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The following document contains material of a highly sensitive nature (including references to death, violence, and abuse) and may be upsetting for some individuals.

**Reigate and Banstead Community Safety Partnership
and
Surrey Safeguarding Adults Board**

**Executive Summary of the
Domestic Homicide Review *and*
Safeguarding Adults Review
relating to the death of Sandra in May 2020**

Report completed April 2024

Panel Chair and Report Author: Helen Collins BA (Hons) PGCE PCET

Preface

Reigate and Banstead Community Safety Partnership, the Surrey Safeguarding Adults Board and the Review Panel wish at the outset to express their deepest sympathy to Sandra's family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of Sandra's death in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by Reigate and Banstead Community Safety Partnership on receiving notification of the death of Sandra in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

It was subsequently agreed to title this report as a Domestic Homicide Review and jointly conduct an Adult Safeguarding review under the provisions of the 2014 Care Act.

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1 The Review Process

- 1.1 This summary outlines the process undertaken by Reigate and Banstead Community Safety Partnership ('the CSP') Domestic Homicide Review/Adult Review panel in reviewing the death of Sandra who was a resident within their area prior to her death.

- 1.2 The following pseudonyms have been used in this review for the victim and perpetrator to protect their identity and those of their families:

The deceased in this case will be known as Sandra, she was 48 years old at the time of her death. She was a white British woman.

Her partner of the time will be known as David who was 47 years old at the time of these events. The couple had been in a relationship since approximately 2012 and lived together sporadically.

- 1.3 On a night in May 2020 Police had been called to the couple's address in Surrey after an anonymous informant reported hearing a disturbance at the flat. This informant also reported hearing a female shouting "Help" and "get the fuck out".
- 1.4 On police attendance Sandra was in her night clothes and was making herself ready for bed.
- 1.5 Both Sandra and David confirmed they had been drinking alcohol all day and were both described as drunk by the attending officers.
- 1.6 Sandra stated she was shouting 'help' as she believed David had taken her mobile telephone and wanted to get it back. The telephone was located lying on the sofa by Police and returned to her.
- 1.7 Whilst at the premises David was found in possession of a small amount of cannabis, receiving a Police caution at the time.
- 1.8 David stated he was going to make himself some tea and then go to be with Sandra.
- 1.9 No other offences were recorded by the Police and due to COVID-19 Lockdown restrictions both David and Sandra were left in the flat together to carry on with their evening.
- 1.10 On the morning of the following day Sandra was found by a member of the public lying on her back on the tarmac outside her home, this being a 6th floor flat within a residential complex.
- 1.11 At her flat Police found an open casement window directly above where she was found.
- 1.12 David was arrested by Police on suspicion of the murder of Sandra, and after interview was released with no charges laid.
- 1.13 David was known to be a user of alcohol and controlled drugs. His account stated that Sandra had taken her own life.
- 1.14 It is within this context that this review is set.

- 1.15 The process of this review began in October 2020 at the height of the COVID-19 pandemic in the United Kingdom. The CSP appointed a Chair/Author, and the first panel meeting was held in November 2020.
- 1.16 All local agencies were asked to identify any prior contact with the Sandra and/or David. The agencies who were found to have had relevant prior contact secured their records.

2 Contributors to the Review

- 2.1 Eight agencies contributed to the Review by way of Individual Management Review (IMR) and they are shown below, being denoted by ‘*’ in the following table.
- 2.2 The independence of the IMR authors was confirmed through the review process.
- 2.3 Specialist support to the review was provided by members who did not contribute and IMR, for example Catalyst mental health and drug service.
- 2.4 After extensive minuted discussions at the initial panel meeting, advice was received from those professionals who had dealings with both David and Sandra’s children not to contact them as part of the process. A risk assessment identified there was considerable risk in retraumatising the children and the Police advised that David was non-co-operative.
- 2.5 This decision was revisited at every significant milestone, and although unusual, was considered to be the most appropriate for the family in order to avoid re-traumatisation.
- 2.6 The members of the original review are listed below. This was a very large panel due to the complexity of the review, with in excess of 20 attendees.

