DOMESTIC HOMICIDE REVIEW: EXECUTIVE SUMMARY

SAFER WESTMINSTER PARTNERSHIP

Report into the murders of Elizabeth & Ash August 2021

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September 2023

From Elizabeth's daughter:
She was a good friend to Henry and others. She did what she needed to do for me to have a good life and she never tried to mess that up. In her own way – she did what she could for other people. She may have coloured outside the lines but ultimately, she was a good person.

In life you always think you have more time with loved ones and in this case, I thought I had more time with my Mum. I miss her deeply.

From Elizabeth's father:

For every parent this situation is their worst nightmare; no parent should have to bury their child, especially in these circumstances. The shock and horror I felt when I opened the door to the police to tell me this news will haunt me for the rest of my days. I still haven't quite recovered from losing my wife in 2019, so the news of losing my daughter only two years later in these tragic circumstances has left me numb. I have just been existing. It hasn't felt appropriate to celebrate any birthdays or Christmas, I haven't put my tree up since as it hasn't felt right to celebrate whilst my daughter wasn't at rest and had no peace…It has been a horrendous few years, losing my wife and daughter so close together. It doesn't feel real that Elizabeth is gone, as my mind will sometimes have me believe she will call. I will always miss her calls. I miss her more than words can describe.

From Ash's sister:

Ash was a pure soul, he was kind, he was gentle, and he was funny, a classy hippy and a precious human being. He was compassionate, he was empathetic, and he was intelligent but most of all he was loved. Just the mention of Ash's name touched that place in your heart and for that moment you only felt kindness and love.

To speak of him in the past tense makes my stomach churn. Goodness has gone. Ash had a great life; he was a qualified dietician chef; he had travelled and lived abroad using these skills. He met people from all over the world that loved him dearly and his unconditional love and kindness for people will be carved in their hearts forever. When he came back to the UK he worked hard and had good friends, then he finally settled down with his childhood sweetheart. Very sadly he recently lost a very dear friend with whom he had stood by through chemotherapy, and the Covid hit. Even then he was helping others by delivering food to the elderly. We will not allow the last year of our brother's life to define him.

He has no convictions and had led a crime free life. What was done to our beautiful brother and what our beautiful family has been put through is indescribable. No words can describe the pain caused, our world shattered and changed forever. We had to tell our elderly, frail mum that her son was dead. The worst thing you could ever tell a parent. We had to watch our mum bury her first born child.

…Ash touched so many lives in so many ways. He shone brightly in this world, but his light was cruelly put out by someone who gave no thought or care to the impact of his actions.

Contents

DHR into the death of Elizabeth[1] and Ash[2]

Preface

The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the deaths of Elizabeth and Ash, and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity, and patience.

1. Introduction

1.1 Domestic Homicide Reviews (DHRs) came into force in 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 he / she was related or with whom he / she was or had been in an intimate personal relationship or

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

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

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 within what timescales they will be acted on, and what is expected to change as a result; apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate; prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity; contribute to a better understanding of the nature of domestic violence and abuse; and to highlight good practice[3].

1.3. In late August 2021, the Safer Westminster Partnership was notified by the Metropolitan Police of a murder. The Chair of the Safer Westminster Partnership consulted with partners, including local specialist domestic abuse services, and in early September agreed that a DHR should be undertaken. The Home Office were duly notified.

1.4. There followed a significant delay in appointing a Chair and report author. An independent Chair was finally appointed in December 2022, the Home Office updated, and the victims' families informed.

[1] Not her real name
[2] Not his real name
[3] Home Office, (2016) "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews", https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.5. The Panel met for the first time in February 2023. Further meetings of the Panel were held in April 2023, May, and June 2023. A draft copy of the final report was circulated over the summer and the Panel met for a final time in September.

1.6. At trial, Darren admitted to the double killing but claimed that Elizabeth's death was accidental, and Ash's was self-defence. The jury did not believe him. In January 2023, he was convicted of murder and sentenced to a minimum term of 39 years.

1.7 Domestic abuse is a key priority for the Safer Westminster Partnership who, alongside the Royal Borough of Kensington and Chelsea, have a joint VAWG Strategy 2021-2026. It has four strategic objectives:

- providing support for victims
- interventions with perpetrators
- early intervention
- partnership working.

