 years. David has subsequently admitted that he is guilty of murdering Alina.

### 3. Parallel reviews

- 3.1. As mentioned immediately above, there was a criminal trial.
- 3.2. The day after the murder a post mortem was conducted by Dr Biedrzycki at Brighton Mortuary. He made a provisional finding regarding the cause of death as being an incised wound to the neck (her throat was slit). The wound measured 10.5 cm in length. There were no defensive injuries to her upper limbs.
- 3.3. An inquest was opened by Her Majesty's Coroner, and was adjourned pending the outcome of the criminal trial. Communication channels were established with the Coroner who at the time of writing this report is deciding whether to re-open the inquest. To aid in this process, it was agreed that a confidential copy of this report will be provided to her prior to Home Office approval.

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<sup>3</sup> DASH RIC is the Domestic Abuse, Stalking and Honour based violence Risk identification checklist



- 3.4. Due to Alina’s contacts with the Police, the Independent Police Complaints Commission (IPCC<sup>1</sup>) also undertook a review of the involvement of Sussex Police with Alina and David. This meant that there were potentially four separate processes in which the family – and other witnesses – would be involved. As such, it was agreed that the IPCC would share statements with the DHR to try to streamline the two processes and keep open channels of communication.

This DHR endorses the quick-time recommendations that the IPCC (now IOPC) have made ahead of the completion of their investigation. These are:

**Quick-time learning 1:** When officers move to a different role they should be given sufficient training to carry out that role.

**Quick-time learning 2:** Domestic violence and stalking training should be made mandatory in Sussex Police and there should be regular refresher training concerning the identification of such issues and the necessary risk assessments. This would be especially pertinent to staff involved in frontline work, and investigations. The IPCC would recommend a review of current training involving domestic violence and stalking, to verify if it is sufficient to allow officers to identify relevant issues, and to carry out the necessary risk assessments.

**Quick-time learning 3:** The system of updating the officer in charge on the computer databases as soon as an officer's role is complete, and flagging that an offence has already been dealt with, needs to be tightened up to ensure that staff know when a new crime report should be logged and who to contact with further information.

**Quick-time learning 4:** Consider whether a new crime should be set up with every call. This would ensure that somebody is reviewing information that is coming in, and taking appropriate action. This is especially pertinent when both the victim and perpetrator have history markers for stalking, domestic violence, or any other serious or complex matter.

**Quick-time learning 5:** Staff should be reminded to use the most effective search technique when provided with key information.

**Quick-time learning 6:** Incidents and allegations relating to offenders or victims with domestic abuse or stalking markers should be reviewed by a specialist officer before the matter is finalised. A process of looking at history markers and having specialist assessment before an outcome is reached would enable specialist advice on the appropriate disposal and allow for referrals to specialist agencies to be made for the victim.

The IOPC report is available at:

<https://policeconduct.gov.uk/news/national-and-regional-recommendations-made-following-shana-grice-investigation-final-report>

## 4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following agencies:

	Davina James-Hanman	Independent Chair
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### Joint Unit

Brighton & Hove City Council / East Sussex County Council	James Rowlands	Strategic Commissioner
BHCC / ESCC	Josi Enright	Joint Partnership Officer

<sup>1</sup> The IPCC has since changed its name to the Independent Office for Police Conduct (IOPC)

## Panel

Sussex Police	Jane Wooderson	Crime Review Team
Brighton & Hove Clinical Commissioning Group	Candy Gallinagh	Named Professional for Safeguarding Adults
Brighton & Hove City Council	Michelle Jenkins	Head of Adult Safeguarding
Brighton & Hove City Council	Deb Austin	Head of Children Safeguarding
Brighton Sussex University Hospital Trust	Debi Fillery	Nurse Consultant for Safeguarding Children and Young People / Supervisor of Midwives
Office of the Sussex Police & Crime Commissioner	Sara Jones	Business Manager Victim and Witness Services
Sussex Partnership Foundation Trust	Marian Trendell	Deputy Director Social Work
RISE / The Portal	Gail Gray	CEO
Community Safety	Peter Castleton	Head of Community Safety
Veritas Justice <sup>4</sup> / Suzy Lamplugh	Claudia Oriz	Director

Panel meetings were also attended by the IPCC (now IOPC).

In accordance with the statutory guidance, the DHR Panel sought to engage with the IOPC who were undertaking a parallel investigation to agree how to manage this process. Both the DHR Panel and the IOPC engaged with each other in good faith and sought to identify how the two parallel processes would work together. This included, for example, addressing this in the Terms of Reference.

Unfortunately there was a misunderstanding about this working relationship in practice. This misunderstanding was held by all parties. It did not become apparent until the latter part of the process.

The misunderstanding was whether the IOPC was a member of the DHR Panel and adopted the associated responsibilities that came with that (the belief held by the DHR Panel) or only an observer to the DHR Panel (the IOPC's belief). Like many misunderstandings it was born from unintentional oversights by both parties.

The IOPC rejects any DHR Panel membership in this case and does not endorse the DHR report. The IOPC does so primarily to protect its independence and the integrity of its investigation. The IOPC wishes to make it clear that is not a public condemnation of the report or the integrity of the DHR Panel and it must not be read as such. DHRs are integral to learning the lessons from tragic events such as these.

Both the DHR Panel and the IOPC deeply regret any confusion this misunderstanding may have caused, especially to the family.

The IOPC, on its part, will continue to work and engage with DHRs in the future to avoid any similar confusion arising again and a recommendation has been made to the Home Office, the sponsoring body for the IOPC to take this forward.

## 5. Independence

The Chair and author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. Davina James-Hanman is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence having been active in this area of work for over three decades. These have included roles at local, regional and national levels in both the voluntary and statutory sector. She has devised a wide variety of original resources for survivors, written innumerable articles, toolkits and manuals for practitioners, is the author of three book chapters and among a variety of other national roles, acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence, forced marriage and 'honour' based violence.

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

## 6. Terms of Reference and Scope

6.1. The full terms of reference can be found at appendix A. The key lines of enquiry for the DHR were as follows:

1. Each agency's involvement with the victim Alina from October 2014 to August 2016.
2. Each agency's involvement with the perpetrator David, including his contact with:
  - Alina from October 2014 to August 2016,
  - Any other female from 2003.
3. Whether, in relation to the either Alina or David, an improvement in communication between services might have led to a different outcome for Alina.
4. Whether the work undertaken by services in this case was consistent with each organisation's professional standards.
5. Whether the work undertaken by services in this case was consistent with each organisation's domestic violence policy, procedures and protocols, and in light of the features of this case, whether the organisation's policy, procedures and protocols adequately address stalking and harassment.
6. The response of the relevant agencies to any referrals relating to Alina, concerning domestic violence, stalking and harassment or other significant harm from David until the point of the death. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

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<sup>4</sup> At the start of the review process, the Suzy Lamplugh Trust (national) and Veritas Justice (local) were contacted to consider representation on the Review Panel. As the Suzy Lamplugh Trust was supporting Sussex Police to review their response to this case, it was agreed that Veritas Justice would be the specialist stalking service representative on the Review Panel.

- (a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

- (b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
  - (c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
  - (d) The quality of the risk assessments undertaken by each agency in respect of Alina and David.
7. The response of the relevant agencies to any referrals relating to David, concerning any other behaviour (including domestic violence, stalking and harassment or other significant harm) from David to any other females. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:
- (a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.
  - (b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
  - (c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
  - (d) The quality of the risk assessments undertaken by each agency in respect of other females and David.
8. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.
9. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.
10. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either adult were explored, shared appropriately and recorded.
11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.
12. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
13. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?
- 6.2. Agencies were asked to search their records from October 2014 for Alina since at the start of the process the Panel was unsure of when her relationship with David began and from 2003 for David to capture the complaints made by other women who came forward after the murder. It later became clear that the relationship between Alina and David began at some point in the summer of 2015.

## 7. Confidentiality and dissemination

- 7.1. The findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication by the Home Office Quality Assurance Panel.
- 7.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used and precise dates obscured.
- 7.3 The Executive Summary of this report has also been anonymised.
- 7.4 This has not prevented agencies taking action on the findings of this Review in advance of publication.
- 7.5 Subsequent to permission being granted by the Home Office to publish, this report will be widely disseminated including, but not limited to:
- Members of the Brighton & Hove Safer Communities Partnership Board, the Local Safeguarding Children Board and the Safeguarding Adults Board, for consideration and dissemination by members of these groups within their own organisations
  - The Pan Sussex Domestic Abuse Management Group.
- 7.6 A number of learning events have been planned to ensure that the lessons are disseminated as widely as possible; the first of these will be a confidential briefing to key local partners which will share critical learning from this DHR (and other DHRs in East Sussex) which is taking place in Autumn 2017. Once permission is granted by the Home Office to publish, this report will be more widely disseminated to the local professional network including:
- The Domestic Violence and Abuse, Sexual Violence and Violence Against Women and Girls Champions Network and Multi-Agency Risk Assessment Conference
  - Targeted briefings including to specialist domestic and sexual abuse services.
  - Brighton & Hove City Council also has an integrated Domestic Violence and Abuse, Sexual Violence and Harmful Practices Training Prospectus 2017/18 (<https://www.safeinthecity.info/training>). A level 1 training course on stalking is being delivered in 2017/18 by Veritas Justice, with the intention of rolling out a level 2 training course in 2018. These courses will reflect lessons learnt from this review.

## 8. Methodology

### 8.1. Individual Management Reviews (IMRs)

8.1.1. The agencies listed below submitted an IMR:

- Brighton & Sussex University Hospitals Trust
- David's GP
- RISE/The Portal
- Sussex Partnership NHS Foundation Trust
- Sussex Police
- Victim Support.

Alina's GP returned a chronology and based on this, the Panel decided that an IMR would not be required.

The Scout Association also returned a chronology and after seeking clarity over some points, it was decided that a full IMR would not be needed.

14 witness statements were shared by either Sussex Police or the IPCC. In some cases, these statements were supplemented with individual meetings with the Chair.

A further ten agencies advised they had not had any contact with either Alina or David.

8.1.2. Agencies completing IMRs and reports were asked to provide chronological accounts of their contact with Alina and/or David prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. The DHR has focused on the contacts of agencies from October 2014 for Alina and from 2003 for David. The recommendations to address lessons learned are listed in section 14 of this report and action plans to implement those recommendations have been developed.

Each IMR / report was scrutinised by the Panel and in some instances redrafted to take account of questions raised.