Contributor	Organisation and role
Community Safety officer	Reigate & Banstead Borough Council
Healthcare Manager	First Community Health Care*
Review Manager	Surrey Police *
Victim Care Team	Surrey Police
Manager	Mount Green Housing*
Investigating Officer	Probation*
Housing Needs Manager	Reigate & Banstead Borough Council*
Manager	East Surrey Domestic Abuse Support Services (ESDAS)*
Children’s Services	Surrey County Council*
Partnerships Team Leader	Reigate & Banstead Borough Council
Head of Housing Services	Raven Housing*

Head of Adult Social Care	Surrey County Council
Director of Operations	Mount Green Housing
Designated Nurse for Safeguarding Adults	Clinical Commissioning Group ICB*
Safeguarding Adults Domestic Abuse Lead	Surrey and Borders Health*
Safeguarding Adults Board Manager	Surrey Adult Safeguarding Board
Designated General Practitioner for Safeguarding	Surrey wide CCGs* On behalf of Surrey GPs
Senior Public Health Manager	NHS
Director of Quality and Performance	Children's services
Manager	Catalyst
Community Safety Manager	Reigate & Banstead Community Safety Partnership Representative
Independent Chair	Independent Chair and report author
Independent Chair Admin	Panel Administrator and Secretary

* Agencies providing IMRs

- 2.7 All members of the panel and IMR authors were independent of direct involvement with either Sandra or David.

3 Review Chair and Author

- 3.1 The Chair served as a senior police officer retiring in 2019. During their career, as well as leading high-profile investigations, they qualified in the College of Policing level 4 complex case management and undertook the role of 'Head of Crime' – responsible for all Public Protection matters. These include introducing the risk management processes relating the Domestic Abuse into the force.
- 3.2 The Chair has completed, or is currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries, including reviews relating to children and vulnerable adults.

- 3.3 Although being an ex-police officer they were not associated with any of the agencies involved in the review. A declaration was completed and accepted by the CSP. There were no conflicts of interest.
- 3.4 The Chair has completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training provided by Advocacy After Fatal Domestic Abuse. They have also recently completed work for the Home Office training prospective chairs and participants relating to Offensive Weapon Homicide Reviews (OWHR). Continuous professional development is undertaken regularly through government and advocacy communications.

4 Terms of Reference

- 4.1 The full terms of reference are set out within the Overview Report, however, the review set out to,
- Explore the specific nature of suicide, and what can be learned from this case to protect others in the future.
 - Explore any specific barriers for victims of coercion and control that may prevent them from seeking support.

5 Summary Chronology

- 5.1 This section summarises the information known to the panel. Full details are contained within the overview report.
- 5.2 Sandra was 48 years old, and David was 47 at the time of the death. Through discussions in the panel meetings, it was felt that Sandra's age may have made her more vulnerable and acted as a barrier to her seeking help.
- 5.3 The intimate partner femicide timeline was used as a framework by the panel for discussion and is referenced in the final report.
- 5.4 As above Sandra's children and partner were not spoken to throughout this review on advice from panel members. Sandra had three children and a grandchild.
- 5.5 Sandra and David had been in an intimate relationship for approximately eight years prior to her death, living at several locations within the East Surrey area before moving to the address in Reigate which Sandra was found outside on the day of her death.
- 5.6 Sandra began her relationship with David in approximately 2012, with the first official record showing them as a couple in October of that year.