1.8. Domestic abuse is also a priority for Westminster City Council (WCC), and together with LB Hammersmith & Fulham and the Royal Borough of Kensington and Chelsea, commission domestic abuse support services. These include:

- the Angelou services[4], which comprises ten specialist 'by and for' agencies led by Advance
- co-ordination of the MARAC via Standing Together Against Domestic Abuse[5]
- refuges delivered by Refuge[6]
- the Restart Service[7]
- For Baby's Sake[8]
- Safe and Together[9]
- The Freedom Programme[10]
- Some counselling via Women's Trust[11]
- two new perpetrator services which started in July 2023: the Drive Partnership[12] and the CIFA (Culturally Integrated Family Approach[13])

2. Overview

2.1. Persons involved in this DHR

Pseudonym used	Who	Age at the time of the incident	Ethnicity
Elizabeth	Victim	46	White British
Darren	Perpetrator / victim's partner	49	White British

[4] https://www.angelou.org/our-services
[5] https://www.standingtogether.org.uk/
[6] https://refuge.org.uk/

[7] https://cranstoun.org/help-and-advice/domestic-abuse/restart/
[8] https://www.forbabyssake.org.uk/
[9] https://www.respect.uk.net/pages/147-work-with-safe-together
[10] https://www.freedomprogramme.co.uk/
[11] https://womanstrust.org.uk/
[12] https://drivepartnership.org.uk/
[13] https://www.rbkc.gov.uk/newsroom/ps15m-funding-help-encourage-abusers-domestic-abuse-change-their-behaviour-and-reduce-reoffending

Athena	Victim's daughter	-	Dual heritage: Jamaican & British
Henry	Victim's long-time friend and landlord	65	White British
Ash	Victim	59	White British

2.2. Summary of the incident

2.2.1. On a Thursday in August 2021, the police received a call from Darren's father at approximately 9.30pm. He said that his son had just left his house after confessing to killing three people. Police attended the father's home.

2.2.2. Officers were dispatched to Elizabeth's address to check on the welfare of the occupants. Entry was forced to the property at approximately 10pm and the only occupant discovered at that time was Henry, the largely bed bound tenant. He confirmed that Elizabeth lived there as his lodger but said he hadn't seen her since Wednesday evening when her and Darren had had *'a big barny'*. He recalled Darren calling Elizabeth '*a lazy cow'* and Elizabeth shouting at him to '*Get out! Get out!*'. Darren had earlier been rolling cigarettes for Henry which he thought *'tasted funny'* and it is possible, although not proven, that he was deliberately drugged by Darren. Upon searching Henry's flat, police officers located a large amount of blood in the room ordinarily occupied by Elizabeth. Her lifeless body was eventually located under the bed. Her throat had been cut.

2.2.3. A murder investigation commenced, and searches were completed at several other addresses to try and locate Darren.

2.2.4. At 2.15am, the police were contacted by London Ambulance Service (LAS) to say they were tending to a male (later identified as Ash). LAS had been contacted by a woman who had attended Ash's flat and found him with his throat cut. She stated that she had last seen Ash alive a few hours previously. Police quickly linked the two murders due to Darren's confession to his father the day before.[14]

2.2.5. A manhunt ensued. A week later, in response to intelligence received, police officers attended a houseboat on the Grand Union Canal in London Borough of Ealing. Darren was located on this houseboat. He produced a blade and cut his neck before being restrained by officers. Emergency medical assistance was provided, and Darren survived. Officers searched the houseboat and seized a number of items including several handwritten notes referencing the murders of Elizabeth and Ash.

2.3. Summary of agency contact.

All of the agencies listed below were asked to complete both a chronology and an IMR.

[14] Darren confessed three murders to his father but at the time of the confession had only committed one. He would go on to commit this second murder in the immediate hours after leaving his parent's house. He had a plan in mind to murder more people but did not, in the end, manage to complete this.

Service / Agency	Summary of Involvement
Westminster City Council (WCC) Adult Social Services	Darren was referred to Adult Social Services in 2016 following a head injury sustained after he fell down a lift shaft whilst committing a burglary. After an assessment, the case was closed as all his needs were being met. There was one telephone contact in with Ash in January 2021, regarding a foodbank referral. He reported a history of depression, which had worsened during lockdown, but his GP was aware and had prescribed anti-depressants. A befriending service referral was made. Elizabeth was known to be a carer for Henry and was supported in this role by ASC. She received carer's assessments in September 2018, August 2019 and March 2021 with other occasional contacts in person and by email/telephone to process Direct Payments.
Westminster City Council Housing Service	Henry was a tenant of WCC Housing Services and Elizabeth his lodger. Ash was also a tenant of WCC Housing Services.
Westminster City Council Housing Solutions	Homeless applications were made by Elizabeth. Darren was being housed in temporary accommodation at the time of the murders. There is no recorded contact with Ash.
National Probation Service	Darren has a long offending history of mostly acquisitive and dishonesty offences although he also had convictions for possession of a bladed article (2004), battery (2006) involving the assault on a hotel staff member, criminal damage (2007) and racially aggravated / threatening behaviour (2008). After 2008 he was convicted for 14 burglaries and on 12 counts of theft. His final conviction before the murders was in 2020 for burglary for which he received a sentence of 40 months. Darren was released early from prison on Home Detention Curfew in February 2021 but subsequently recalled for a breach in March 2021. His sentence ended in June 2021, and he was released and housed by WCC.
Westminster City Council Public Protection & Licensing	The property (address 1) where Elizabeth was discovered had been subject to numerous unsubstantiated complaints of anti-social behaviour (ASB) which were subject to ongoing investigations. In the course of managing these complaints, there were various interactions with Elizabeth and Darren, although neither were Westminster City Council tenants. There were 13 contacts with Elizabeth between June 2017 and August 2021 and three contacts with Darren between October 2018 and August 2021. There was contact with Ash on matters unrelated to those described above. He made various requests for repairs to his home address and an ASB report was made by him on 30 April 2019 regarding allegations of drug dealing near his property. This was closed on 20 May after interventions by the ASB team.
Westminster City Council Housing ASB Team	