The Review Panel has checked that the key agencies taking part in this Review have domestic violence policies and is satisfied that where these exist, they are fit for purpose. Where they do not exist, recommendations have been made.

The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

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

- The Individual Management Reviews (IMRs), chronologies and short reports
- The Police Senior Investigating Officer
- Witness statements from the criminal trial and associated press articles.
- Witness statements gathered by the IPCC
- Alina's Facebook page
- DHR Panel discussions
- Information from friends, family members and the perpetrator

- The collective expertise of the Panel which included stalking specialists
- Electronic communications made via text, email or voicemail which were recovered from Alina and David's phones. These were in excess of 25,000 over a 12 month period
- Electronic communications made via text or email between Alina and Simon
- The Crown Prosecution Service whose assistance was sought to clarify several evidential matters raised by the family

The Brighton & Hove Community Safety Partnership is responsible for monitoring the implementation of the action plans that have been developed.

## **8.2. Involvement of family and friends**

8.2.1. The family of the victim were informed about the commencement of the DHR and invited to participate. This was initially via a family friend which allowed them an opportunity to comment on the Terms of Reference. Information was provided about Advocacy After Fatal Domestic Abuse (AAFDA). Once the trial had concluded, the family communicated that they wished to continue their involvement only through the family friend which was duly done with them receiving regular updates from the Chair. A copy of the draft report was sent to the family prior to submission to the Home Office and extensive efforts were made to include their comments, views and recommendations. However, towards the end of the process, the Chair received a short email from the family friend stating that his role as an intermediary had ceased. Subsequent to that, the Chair communicated directly with the parents who repeatedly stated their dissatisfaction with the report but were unable to provide any specifics beyond their sense that the report was unfair to their daughter. During this communication, Alina's parents asked that the information they had previously provided to the review not be used. The Chair, with the agreement of the CSP, agreed to respect the family's wishes as far as it was possible to do so. This report therefore does not include either a family impact statement or a pen portrait of Alina. Where amendments have been made to the report in relation to factual accuracy or clarity, based on feedback from the family or family representatives about specific issues, these have been left in the report, as these changes are not identifiable to the reader.

8.2.3 David's mother, a former colleague and an off-on intimate partner also participated in the Review. Information from them has also been integrated into this report. Others were invited to participate but declined or did not respond..

## **8.3. Involvement of the perpetrator**

8.3.1. Post-conviction, the perpetrator was contacted through his Offender Manager and agreed to participate. The Chair duly met with him in prison. Notes of this meeting were provided to Alina's parents at their request. Information provided by David has been integrated into the narrative below.

## **9. Key events**

In the narrative below, it should be noted that Alina is dead and thus cannot give her own account, dispute what is said or explain her actions. However, as noted above, the narrative does include statements made by Alina at the time of events being described including her electronic communications with both David and Simon.

## 9.1. 2005 - 2010

- 9.1.2. In 2005 David, by now aged 16, was involved as an assistant in a camping trip organised by the Girl Guides and Scouts. He is believed to have texted Alison who was aged 11 years at that time, asking if he could see her. This text was found by Alison's father (a retired police officer) and he contacted the Guide Leader to report it. All further contact stopped for a number of years until David started passing Alison on her way to and from school and offering her lifts which she declined. There was a further incident in 2015 (see below). These incidents were not reported to the police until after the murder.
- 9.1.3. Barbara reported that she met David in 2000 when she was 9 years old via a Scout marching band and because he was friends with her older sister's friendship group. At some point in 2006, when she was 16 years old, David was at her family home. David tried to kiss and cuddle her but she pushed him away and he then acted as if it had not happened. When she was 18 (2008) she started to drink at the same pub and came into contact with David again as it was also his local. She then started receiving explicit photos from him and offers to pay her for sex. These incidents were not reported to the police until after the murder.
- 9.1.4. Carla knew David from when she was in the Girl Guides and then the Rangers. In 2008, when she was 15/16 years old she began receiving sexual texts from him saying he was touching himself. When she informed him that she did not like it, he just laughed it off. This was not reported to the police until after the murder.
- 9.1.5. In 2009, David's Grandfather died. They were very close and his death affected David enormously. At interview, David said that it was from this point on that he stopped talking about his feelings and began to bottle up everything inside. A pattern begins to emerge where David reacts to any loss as a major catastrophe, often resulting in him threatening or even attempting suicide although it is clear that he also used it as a form of manipulation.

## 9.2. 2010-2012

- 9.2.1. In October 2010, David was in a volunteer position with The Scout Association and was suspected of grooming Daphne, a 14 year old girl who attended the group. He sent inappropriate messages via text and Facebook. David was arrested on suspicion of grooming an underage girl and he was suspended from the Scouts. Following an investigation, the incident was closed as the offence could not be proven. However, a sex offender marker was placed on NICHE (Sussex Police recording system).
- 9.2.2. The Scout Association (TSA) was duly informed by an email from the Police that David had not been charged with or convicted of any offences but a record would be kept as regards to the investigation taking place. TSA was also informed that this would come to light in any subsequent Criminal Records Bureau check (now Disclosure and Barring Scheme: DBS) of David. Although a subsequent DBS check was done, the information outlined here was not shared (see July 2015 for further detail). With no corroborative information, the Scouts decided that David should no longer be suspended and should be allowed to return to his normal Scout Leader duties. However, before this occurred, David verbally resigned. A letter was sent to him confirming his resignation but David disputed that he had in fact resigned. He was told that as he did not meet the threshold for an automatic national exclusion he could reapply for membership in the future and the current concerns would be considered as part of any vetting or appointment process.



### 9.3. 2013

- 9.3.1. By now, David was involved in a Drum Corps and in June he met Elsa who he began dating in November of the same year. Elsa stated that David was nice to begin with but became very controlling, demanding she text him constantly and tell him who she was with. Elsa lived in Essex and David in Sussex so they were often apart but he still tried to control her. Elsa would comply to avoid arguments.
- 9.3.2. Alina left school this year (she was 16). Whilst at school she met and began a relationship with Simon which continued (with some break-ups and reconciliations) until her death.

### 9.4. 2014

- 9.4.1. Elsa went to a dance competition in Stoke in April and was accompanied by David. Elsa stated that during the day when she was interacting with other performers, David asked to speak to her in private. They went to their room and he accused her of ignoring him. When she went to leave, he pushed her hard against the wall and put his face next to hers. When she went to break free he grabbed her wrist. This upset Elsa and she began to cry. David then walked away. This was not reported to the police until after Alina's murder.
- 9.4.2. David became friends with Fiona who was 17 years old. She disclosed personal details about herself to David, including that she used to self-harm. She did sleep fully clothed in the same bed with him on one occasion, although without any sexual activity taking place. Fiona regretted this and told him that they would never be more than friends. Fiona was then bombarded with texts telling her to cut herself or with David threatening suicide. He also parked up near her home or school on numerous occasions. This stopped when a family member warned him about his behaviour and was not reported to the police until after Alina's murder.
- 9.4.3. In October Elsa went with friends to Tenerife for a long weekend. David did not want her to go. As she was boarding the plane to depart, David sent her a picture of a local beach and said he was going to walk into the sea and drown himself. Elsa was constantly bombarded with texts whilst she was away. On the Saturday of that weekend David sent her pictures of two knives and said he was going to use them to commit suicide. Elsa was so anxious that she got her mother to contact Jane (David's mother) to check on him and he was fine. Elsa ended the relationship that same month.
- 9.4.4. The following day, David went to his GP and disclosed his suicidal ideation which he said was due to depression over the death of his Grandfather and the ending of his relationship. He was assessed and received a diagnosis of severe depression and severe anxiety. He was prescribed Sertraline 50mg daily (antidepressant) and Zolpidem 10mg at night (sleeping tablet). A crisis plan was discussed and information given about a cognitive behavioural therapy website along with an 'unfit to work' certificate which was subsequently lifted in November after David was reassessed and scored for moderate depression and moderate anxiety. He was seen by the GP at two week intervals until the end of the year and his medication adjusted slightly. There was a review at the end of January 2015 when David said that things were much better at work, he was socialising with friends, exercising regularly and sleeping better. There was then a plan to review again in two months.

### 9.5. 2015

- 9.5.1. Although his relationship with Elsa had ended the previous year, David turned up unannounced at her place of work in March and tried to give her an envelope, at the same

time saying that he was going to jump in front of a train. Elsa called the police and Jane, David's mother. The following day, Jane contacted their GP saying she was worried about her son. He had given goodbye letters to his girlfriend for his family and friends. The letters said he could not be without his girlfriend and said sorry for what he would do. The GP arranged for David to come to surgery later that day for assessment. At this appointment, David continued to express suicidal thoughts stating he did not want to carry on living if he was not able to continue his relationship with Elsa. He was referred to Brighton Urgent Response Service (BURS) (now the Mental Health Rapid Response Service – MHRRS) and risk planning was put in place with his mother. The BURS worker called David who agreed that he would benefit from mental health services. He did not present with any overt mental health symptoms and displayed good concentration and was warm and friendly with the ability to make jokes. However, due to work commitments, David said he would not be able to attend an appointment immediately. He asked if he could ring BURS in a few days when he had had some time to review his feelings. He was given contact numbers for support if he felt he needed it over the weekend.

- 9.5.2. The following month, David sent a Snapchat message to Alison offering her £500 if she would spend the night at a hotel with him and let him do anything he wanted to her. Alison ignored this. David also sent an image of the front of her house saying that he could see her. On another occasion Alison posted a picture of her sunburnt skin onto Facebook which resulted in David messaging her asking if he could put cream on it. Subsequent to this, chance meetings in the local pub would often lead to unsolicited messages being sent to Alison from David. These would suggest that they should be together when it was obvious to all that she had a boyfriend.
- 9.5.3. In June, Alina started work at the same company as David. By the following month they were exchanging text messages and by the autumn, the relationship had progressed to a sexual one. By the time of her death, there were in excess of 25,000 media messages between them in the form of text, WhatsApp, Facebook Messenger and Snapchat. These show an obsessive and complicated relationship with a number of messages being highly sexualised in content. David appeared to pressure Alina into ending the relationship with Simon (something he would later deny when meeting with the Chair). It is evident that Alina had strong feelings for David; it is equally evident that David is obsessive.
- 9.5.4. In July, David applied for membership of Scouts and he was not recognised as a past resigned member. This meant that the previous information was not considered. This was a temporary glitch in the IT system which has now been resolved. His application was progressed which included submitting an application for a Disclosure and Barring Scheme certificate. In October, a 'clear' DBS certificate was issued for David. He began volunteering again as an Assistant Section Leader but was subsequently described as unenthusiastic and resigned in February 2016. The 'clear' DBS certificate occurred because when enquiries were made of Sussex Police a decision was made not to disclose David's history. This decision was fully documented and based on: the length of time since the previous allegation; that no further offences had been alleged; that David had not come to the attention of Sussex Police since then for any other reason; that David had been interviewed and understood his actions were wrong and that the disclosure of the information might be detrimental to his job prospects. The assessment concluded therefore that disclosure would be disproportionate. The matter was then reviewed by the Chief Officer delegate, who agreed with the decision.
- 9.5.5. In August, David sent a friend request on Facebook to Gail who he knew from school and would bump into occasionally after they had left. Gail accepted the request and then received an email from David asking if she lived at a specific address. She realised that his work brought him into the area and that he must have seen her coming and going. Gail then began to notice David's van parked up outside of her home address several times even on

days he was not due to be working there. She began to feel harassed by him and took steps to avoid seeing him. This was not reported to the police until after Alina's murder.

