



Neutral Citation Number: [2025] EWHC 33 (Admin)

Case No: AC-2022-BHM-000230

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Birmingham Civil and Family Justice Centre
33 Bull Street, Birmingham, B4 6DS

Date: 13/01/2025

Before :

MRS JUSTICE STACEY

Between :

**THE KING (ON THE APPLICATION OF
CHARNWOOD BOROUGH COUNCIL)**

Claimant

- and -

**SECRETARY OF STATE FOR THE HOME
DEPARTMENT**

Defendant

James Cornwell (instructed by Charnwood Borough Council) for the Claimant
Ben Keith (instructed by Government Legal Department) for the Defendant

Hearing date: 29th July 2024

Approved Judgment

This judgment was handed down remotely at 10.30am on 13th January 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE STACEY

Mrs Justice Stacey :

1. This case arises out of the tragic and premature death of a person who shall be referred to as CB, whilst at home with her partner, who shall be referred to as M. Thankfully their 10 year old son was away for the weekend. CB had multiple injuries. The police investigation after CB's death concluded that there was no evidence of third party involvement and closed the investigation and at the subsequent inquest it was recorded as an accidental death by the coroner. The central issue in the case is whether the circumstances of CB's death fulfilled the criteria necessary to enable the defendant to direct the claimant to establish a domestic homicide review ("DHR") pursuant to s.9(1) of the Domestic Violence, Crime and Victims Act 2004 ("the 2004 Act"). If so, did the defendant exercise her powers in accordance with public law principles in making such a direction.
2. The claimant, Charnwood Borough Council ("CBC"), acts in its capacity as lead authority for the Charnwood Community Safety Partnership ("CSP"). CSPs were introduced by s.5 Crime and Disorder Act 1998 and bring together local partners to formulate and deliver strategies to tackle crime and disorder in their communities. Responsible authorities that make up a CSP are the police, the fire and rescue authority, local authorities, health partners and probation services. CSPs are not legal entities.
3. The claimant challenges the decision of 27 July 2023 by the Rt. Hon. Chris Philp MP, then Minister of State for Crime, Policing and Fire ("the Minister"), acting under powers delegated by the defendant, the Secretary of State for the Home Department ("the Secretary of State"), which directed CBC to establish a DHR following the death of CB, under s.9(2) of the 2004 Act ("the Decision"). A DHR is 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 defined group of persons (s.9(1) of the 2004 Act).
4. Permission to apply for judicial review was granted by Mrs Justice Lieven on 27 February 2024. Three grounds are relied on. In ground one it is alleged that the Minister implicitly misdirected himself in law that it was sufficient for a DHR to be established to ensure that lessons could be learned from a death, without any express finding that the death appeared to have resulted from domestic violence, abuse or neglect by M. Alternatively, the direction was ultra vires in the absence of such a finding.
5. Ground two argued in the alternative that if the decision could be read as implicitly containing a finding that CB's death appeared to have resulted from domestic violence, abuse or neglect, the decision was not sustainable and in any event was vitiated by a number of public law errors such as *Wednesbury* irrationality, failure to take account of relevant considerations and taking irrelevant considerations into account.
6. Ground three challenged the reasons given for the Decision in the defendant's response to the pre-action protocol letter ("the PAP response"), which were said not to have formed part of the Minister's reason at the time of the Decision and should therefore be disregarded, but in any event represented a misdirection of law by the Minister by applying a lower threshold for the establishment of a DHR than that set out in the statute. Even if the Minister had correctly directed himself, the conclusion that the necessary test had been satisfied was irrational and had failed to take account of relevant considerations and erroneously considered irrelevant matters.

7. A concern of breach of the duty of candour was not advanced as a free-standing ground for judicial review by the claimant which acknowledged that there had been full compliance with the duty by mid-June 2024 at the latest.
8. The claimant’s unopposed application for permission to rely on additional evidence consisting of a second witness statement of Michael Oliver dated 10 May 2024 was granted at the outset of the hearing.

The law, statutory guidance, practice and background facts concerning DHRs in general.

9. Section 9 of the 2004 Act is in Part 1, entitled “Domestic Violence etc.”. It defines a DHR, sets out who has the power to establish a DHR and provides that statutory guidance must be followed in the undertaking of a DHR:

“9 Establishment and conduct of reviews

(1) In this section “domestic homicide review” means 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 was related or with whom he was or had been in an intimate personal relationship, or
- (b) a member of the same household as himself,

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

(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) to establish, or to participate in, a domestic homicide review.

(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.

...

(4) The persons and bodies within this subsection are—

- (a) in relation to England ...—

...

local authorities;

...

(5) In subsection (4)(a) “local authority” means—

- (a) in relation to England, the council of a district ...”