Service / Agency	Summary of Involvement
Turning Point: Drug & Alcohol Wellbeing Service (DAWS)	Darren and Elizabeth were both known to DAWS since 2018 and Elizabeth was engaging regularly (every four weeks) with the Shared Care Scheme. This is when a Substance Misuse Provider (in this case Turning Point) works together with a GP to provide treatment; the GP prescribes, and Turning Point provides the additional wrap around support. Darren was referred through the prison release system into the same scheme, but his continuity of care was interrupted by his frequent returns to prison.
Metropolitan Police	Officers carried out weekly welfare visits to Henry's property, where Elizabeth was also living and attended to numerous reports of ASB. There was also extensive historical involvement with Elizabeth and Darren.
London Ambulance Service	Over the period of January 2019 to August 2021, the London Ambulance Service had eight contacts with the subjects of this DHR.
Integrated Care Board (GP's)	Elizabeth was registered with her GP for over 20 years. Elizabeth was on oral substitution therapy[15] and was managed under shared care arrangements by her GP and the allocated shared care worker employed by Turning Point.

2.3.1. It is worth noting that much of the recorded agency contact was tangential to this DHR.

2.3.2. There was extensive contact with Henry due to his personal care needs and as his lodger, glimpses of Elizabeth are occasionally evident in these records despite her not being the primary reason for agency contact. Nevertheless, Adult Social Care (ASC) worked closely with Elizabeth from September 2018 onwards. During that time, ASC completed three formal carer assessments and the outcome of those assessments led ASC to provide Elizabeth with carers personal budgets to support her role in caring for Henry. Due to the progressive nature of Henry's illness, Elizabeth's involvement as a hands-on carer decreased over this time, but Henry very much wanted her to remain involved as an informal carer. Henry often said he viewed Elizabeth like a daughter, so she continued to help with things such as domestic tasks, shopping and financial management.

2.3.3. The housing estate, and specifically Henry's flat and its occupants, forms the backdrop to a prolonged and escalating dispute between the block's Residents Association on the one hand and Westminster Housing and the police on the other. From 2018 onwards[16], there were escalating complaints, from the Resident's Association about activities they alleged were taking place at Henry's flat. These included the flat being used as a drugs den, anti-social behaviour, prostitution and other criminal activity. Despite extensive and regular investigations, none of the complaints were substantiated and there is some evidence to suggest that at least some of the activities, whilst occurring, did not involve Henry's flat or its residents.

[15] OST involves substitution of injecting opioid drugs with oral medication that effectively minimises craving and withdrawals, and thereby enables Intravenous Drug Users to stop injecting drugs.
[16]The Resident's Association claimed this had been going on for ten years, but this is difficult to substantiate.

3. Parallel reviews

3.1. At the start of the DHR process, the coroner was notified that a DHR was taking place. An inquest was opened and then suspended pending the outcome of criminal investigations. It has not been resumed.

3.2. When police officers located Darren on the houseboat, he injured himself quite severely. As a consequence, the matter was referred to the Independent Office for Police Conduct. The investigation was solely around the actions and decision making of officers involved in the manhunt and arrest. The IOPC concluded there were no lessons to be learned.

3.3. Two post-mortems were carried out. The cause of death for Elizabeth was a long and deep slash wound to the left side of her neck. The cause of death for Ash was also a long slash would to the left side of his neck.

3.4. A criminal trial took place concluding in February 2023.

3.5. The National Probation Service undertook a Serious Further Offending Review. The final report was submitted to the DHR Panel in lieu of an Independent Management Review[17].

4. **Domestic Homicide Review Panel**

The DHR Panel was comprised of the following:

Name	**Title**
Davina James-Hanman	Chair and Report Author
Grace Lauchlan	Minute taker
Amanda Gow	Head of Tamar, Tamar
Anna Robinson	Professional Safeguarding, Imperial College Healthcare Trust
Chris Shoubridge	Divisional Head of Housing Neighbourhoods, Westminster
Delyth Shaw	Strategic Safeguarding Adults Manager, Bi Borough
Hugh Constant	Safeguarding Operational Manager, Bi Borough
James Breed	Homelessness Commissioning Manager
Janet Durrant	Community Safety Manager, Westminster Housing
Jennifer Peckett	Operations Manager, Turning Point
Jessica Whittock	Domestic Abuse Coordinator, Chelsea & Westminster Hospital Trust
Julie Ryan	Substance Misuse Safeguarding Manager, Turning Point

[17] This is a single agency report, detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation.