- 5.7 During the course of 2012 agency records relating to her GP surgery show Sandra reaching out for support resulting in her being referred to the Surrey Harm Reduction Team.
- 5.8 In 2013 the first record was found relating to Sandra having suicidal ideation and requesting assistance with detoxification (alcohol), this request was made to the Surrey and Borders Partnership NHS trust and the results of her assessment were shared with her GP.
- 5.9 Throughout 2013 Sandra was supported by her GP, in relation to her drinking and ideation.
- 5.10 In December of 2014 a note is recorded by the first community Health team after a telephone call was received from the home school liaison worker to a health visitor. This stated that, third parties were worried about Sandra's youngest child, and reported that Sandra was drinking again and had stopped attending support group. The record intimates that this was due to the recent death of Sandra's sister but there is no further information in relation to how Sandra was coping. Concerns are then recorded regarding the lack of supervision for her child who had recently returned home from foster care.
- 5.11 At the end of this record, it is noted that Sandra is 'unable to protect her children due to a history of sexual harm' and the home school liaison officer is advised to contact Social Services. It is clear that this contact occurred from this agency's records, but no details were included in Sandra's health record. What is also clear is that this is an example of victim blaming as per the work undertaken by Dr Emma Katz.
- 5.12 2015 sees a 'team around the family' meeting held with Sandra and David in attendance. It was also recorded that the couple had completed detox programmes, however they were facing having to move home due to their rented property being sold. A note was made that Sandra was to be supported in chasing up Respond (Community Alcohol & Drug Service) and that she was to contact community debt advice service. It is unclear what ongoing support Sandra received and if she did contact the debt advice service.
- 5.13 In April of this year Sandra approached Reigate & Banstead Borough Council Housing department stating she was about to be homeless. During this application Sandra confirmed David would be living with her at any new address and when asked if she had ever been the subject of any Domestic Abuse gave a negative response.
- 5.14 Sandra also attended accident and emergency at her local hospital after being found intoxicated in the street during this year. Sandra had been drinking and it was established that she had increased her consumption after the recent death of two family members.
- 5.15 David was with Sandra at this time and although he stayed for the consultation with her consent the recording nurse noted they appeared to have a 'volatile relationship', as they continued to argue during the assessment. There is no record of any exploration by this practitioner of the behaviour displayed, showing a lack of routine

enquiry and professional curiosity. In this consultation Sandra stated she was suffering from suicidal ideation and was concerned about her youngest child. Referrals were made to Sandra's GP, bereavement Counselling and Respond (now Catalyst).

- 5.16 There is no record of any thought being given to seeing Sandra on her own and no evidence of professional curiosity being applied to Sandra's circumstances, therefore confirmation bias around her use of alcohol seems to be identified.
- 5.17 In the same month, on the 20th of July, Sandra is recorded as having suicidal thoughts and being intoxicated and after saying that she would jump off a bridge on the M25 motorway she was admitted to hospital. It is recorded that she was seen by an emergency department doctor and a psychiatric liaison nurse and discharged home.
- 5.18 In December of this year the Council accepted a full duty to provide accommodation to Sandra.
- 5.19 During 2016, Adult Social care were contacted by Surrey Police after Sandra had stated she wanted to end her life after David had been arrested. Referrals were made to the local Multi-Agency Safeguarding Hub (MASH) and the local mental health team.
- 5.20 In response to this a strategy discussion was held which included, the named nurse for safeguarding, the Police, children's services, the housing association, and the school deputy head. This ultimately led to Sandra's youngest child being made subject of a child protection plan under the category of neglect.
- 5.21 Throughout 2016 police were called to Sandra's home address on four separate occasions. On the first of these, in June, David was at the address and was arrested at the scene, being charged with Battery after an investigation. David pleaded guilty at Court and received a 12-month conditional discharge. All required referrals were made, and a safety marker was placed on Sandra's records.
- 5.22 On another occasion Sandra alleged David had assaulted her, this had taken place in front of her youngest child. David was arrested but due to lack of evidence this case was filed No Further Action. A Domestic Abuse, Stalking and Honour Based Violence Risk Assessment (DASH) was completed along with a 'Child at Risk' form, and this was shared with Children's services and the Education team at the local Council. Sandra was recorded as a repeat victim, but a referral was not made to Adult Social Care.
- 5.23 It is in this year that Sandra had her first contact with East Surrey Domestic Abuse Services (ESDAS) who offered support.
- 5.24 Due to anti-social behaviour issues Sandra signed an acceptable behaviour Contract stating that she would not cause a nuisance to others and take responsibility for the behaviour of any visitors she had to the flat and was subsequently rehoused with David and her child in her final address.