10. The explanatory notes to the 2004 Act set out the aims of the legislation which include assisting in tackling domestic violence (paragraph 3). The purpose of the statutory guidance referred to in s.9(3) on the establishment and conduct of DHRs is said in the explanatory notes to be so that statutory and other agencies can learn lessons from them in order to assist in reducing domestic violence in future and other cases. It was envisaged that the guidance would encourage multi-agency reviews in relevant cases (paragraphs 46-49).

11. The most recent version of the statutory guidance issued under s.9(3) “Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews” was published in December 2016 (“the Guidance”). It updated the previous statutory guidance in light of the advanced understanding of domestic violence and abuse and aimed to capture the common themes and threads from analysis and key findings of the DHRs conducted since the enactment of the legislation.
12. The Guidance is statutory and must be taken into account by those conducting a DHR. Although the issue in this case is whether a DHR should be conducted, rather than how a DHR that has been established should be conducted in compliance with the Guidance, parts of the Guidance as set out below are still relevant and elucidate the purpose and scope of a DHR.

“7. The purpose of a DHR is to:

- a) 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;
- b) 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;
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) 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;
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

8. It is, however, important to note that reviews should not simply examine the conduct of professionals and agencies. Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions.”

13. A DHR is not an inquiry into how the victim died and nor is it an enquiry into who is culpable, which is a matter for the coroners and criminal courts. Nor is it part of any disciplinary inquiry or process (Guidance para 11). The rationale for the DHR “includes ensuring that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence. The review will also assess whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff” (Guidance para 12).

14. The working definition of domestic violence is also explained in the Guidance:

“15. In March 2013, the Government introduced a cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

“any incident or pattern of incidents of controlling, coercive or 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. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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 is: a continuing 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.” ” (Para 15)

15. An example of when a DHR should be undertaken is provided in para 18:

“Where a victim takes their own life and the circumstances give rise to concern, for example it emerges that there was coercive

controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable”.

16. Overall responsibility for establishing a DHR rests with the local CSP and the Guidance explains that this is because they are ideally placed to initiate a DHR and a review panel due to their multi-agency design and locations across the jurisdiction (section 3, para 19). A local DHR panel (“the local review panel”) must be established for every DHR – on either a bespoke or standing basis – which agrees the scope of the DHR and terms of reference with the independent chair appointed to conduct the DHR. The chair of the DHR is responsible for managing and co-ordinating the DHR process and for producing the final overview report. The chair of the DHR and the local review panel consider the scope of the review process and draw up clear terms of reference proportionate to the nature of the death. The terms of reference should consider the most important issues to address in identifying the learning from the death and which agencies and professionals should be asked to contribute to the review, bearing in mind any other statutory reviews that are running in parallel (Guidance para 40). The local review panel is tasked with ensuring that there is robust analysis and interrogation of the events leading up to the death and ensuring learnings to improve safeguarding practices are identified (Guidance para 31). In order fully to analyse the events leading up to the fatality, it may be necessary for the local review panel to include representatives from housing associations and social landlords, health professions or specialist or local domestic abuse services (para 32 Guidance).
17. During a DHR which follows the Guidance an independent chair gathers and analyses information from local agencies (such as health, social care and the police), family and the wider community to build a picture of the victim and perpetrator’s lives and understand whether opportunities for intervention were missed. A DHR will include recommendations to local and national agencies and an action plan for the local area on how to address any gaps identified to improve victim safety and reduce the risk of further deaths occurring in similar circumstances.
18. The procedure to be followed is set out in the Guidance. For the avoidance of doubt it is common ground that the procedure was correctly followed by the claimant in this case, but it is nonetheless necessary to set out the procedure by way of background and context to the facts which follow. The decision about whether to conduct a DHR is made at local level by the CSP which must notify the Home Office of their decision. The Home Office received 121 DHRs in 2021, 96 in 2022 and 154 in 2023. Examples of recommendations from recent DHRs include a recommendation that Wiltshire Community Safety Partnership promote routine enquiry, and seek assurance from front line health services that routine enquiry into domestic abuse is being undertaken and embedded into local procedures, where health indicators are present.
19. If a CSP chooses not to proceed with a DHR, a summary of the case and their rationale is provided to the Home Office which is then verified by a Quality Assurance Panel (“QA Panel”) made up of voluntary representatives appointed by the Home Office from policing, the probation service, health and third sector domestic abuse organisations. The QA Panel is chaired by the Home Office. Current membership of the QA Panel includes representatives from policing, HM Prisons and Probation Service, NHS England, Victim Support, Advocacy After Fatal Domestic Abuse (“AAFDA”),

Surviving Economic Abuse and Standing Together. The QA Panel is convened monthly, members are nominated by their organisations and are involved in a voluntary capacity.

20. If on review the QA Panel disagrees with the CSP's decision, they provide feedback and ask for it to be reconsidered. If, following feedback, the CSP still disagrees and the QA Panel still believes that a DHR should be conducted, the matter is escalated to the Minister for his consideration. Under s.9(2) of the 2004 Act the Home Secretary has power to direct a local authority to conduct a DHR. This power has been delegated to the Minister.