Kathryn Hunt	Head of Service, Brent PDU, National Probation Service Probation Service
Kylie Rowsthorne	Service Manager, Advance Charity
Manju Lukhman	DHR Support Officer, Bi Borough Violence against Women and Girls Strategic Lead
Mark Dronfield	Operations manager, Turning Point
Musthafar Oladosu	Designated Professional for Safeguarding Adults, Bi Borough ICB
Natalia Croney	Safeguarding Specialist London Ambulance Service
Nicky Crouch	Director of Family Services, Westminster
Ross Harvey	Housing Needs, Westminster
Sally Jackson	Partnership Manager, Standing Together
Sally Pattison	Specialist Case Review Team, Metropolitan Police

4.1 Expert advice was provided on domestic abuse by Advance and Standing Together. Expert advice was provided on the impacts of involvement in prostitution by Tamar.

5. Independence

5.1. The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. She has not previously undertaken any DHRs in Westminster City Council nor is she associated with any of the agencies there. Davina is an experienced DHR Chair and is nationally recognised as an expert in domestic abuse having been active in this area of work for almost four decades.

5.2 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 Temporal Scope

6.1. The key lines of inquiry were as follows:

1. Each agency's involvement with the following people between January 2019 and August 2021:

(a) Elizabeth, a lodger at address 1 (where Henry, the tenant, also lived)

(b) Ash, resident at address 2

(c) Darren, officially resident at address 3 but often staying at address 1

2. Whether any improvements are needed in communication and information sharing between services.

3. Whether responses to each of the subjects of this DHR were consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols.

4. The response of the relevant agencies to any referrals relating to the subjects of this review concerning domestic violence or other significant harm. This should include an analysis of any assessments, decision making, referrals and whether appropriate services were offered/provided and whether these responses were informed, professional, timely and effective. Were thresholds for intervention appropriately calibrated, and applied correctly? Are these adequate when a client is experiencing multiple issues?

5. Were there any missed opportunities to enquire about domestic abuse? Was your agency aware of the other issues facing the subjects of this DHR and if so, what actions did you take in relation to these?

6. Was the (alleged) perpetrator effectively managed and what forms did this take?

7. How accessible were services for the victims and the (alleged) perpetrator? What might have made a difference in terms of increasing their engagement with services?

8. Whether practices by all agencies were sensitive to the nine protected characteristics of the DHR subjects and whether any special needs or vulnerabilities were explored, shared appropriately and recorded. Please provide evidence for your assertions.

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

10. What learning can be identified from this case? What changes would you suggest to avoid such tragedies occurring in the future?

7. Narrative chronology

BACKGROUND

7.1. Elizabeth was aged 46 when she died. She had a child, Athena, when she was 22 years old and moved to London with the child's father a couple of years later. They found it difficult to find suitable accommodation and employment and felt this wasn't a good environment for a child. When she was around three years old, they took her back to her grandparents in Yorkshire. This was initially intended to be a temporary arrangement but ended up being permanent, so Athena was raised by her grandparents into adulthood. Elizabeth visited her parents and her daughter in Yorkshire, and in turn, they would come to London several times a year to meet with Elizabeth. Elizabeth was particularly close to her mother who never gave up on her and always hoped that she would overcome her problems. Elizabeth's mother passed in 2019. Elizabeth was a user of class A drugs and had been involved in prostitution but her arrests for the latter ended in 2013 after she moved in with Henry. When Elizabeth moved in with Henry, her family thought this was a very positive move as it seemed to give her a degree of stability and he treated her like a daughter.

7.2. Elizabeth was an informal carer for Henry, a man who at the time of the murders was aged 65 and had Multiple Sclerosis. Henry has complex care and support needs and is wheelchair dependent, having to spent long periods of time resting in bed. Henry

held a tenancy in a block of flats and Elizabeth had lived informally with him for approximately eight years. Henry had a formal package of care commissioned by Westminster Adult Social Care (ASC) consisting of multiple daily visits which increased as his condition deteriorated. This meant that Elizabeth gradually provided less care but in line with Henry's wishes, continued to provide support with domestic tasks, meal preparation and financial management.

7.3. Elizabeth's boyfriend, Darren, also lived there sometimes over this period. Henry didn't care for him very much but kept his counsel out of respect for Elizabeth.