- 9.5.6. In September, Alina's car had a flat tyre. David helped her to fix it
- 9.5.7. In October, David sent an unsolicited text to a neighbour, Harriet, asking her for a date; this was followed by another text saying he was all alone in his house. She consulted her mother and they decided on an appropriate form of reply expressing a lack of interest which they did. This was not reported to the police until after Alina's murder.
- 9.5.8. In December, a young woman called Ingrid was in David's local pub and went to the bathroom to redo her makeup. On leaving the bathroom, she saw David standing against the wall. As she walked past, he grabbed her wrist and pulled her towards him with his face pushed close to hers preparing to kiss her on the mouth. She pulled away and laughed loudly to play down the incident but really felt 'creeped out' by it. She went to the bar and told her friend what had happened and they both left the pub. The following day she received a Facebook friend request from David saying '*Hey .. was very nice meeting you...sorry with what happened but you wanted it too (smiley face) xx*'. She did not respond. This was not reported to the police until after Alina's murder.
- 9.5.9. The same month, a young woman called Julie was in David's local pub. As she passed David he put his hands on both of her hips. She did not know if this was sexual or accidental but the next day she received a Facebook message from David outlining his desire to perform oral sex on her and detailing what he would do. This was not reported to the police until after Alina's murder.
- 9.5.10. At the company Christmas party, David was moody and scowling at any man who spoke to Alina but this did not stop Alina from enjoying herself. David went outside and was refused re-entry due to being drunk. Alina stayed at the party.
- 9.5.11. In mid-December, David's step father called MHRRS (Mental Health Rapid Response Service – formally BURS) reporting that he was worried as David seemed to be depressed again. He reported that David had stated that he 'can't do it anymore' after attending a work's Christmas event. When the family tried to contact David they were unable to locate him. Eventually his father managed to get hold of him and he was found in a corner behind a warehouse and was not willing to talk to anyone. He refused to talk to the MHRRS worker but said that he would call them back later. The family were instructed to call the MHRRS team again if they were concerned about David's safety.
- 9.5.12. David did later call the MHRRS team. He could not articulate why it had all got too much for him but he said that there was 'other stuff going on' but would not elaborate. He told the MHRRS worker that he had been on Sertraline (antidepressant) for over a year and they had initially worked for him. He reported suicidal thoughts for a few years on and off but that he had been feeling suicidal for two days and before that for two weeks prior. He said that he had felt depressed since the death of his Grandfather. He denied any current plan to end his life but stated he did just want it to end. He reported that he had taken paracetamol in the past and had not told anybody, having most recently done this two months ago.
- 9.5.13. David was advised to go to his GP to discuss either an increase or a change in his antidepressant medication and to ask his GP to refer him for counselling. He was also given the contact number for Cruse (bereavement counselling) and the Mental Health Line. David did not contact either of these agencies but he did visit his GP for a series of appointments for the rest of December during which time his medication was slowly reduced without

further incident. David would later reflect that he should have accessed counselling and not just relied on medication.

- 9.5.14. On New Year's Eve, Simon found a handwritten note on his windscreen which read: *'Alina has and always will cheat on you. Happy New Year'*.

## 9.6. 2016

- 9.6.1. In mid-January, Alina received a bouquet of flowers at work with a card that read 'Have a nice day. Love you'. It was unsigned. Alina initially thought they were from her boyfriend Simon but upon calling him to say thank you, discovered he had no knowledge of them. Alina called the florist and was told that they had been paid for with a credit card owned by David. Alina spoke to a work colleague and disclosed that David had been 'bumping into her' on a regular basis on her route to and from work. She also disclosed that she had been having a series of flat tyres on her car which had started occurring since last September. This was reported to her manager who contacted HR. David's company van tracker was studied and it was revealed that there were several occasions when the van had been near Alina's house or her mother's house during work time when it should have been elsewhere. David denied everything and later claimed in interview that his employer believed everything Alina said and disbelieved him.
- 9.6.2. Shortly after this, Alina's tyres were slashed. Simon's car was similarly damaged as well as being scratched down one side.
- 9.6.3. Towards the end of January, David saw his GP again and reported that the new medication regime was working much better and that he was eating and sleeping well. He was seen again in February at which point it was agreed that a subsequent review would take place in three months.
- 9.6.4. In February, Alina made the first report to the police. She shared the information detailed above and described David as a colleague and friend. She was told that her case would be allocated for further investigation. A Domestic Abuse Stalking and Harassment Risk Identification Checklist (DASH RIC) was completed and Alina was assessed as medium risk.
- 9.6.5. The police spoke to the HR manager at Alina's workplace, flagged her address and her mobile number, referred Alina to RISE and advised Alina to keep a record of any further incidents. The officer also gave Alina contact details for the National Stalking Helpline (NSHL <https://www.suzylamplugh.org/contact-the-helpline>) although it should be noted that the NSHL only respond to around 43% calls due to high demand and were not offering advocacy case work at this time.
- 9.6.6. David was spoken to and denied everything. The case was filed due to insufficient evidence. This appears to have sent the message to Alina that incidents were not worth reporting if she did not have proof that David was the culprit as she subsequently mentions her lack of evidence to several friends and colleagues when explaining why she is not reporting an incident.
- 9.6.7. As the case was a Medium Risk Crime RISE received a referral from the Police and tried to make telephone contact with Alina. There was no response so a safe voice message was left.
- 9.6.8. Towards the end of March, Alina returned to her home address after being at the pub when two of her housemates returned home with David and some other friends. Alina was unhappy about this and had a verbal argument with David before packing to go to stay with Simon. David chased her down the street and ran up behind her while she was on the phone

to Simon. David tried to grab the phone from her and pulled her hair, causing pain but no injury. A passing car stopped and asked her if she was OK. Alina accepted a lift from them to Simon's house where his mother insisted on calling the police.

- 9.6.9. David was interviewed and disclosed that Alina and he had been having a secret affair since the previous year. He shared text messages on his phone including one from the previous day from Alina saying she still wants David. Alina admitted to the police officers that they were much more than friends. She was advised that wasting police time was a criminal offence and issued with a Penalty Notice for Disorder (PND). The matter was then filed.
- 9.6.10. The following day Alina called her mother saying she needed to move out and find a new job. Relations with one of her housemates had become strained since it became evident that Alina was sleeping with David despite her many denials over recent months. Four days later Alina left her job citing David as the reason. She was unemployed for a few weeks during which time David was visiting her at home during work hours as revealed by the monitoring that his employer was still undertaking of his whereabouts. David was later told that he was to attend a meeting to discuss this evidence.
- 9.6.11. Meanwhile, Victim Support received a referral about Alina experiencing assault occasioning actual bodily harm for the incident described above (it is unclear how this occurred given that the incident did not result in injury). However, there was no domestic abuse flag on it. Also at this time, Rise was still trying to establish contact for the report made in February but always got voice mail. On the third attempt, in line with policy, they left a message saying they would not try again but including the number of the helpline if she would like to call.
- 9.6.12. In mid-April, David took an overdose; a combination of Paracetamol, Ibuprofen and alcohol. He was accompanied to A&E by his mother where he was seen by the Mental Health Liaison Team. David stated that he was feeling low in mood as it was 7 years since his grandfather died and he had been informed that he may be made redundant from his job (this is untrue; he may be sacked). He had drunk alcohol which led to an impulsive overdose. He said he regretted his actions and felt positive about getting another job. He said the counselling he had received was helpful (no record can be found of David ever accessing counselling) and denied he had any intention of harming himself or others. The whole assessment took around five minutes as David was anxious to leave, had declined a full assessment and was not displaying any significant symptoms of a mental illness that would make him detainable.
- 9.6.13. Three days later, David resigned from his job in advance of the meeting where he would have been challenged with the evidence of his company vehicle being near Alina's home on work time and a witness who saw him entering and leaving Alina's house.
- 9.6.14. At some point, possibly inspired by his experience at work, David purchased and fitted a tracker to Alina's car and kept appearing wherever she was. The evidence on this issue is confusing since email records show a delivery receipt for the tracker being received in late July but this behaviour began much earlier. It is possible that David found another way to track Alina's movements or indeed that the tracker purchased in July was a replacement for a previous tracker. On several occasions when he was spotted, he was confronted (usually by whoever Alina was with) and he always passed it off as mere coincidence. From around this time onwards, however, different people would later describe how David always seemed to be lurking around. At the same time, however, it is clear that Alina and David were still conducting a secret on-off relationship.
- 9.6.15. In May, David sent a woman called Karen an image of him masturbating on a bed via Snapchat. She was shocked and deleted the image immediately. The following morning she messaged him and said 'What the fuck?' David responded by saying it was sent in error.

However he subsequently sent another message asking Karen if she liked it. Karen replied that she did not. When reporting this incident to the police after Alina's murder, Karen also mentioned that when she was 15 or 16 years old (in 2009) David would send her messages detailing what he would like to do to her sexually.