The chronology and the facts.

21. CB died in the early hours of 5 June 2021. She was at home alone with her partner, M, who called an ambulance at 6.57am. She was pronounced dead by the paramedics who arrived at 7.07am who noted that she had been dead for around two hours before they had arrived. She was 33 years old.
22. The pathology report, completed by Dr Biggs in July 2021, gave the cause of death as internal haemorrhage, abdominal injuries. There was presence of multiple bruises, abrasions to face, torso and limbs and significant injuries to the abdomen. The pathologist found that the distribution of injuries appeared to correlate to the account given by M of the previous night. M's account was that CB had been drinking heavily and fallen down the stairs several times before he managed to get her into bed. After finding her unresponsive in bed the next morning he called an ambulance. The police summary of the pathology report was that a fall down the stairs followed by death at some point over the next few hours was consistent with the observed injuries. A police investigation concluded on 23 of September 2021 that there was no third party involvement in CB's death or criminal activity. M was at no point treated as a suspect but as a material witness. CB's phone was given to him by the police shortly after CB's death.
23. Following a complaint by CB's father to the police about the quality of the police investigation a peer review by a second senior investigating officer ("SIO") was conducted. The police investigation was then reopened and led by a third SIO. A supplementary pathology report was provided by Dr Biggs and a pathology peer review conducted by Dr Hollingbury. Both concluded that the number and pattern of injuries observed were not sufficiently specific to conclude that CB had been assaulted or forcibly restrained prior to her death. The pathological evidence did not contradict the witness account given, but the report did not exclude the possibility of additional factors, such as an assault having taken place. However the overall pattern of injuries was consistent with a fall or falls down the stairs. The police investigation was finally concluded with no further action on 6 July 2022.
24. Around 29 September 2022 the charity AAFDA contacted the then chair of the CSP, Councillor Leigh Harper-Davies, asking on behalf of the family for CB's death to be considered for a DHR. The suggestion was supported by Councillor Leigh Harper-Davies who submitted a request to the Leicestershire and Rutland Safeguarding Children Partnership and Safeguarding Adults Board Case Review Group ("CRG") to consider whether to recommend to the CSP that a DHR be conducted, under the procedure established locally. In Leicestershire and Rutland the CRG is tasked with

considering referrals for DHRs and issuing a recommendation to the relevant CSP as to whether or not a DHR should be established. The CRG agreed to consider it and the police provided the CRG with a report entitled “Leicestershire police report for Leicestershire and Rutland joint CRG December 2022” (“the Police Report”). The Police Report stated that the ambulance service had informed the police at 7:08am on Saturday 5 June 2021 that they were in attendance at the death of a female, CB. She was found to be in her bed with blood around her mouth and M was the only person with her throughout the night. Witness accounts obtained from a work manager stated that by 3:35pm the previous day (4 June 2021) CB had clearly been drinking and at 6:15pm her neighbours saw her and described her as drunk. In the early evening M and CB went to a friend’s house for drinks. The friend provided an account of a pleasant evening with no issues or arguments, where all parties were drinking. CB drank throughout the evening and was described as very intoxicated when she left. CCTV recorded CB and M leaving the friend’s house at 1.49am. CB was unsteady on her feet nearly falling over twice in the short walk between their houses. She appeared to fall towards but not into a car bonnet and stumbled into the front garden prior to both of them reaching their front door together.

25. At 2am neighbours in the adjoining house to CB and M were woken up by thudding noises coming from the stairway area next door. The noises were repeated several times and they heard mumbled voices but not any shouting or sound of an argument.
26. The friend whose house they had been in earlier twice telephoned CB’s address at 2.09am and 02.13am as the friend was concerned due to CB’s intoxicated state. She spoke to M and described hearing CB in the background making a noise described as upset, but not frightened. On the second call M stated he had put CB to bed.
27. M had provided a witness account that CB had alcohol issues, that she was extremely drunk when they returned to their address just before 2am and was unsteady on her feet, stumbling up the stairs before falling to the bottom. He helped her upstairs again, prior to her falling down again on her own and on the final time he had managed to get her into bed. The Police Report states that on waking on the morning of 5 June 2021 M told them that he went downstairs initially and then went back upstairs finding CB unresponsive in bed. At this point at 6:57 he called an ambulance. The Police Report notes that M’s account has been consistent throughout.
28. The next section of the Police Report is entitled relevant history and records that there was limited domestic abuse history with two police incidents recorded in 2007 and 2014. Nottinghamshire police had one recorded domestic incident between the couple in February 2007 when they were 19 and 20 years old which involved an argument following a breakup and consisted of both parties hitting each other. No statement was provided. Leicestershire police had one recorded incident of domestic abuse between the couple in November 2014. Both were drunk and arguing over car keys. CB stated that M had pushed her over in a garden causing a small cut to her head. M was arrested and denied the offence stating they were both pushing each other. CB did not support a prosecution and no further action was taken. The report then stated that:

“As a result of a disclosure from a witness in the coronial investigation Leicestershire police investigated an historic report of domestic abuse from February 2021. This involved an alleged assault on CB causing a black eye. This was not reported at the

time, and there was no evidence uncovered to prove any involvement by M or evidence stating M was responsible. The case has been filed no further action.