7.4. Elizabeth and Darren met in rehab around 2007 and they went on to form a long-standing on/off relationship which was also interrupted by periods of Darren being incarcerated. Elizabeth would visit Darren in prison when he was serving a sentence[18] although this changed in 2021. After Elizabeth was murdered, lots of letters from Darren to Elizabeth were found among her belongings. These were often very toxic (*No-one will ever love you like I do* / *You can't live without me* etc) alongside lots of him begging her for forgiveness.

7.5. Both family and friends commented on how they experienced Darren as very manipulative and controlling although he could also be very charming. Athena described how sometimes when she visited her mother, Elizabeth would end the visit by saying '*I've got to go now, Darren will be waiting'*. If she didn't leave, her phone would blow up with constant texts and calls until she answered. Another example is that Elizabeth was a natural redhead and she used to have gorgeous long hair. After she met Darren, however, it was always short and blonde as *'Darren prefers it that way'*. Elizabeth often made positive progress when Darren was incarcerated, switching to methadone and vastly reducing her illegal drug intake. Both friends and family members commented that Elizabeth always looked much better – happier and healthier - when Darren was in prison.

7.6. Ash was 59 when he died. His friend Leah[19] had been staying with him for a couple of weeks as her granddaughter had appointments at a local hospital. She said that she and Ash '*had loads of things in common like travelling and food'* and that he was always nice to her. Ash was a qualified dietician and was very well travelled. He previously lived with his partner and his three stepchildren. He was a father figure to the family and was a stepfather for 15 years. In January 2021, Ash was referred to Octavia Older People Befriending service by Adult Social Care as he was experiencing low moods and depression, which had been exacerbated by the lockdown and a breakup with his partner. Leah said that Ash was a friendly person who disliked confrontation and even when he was on drugs, he *'never raised his voice at anyone'.*

7.7. Leah said that Ash lived quite a '*lonely life'* and did not have many other visitors or friends and family nearby, although he did call his mother every day. She added that Ash was a recovering alcoholic and she believed he had stopped drinking the previous Christmas. She said he took crack cocaine '*sporadically'*.

7.8. Ash's friend John[20], who discovered Ash's body with Leah, lived on the same landing as Ash for the previous five years. The two men had grown up together, attending the same schools and John regarded Ash as '*one of my best friends who I could always rely on'*. They saw each other '*on a daily basis'*, visiting each other's flats. Ash had been unemployed for nine months since he was involved in an accident which

[18] Obviously, this does not include periods when pandemic restrictions were in place.
[19] Not her real name.
[20] Not his real name

injured his back. John had also known Darren for ten years, considered him a good friend and thought that he dealt drugs.

7.9. Ash and Darren knew each other according to police reports as *'part of the same social group'* but the exact nature of their relationship was unclear although it seems likely that it was drug related. Darren variously believed, without evidence, that Ash was a dealer, that he had introduced Elizabeth to dealing while Darren was in prison, and that Elizabeth and Ash had been having an affair. Ash's friend Leah, who knew all the parties concerned well, denied that there was any romantic involvement, despite Darren's apparent jealousy about their relationship. There is some suggestion that Elizabeth may have seen him as a possible solution to her housing problems, viewing him, like Henry, as a kind of father figure.

7.10. Darren was 50 at the time of the homicides. He was a trained carpenter, a drug addict, had mental health difficulties and was a prolific burglar with 16 convictions for 52 offences. He had served several prison sentences and committed a significant number of offences while out on bail. He was incarcerated for 20 out of 32 months of the review period.

CHRONOLOGY OF EVENTS FROM JANUARY 2019 ONWARDS

7.11. As mentioned above, there was a background of continuing allegations of anti-social behaviour (ASB), largely unproven, centred on the flat for which Henry held the tenancy but shared his residence with Elizabeth, and also occasionally Darren, throughout the period covered by this review. Throughout these allegations, the ASB Team undertook a number of in-depth investigations and implemented a number of risk mitigation actions which largely failed to satisfy the Resident's Association. There were no disclosures of domestic abuse.

7.12. In early 2019 Elizabeth complained to her GP about the way Darren was treating her, saying he was verbally abusive. She appeared 'very underweight' and admitted to taking both heroin and crack, often together. When she attended an appointment with Darren (they often seemed to go around together), her GP noted: '*not good consultation wise as I feel that she wants to talk more but holding things back'.* Elizabeth was offered further support with her relationship, but this was declined. She was also offered – but declined - residential rehab treatment.

7.16. In March, following renewed complaints of ASB involving the flat, the police attended. Henry told police that whilst Elizabeth and Darren supported him, he felt '*uneasy'* about the situation and wanted to live on his own. At the same time, he maintained that he did not want to make Elizabeth homeless.

7.13. In early April 2019, Darren was arrested for an alleged theft and recalled to prison for breaching conditions. He was released on license a couple of weeks later but rearrested in the summer for an alleged burglary.