- 9.6.16. Also in May, David went on holiday to Turkey and contacted Elsa again threatening to kill himself as he was so unhappy without her. He informed Elsa that he had previously tried to overdose two months earlier. Elsa later went on to block David from all social media to avoid further contact with him.
- 9.6.17. Elsa was contacted via Facebook by Alina in June even though the two did not know each other but were connected through a mutual friend. Alina asked Elsa what her relationship with David was like and stated that he was pestering her and she didn't want to be with him. Elsa told her not to let him stop her doing what she wanted to do.
- 9.6.18. Alina started a new job. She was currently on a break-up from Simon and, whilst David was away on holiday for two weeks, spent time with Andy with whom she had been having a sexual relationship over the past ten months. David returned from his holiday three days early. Alina found her tyres slashed and suspected David. A couple of days later, Alina was staying with Andy when David turned up at his house, pushed his way inside and confronted Andy. Andy denied having a sexual relationship with Alina.
- 9.6.19. At some point Alina and David reconciled and they were 'officially' in a relationship from 4 June to early July at which point Alina resumed her relationship with Simon but continued to see David in secret. Numerous text messages were exchanged between them with both emphasising the secret nature of their liaison.
- 9.6.20. In the same month, David made contact with Alison again. She described how he talked his way into her flat and pushed against her sexually. She rebuked him and asked him to leave but he followed her into the bedroom and pushed against her causing her to fall on the bed. This was recorded as a crime when Alison reported it after Alina's death but she did not wish to support a prosecution.
- 9.6.21. In early July, Lorraine was contacted by David. She had known him from Girl Guides over a decade ago and during this time there were no incidents of note. However, their paths crossed again via the Tinder dating app about eight months previously. They messaged for about a week and then exchanged mobile numbers. Lorraine began to get irritated due to the fact that David would send her 20 to 30 texts a day. This went on for two weeks and although she had agreed to go to dinner with him, she changed her mind and the messages stopped.
- 9.6.22. Then in early July, she received a close up image of David's erect penis saying 'This' and a further one three minutes later with his hand holding his penis saying 'No strings just this making u cum'. Lorraine replied 'Stop sending me dick pics. It's weird'. This was not reported to the police until after Alina's death.
- 9.6.23. The following day, David went to Alina's house to collect some of his belongings. Whilst he was there he stole the back door key and returned to Alina's house early the following morning when she was still in bed. She woke when he let himself into the house but pretended to still be asleep and hid her head under the covers. She would subsequently describe herself as being 'very scared'. David stood at the foot of her bed for a few moments and then left. Once she heard the door close, Alina got out of bed and was able to identify that it was David walking away from the house. After discussing this with her housemates, she decided to call David and confront him with the aim of recording the call so that she would have evidence to give to the police.

9.6.24. The transcript of this call is as follows:

Alina: *'If you come near the house again...'*

David (cutting her off): *'I won't, I won't contact you again.'*

Alina: *'I think that's best because it's just going to keep going round this vicious circle isn't it?'*

David: *'I know, I'm just not right in the head. If I was I wouldn't have done that would I?'*

Alina: *'Well maybe you need to get help then.'* [ends]

9.6.25. Alina reported the incident to Sussex Police and David was arrested. He admitted his actions and was cautioned for theft from a dwelling. A PIN was also issued and he was told to stay away from Alina.

9.6.26. The following day Alina called the police again over a series of four calls. She stated that she had received six or seven missed calls; one from a landline and the others from a withheld number. She was wondering if it was the police trying to contact her but it was quickly established that it was not. One call was answered and she could hear heavy breathing. Alina described herself as 'worried and 'really scared'. She was advised not to answer calls from withheld numbers. Record keeping of these calls was poor. An enquiry was made eight days later which resulted in the landline being identified as originating from David's address. No action was taken.

9.6.27. A few days after the key incident, Alina called Simon saying she did not feel safe in the house. Simon stayed for the weekend. Over the next week, David was seen several times following Alina to work. This was reported to the police but as there was no direct approach made, it was determined that the risk was low. No action was taken. Alina told a work colleague that she was too afraid to go to her kitchen at night as she felt someone was in the garden watching her. David continued to appear 'coincidentally' wherever Alina went. Simon received a text messages from a 'John Smith' reporting on Alina's behaviour when she was out without him.

9.6.28. A referral was made to Victim Support but after three attempts to contact Alina (from a withheld number), they sent an email to Sussex Police informing them that contact attempts had been unsuccessful and thus no DASH risk identification checklist had been completed.

9.6.29. David called Sussex Police stating that he needed to get in touch with Alina with regard to monies owed and he was seeking advice on how to do this without getting himself into trouble as he has been ordered to stay away from her. He asked if contact by letter was allowed and was told that his message would be passed to the officer in charge to make contact with him. The call-taker states that they relayed the message but there is no mention on the NICHE record that the officer in charge received or acted on this information. It is probable that the officer considered the matter closed, with action having been taken against David. Due to the IPCC investigation, it was not possible to interview the officer in question.

9.6.30. A referral was made to RISE using a SCARF (the Single Combined Assessment Referral Form used by Sussex Police) with a 'medium' risk assessment attached. The SCARF/DASH RIC was reviewed in line with policy and it was deemed appropriate to contact Alina and offer a service. A week later, a RISE worker made the first attempt to

contact Alina (from a withheld number). The call was not answered so a safe voice message was left.

- 9.6.31. David continued to be spotted in the vicinity of Alina's house and although a friend urged her to report this to the police, Alina said she was reluctant to do so as she thought the police would think she was 'blowing it out of proportion'.
- 9.6.32. In early August, a RISE worker made two further attempts to contact Alina. In both instances, the call was not answered so a safe voice message was left and the case closed.
- 9.6.33. In mid-August, Alina met up with Andy again.
- 9.6.34. A couple of days later, David told one of his friends that Alina had dumped him and gone back to her ex. He said he was depressed. As he was parting from his friend, he whispered in her ear 'she'll pay for what she's done'. It should be noted that threats to kill occur in 55% of stalking homicides and in some cases, as in this one, the threat is articulated to a third party as well as the victim. (Monckton Smith, 2017).
- 9.6.35. Three days later, via a series of text messages, Alina willingly arranged to meet David at a nearby hotel. He would later describe this as being for 'one last fling'. They spent a few hours at the hotel and agreed that it was over between them.. Around this time, Simon told Alina that he wanted to break up with her although he stayed the night at her home the following day.
- 9.6.36. A neighbour would later give evidence that they heard a raised woman's voice from Alina's home shortly after 7.30am. About 30 minutes later, David was caught on CCTV at a cash machine. £60 was withdrawn from Alina's account at the same time. He then returned to Alina's home with a water bottle, believed to contain petrol. CCTV would later reveal David purchasing petrol in a can the previous day. This suggests planning and intent on his part.
- 9.6.37. After Alina failed to turn up at work, Alina's manager called Simon who in turn called his sister who went to Alina's house. On arriving at the address she saw there was a bloody footprint on the doorstep of the property. Simon's sister phoned the police as well as her father. She was too scared to go into the property or knock on the door. Her father was in the local area and arrived at the address within a matter of minutes. He began banging on the doors and windows calling Alina's name.
- 9.6.38. He attempted to gain entry by going to the back of the property but failed (he assumed the front door would be locked). He returned to the front of the house and opened the letter box to see in. At this point he could smell smoke. Neighbours heard the commotion and tried to help gain access. They also went to the back of the property and were discussing breaking a window but felt that this could cause an explosion with the fire.
- 9.6.39. Simon's father tried the handle of the front door and it opened. He entered the property and became aware of the extent of the smoke. He was struggling to breathe and had to come back out of the house.
- 9.6.40. On exiting the house he became aware that his sister in law had arrived to help. Both of them entered the bungalow and managed to get to Alina's bedroom. Through the hazy smoke they were able to see a body lying face down on the bed. Although they could not see the person's face they were able to see long blond hair that looked like Alina's. It was



apparent to them that she was dead. They ran from the bungalow to find that the police and ambulance had arrived. A paramedic pronounced Alina dead at 10.03am.

## 10. Analysis

The Individual Management Reviews have been carefully considered through the view point of Alina, to ascertain if each of the agencies' contacts was appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the lessons have been identified and are being properly addressed.

The Review Panel is satisfied that all agencies have engaged fully and openly with the Review and that lessons learned and recommendations to address them are appropriate.

The authors of the IMRs and Reports have followed the Review's Terms of Reference carefully, and addressed the points within it that were relevant to their organisations. They have each been honest, thorough and transparent in completing their reviews and reports.

### 10.1. Each agency's involvement with the subjects of the Review.

This is detailed in the chronology above.

### 10.2. Whether, in relation to the either Alina or David, an improvement in communication between services might have led to a different outcome for Alina.

- 10.2.1. There were a number of instances where better communication would have improved the services offered to Alina or David but in only a couple of instances could this potentially have affected the outcome for Alina.
- 10.2.2. David's behaviour towards other women was largely unreported until after the murder and as such, there were no opportunities for partnership intervention. The exception to this is that in 2005, an eleven year old Girl Guide reported to her parents that David was sending her inappropriate text messages. The girl's father, in turn, reported this to the Guide Leader. Whilst the behaviour stopped at that point, David re-contacted the woman ten years later offering to pay her for sex. This latter incident was not reported to the police until after the murder had occurred.
- 10.2.3. There is no record of any report to Sussex Police from the Guides / Scouts regarding this incident. However, it should be noted that David was only 16 at the time and this was a single text message. Furthermore the Sexual Offences Act 2003 was in its infancy then. A potential grooming offence could have been overlooked, due to safeguarding responses at that time not being fully developed.
- 10.2.4. David clearly used youth movements, which appealed to young women and girls, to allow him access to victims and to attempt to meet sexual partners. For example, between 2003 and 2005 he met a girl, again through a joint event between the Girl Guides and Scouts, who he went on to offend against in 2016. In 2008 he sent text messages of a sexual nature to a teenage Girl Guide, which went unreported. In 2010 he was arrested on suspicion of grooming a 14 year old girl whilst working as a Scout volunteer leader. Finally in 2013, he met his previous girlfriend in a Drum Corps and later assaulted

and harassed her. There is extensive research suggesting that predatory stalkers and sex offenders have similar characteristics, potentially posing a significant risk to their target group. Today, it is likely that a Sexual Risk Order would have been considered but these were not introduced until 2014.