In May 2021, a month before her death, CB provided information to a support agency she was engaging with for anxiety. She stated she felt at no risk from others in her life and provided M's details as a person who helped her manage her mental health and to keep her safe."

29. The Police Report then set out the timeline of the police investigation and the history of the peer review and reopening of the investigation. It was explained that the key focus of enquiries was regarding consideration if criminal activity could be identified and if there are any further proportionate enquiries required for the coronial process.
30. A bullet point summary of the pathology findings from both Dr Biggs' initial and supplementary report stated as follows:

“Pathology Findings

Completed by Dr Biggs July 2021

- Cause of death – Internal Haemorrhage, Abdominal Injuries
 - Presence of multiple bruises, abrasions to face, torso and limbs, significant injuries to the abdomen. Distribution of injuries appear to correlate to the stated scenario
 - Deceased had an alcohol blood level 6.2 times above the legal driving limit. It is probable this would have been higher at the time of sustaining her injuries
 - Alcohol level may have led to drowsiness and masked symptoms of pain
 - Alcohol level would account for the CCTV appearance of the deceased moving as if under the influence of alcohol and would have placed her at risk of falls, including down stairs
 - Multiple bruises and abrasions to the face, torso and limbs, majority over bony prominences could be accounted for by a number of falls. However, the possibility of inflicted injury cannot be excluded
 - The report concludes that a fall down the stairs followed by death at some point over the next few hours is entirely consistent with the observed injuries

Supplementary Report April 2022

- The number and pattern of injuries observed were not sufficiently specific to conclude that the deceased was assaulted or forcibly restrained prior to her death

- No typical defensive injuries identified
- No old or healing fractures were identified, and so all of the observed fractures are likely to be represent recent trauma (i.e. fall or falls down stairs)
- The report does not exclude the possibility of additional factors (e.g. an assault) having taken place but the pathological evidence does not contradict the witness account given
- The additional report upholds the findings of the June 2021 report
- Pathology voluntarily peer reviewed by Dr Hollingbury who supports the conclusions reached in the reports
- The overall pattern of injuries was consistent with a fall or falls down the stairs”

31. The Police Report explained that:

“The police rationale for the decision not to make an agency DHR referral was that the death was not suspected to be as a result of violence, abuse or neglect

Whilst there is some limited domestic abuse history and the family have raised concerns about domestic abuse, as this is not deemed to be a suspected suicide, DA related controlling and coercive behaviour would not be relevant to any DHR identification

Therefore, based upon the evidence uncovered during the police investigation, the police position remains that the case does not meet the criteria for a DHR referral.”

32. Councillor Leigh Harper-Davies had been provided with additional information by AAFDA acting as advocate for CB’s family which supported the establishment of a DHR.
33. At its meeting on 1 December 2022 the CRG decided not to recommend to the CSP that a DHR be established. It was the view of the legal advisor to the CRG, Michael Oliver, that there was not enough substantive evidence of a causal link between the previous domestic incidents and CB’s death. The CRG agreed that the case did not meet the criteria for a DHR.
34. AAFDA then wrote to the chair of the QA Panel on 9 December 2022 explaining that they and the chair of the CSP were clear that the death met the criteria for a DHR because of the domestic abuse suffered by CB and “the suspicious circumstances of her death pointing to neglect.” They noted that the CPS (sic)¹ was not planning to inform the Home Office of the intention not to commission a DHR. Their understanding of the

¹ Although likely to be a reference to the CSP, rather than the Crown Prosecution Service.

facts was a little different to that of the police and they set out 7 bullet points explaining why they considered CB's death pointed to neglect following domestic abuse suffered:

- “• On two occasions police had been called to domestic abuse incidents with CB the victim.
- CB's father has accounts of the abusive behaviour:
 - Holding CB and her friend A hostage with a knife
 - Beating CB
 - Coercive control including limiting her spending, limiting her friends, being a nuisance at her place of work, even accompanying her to the hairdressers.
- In the 999 call following CB's death, her partner claimed that “she fell down the stairs multiple times”. He said she was still breathing, but the attending paramedic found her obviously deceased, cold with rigor-mortis setting in, her upper garments were around her neck, her lower garments around her ankles, there was dried blood on her mouth and nose.
- The family is clear that in a vulnerable state, she was neglected and this led to her death.
- A post-mortem found injuries including six broken ribs, lacerated liver, internal bleeding, damage to her neck, finger pad bruising to her jaw line and more.
- Within hours of her death, the Police had decided it was an accidental death, without having full knowledge of the situation and ignoring conflicting witness statements.
- Four months before her death, we know her partner beat her again, resulting in CB telling her father, her employer and others that she had had enough and was going to leave him. I am now aware she was in very severe debt, the family believe this was due to financial abuse. The consequences of this meant she could not rent her own accommodation, felt trapped so forced to move back in with her ex-partner.”