- 5.25 This year appears to have been difficult for Sandra after receiving a community order after a drink driving offence. This led to 16 separate interactions with the Probationary services.
- 5.26 In October an Offender Assessment System (OASys) assessment was completed with Sandra and within this process it was assessed that she was a victim of domestic abuse and had significant problems with alcohol misuse.
- 5.27 The following year (2017) a Non-crime domestic incident was recorded by Police after they had been called to Sandra's flat, where they found her in company with David. Both had consumed alcohol and stated they had been involved in a family argument. A DASH was completed along with a Child at Risk referral due to Sandra's youngest child being present.
- 5.28 Further calls for service were received and in June a Domestic Violence Protection Notice was served on David and a Domestic Violence Protection Order (DVPO) was granted at court.
- 5.29 Over the next three years Sandra's youngest child remains with her foster carer, whilst Sandra maintains her relationship with David.
- 5.30 Sandra received support from ESDAS, but unfortunately an application under Claire's law was refused. This leads to Sandra continuing to report low mood and suicidal ideation to her GP, police and other agencies.
- 5.31 David and Sandra's relationship issues led to a court case where David was convicted of damaging Sandra's property, and she entered into a formal support programme (Freedom programme). However, Sandra did not finish the course.
- 5.32 This pattern of behaviour, in not completing course or treatment pathways continued and Sandra stopped attending her psychiatrists' appointments.
- 5.33 During this time David was convicted of assault by beating of Sandra and commenced a community order. Unfortunately, the probation supervision of this order did not take place in a comprehensive and thorough manner, and David began failing to attend appointments.
- 5.34 In 2020 Sandra was still under the care of her GP and was receiving treatment for her sleep disorders, anxiety and low mood.
- 5.35 Referrals were made to her GP in February and May of this year and it was confirmed that her last appointment was a telephone appointment due to the Covid pandemic lockdown rules.

6 Key issues and lessons identified

- 6.1 This Review has identified several key issues that it has sought to explore; identified lessons that can be learned; and made recommendations that will help keep others safer in the future.
- 6.2 The Review has sought to identify any trail of abuse that existed within the relationship between Sandra and David.
- 6.3 Sandra, although alluding to inappropriate behaviour by David and on occasions reporting this to police did not report all instances and information was held by many different agencies, which when taken together shows a pattern of sustained abuse.
- 6.4 The panel has tried to understand how Sandra felt, why she did not always report abuse to the police and why she did not exit the relationship for good. To that end, this review has sought specialist advice about coercive control and psychological abuse from Domestic Abuse specialists, referencing the work of Jane Monkton Smith.
- 6.5 The Review examined the role that services played when they were called.
- 6.6 Prosecution decisions relating to David were discussed at length by the panel and the Crown Prosecution Service provided inciteful information into current practices of decision making, since the death of Sandra.
- 6.7 On the last occasion of police attendance, as stated this was during the height of the COVID-19 pandemic and as such Sandra and David remained in the same premises, something which potentially would not occur now. The COVID-19 pandemic had made non-personal (not in person) appointments more likely for those seeking medical, social, and cultural support and as such this concept of curiosity becomes even more important. Lockdown also had an impact on policing nationally and this may have had an impact on the policing response Sandra received the evening before her death. It is impossible for the panel to draw a firm conclusion in relation to the impact of this.
- 6.8 This Review has had the opportunity to examine that investigation through the lens of the specialist domestic homicide review panel. The panel was concerned that there did appear to be a lack of recognition that Sandra could have been a victim, particularly in relation to coercive and controlling behaviour by David.
- 6.9 The evidence that this review has been able to attain and the specialist lens through which it is viewed would suggest that the relationship may well have contributed more than minimally to Sandra's state of mind at the time she took her life.
- 6.10 Sandra's relationship with David clearly shows that she experienced domestic abuse at his hands, and it can be asserted that he was controlling and manipulative on occasions. This is evidenced by the repeated contacts with the Police, his convictions, and his displayed behaviour whilst under supervision.

- 6.11 There are several agencies (Probation, Police, GP) providing varying services to Sandra and David who the Panel believed had a duty to raise the risks posed in relation to Sandra to the Surrey County Council Adult Social Care team. The fact that these agencies did not potentially recognise the risk and did not identify Sandra as an adult at risk of abuse or neglect (through lack of professional curiosity) are clearly opportunities missed to intervene.

7 Recommendations

All the below recommendations have been accepted by panel and by the specific agency they relate to.