- 10.2.5. The Police IMR identifies that it is unclear whether, and at what point, Alina's treatment, at the hands of David was identified as domestic abuse and whether she was dealt with accordingly. The only documented evidence of the police making any referral to an outside agency was during the investigation of the first reported offence in February for stalking and damage to Alina and Simon's cars, when a referral was made, rather inexplicably, to RISE, despite this matter not being identified at the time as domestic abuse. No referral was made or advice given to Alina on the stalking aspects of the allegation, despite the fact that stalking and harassment was mentioned. Later, during the investigation of the incident when David entered Alina's home, an auto generated prompt to refer the matter to the 'National Centre for Domestic Violence' (NCDA) appears to have been ignored. It seems that the reported incidents were viewed in isolation so patterns of behaviour and escalation were not identified or dealt with despite the best efforts of the investigating officer to the first incident reported in February (see chronological narrative above).
- 10.2.6. RISE notes that when the assault in March occurred, no DASH RIC was completed. Had RISE received a SCARF for this incident, when reviewing the referral they would have noted that three SCARFs had been received, which would have triggered an automatic referral to MARAC (Multi-Agency Risk Assessment Conference) from RISE. This was a missed opportunity for Alina to receive more holistic and structured help.
- 10.2.7. Victim Support does not currently receive the SCARF when it receives an automated data transfer from Sussex Police and was therefore unaware of the Police risk flagging for this case. The impact on process and associated risks around this is currently under discussion between Victim Support, the Office of the Police Crime Commissioner and Sussex Police. The GP (for David) IMR did not find any instances of where an improvement in communication would have led to a different outcome for Alina.
- 10.2.8. SPFT noted that although the outcome was unlikely to have been affected, an improvement in communication between MHRRS and the GP would lead to better care. Currently MHRRS do not routinely inform GPs of all contact; their policy is to liaise with GPs only if they assess significant mental health issues or risk and when they carry out face to face assessments. SPFT also note that there was no clinical recording evidence of liaison with David's GP following his assessment at the Royal Sussex County Hospital even though this is their routine practice. This practice has since changed and now liaison with the GP is recorded within the team for audit purposes.

### **10.3. Whether the work undertaken by services in this case was consistent with each organisation's professional standards.**

- 10.3.1. With the exception of Sussex Police, all IMRs felt that staff had acted consistently and in line with their organisational professional standards and this was endorsed by the Panel.
- 10.3.2. In the case of Sussex Police however, there were shortcomings in respect of risk assessment and policy compliance. These have been scrutinised in depth by the IPCC and their recommendations are now in the process of being implemented.

There were additional recommendations made by this Review and these are included below.

10.3.3. The Scout Association (TSA) has recently concluded a major review of safeguarding cases looking at non-recent cases going back many decades through the lens of today's safeguarding standards. This review was conducted by a team of independent safeguarding experts and overseen by Hugh Davis QC and addresses the issues raised within this DHR.

**10.4. Whether the work undertaken by services in this case was consistent with each organisation's domestic violence policy, procedures and protocols, and in light of the features of this case, whether the organisation's policy, procedures and protocols adequately address stalking and harassment.**

10.4.1. As noted above, the responses of Sussex Police did not meet expected standards. With respect to the grooming incident involving David in 2010, there were no policies or procedures in force that would have ensured that he would be subject to additional scrutiny should he offend further.

10.4.2. When Alina made her first report to Sussex Police in February, although much of what the call taker did was in line with expected practice, the harassment policy<sup>5</sup> was not fully complied with in that there was no indication that the initial risk assessment was undertaken. Whilst this did not appear to have affected the call-takers decision making or the amount of information she recorded, it did mean that there was not a record of the risk factors so that subsequent reports could compare whether new factors or an escalation had occurred. However, the next report about damage to her and Simon's car was not even linked to this first report so an opportunity to see the emerging pattern of behaviour was lost. This was rectified when the report of the assault in March was made when it also became clear that the force domestic abuse policy should be applied. However, a DASH form was not completed and the domestic abuse flag was omitted when the referral was made to Victim Support. The focus on Alina as a victim changed when it became clear she had concealed the nature of her relationship with David. It appears that the officers allowed this to negatively affect their opinion of the whole investigation on the basis that it was unlikely ever to be capable of charge due to, in their view, unreliable evidence. Even within this context, the decision to issue Alina with a PND is highly questionable. Had the case been dealt with by officers more used to dealing with vulnerable victims, it is more likely that the complexities involved with a victim's reluctance to report the full facts immediately would have been better understood. There was a clear opportunity to draw a line under this matter without issuing a PND as an officer had already given her strong words of advice and received an apology from Alina.

10.4.3. By the time of the July incident involving the back door key, it was clear that David's behaviour was escalating. What is less clear is why officers did not seem to recognise this and instead opted for a 'theft from a dwelling' charge. David's immediate confession when challenged appears to have encouraged officers to close the case quickly; their interview with him lasted a mere 12 minutes. There were errors in the subsequent reports of silent calls too; the record keeping was below expected standards; Alina was advised not to answer calls from a withheld number without considering that partner agencies offering support would also be calling from a withheld number and it took eight days to identify that the one call from a landline was from David's home. Even this discovery did not seem to alert officers to the fact that David was clearly in breach of his conditions to stay away from Alina and represent a missed opportunity to intervene with David.

10.4.4. In 2016 The Scout Association (TSA) reviewed their Vetting and Safeguarding Guidance; a mechanism for considering a range of offences (including cautions) and various responses to such disclosure. This is a traffic light system where the red category leads to

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<sup>5</sup> Sussex Police Protection from Harassment policy – 578/14.

automatic exclusion. This includes any offences against a child or behaviour indicative of sexual interest in children. Other serious crimes of violence and other serious criminality sits in red. In amber there are a range of lesser offences which could also lead to exclusion but with a right of appeal. The green category is reserved for minor historic offences, typically a single caution or conviction of youthful dishonesty or thoughtless misbehaviour. This revised Guidance would not have alerted them to David's history since police determined that disclosure was disproportionate and thus did not provide it on the certificate.

- 10.4.5. Domestic violence and stalking was not discussed with David by his GP as it was not an issue he identified when being assessed.
- 10.4.6. Separately to this review, Brighton & Hove City Council policy to support employees experiencing domestic or sexual violence was scheduled to be refreshed in 2016/17 and, of relevance to this review, it is noted that the document makes limited reference to stalking. In April 2017 a revised Policy to Support Employees experiencing Domestic Violence & Abuse or Sexual Violence was released. This policy addresses stalking and harassment specifically among a range of other forms of violence and abuse. No additional recommendation is made here.
- 10.4.7. The work undertaken by the remaining agencies in this case was consistent with their policies and procedures.

**10.5. The response of the relevant agencies to any referrals relating to Alina, concerning domestic violence, stalking and harassment or other significant harm from David until the point of the death. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:**

**(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.**

**(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.**

**(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made**

**(d) The quality of the risk assessments undertaken by each agency in respect of Alina and David.**

- 10.5.1. Alina's family and friends gave evidence in court stating that although Alina recognised and reported that she was being stalked, she felt she was not believed, so she had to turn to her friends and family for safety planning as no other support was made available
- 10.5.2. As detailed above, it is clear that Sussex Police did not recognise the true extent of the risk to Alina. Assessments and interventions were neither timely nor effective given that the characteristics and complexities of stalking were not identified or understood at the time of reporting despite Alina herself naming her experiences as stalking from her very first report to the police. Alina was referred to a domestic abuse charity (RISE) rather than a specialist stalking agency<sup>6</sup> despite several high risk factors being present. David's motivation for keeping text messages between him and Alina were not fully explored.

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<sup>6</sup> It should be noted that where stalking is present in a current or former intimate partner relationship or family relationship RISE can provide expert support but this does not detract from the fact that Alina was naming her experience as stalking and not domestic abuse.

Research suggests it is through intention rather than severity that the risk of stalking should be assessed (Norris et al, 2011).

10.5.3. Domestic violence and stalking was not discussed with David by his GP and was not an issue he identified when being assessed. The mental health assessments carried out when he presented as suicidal were based on risk to self. He mentioned during his assessment that he found the break up difficult and that he could not go on without his girlfriend but did not present any risk to her and this was not assessed. GP's do not routinely ask about risk to others in a structured way despite the close links<sup>7</sup> between suicidal ideation prompted by relationship breakdown and homicide. This issue has been discussed in the clinical lead meetings as an area to be considered in the future.

**10.6. The response of the relevant agencies to any referrals relating to David, concerning any other behaviour (including domestic violence, stalking and harassment or other significant harm) from David to any other females. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:**

**(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.**

**(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.**

**(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made**

**(d) The quality of the risk assessments undertaken by each agency in respect of other females and David.**

10.6.1. At the times that David was being assessed by health care providers, the risks he was presenting with were relatively low and were of a nature that was harmful to himself rather than to others. He was assessed to have capacity in making decisions and clearly regretted his overdose whilst under the influence of alcohol and was quickly able to make future plans and identify protective factors. There was no formal risk assessment tool used by MHRRS in their contact with David although a thorough history was recorded.

10.6.2. Although the contact with the MHRRS nurse was brief it is noted that David was in custody for 'alleged assault'. This was the assault reported by Alina. It was therefore a missed opportunity for further exploration by subsequent mental health services to assess risk but this was not elaborated on further by the MHRRS nurse.

10.6.3. The risk assessments undertaken by the police show a lack of understanding with regard to what constitutes risk in stalking cases. The risk of harm is only rarely related to direct physical approaches or violence and as such, the seriousness of stalking should not be measured solely by the severity of the incidents. Stalking by proxy or abuse of process (such as when David introduced issue of money owed him by Alina and attempted to gain 'permission' to make written contact) is a commonly used tactic to secure contact with victims. As such, it needs to be seen in the context of other behaviour to adequately assess escalation and risk. On the first occasion that David came into contact with Sussex Police in respect of Alina, there was an opportunity to arrest and interview him for this offence. There was also an available line of enquiry to follow regarding the damage to Simon's car. At the

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<sup>7</sup> Suicidal threats were identified as high risk markers in 23% of domestic homicide cases (presumed higher) Monckton Smith 2017

very least the matter should have been dealt with as a harassment related offence, given that David had already been confronted by his employer. Had David been issued with a PIN at this point, it may have led to different decisions being made when further reports were made.

**10.7. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.**

10.7.1. Level 3 Children and Adult Safeguarding training is offered to all GP safeguarding leads in Brighton and Hove and is delivered by the Named GP for Safeguarding Children and the Designated Nurse for Safeguarding Adults. Both adult and child training includes domestic violence and abuse and a rolling programme of update sessions have been specifically focused on domestic violence and abuse and the impact on children. In 2015 and 2016 a domestic violence and abuse in Primary Care session for trainee GP's was delivered by the Designated Nurse and the Specialised Safeguarding Nurse from the Multi Agency Safeguarding Hub. Information and learning from Domestic Homicide Reviews, Safeguarding Adult Reviews, Serious Case Reviews is shared with the safeguarding leads during training.