35. The letter from AAFDA to the QA Panel enclosed a statement from CB's father which set out further incidents of abusive behaviour towards his daughter by M in addition to those reported to the police. Photographs of his daughter with visible injuries that her father said were caused by M were attached. CB's father reported that the police had erroneously insisted the injuries were self-inflicted or as a result of a bump with a door frame. Instances of coercive and controlling behaviour such as M limiting CB's spending, limiting her friends, being a nuisance at her place of work and accompanying her to the hairdressers were cited by CB's father. He reported that four months before her death M beat CB again, resulting in CB telling her father, her employer and others that she had had enough and was going to leave him. Since her death CB's father had learnt that she was in very severe debt but still appeared to have plans to move to friends in Portsmouth. M knew that she intended to leave him. Further details of the injuries in the pathologist's report that were not included in the Police Report summary were provided by CB's father in his statement attached to the AAFDA letter which were that

her injuries “included six broken ribs, a lacerated liver, internal bleeding, damage to her neck, finger pad bruising to her jaw and more”.

36. The AAFDA letter also identified inconsistencies as between what M said in the 999 call and to the police and which sat uneasily with the evidence of the paramedics who attended that morning. In the 999 call M stated that CB was still breathing, but the paramedics found that she had been obviously deceased for two or more hours, rigor mortis was setting in and there was dried blood on her mouth and nose. Her upper garments were around her neck and her lower garments around her ankles. The letter made a number of criticisms of the police.²
37. Text or WhatsApp messages enclosed with the AAFDA letter provided by CB’s father were from September 2020 through to February 2021 in which CB describes problems she was experiencing in the relationship, for example of being undermined by M “I’m sick of being spoken to like a piece of shit, told I’m fucking useless and I’m losing my atse (sic) and I do his head in”. On another occasion she reports that she is told she is a “piece of crap” and that she is useless and worthless. She reports that her stepson, M’s son, is copying M’s behaviour towards her which upsets her and she needs to take a break from the house for her mental health. On 30th October 2020 she messages that M “smashed a glass last night and almost amputated my toe” and that she almost passed out the previous night. In early December 2020 she complains that she cannot do this much longer and is being constantly pulled down, that “every sentence he speaks there’s something in it to bring me down” but she is planning on seeing Christmas out for the sake of their son and would start making plans in the New Year as she is “suffering while M does as he pleases” and she “can’t keep being here”.
38. On 16 February 2021 CB texts her friend to say that she has told M that it is over and sends photographs of her face with injuries to her friend. Her friend replies telling her to pack her things and leave. Her friend asks if what M did was before or after CB had told him that she was leaving and the relationship was over, but the question is not answered. CB tells her friend that she had decided to stay that night to talk to M in person before he went away for a week to Germany, and she would go to her friend the next day. The friend makes plans to drop suitcases and boxes off the next day and for CB to pack everything that is hers surreptitiously and suggests CB calls women’s aid for advice if she thinks he will come after her. CB replies to say that she does not think he will and that he is now all sorry and asking if they can stay as friends. Her friend replies that there are no excuses for abuse and suggests that CB “take him to court for DV. You pull out your phone with recordings of him belittling and gas lighting you. You pull out photos of all the physical damage he’s done. What’s he going to say to the judge?... “She made me do it”?!” followed by emojis. CB replies “I don’t want court I just want to be happy.”
39. There was further discussion in the text exchanges about CB leaving, the logistics, arrangements for their child and pet rescue websites. While M was away CB packed all her clothes bar what was in the wardrobe and shoe cupboard on 18 February 2021. She then told her friend on 9 March 2021 that at his request she had agreed to give him one

² Since the police questioned the accuracy of parts of CB’s father’s statement, those matters that they have challenged – for example that they had accepted making mistakes and had decided that it was an accidental death within hours without establishing the full facts – have not been included in the summary above and have been disregarded.

more chance, but that she would leave if he did not prove his worth. The material from the AAFDA was not provided to the Minister himself. It is necessary to set out here since it was before the QA Panel and informed their advice to the Minister.