7.14. In the summer of 2019, Elizabeth was taken to hospital after taking an 'impulsive' overdose of antidepressants; she expressed 'regret' soon afterwards and discharged herself. Elizabeth's mother was dying around this time and Elizabeth travelled back to Yorkshire for her final days, with Darren, and then the funeral. Henry's condition also deteriorated at this time, and he had to be hospitalised. Elizabeth feared becoming homeless if Henry had to be institutionalised and worried that if she was put into a hostel, she would '*revert to old habits.'*

7.15. In August 2019, Elizabeth reported to her GP that she was stressed dealing with both Henry and Darren (who suffered from epilepsy) and coping with her mother's recent death.

7.16. Following escalating complaints, and on police advice, the Residents' Association applied for a community trigger review[21] in September 2019. This led to Henry being issued with a formal warning in October 2019 regarding ASB and moves were initiated to create a housing pathway for Elizabeth. However, despite several meetings, she did not follow the necessary application process and little progress was made. At this time Darren was back in prison.

7.17. In early December, Elizabeth spoke to her GP about her partner being in jail and how *'she is really worried for him, because he has fits all the time'.* She talked about them both going to rehab as she was '*fed up'* with the life she had been leading and wanted to make changes. In late April 2020 Darren was sentenced to 40 months in prison for various burglary-related offences.

7.18. By mid-2020 renewed efforts were being made to rehouse Elizabeth but an application on medical grounds was rejected. She reported phoning Darren in prison daily over this period; she was concerned for him as he was locked up 23 hours a day due to the pandemic. Elizabeth admitted smoking crack every day to her doctor but no other illegal drugs (apart from smoking marijuana).

7.19. In a two-month period between June and August 2020 there were eight incidents recorded by the police relating to Elizabeth / Henry and disturbances in or in the vicinity of the flat, all of which seemed to involve drink or drug-fuelled disputes.

7.20. Throughout the autumn, ongoing attempts were made to find Elizabeth a housing pathway so that Henry could move to more suitable accommodation. The flat was visited regularly by police, ASC and housing throughout 2020 and into 2021.

7.21. In early February 2021, Darren was released from prison to a bail hostel in Edmonton on a Home Detention Curfew[22]. Within five days he was issued a warning letter for having Elizabeth stay overnight at his hostel. Two weeks later he was taken to hospital having had a seizure. A week later he was returned to prison as he had breached hostel rules again by spending two nights at Elizabeth's.

7.22. From this point on, Elizabeth started to vocalise her dissatisfaction with Darren more openly and to more people, albeit to friends and family members rather than professionals. She stopped visiting Darren in prison and complained about how Darren was always claiming to be on the verge of change – of getting clean, of getting a job or a flat - but that nothing ever changes and here he is, in prison, again. She tells friends that she is always much happier when Darren is incarcerated as she can '*do what she wants.'*

7.23. In March 2021, a notice of possession proceedings was served on Henry as a tenant because of the complaints of ongoing ASB and nuisance involved with the property. During spring, there were a number of incidents suggesting ASB in or around the flat, but no further action was taken.

7.24. Darren was released from prison again as scheduled in early June[23]. Although initially placed in multi-occupancy temporary accommodation outside the borough, within a week he was in temporary accommodation inside the borough.

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[21] A community trigger review allows repeat victims of anti-social behaviour (ASB) to have a greater say in how their complaints are handled - allowing those who have made three separate complaints about anti-social behaviour in the last six months to have their cases reviewed.

[22] Home Detention Curfew is a scheme whereby fixed-term offenders serving between three months and four years in prison may be released between 15 days and 180 days (depending on sentence length) earlier than their 'normal' release date to allow them to integrate back into society. Typically, prisoners under HDC are required to remain in their designated home between 7 pm. and 7 am.

[23] Darren was released in June as this was the halfway point of his most recent sentence and thus when he became eligible for a Conditional Release Date (CRD). He was scheduled to remain on licence until

7.25. Shortly afterwards, the ASB team began exploring options to remove or prohibit Elizabeth from residing at or even visiting Henry's address, given the ongoing complaints about her ASB. A tense meeting took place at the flat in the first week in August with Elizabeth, Henry and Darren. Also present were officials from housing, ASC and a police officer. Darren claimed to be only visiting as Elizabeth '*wanted him there for support'*. The case officer said that they had had problems with engagement in the case and said that a male had been answering the phone and then putting it down. Darren admitted that this was him. Darren and Elizabeth told the officer that they wanted to get '*their own place'* – and were advised to approach Shelter, Citizen's Advice Bureau or the Council One Stop Service for impartial advice and also to seek assistance with letters.

7.26. It was noted that Henry was *'visibly upset and shaking'* and they tried to reassure him that he was not going to get kicked out on the streets. Henry again refused a verbal offer of Management Transfer and said he was happy there. The housing officer also noted that when Darren was on his own, he told her that Elizabeth had got into debt with some drug dealers and that she had to repay the debt by '*holding onto things in the flat'*. He said that he had '*tried to keep these people away but Elizabeth had got in over her head and that they were bad people'*. This information was immediately relayed to the police and ASC. No evidence has come to light to support these allegations.