Surrey County Council Adult Social Care

- 7.1 When referrals are made to Adult Social Care (ASC) the referrer needs to be clear in their own mind why they are making the referral. They need to communicate that reason clearly to the person that is being referred and to ASC. ASC need to consider both whether they need to act on the issue the referrer has in mind, and whether there are any other indications there may be a role for ASC. This is joint learning for Surrey Police, and it should be noted that it is being addressed and monitored.
- 7.2 Adult safeguarding concerns relating to domestic abuse must be recognised, and they must be identified as being about domestic abuse. Again, this is currently being addressed by ASC and the impact of these steps is illustrated by the increase in the level of domestic abuse related adult safeguarding work now carried out. For example, in 2020/21 12.4% of adult safeguarding concerns identified domestic abuse (1756 cases), a rise from 1.6% in 2016/17.
- 7.3 Adult Social Care must recognise, and act, when s11 of the Care Act places it under a non-negotiable duty to carry out a s9 Care Act assessment. Work is ongoing in this area, but a dip sampling review should be commenced to ensure compliance.
- 7.4 ASC and Children's Services need to work together to ensure the local authority is meeting its duties to all members of families where a parent's care and support needs are impacting on their parenting capacity and / or on their ability to protect themselves from abuse or neglect.
- 7.5 Since the time of these events children's services in Surrey have adopted the Family Safeguarding model, and this means it is likely that in similar circumstances there would be a more effective response to the needs of a parent at risk of domestic abuse who has issues relating to alcohol use and/or poor mental health. But that support will come from NHS and / or voluntary sector services embedded within the Family Safeguarding teams, and it is not clear that any duties the local authority owed the person under s9, s11 and / or s42 Care Act would be discharged under current arrangements.
- 7.6 When information is received by ASC that an adult with care and support needs has died, and the death may be related to abuse or neglect, consideration must be given to referring to the Safeguarding Adults Board for a possible need for Safeguarding

Adults Review. Current trigger mechanisms need to be reviewed to ensure compliance and the ability to audit if referrals take place and are appropriate.

Housing agencies (Mount Green, Reigate and Banstead and Raven)

- 7.7 The allocation of support worker (accountable/responsible person) at the onset of a tenancy must be mandatory to ensure vulnerable clients receive the appropriate support and a single point of contact for agencies is established.
- 7.8 Income Officers should be identified for each client and must ensure that residents in arrears are promptly referred to internal welfare benefits officer or another appropriate support agency to assist with managing debts.
- 7.9 The housing pathway for customers with mental health issues should be reviewed to ensure compliance with current legislation and guidance, so ensuring risks are identified early and acted upon. This links to the need to work towards Domestic Abuse Housing Alliance Accreditation.

Police

- 7.10 There were at least three incidents between Sandra and David where Sandra had been held by the neck. 'Non-fatal strangulation' needs to be identified as high-risk behaviour in offenders and potential offenders. In terms of risk, training needs to be intensified in terms of 'risk identification and appropriate recording', this should link with increasing understanding of the coercive and controlling behaviour which can be displayed by perpetrators.
- 7.11 Training to reinforce the thresholds for Multi Agency Risk Assessment Conference (MARAC) assessments needs to be provided to frontline staff and those dealing with Domestic Abuse at any level, but particularly at first line supervisor rank.
- 7.12 Sandra clearly presented as an adult with care and support needs, training needs to be considered in relation to the identification of adult need, associated vulnerability and the potential for confirmation bias to creep into investigations and enquiries.
- 7.13 The escalation of risk needs to be embedded in report writing by those staff responsible for DASH risk assessments. The review notes for the incidents involving Sandra show that each occurrence appears to have been viewed in isolation as opposed to holistically, taking into consideration all relevant history between the parties involved. The risk to Sandra is explicit as evidenced on the DASH form but does not give rise to any obvious consideration of the indicators being potentially 'high risk' in themselves.
- 7.14 Non-fatal strangulation is now a stand-alone criminal offence and specific investment in training for Police is required. Along with ongoing input regarding signs and symptoms of coercive control displayed by potential victims.
- 7.15 Specific investment in Homicide and Suicide Timeline training for officers should be developed and delivered to ensure that they have the confidence and skills to identify patterns of abusive behaviour as this would prevent incidents being viewed in isolation and would prevent victim blaming.