10.7.2. Sussex Police had been experiencing low reporting and recording of stalking offences. In September 2016, information and guidance on the provisions of the Protection of Freedoms Act 2012, was circulated to all staff via the Sussex Police intranet. As a result reports of stalking have increased, as officers are now more informed and better able to distinguish between the different offences. Frontline officers have also been directed to complete mandatory NCALT training packages for this legislation and there have been further intranet circulations and briefing slides for staff. Sussex Police have also identified Divisional SPOC's for this legislation, and commissioned training days by Paladin<sup>2</sup> for those staff.

**10.8. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.**

10.8.1. Stalking behaviours are present in 92% of domestic homicides<sup>8</sup> and it is often reached through an emotional journey rather than an unpredictable burst of anger. Understanding of the risk a predatory stalker poses on the victim to trigger an intervention can only be achieved through meaningful engagement with the victim to understand the context of the perpetrator's behaviour and motivation.

10.8.2. The assault reported to the police by Alina in March was dealt with in isolation and was not linked with the earlier offence. The case for looking further into the relationship appears to be strengthened when it became clear that this was in fact a domestic matter. The risks associated with a domestic or stalking and harassment situation should have been more fully examined.

10.8.3. In response to Alina's murder RISE reviewed its triage process which was brought in to manage demand and applied to all police medium risk referrals to RISE/ the Portal service in Brighton and Hove. All SCARF's, case notes and referrals logged onto the case management system in the last three months have now been reviewed and repeat incidents and escalation are now more likely to be identified.

10.8.4. Thresholds for intervention in regard to David's mental health appear to be appropriately calibrated and applied, based on the information presented to the GP.

**10.9. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either adult were explored, shared appropriately and recorded.**

All nine protected characteristics in the 2010 Equality Act were considered by the DHR Panel. Two protected characteristics were found to have relevance to this DHR. These were:

**Ethnicity:** Alina and David were both of white British origin and this was not felt to be a factor.

**Sex:** Sex is relevant as there is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured or killed<sup>9</sup>. Latest published figures show that just over half of female victims of homicide in the UK aged 16 or over had been killed by their partner, ex-partner or lover (54%). In contrast, only 5% of male victims aged 16 or over were killed by their partner, ex-partner or lover.

According to the Crime Survey for England and Wales 2015/16, 4.6% of women and 2.7 % of men aged 16 to 59 self-identified themselves as having been victims of stalking. Stalking can be perpetrated by both men and women but women are more likely to be victims, and 80% of stalkers are male (Osteryemer et al 2016). Women are found to be more likely to suffer serious harm and homicide when they are stalked, especially where there is a previous intimate relationship with the stalker (McFarlane et al 2002). Stalking and domestic abuse are highly correlated and there is a suggestion that coercive control and stalking are often simultaneously present (Norris et al 2011).

**Age:** Alina was only 19 when she was so brutally murdered placing her squarely in the age category which experiences the highest rates of domestic abuse (16-24 years old).

With respect to the agencies involved in this review, the Panel concluded that age was the only protected characteristic which potentially impacted on the services delivered. Recommendations have been made relating to this.

**10.10. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.**

10.10.1. The Police IMR notes that the supervisory input on the investigations appear to have focussed on recording and disposal issues. Due to the nature of police work, stalking offences are often disregarded in favour of more immediately identifiable offences, many of which are routinely committed as a part of a course of conduct, in this case, theft of a key, criminal damage to a vehicle, harassment and common assault. There is little evidence that any assessment of vulnerability was carried out by supervision and nothing to suggest that any of the anomalies noted were identified at any supervisory intervention. Alina reported stalking and this should have resulted in the case being escalated to specialist units. First respondents and call handlers are not sufficiently trained to identify stalking and its dangers.

10.10.2. The GP's IMR notes that the GP's who assessed David's mental health appropriately offered regular review and support and referred on to specialist mental health services following concern of risk to himself. Information was clearly recorded in his records

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<sup>9</sup> Smith, K. et al. (2011) Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin 01/11. London: Home Office

to ensure when seen by others at the practice they were aware of the treatment plan and risks. Escalation internally within the practice to senior management does not apply in the same way in general practice.

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

10.11.1. Of the agencies submitting IMR's only RISE raised issues relating to organisational change.

10.11.2. They identified that there were significant challenges for RISE/The Portal service during the period under review. RISE was implementing a new service delivery model, and had also moved premises in December 2015. In addition, RISE was experiencing higher than normal levels of staff turnover and inducting new, less experienced staff.

10.11.3. The greatest impact for RISE during this period was that demand for their services outstripped resources. In the first half of 2016 this was having a significant impact on their ability to respond to referrals within reasonable timescales. The first referral for Alina was received in February and although their first attempt to contact her happened within a week, there was then a gap of six weeks between this and the second attempt, and a further gap of five weeks between the second and third contact. As a means of managing these issues, RISE implemented a Demand Management Plan from June 2016. This included an "Operation Clean Slate" at the end of June 2016 during which all staff resources were pulled in to clear the backlog, which was then immediately followed by the implementation of a new triage process. These and all other aspects of the Demand Management Plan were negotiated with and signed off by the local commissioner who was also given regular updates on the level of backlog.

**10.12. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?**

10.12.1. The Police had no documented concerns raised by family members other than contact from Simon's mother, when she called the police on Alina's behalf, to report that David had assaulted Alina. Alina and David's HR manager did have contact with the police but the police did not make good use of the evidence they collected.

10.12.2. The Panel did consider whether there were any barriers to Alina herself coming forward. Alina was prepared to contact the police to report some of her concerns and to make follow up calls to check on progress although it is now clear that there were many more incidents which went unreported. The issuing of the PND to Alina and the impression she gained that hard evidence would be needed are obvious explanations for the sporadic reporting of incidents. It is also possible that her decision making was influenced by the off-on nature of her relationship with David.

10.12.3. It should be noted that extensive testimony was presented at trial from family and friends that Alina had no confidence in the police. She knew that she would not be believed and so, many incidents were unreported except for the ones she judged to be the most significant as escalation became evident. It seems unlikely that the time gaps between reports were due to a lack of stalking activity but rather the result of her attempts to manage David's behaviour herself.



10.12.4. In his sentencing remarks at trial, Hon Mr Justice Green said *'When further incidents of stalking occurred Alina did not complain to the police because she felt that her complaints were not taken seriously. Evidence was given to this effect during this trial by those close to Alina'*.

10.12.5. The GP IMR notes that David's mother was involved when he attempted suicide. The GP spoke to her over the phone and arranged for David to be reviewed. When he was assessed as a risk to himself, the GP supported his mother in safety planning

## 11. Good practice

- 11.1. The Panel were impressed by the robust response made by Alina and David's employer and would encourage other employers to emulate them.
- 11.2. In Brighton & Hove work is underway to encourage all employers to take such a proactive approach. Brighton & Hove City Council has refreshed its own Policy to support Employees experiencing Domestic Violence and Abuse or Sexual Violence to include stalking. To support the adoption of best practice in relation to employer's responsibilities Brighton & Hove City Council has also developed guidance to encourage commissioners to address domestic violence and abuse, sexual violence and a range of other forms of violence against women and girls in commissioning and procurement approaches. This includes proactively asking bidders about staff policies. This internal guidance was published in April 2017 and externally it is reflected in the city's Social Value Framework<sup>10</sup>. A recommendation has been made in this regard.
- 11.3. Education

Unusually, work taking place on healthy relationships in Brighton & Hove already includes a focus on stalking (see below for further details). The Panel has made recommendations to further develop this work but wished to acknowledge the excellent work that is already in place.

## 12. Key findings and lessons learned

### a. Lack of recognition of the dangers of stalking

Stalking related homicides are not an exact science. We acknowledge that stalkers and their victims are a varied group with diverse and complex characteristics, behaviours and motivations. Nevertheless, there are common and identifiable themes that can be observed in the patterns of behaviour of obsessive and fixated individuals in the pursuit of their victims.

Stalkers are careful and scrupulous planners and often serial in nature. Extensive evidence was presented during the trial showing that David planned Alina's murder using the information about her movements, which he gathered through his surveillance activities. There were many attempts by David to force contact with Alina and as we now know David had a history of displaying similar types of behaviour, so whilst no interventions could have been made in relation to the previous victims, Alina's reports did provide intervention opportunities. However Alina's reports were not taken seriously, lines of enquiry were not pursued and therefore those opportunities were missed.

*'Escalation and frequency or severity of concerning behaviours appears to be an important indicator that the emotional journey may be reaching crisis point. Escalation seems to coincide with the presence of a trigger for serious harm. In many cases the key trigger appeared to be separation or its threat, diminishing control, or revenge and resentment.'* Monckton Smith (2017)<sup>11</sup>

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<sup>10</sup> <https://www.brighton-hove.gov.uk/content/life-events-and-communities/community-and-voluntary-sector-support/social-value>

<sup>11</sup> Monckton-Smith, Jane and Szymanska, Karolina and Haile, Sue (2017) *Exploring the Relationship between Stalking and Homicide*. Suzy Lamplugh Trust

Stalking campaigns are often built on small, seemingly isolated and low level crimes so early well informed multiagency interventions are central to reduce risk of harm to the victims, giving particular attention to the presence of high risk markers.

Stalking allegations must always be taken seriously and the starting point should always be to believe the victim. The absence of physical evidence of violence is insufficient reason to grade the risk as 'standard' or 'medium'; coercive control and jealous surveillance are far more reliable risk indicators. In addition, a greater focus on the amount of time that stalkers invest into their stalking activities may yield more accurate risk assessments.

## **b. Language**

Alina identified her experience as stalking rather than as domestic abuse. This may have impacted on her willingness to respond to RISE which is identified as a domestic abuse charity. However, the Panel also identified issues with making contact with clients who have not given their consent such as when the Police share information with local specialists. This highlights the need for agencies to seek client consent for sharing information, including notifying them of the name of the agency likely to make contact, rather than relying on the legal ability to share information without consent. When referral agencies make subsequent contact with the victim, this necessarily needs to be done in a safe way. However, this then limits what can be said in a text message or voicemail should the client not answer the phone directly until it is verified that the number is safe (i.e. not monitored by the alleged perpetrator). This practice is being reviewed with consideration being given to changing practice in cases where the support agency is confident that the perpetrator is already aware that there has been police involvement. This would allow a message to be left stating that the police have informed them of an incident and it is being followed up as standard practice.