40. As a result of the AAFDA letter the Home Office began correspondence with the claimant. The Home Office was informed on 5 January 2023 that the final decision of the CSP not to undertake a DHR was made on 1 December 2022. A draft DHR referral form was completed by the chair of the CSP panel which expressed concern that the case may meet the criteria within the s.9(1) definition and that there was an opportunity for lessons to be learnt from CB's death, notwithstanding the conclusion and outcome of the police investigation and that no charges had been brought. The chair considered that there "appears" to be circumstances that may lead to the conclusion of domestic abuse, which would qualify for DHR. However, in section 2 of the form a DHR was not recommended since the chair had accepted the opinion of the other group members. The group accepted that there had been domestic incidents in the relationship between CB and M but there was no evidence to suggest a causal link between the past domestic incidents and the death of CB. The Police Report was attached at appendix A. As per the Police Report it was stated on the draft form that there had been numerous lines of enquiry into CB's death and no criminal activity identified. This remained the view of the police after three investigations by SIOs and a peer review of the pathology report – there was no evidence to support murder or manslaughter offences or third party involvement. At no point since June 2021 had the police considered that the case met the DHR criteria. They considered that there was "no evidence to support a criminal act being committed and M had been treated as a witness throughout." The pathology report also did not support that CB's death was as a result of third party's actions. The peer review supported the original decision not to arrest CB's partner but to treat him as a witness.

"The investigation has been filed with no criminal offences being identified. Therefore, the death is not suspected. As this is not deemed to be a suspected suicide, DA related controlling and coercive behaviour would not be relevant to any DHR identification. Therefore, based upon the evidence uncovered during the police investigation the case does not meet the criteria for a DHR referral."

41. Further information was sought by the Home Office and the CSP then completed and submitted the correct template subsequently provided by the Home Office explaining the rationale for its decision not to conduct a DHR. It set out the facts as they understood them to be and concluded as follows:

"There are past domestic incidents in the relationship between [CB] and [M], (the most recent alleged incident occurring in February 2021. There is no evidence to suggest any causal link between the past domestic incidents and the death of [CB] which at this stage is believed to be accidental, subject to the Coroner's findings. In light of this currently there is no information or evidence to support the proposition that the death "has or appears to have" resulted from violence, abuse or neglect.

Therefore based on the current information available applied to the statutory criteria for a DHR no Homicide has occurred and therefore no grounds to undertake a domestic homicide review despite the tragic circumstances resulting in [CB]’s death”

42. The death was believed to be accidental.
43. The Home Office QA Panel considered the case via email exchanges between 23 January 2023 and 1 February 2023 and on 6 February 2023 the Home Office Interpersonal Abuse Unit (“IAU”), which had been in correspondence with the CRG, informed the CRG that the QA panel considered the case “would benefit from a DHR.”
44. An inquest into CB’s death was conducted on 20 February 2023 by HM assistant coroner Miss S Evans which concluded that CB’s death was an “accidental death” and found that M was unaware that CB had injured herself before he had helped her into bed.
45. There was a further exchange of correspondence between the CRG/CSP and IAU. The CRG again concluded that the criteria for a DHR were not met and the CSP accepted the recommendation not to establish a DHR.
46. The Home Office was informed and the Minister was provided with a written submission from Home Office officials recommending that a DHR should be directed dated 5 July 2023 (“the Submission”). The Submission accurately set out the statutory framework and the Secretary of State’s powers, delegated to the Minister, to direct a DHR, described the make-up of the QA Panel and their recommendation that the Minister direct the CSP to conduct a DHR. Annex A to the Submission set out the advice of the QA Panel and recommendations. It accurately summarised the case provided by the CSP and its reasons for deciding not to conduct a DHR which was that it considered that there was no evidence to suggest a causal link between past domestic incidents and CB’s death. It set out that the family had provided the Home Office with additional information (a reference to the AAFDA letter and enclosures described above) and the family’s belief that CB was in a vulnerable state and neglected which led to her death. The family had provided information on specific incidents of domestic abuse including disclosures to her employer that she was planning to end the relationship with M.
47. The QA Panel’s advice was that the case would benefit from a DHR on the basis that there were a number of abuse incidents between CB and M between 2007 – 2020 involving assault and threatening behaviour with a knife/holding her hostage. The injuries sustained and the pathology report finding that states that the possibility of inflicted injury could not be excluded and screenshots of messages shared by the family with the QA Panel show CB’s intention to leave, patterns of coercive and controlling behaviours and disclosures of domestic abuse to friends.
48. The QA Panel had also noted that there was little information relating to other services included in the submission other than police information. The QA Panel had recommended engaging health services, CB’s employer, her child’s school and that friends and family should all inform the decision to commission a DHR. The CSP continued to disagree that a DHR was necessary. The advice was that the civil servants were clear that the statutory criteria for a DHR had been satisfied and furthermore, the

recommendation was based on the advice of the expert QA Panel. The Minister also received the DHR criteria in Annex B to the Submission and a draft letter in case he was minded to follow the recommendation.