Surrey Adult Safeguarding Board and the Surrey Children's Safeguarding Partnership

- 7.16 Regarding the joining up of different agencies in terms of risk assessment and the term 'Think family' as opposed to the individual parts receiving individual care and support from one agency or another. The Adult Safeguarding Board and the Surrey Children's Safeguarding Partnership should consider how best to navigate this diverse landscape, in this way for example, Children and Adult Services may not be so focused on their own business but would operate in a more holistic and 'whole family' way. Both of these boards give annual reports to the Surrey Health and Wellbeing Board, so in doing this complete join-up of activity and oversight would be achieved.

Surrey and Borders Partnership (SaBP) NHS Foundation Trust

- 7.17 It appears staff did not consider Sandra as a potential 'adult at risk' with care and support needs despite being in contact with SaBP services. Adult Safeguarding procedures need to be reviewed and circulated to front line staff to ensure all the issues and risks to victims under the safeguarding framework and coordinated multi-agency working are fully understood.
- 7.18 SaBP Teams now refer adult safeguarding concerns to the Surrey County Council ASC team in the MASH. In addition, domestic abuse forms a significant part of the Trust safeguarding adults training and DASH training has been provided on an ad hoc basis in partnership with Domestic Abuse Outreach services in the Trust. MARAC and DASH are discussed as part of safeguarding training as well as coercion and control. This now needs to be strengthened and dip sampled to ensure staff are complying with the new required processes.
- 7.19 There were opportunities to speak to Sandra about potential domestic abuse that were missed, particularly when she was seen in A&E. Staff noted that they appeared to have a volatile relationship but did not attempt to speak to Sandra separately from her partner. Professional curiosity needs to be embedded in training at all levels to ensure those who wish to have their voices heard can do so safely. This needs to be combined with excellent report writing and comprehensive assessments following a process to ensure all risk factors are recorded and actions allocated to named individuals.
- 7.20 In April 2017 Sandra was advised that she was eligible for a social care assessment, but it is unclear if that took place and there is no indication that her non-attendance of appointments was discussed at the mental health team meetings. Since the end of the s75 agreement in November 2019, this now falls to a SCC ASC team to carry out, therefore learning needs to reflect the specific issues for SaBP and for ASC.

Crown Prosecution Service (CPS)

- 7.21 As stated earlier in the report the CPS have confirmed that DA training has now been formalised to include reference to myths and stereotypes as well as including includes sessions on victim blaming and coercive control. The Community Safety

Partnership senior leadership team should request confirmation of this training programme in terms of its successful outcomes and satisfy itself that victim blaming is a thing of the past within the local judicial system.

Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC) Probation

- 7.22 In May 2019 direction was given to all KSS CRC responsible officers to structure their written records of appointment with service users using the ROSH template. This template comprises of four sections 1. Review and assess 2. offending behaviour 3. safeguarding 4. holistic. The notes within each section should relate to the heading title for that section ensuring that KSS CRC sufficiently Reviewed pertinent areas in each contact with a service user. This should now be reviewed for compliance measures.
- 7.23 The direction to deliver structured intervention in every KSS CRC session with service users was introduced in the summer of 2019 through the delivery of the not this again workshops. This needs to be reviewed to ascertain if this is now embedded practice.
- 7.24 Consideration should be given to monitoring and recording the number of practitioners involved in any given specific case with a desired outcome of continuity of care and service. This needs to be reviewed considering the demise of KSS CRC and the reconstitution of Probation services in Surrey. This should be monitored through the Surrey Criminal Justice Partnership Board.

8 Conclusions

- 8.1 This review has looked to see what lessons can be learned from the death of Sandra.
- 8.2 There is unequivocal evidence that Sandra took her own life and an inquest into her death has ruled on a cause of death.
- 8.3 Sandra was a woman with three children and a life to look forward to. She appeared to enjoy and relish her life; however, this review has uncovered that she was involved in a difficult relationship with David.
- 8.4 The police have since reviewed Sandra's calls for service and these reviews have not resulted in prosecutions.
- 8.5 This review is able to shed some light on the run up to Sandra's death, but it is unable to report with certainty the full facts leading up to her fall from the 6th floor window.
- 8.6 The review panel are confident that the recommendations we have made will help secure a safer future for others who may find themselves in a similar position to Sandra.