7.27. Around about this time, Elizabeth's complaints about Darren started to increase. She claimed he was constantly harassing her and wouldn't leave her alone and told others that she had much more freedom when Darren was in prison. She started to talk about a future that didn't involve Daren and unable to accept that this might be her choice, Darren blamed her new friends, made whilst he was in prison, for '*corrupting*' her.

7.28. Just over a week later, in the early hours of the morning, Elizabeth sent Darren 22 furious texts within less than an hour, indicating that she had thrown his stuff out and never wanted to see him again. The messages are interspersed with a large number of calls so it isn't always easy to make sense of the texts but there is a strong suggestion that Elizabeth had discovered that Darren had been cheating on her. At one point she asserts that '*we both know it's over and [we've] been done for long time'* and '*There no going back now u will never hurt me again'.*

7.29. Four days later, Darren killed Elizabeth. Unable to get money from his mother or sister, he then went to see his father who had not seen him for almost three years. Darren originally confessed to him that he had killed three people, although no evidence of a third murder was ever uncovered and at this point, he had not yet murdered Ash. After Darren left, his father called the police. Elizabeth's body was found in her room at Henry's flat; Ash's body was discovered in the early hours of the following day at a separate address. Both had had their throats cut.

7.30. Darren went on the run after the deaths were discovered. The police announced a £20,000 reward and, after a five-day manhunt, he was discovered staying in a houseboat on the Grand Union canal.

February 2023. In practice, this meant he was required to abide by the standard license conditions (see here for a complete list: https://www.gov.uk/government/news/licence-conditions-and-how-the-parole-board-use-them) No additional conditions were attached.

7.31. At trial, Darren was found guilty and sentenced to 39 years. The judge concluded that Elizabeth's murder was not premeditated but that Ash's showed a *'significant level of premeditation and planning'.*

8. Key findings by the DHR Panel and recommendations

8.1. This section addresses the overarching lessons that have been learned from this DHR. Each agency who provided an IMR to this process also identified their own lessons.

8.2. The DHR process has yielded few lessons that are domestic abuse specific.

8.2.1. No agency was aware of any domestic abuse between the couple despite considerable agency involvement in the lives of those around them, in particular, Henry. Darren had a long offending history but almost all of his convictions were for dishonesty and theft. Elizabeth did occasionally mention relationship issues with those she trusted – her GP and her Turning Point worker – but was evasive if further questions were asked.

8.2.2. Whilst there is no direct evidence of physical abuse from Darren prior to Elizabeth's murder, information provided by friends and family suggests there may have been coercive and controlling behaviour, jealousy, a probable sense of entitlement, possible use of financial control, manipulation, and harassment by Darren. At the time, none of these behaviours were recognised as abusive by Elizabeth or those closest to her, which highlights that not all abuse is easily identifiable or considered abusive in the moment. Henry also stated that Elizabeth claimed that Darren was also physically abusive to her.

8.2.3. Elizabeth's family acknowledge they had felt uncomfortable with some of Darren's behaviours but had not identified his behaviour as threatening to Elizabeth's safety. This highlights the need to be able to raise awareness in being able to identify behaviours, patterns, risks factors and how to support those who are subjected to this form of what Johnson has termed intimate terrorism.[24]

8.2.4. Despite the lack of professional knowledge of domestic abuse, the DHR process has afforded an opportunity for each participating agency to reflect on its current practice, including in relation to domestic abuse where relevant. It has also highlighted how professionals may need to be more holistic in their consideration of domestic abuse indicators. Whilst it is often stated that anyone can experience domestic abuse, it is also the case that some groups are more likely to be victimised than others either in terms of individual characteristics such as disability, or in terms of life experiences such as drug addiction. Of course, not every member of these groups is, or will be, a victim of domestic abuse but the higher prevalence rates of some groups justify routine enquiry.[25] In this particular case, the co-existence of depression, addiction, a history of

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[24] '*Typology of Domestic Violence: Intimate, Terrorism, Violent Resistance, and Situational Couple Violence'* Michael P. Johnson, 2008

[25] See, for example, NICE guidance which recommends that health and social care staff 'Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.' https://www.nice.org.uk/guidance/ph50/chapter/1-Recommendations#recommendation-5-create-an-environment-for-disclosing-domestic-violence-and-abuse

involvement in prostitution and insecure housing should all have prompted a routine enquiry.

Recommendation 1: Review local domestic abuse training to ensure that routine enquiry is advocated for high-risk groups.

Recommendation 2: Undertake a dip sample of relevant services to ensure that routine enquiry has been embedded.

Recommendation 3: Review local domestic abuse materials to ensure that the focus is on giving examples of behaviours where some people still have doubts rather on those that are widely accepted as abusive.