## **c. Young people**

In addition to Alina, a further twelve young women came forward for the first time after the murder. Clearly the current configuration of local services is not successfully engaging with young women who experience stalking or harassment. The Panel noted examples such as Hollaback<sup>12</sup> which might encourage reporting as well as raise awareness.

It is of concern that twelve girls / young women did not contemporaneously report their experiences of stalking and harassment. It is too easy to suggest that the victims' behaviour should change (i.e. that they *should* report) but it is the responsibility of public services to meet the needs of the public not the other way around. The relevant agencies need to examine *why* such levels of underreporting occur. Are all agencies confident with respect to their community engagement or is it hopelessly skewed by age and gender? Are agencies cognisant of the different ways in which young women engage with services which may not 'fit' the current structures?

Additionally, the prevailing culture also needs to be addressed. Stalking behaviours are frequently framed as 'romantic'<sup>13</sup> and it is currently routine for sexual harassment to begin in the early teen years of girls and for them to be subjected to an endless bombardment of messages that inform them they are valued for how they look over their accomplishments. This dominant narrative creates a conducive context in which stalking and harassment is minimised, normalised or even rationalised as 'romance' and in which women's discomfort

<sup>12</sup> <https://ldn.ihollaback.org/>

<sup>13</sup> See, for example any of the small sample of the following films in which stalking is framed as 'romantic': *Love Actually*; *The Notebook*; *American Beauty*; *St Elmo's Fire*; *Labyrinth*; *Crazy, Stupid, Love*; *There's Something About Mary*; *The Notebook*; *Twilight* and *Fifty Shades of Grey*.

and fear is routinely dismissed as being 'unable to take a joke' or 'making mountains out of molehills'.

#### d. Sex and relationships education in schools

David did not recall receiving any sex or relationships education during his school career. As part of the review, enquires were undertaken with the Brighton & Hove City Council Families, Children and Learning Directorate to identify which school David attended. Based on the time period when David was at secondary school, it was likely that sex or relationships was not a priority in the school at the time. In addition, David did not recall any sex or relationship education at any of the youth groups with which he was involved. Although highly speculative, it is possible that quality healthy relationships education may have enabled David to understand the unacceptable nature of his behaviour toward many of the women who later complained as well as Alina.

Tragically it is not possible to ask Alina about whether she received any sex or relationship education. As with David, enquiries were undertaken to identify which school Alina attended. Based on the time period when Alia was at secondary school she would have received a programme of relationships and sex education, although since then content is likely to have developed to encompass issues like healthy relationships and consent.

It is noteworthy that work colleagues of David who participated in this DHR also did not recall any relationship education but did speak to David about his unacceptable behaviour towards Alina. Their unwillingness to remain silent is to be applauded.

Brighton & Hove City Council (the Families, Children and Learning Directorate and Public Health) provide training, consultancy and resources to support the delivery of sex and healthy relationship education into the school system. This includes a Personal, Social, Health and Economic (PSHE) education programme of study (which references healthy relationships at Key Stage 3 / 4 and then stalking at Key Stage 4), as well as revised Relationships and Sex Education guidance (which explicitly includes stalking)<sup>14</sup>.

There is also a Safe & Well at School Survey (SAWSS), which is an annual online questionnaire designed to gather information from children and young people about their health and wellbeing. SAWSS can be used by schools to validate, inform and develop school's work around health and wellbeing, especially the PSHE and Citizenship curriculum and health and wellbeing improvements. Currently the SAWSS includes some questions relating to domestic and sexual violence, but does not address stalking.

Locally, there is a recognition that further work could be done to develop these resources including ensuring that there is sign posting to age appropriate lesson plans that address stalking, and ensuring a focus on stalking as part of the local 'relationships and sex education review' undertaken in 2017. Additionally the SAWSS questions could be reviewed to identify whether it would be possible to include an age appropriate question about the experience or impact of stalking on young people.

It is important to note that, as a wider context, all local authority areas will need to respond to the UK Government's proposals to place PSHE on a statutory footing.

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<sup>14</sup> The server where these documents are being held is being migrated. For further information on these resources contact [PSHE@brighton-hove.gov.uk](mailto:PSHE@brighton-hove.gov.uk)

#### **e. Failure to follow procedures**

There were a number of instances where existing policy and procedure were not followed by Sussex Police as detailed above.

#### **f. Under-utilisation of family and friends**

In this case, many friends and family members were aware of David's stalking behaviours towards Alina. Like many of the professionals involved, there was an under-appreciation of the dangerousness of stalking. Although friends and family encouraged Alina to report incident to the police, they themselves made no reports. There were a range of valid reasons for this – including respecting Alina's wishes - but seeing it as '*not my place*' or not knowing that they could make a third party report are reasons that can and should be addressed. The Panel acknowledges that in this particular case, the Domestic Violence Disclosure Scheme would have offered little to any enquirers. Nevertheless, there is potential to further raise awareness of the Scheme and it is still possible that greater attention may have been paid to David had several enquiries been made from previous victims or friends and family of Alina.

Locally, learning from another Domestic Homicide Review identified the importance of professionals being aware of their role in holding perpetrators to account. This will include reviewing local training and resources for professionals. Additionally there is ongoing work to develop interventions for perpetrators in a community based setting, including the use of bystanders in the community to help with early intervention. The overarching aim is to tackle perpetrators of domestic violence by spotting the signs of abuse earlier and to allow for earlier options for intervention by specialist services. As this work is already underway, there are no additional recommendations made on this issue from this DHR.

## 13. Recommendations

### 13.1. Single agency recommendations:

#### 13.1.2. Sussex Police

##### **Recommendation 1.**

The Specialist Crime Command (SCC) should ensure that a system is developed, within 3 months, to ensure that chronologies provided, in respect of statutory reviews, include the full information on contact between Sussex Police and the subjects of the review. All IMRs provided to chairs of reviews should include a full summary of this information. This information should be obtained from interrogation of the 'RedBox' system where appropriate.

*Author's note: This action is now completed.*

##### **Recommendation 2.**

The Communications Department (CD) should review the guidance to call takers on completion of risk assessments and clarify when the information should be displayed on the serial. This guidance should then be promulgated to call-handling staff within 3 months.

*Author's note: Work on this recommendation is almost complete.*

##### **Recommendation 3.**

Guidance on the use of PINs in relation to domestic abuse and stalking offences should be reviewed and reiterated to all staff as soon as practicable.

*Author's note: Since December 2016, PINs cannot be used for domestic abuse and stalking incidents. Two audits of their use have been conducted and compliance with the instruction is now monitored by the Sussex Police 'Crime Management Unit' (CMU). The SIP shows that this action is complete.*

##### **Recommendation 4**

Within 3 months CD should review and republish the guidance on recording of contact with members of the public and on the identification of lines of enquiry.

*Author's note: This recommendation is on the SIP and is in progress.*

##### **Recommendation 5**

There is an opportunity to increase the awareness of staff dealing with prima facie offences, to check if what they are dealing with amounts to a Safeguarding Investigation and seek advice if in doubt. Within the next 6 months the relevant department should ensure that staff awareness on vulnerability and risk assessment is enhanced.

*Author's note: This action is complete.*

##### **Recommendation 6**

Within 3 months Communications Department management should develop and promulgate guidance to PCC staff to check OIC availability prior to leaving messages regarding incidents that may require action.

*Author's note: This action is complete.*

### **Recommendation 7**

Within the next 6 months the relevant department should ensure that guidance is developed and promulgated to all staff, on the options for action to be taken against potential vulnerable victims found to have committed offences during an investigation, reasons that they may do so and options to deal with such cases.

*Author's note: This action is now complete. A 'Safeguarding Toolkit' has been added to the NICHE system for the use of staff dealing with such situations.*

#### **13.1.3. RISE**

- RISE to present new proposals for managing demand within safe practice guidelines to Commissioner
- RISE to progress review of leaving safe messages

*Author's note: This has been completed.*

- RISE to review triage process as an outcome of demand management proposal

#### **13.1.4. BSUH**

- Staff should be reminded of the domestic abuse policy.
- Staff should be supported and reminded of their responsibility to safeguard patients via the BSUH safeguarding training and to reiterate how common domestic abuse is by using local domestic homicide examples.
- To remind staff of the potential indicators of domestic abuse as this may prompt them to opportunistically ask about domestic abuse.
- Consideration should be given to reviewing the BSUH documentation relating to social issues as it is aimed at housing, falls and support systems and does not prompt discussion about abusive relationships. This is especially relevant to A&E settings

#### **13.1.5. Primary Care**

- NICE guidance and local practices would recommend referral to psychological therapies when depression and anxiety start to improve from antidepressant therapy. To continue discussions with clinical leads and SPFT on developing a recommended local pathway protocol for suicide interventions.
- To improve communication on discharge from hospital in relation to follow up. To address how GP's can be clear if plan requires an action from them or if the summary is for information only.
- To continue discussion with clinical leads on how primary care can incorporate assessment of risk to others where appropriate.

#### **13.1.6. SPFT**

- That Police and Court Liaison and Diversion Service staff routinely record the alleged offence that the client is in custody for, in detail, in order for this to be taken into consideration if further risk assessment is needed.
- That routine liaison with GP is considered by MHRRS so that any contact to MHRRS is known to the GP. This should include the sharing of discharge summaries so that

all parties are clear on actions as to who is responsible for each action and whether the summary is for information only.

- That MHRRS develops a localised risk screening tool to record their assessment in a formal documented way, including risk to others.
- When a referral is made to MHRRS, to ensure the outcome is recorded in the notes. This will ensure the intervention took place, that follow up is planned and information is clear to practitioners assessing the records.