49. The Minister accepted the recommendation and issued his Decision in a direction to the claimant under s.9(2) of the 2004 Act:

“The decision has been reviewed and I am not satisfied with the conclusions reached by Charnwood Community Safety Partnership (CSP) that there are no lessons to be learned from this tragic death.

Under section 9(1) of the Domestic Violence, Crime and Victims Act 2004 (DVCVA), a DHR is 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 was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, and this review is held with a view to identifying the lessons to be learned from the death. Furthermore, the statutory guidance issued under s.9(3) of the DVCVA 2004, to which you and other bodies in the CSP or involved in the DHR must have regard to, clearly states several purposes for conducting DHRs, including to:

- 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

The CSP have focused their decision not to conduct a review on the basis that there is no evidence to suggest a causal link between the past domestic incidents involving CB and M and the death of CB. Furthermore, as the coroner recorded the death as accidental, the CSP believe it does not appear from the evidence available that the case meets the criteria for a DHR.

However, DHRs offer a rare opportunity to understand the victim's life and it would be pertinent to conduct a review to examine the circumstances which led to this death and ensure lessons are learned. There were multiple domestic abuse incidents between CB and M between 2007 and 2020, involving assault as well as threatening behaviour with a knife and holding her hostage. As part of these incidents, there are several factors which could be examined including the injuries sustained, the pathology report which states the possibility of inflicted injury,

the screenshots of messages showing CB's intention to leave M the patterns of coercive and controlling behaviours, and the disclosure of domestic abuse to friends.

That is why under section 9(2) of the DVCVA 2004 (powers delegated to me by the Home Secretary) I am directing Charnwood Borough Council, as the body within section 9(4) of the 2004 Act with lead responsibility in the Community Safety Partnership for DHRs, to establish a DHR.”

50. The Deputy Chief Executive of the claimant wrote to the Minister on 8 August 2023 asking him to review his decision, pointing out that it had not seen the letter from the AAFDA and reiterating the claimant's view that the statutory criteria were not made out to enable the Minister to direct them to conduct a DHR and asked for their letter to be shared with the QA Panel and for their reasons for considering that the statutory test had been met. No substantive response was received before the claimant's pre-action protocol letter before action was sent on 25 September 2023 which was in similar terms to the letter of 8 August 2023.
51. The QA panel reconsidered CB's case remotely on 27 September 2023 after an exchange of emails from 21 -27 September 2023. They were not provided with the letter before claim before their meeting, but they had the claimant's letter of 8 August 2023 and a full recital of the coroner's findings. The case was fully discussed and the various participants shared their views. All but one of the participants who spoke considered that the DHR criteria had been met and that a DHR should be conducted. In her witness statement in defence of the proceedings the head of Domestic Abuse Perpetrator and Homicide Policy within the IAU, Ms Patel explains that the QA panel position did not change, but they added that the death also met the criteria for a DHR on the basis that it could appear to be attributed to neglect given that the deceased was put to bed after falling down the stairs multiple times and sustaining fatal injuries.
52. In its PAP response of 9 October 2023 the defendant resisted the proposed judicial review in the following terms:

“5. The SSHD retains a broad discretion to order a DHR. The statutory guidance on conducting DHRs states:

11. DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the DHR process. Alternatively, some DHRs may be conducted concurrently with (but separate to) disciplinary action.

6. The letter [a reference to the pre-action protocol letter sent by the claimant] seems to suggest that the conclusions of the

coroner and police are the end of the matter. That is a misreading of the breadth of the discretion and the purpose of a DHR. The police look at potential criminal liability and the coroner looks at the reasons that that individual died. The DHR is an additional process to examine what has gone before including dealing with multi-agency evidence to see if there are any lessons that can be learnt as per section 9(1) of the Act. Therefore, whilst the coroner's inquest and police investigation will be of considerable assistance to the DHR, they are not determinative of the examination of the facts or any findings as to lessons learnt.

7. The letter seems to challenge that the SSHD has given a broad interpretation to "or appears to have, resulted from violence abuse or **neglect**" (emphasis added). There are several interpretations of the facts that could be examined, that is a matter for the DHR to examine in the round. All that is required is that the death 'appears to have resulted from neglect'. The facts surrounding the death, including the failure to call for medical assistance in a timely manner, can have that interpretation.

8. There is on any view of the facts, circumstances that suggest that the death could appear to have resulted from neglect.

9. The Council also argues that in effect because the coroner has already examined the case and concluded accidental death that is the end of the matter. That is to introduce a condition precedent that a DHR can only be implemented if the coroner approves. That is the antithesis of the legislation. Its purpose is to add an additional layer of scrutiny.