8.3 Review the role of informal carers.

8.3.1. Elizabeth was seen through the lens of being an informal carer for Henry who was the actual client of Adult Social Care. Subsequent to this DHR, ASC has embarked upon a programme of work to ensure that ASC practitioners are supported to develop their practice and confidence. This is with the aim of enabling them to explore what may be 'difficult conversations' with informal carers, who may have their own vulnerabilities, for example, in relation to substance misuse. The aim is to have conversations to support the person to reflect on how this may impact on their caring role, and what additional support may be required.

8.3.2. As this work is already underway, there are no recommendations made here.

8.4. Family and social networks are critical in gaining a 360◦ understanding.

8.4.1. The Panel is indebted to family members and friends who provided their knowledge to this DHR. Through sharing their experiences and insights, the Panel was able to gain a much richer understanding of the circumstances surrounding these murders and thus able to think more creatively about solutions (see above for details). It is also a timely reminder to agencies that they tend to get a snapshot rather than a full picture and thus maintaining an active professional curiosity is essential to understanding what the problems are, and how interventions might be made more effective. This is especially true for clients with multiple needs.

Recommendation 4: Review local domestic abuse training to ensure that the practical application of professional curiosity is included within the content.

Recommendation 5: Publicise pathways for friends and family to follow if they have concerns about someone. This should include more than making an official report and also encompass gaining guidance on ways to respond.

8.5. The centrality of housing to resolving issues faced by residents with multiple and longstanding needs.

8.5.1. Westminster CC adopted a Housing First approach in 2018. This is a recovery-oriented, evidence-based philosophy and approach that recognizes that housing is a basic human right, and that people are better equipped to make progress in their lives if they have a safe and stable place to live.

8.5.2. Had Elizabeth's housing situation been more critical, that is if she had been roofless rather than 'just' in an insecure housing situation, she may well have been given a greater degree of assistance. Elizabeth's own efforts to secure alternative accommodation should Henry be rehoused were somewhat half-hearted, perhaps due to the apparent lack of urgency. She may also have felt ambivalent about moving in with Darren.

8.6. Problematic substance use

8.6.1. All three subjects of this DHR were users of illicit substances. We do not know much of Ash's drug taking as he was never arrested and never sought assistance for his drug use.

8.6.2. We know much more about Darren and Elizabeth's drug use. Their drug use started separately becoming more entwined once a relationship formed between them. We do know that Elizabeth's drug use seemed more under control when Darren was incarcerated, albeit that it did not stop entirely. Other than the fact that Darren met Elizabeth in rehab, he seemed to make very few efforts otherwise to address his addiction. Darren did not take the opportunity afforded by incarceration to address his addiction and there were obvious signs of an immediate increase again once he was released. Help and opportunities were available to Darren if he had chosen to take them.

8.6.3. The Panel discussed at length whether professionals who came into contact with Elizabeth viewed her as a drug addicted woman who was involved in prostitution, accused of ASB and treated as such, or as a woman who wanted to change her life and offered opportunities to do that? In other words, was a trauma informed approach taken that focused on her strengths or was the gaze firmly clamped on her (perceived) deficits? At times, it seemed as if the focus was only on keeping Elizabeth in treatment rather than seeing that she had a range of issues which needed addressing and that treatment was bound to fail if these were not also in focus.

Recommendation 6: Learning to be shared from these two local models regarding engagement with women with multiple needs

8.7. Impact of covid

8.7.1. In many homicides which occurred during the pandemic lockdowns, service delivery was negatively affected. Whilst it is the case that Elizabeth had some services (Turning Point, Carer's Assessment, etc) move online, there is no evidence that this had a negative impact. Rather, the lockdowns may have acted as a catalyst for Elizabeth to start reimagining her life. Records of her calls, prison visits and letters prior to the pandemic show that even when he was incarcerated, interacting with Darren still shaped her daily life. When the lockdown restrictions began, although some contact was still possible it wasn't so all-encompassing leaving Elizabeth free to form new friendships and 'practice' what having a life without Darren might feel like. When he was initially released in February, she was glad to see him and to start planning a new life again but within a matter of days, he was found to be in breach of his conditions and was once again in prison. It is from this point on that Elizabeth seemed to be more seriously contemplating a Darren-less future.

8.8. Ending abusive relationships is fraught with risk

8.8.1. It is a well-established fact that leaving an abuser, especially one who is adept in coercive control, significantly raises the risk of homicide. Although Elizabeth had voiced dissatisfaction with her relationship before, from around March 2021 onwards her resolve seemed to harden and grow. Unable to believe that Elizabeth might be rejecting him, Darren concocted imaginary affairs / reasons which raised the risk still further. Exhibiting sexual jealousy – even in the absence of any evidence - is a common behaviour exhibited by abusers - especially those who are homicidal.