### 13.2. Multi-agency recommendations

- The Partnership Community Safety Team to continue to work with partners to further develop the stalking content in the local Domestic Violence and Abuse, Sexual Violence and Harmful Practices Training Prospectus. This should ensure that there is a robust multi-agency training offer that increases understanding of the complexities of stalking so that frontline professionals are better equipped to identify stalking victims and provide appropriate responses that include promoting their safety.
- The Office of the Police and Crime Commissioner and the Safe in the City Partnership should review the current commissioning arrangements to further develop locally specialist stalking support for victims, as well as liaison with other professionals and agencies to support their identification, assessment and response to stalking.
- The Safe in the City Partnership should ensure there is further publicity to raise awareness amongst the general public of the following issues:
  - Coercive control and the risks associated with it
  - Stalking behaviours and the help available
  - Opportunities for family and friends to report their concerns and the use of schemes like Domestic Violence Disclosure Scheme with particular emphasis on the range of people who have the 'right to ask'.
  - Actions that friends and family members of victims can take to protect and support their friend / family member
- The Office of the Police and Crime Commissioner and the Safe in the City Partnership to undertake a review of local specialist domestic abuse, stalking and victim support services with regard to their degree of engagement with young people.
- The Office of the Police and Crime Commissioner and the Safe in the City Partnership to review and improve the use of the referral pathways so that specific support is offered to as many victims of stalking as possible as they come into contact with frontline services particularly domestic abuse support services and police.
- Sussex Police to work in partnership with Office of the Police and Crime Commissioner, the Safe in the City Partnership and other Community Safety Partnership in Sussex, towards the development of a local Stalking Clinic that reflects local needs and resources, based on the recognised model of good practice of the Hampshire Stalking Clinic
- The Safe in the City Partnership should to continue to work to promote the adoption of employer policies as an example of best practice.
- The LSCB and SAB to undertake further DBS awareness/ safer recruitment training for adult social care practitioners and front line staff as well as children's services staff with particular attention to be given as to how this information reaches staff in voluntary organisations.



### 13.3. National recommendations

In the course of this review, several process issues arose which the Panel felt have national significance / may be useful for other DHRs. As such, we make the following recommendations:

- The Home Office to work with the IOPC to draw up clear guidance with respect to the relationship between DHRs and the IOPC when parallel investigations are being conducted. The subsequent guidance to be added to the DHR section of the Home Office website where it will be easily accessible for other DHR Chairs and Report Authors.
- As a matter of some urgency, agree a cross-Government definition of stalking.
- Include within the next Review of DHR statutory guidance:
  - a requirement to also give advance notice of publication to family members of the perpetrator
  - clearer guidance with regard to self-generated publicity in advance of publication by agencies involved in a DHR

## Appendix A: Terms of Reference

### Overarching aim

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

### Principles of the Review

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

### Specific areas of inquiry

The Review Panel (and by extension, Individual Management Review authors) will consider the following:

1. Each agency's involvement with the victim Alina, resident at address 1 from October 2014 to August 2016.
2. Each agency's involvement with the perpetrator David, resident at address 2 including his contact with:
  - Alina from October 2014 to August 2016,
  - Any other female from 2003.
3. Whether, in relation to the either Alina or David, an improvement in communication between services might have led to a different outcome for Alina.
4. Whether the work undertaken by services in this case was consistent with each organisation's professional standards.
5. Whether the work undertaken by services in this case was consistent with each organisation's domestic violence policy, procedures and protocols, and in light of the features of this case, whether the organisation's policy, procedures and protocols adequately address stalking and harassment.
6. The response of the relevant agencies to any referrals relating to Alina, concerning domestic violence, stalking and harassment or other significant harm from David until the point of the death. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:
  - (a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Alina and David.

7. The response of the relevant agencies to any referrals relating to David, concerning any other behaviour (including domestic violence, stalking and harassment or other significant harm) from David to any other females. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of other females and David.

8. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

9. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

10. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either adult were explored, shared appropriately and recorded.

11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

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

13. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?

### **Family involvement and Confidentiality**

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

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

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

### **Disclosure and Confidentiality**

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an Individual Management Review, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this Domestic Homicide Review, therefore all material received by the Panel must be disclosed to the Senior Investigation Officer and the police disclosure officer
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by pseudonyms.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

### **Timescales**

All Domestic Homicide Reviews are to be submitted to the Home Office within 6 months of notification. This Domestic Homicide Review is likely to be delayed due to the criminal trial, which commences in March 2017, and an Independent Police Complaints Commission (IPCC) investigation, which is estimated to take between 6-9 months. A revised timeline will be communicated to the Home Office.

The Review commenced in January 2017, and subject to the conclusion of the Criminal Trial, will reconvene in April 2017, with further meetings scheduled thereafter.

All meetings will be held at Hove Town Hall.

### **Media strategy**

Any media enquiries prior to the conclusion of the trial must be referred to the Sussex Police, who will liaise as appropriate with the Independent Police Complaints Commission and the Safe in the City Partnership. Post-trial, enquiries should be directed to the Chair, who will agree a media strategy with Safe in the City Partnership in consultation with the family.

### **Chairing and Governance**

An independent chair has been appointed to lead on all aspects of the review and will report to the chair of the Safe in the City Partnership.

A Panel has been convened specifically to overlook the review process. This is a mix of statutory and voluntary sector agencies and includes specialist domestic violence services.

The Safe in the City Partnership will sign off the final report and submit it to the Home Office Quality Assurance process.

The Independent Police Complaints Commission will be included on the panel in order to ensure clear lines of communication with the Domestic Homicide Review; this will include cooperating over contact with witnesses in order to minimise the impact on the family, sharing information where appropriate on lines of enquiry and coordinating the timeframes for the publication of any findings.

### **Agency roles and responsibilities**

- Delegate a senior officer to lead on the review on behalf of their organisation
- Senior officers will attend all Panel meetings
- Complete Individual Management Reviews within agreed timeframes
- Contribute to the Review Report.

### **Information Sharing and Confidentiality**

The principles outlined in Sussex Criminal Justice Board Information Sharing Guidance<sup>15</sup> will be applied at all times. In addition to this, further reference will be made to the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews<sup>16</sup>.

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15 [http://www.sussexcriminaljusticeboard.org.uk/media/803222/scjb\\_isg.pdf](http://www.sussexcriminaljusticeboard.org.uk/media/803222/scjb_isg.pdf)

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

## **Appendix B: Cross-Government definition of domestic violence**

The cross-government definition of domestic violence and abuse is:

any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

### **Controlling behaviour**

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

### **Coercive behaviour**

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

## Appendix C: Definition of stalking

In their recent joint inspection on the police and CPS response to harassment and stalking<sup>17</sup>, HM Inspectorate of Constabulary and HM Inspectorate of the Crown Prosecution Service discuss the issues relating to the lack of a single national definition of stalking. These include identifying that the absence of a single accepted, consistent definition of stalking was a very significant contributory factor to the unacceptably low number of recorded crimes and prosecutions. The report goes on to say that it is also one of the main reasons that police officers, staff and prosecutors gave them varying interpretations of stalking. The result for victims was that offences were not dealt with appropriately by using stalking-specific powers (for example, the power to search premises and seize evidence). Incidents of victimisation were dealt with as isolated cases and were not treated seriously or quickly enough, and victims were left at risk. In some cases, the charges did not reflect the seriousness of the offending. There is not an exhaustive definition of stalking in legislation. This is one of the main reasons why there is a lack of common understanding about which actions can be counted as stalking. At present, identifying stalking is frequently a matter of subjectivity, which can lead to error and/or omission.

There are a number of definitions of stalking in circulation. For the purposes of this report, the following definition was used:

*Stalking is a pattern of unwanted, persistent pursuit and intrusive behaviour directed by one person to another that engenders fear and distress in the victim and is characterised by an obsessive fixation with the victim.*

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<sup>17</sup> *Living in fear – the police and CPS response to harassment and stalking A joint inspection by HMIC and HMCPSI, July 2017*

## Appendix D: Pan Sussex Stalking and Harassment Working Group - Terms of Reference

### Aim

To ensure there are appropriate services and responses to victims and perpetrators of stalking and harassment.

### Purpose

To produce recommendations to improve partnership response to stalking and harassment, with a focus on putting victim (and others, such as children) at the centre of service delivery, having a clear focus on perpetrators and taking a system-wide approach to ensure that solutions safeguard those affected.

The group will seek to:

- Better understand the prevalence and impact of stalking and harassment across Sussex
- Build a demand picture of stalking and harassment across Sussex
- Map existing provision across Sussex
- Identify the current pathways and any joint working arrangements and area of unmet need
- Review what works well currently locally, as well as identify gaps and areas for development
- Bring together learning from a number of local reviews and enquiries
- Reflect on best practice nationally

### Background

There has been significant national and local attention focused on the issue of stalking and harassment. This has followed National Stalking Awareness Week, which ran between 24th April until Friday 28th April, as well a number of high profile cases nationally and locally that have involved stalking.

### Definition

Stalking can be defined as persistent and unwanted attention that makes you feel pestered and harassed. Stalking and harassment includes behaviour that happens two or more times, directed at or towards you by another person, which causes you to feel alarmed or distressed or to fear that violence might be used against you.

### Membership

Office of the Sussex Police and Crime Commissioner	Sara Jones - Head of Commissioning (Co-Chair)  Micha Dawes - Commissioning Officer
Local Authority Leads	James Rowlands - Strategic Commissioner for the Joint Domestic, Sexual Violence and Abuse and VAWG Unit - BHCC and ESCC (Co-Chair)  Rachel Tandy - MASH Manager- WSCC
Sussex Police	Jason Tingley - Detective Superintendent Public Protection  Pip Taylor - Chief Inspector Public Protection



	Shivani Nayee - Strategy and Compliance Supervisor
National Probation Service	Andrea Saunders - Head of Probation Debbie Knight - Senior Probation Officer
Crown Prosecution Service	Charlotte Chirico
Cafcass	Andrea Holtmam - Service Manager
Children's Services	Chrissy Bulling - Lead Practitioner for Children's Social Work Services- BHCC Karen Leie - SWIFT SFS Practice Manager- ESCC
Specialist Services	Sam Taylor - Co-founder and Director- Veritas Justice  Claudia Miles - Co-founder and Director- Veritas Justice  Rose Hawkins - Rise UK  Suky - Suzy Lamplugh Trust  Tracey Ratcliffe - Team Leader CGL

### Responsibilities

- To participate in the short life working group and to be a source of expertise and knowledge, sharing local, regional or national developments which may affect the delivery of the project across the pilot sites
- To provide guidance in relation to any challenges or obstacles which may arise and / or taking appropriate actions within their organisation to support delivery
- To support the development of recommendations to improve partnership response to stalking and harassment
- To feedback progress and performance of the short life working group to the appropriate operational / strategic bodies to ensure stakeholder are kept informed

### Accountability

This group will be accountable to the PAN Sussex Domestic Abuse Management Group.

### Frequency of Meetings

The meetings will take place bi-monthly at the Office of the Sussex Police and Crime Commissioner.