10. The statutory criteria are therefore met in this case.

11. The SSHD therefore maintains the direction to establish a DHR."

53. In the PAP response the Secretary of State hoped that the matter could be resolved without litigation and explained that she was willing to consider ADR, or further discussions with the claimant regarding the factual circumstances of the death, if it would be helpful. The claimant did not take her up on the offer and proceedings then ensued.
54. The above is a brief outline of the chronology of events. Much of the documentation in the bundle focused on the claimant's decision not to establish a DHR, but it is important to bear in mind that it is the defendant's Decision to direct the claimant to establish a DHR that is under challenge in this case. The claimant does not have to justify its decision not to establish a DHR. The claimant's reasons for deciding not to do so are relevant only to the extent that they challenge and test the Minister's Decision. Neither the CSP, the defendant nor the QA Panel had the evidence gathered by the police in their investigation: they did not have the witness statements, the CCTV or the pathology report itself and none of those documents were in the bundle before me. Although

minutes from the CRG meetings when the matter was discussed, a transcript of the 999 call and an extract from a note by the SIO DI Markham were put in evidence before this court, these documents were not before the defendant when the Decision was made. However I note that the 999 call is corroborative of the points made by the AAFDA about the inconsistencies in M's account about the circumstances and timing of CB's death to the police on the one hand and the information he provided in the 999 call on the other.

55. The QA Panel considered CB's case by email before the Minister's Decision. The QA Panel did not discuss the matter in person because the Home Office had been asked for a rapid decision before the coroner's inquest. All but one of those on the QA Panel who responded to the email request for their views on what recommendation to make to the Minister considered that a DHR should be conducted. The documents before them were the CSP's decision not to conduct template form, the CRG's completed DHR referral form, the Police Report and the additional information given by the deceased's family in the letter of 9 December 2022 from AAFDA and the messages and statement enclosed with it.

Parties' submissions

The claimant

56. The claimant submitted as a preliminary point that the Minister's actual reasons in the Decision letter were not the same as those now relied on. The parties were agreed that it is the lawfulness of the Minister's Decision which must be assessed and that if the reasons advanced in the course of proceedings had changed from the reasons given in the Decision then the later, different explanation must be ignored (see, e.g., *R (Bancoult) v Secretary of State for Foreign and Commonwealth Affairs* [2007] EWCA Civ 990, [2008] QB 365 at [70]). The claimant's submission was that the further correspondence and explanation was not a mere expansion of the earlier reason but an ex post facto rationalisation which a court should be astute to spot (*Caroopen v Secretary of State for the Home Department* [2016] EWCA Civ 1307, [2017] 1 WLR 2339, per Underhill LJ at [30]-[31]). By now suggesting that the Minister's basis for the Decision was neglect of CB by M, which had not previously been mentioned in the Decision, represented a fundamental change. The court should disregard the explanation of the decision to direct the claimant to establish a DHR set out in the defendant's PAP response and statement of case.
57. **In ground one**, the claimant submitted that on a correct interpretation CB's death did not result, or did not appear to have resulted, from violence, abuse or neglect and without the presence of that necessary element the defendant had no power to direct the claimant to establish a DHR. There is no case law that interprets s.9 and the Guidance did not address the question. In any event the Guidance could not be relied upon as an aid to its interpretation (cf. *R (CXF) v Central Bedfordshire Council* [2018] EWCA Civ 2852, [2019] 1 WLR 1862, per Leggatt LJ at [24]-[25]) since it was prepared 12 years after the enactment of the 2004 Act. Even if it had been contemporaneous, it would not be binding as to the meaning of the statute.
58. It was submitted that words "resulted from" clearly imports a requirement of causal connection between the death and the relevant violence, abuse or neglect - the death must be the effect of one of those. Relying on the Shorter Oxford English Dictionary

(2007), Vol.2, p.2554 the definition of the verb “result” is “(1) Arise as an effect, issue or outcome from some action, process or design...”. In *Rothwell v Caverswall Stone Co Ltd* [1944] 2 All ER 350, per du Pacq LJ at 365, “result from” was interpreted (in the Workmen’s Compensation Act 1925, s.9) as “follows from, and is caused by ...”.

59. It was said that for a death to have “resulted from” the relevant violence, abuse or neglect means that, on the balance of probabilities, the death resulted from one of those.
60. As to the word “appear”, it is defined in the Shorter OED, Vol.1, p.101, as, inter alia: “(5) Be clear or evident to the understanding, be manifest... (6) ... Seem to the mind, be perceived as, be considered...”. Section 9(1) does not specify that the death “appear” to a particular person or body (e.g., a person or body specified in s.9(4) or to the Secretary of State) to have so resulted. That indicates that the test is objective.
61. In *R v Dickens* [1990] 2 QB 102, CA, Lord Lane CJ at 107b-c held that “appears to the court” required prima facie evidence. In the present statutory context, it was submitted by the claimant that the degree of probability required to attach to the “appears to have resulted” limb may be less than for the “has resulted” limb, but there has to be prima facie evidence that objectively warrants the view that the death resulted from the relevant violence, abuse or neglect - mere suspicion or grounds to suspect would not suffice.
62. There must be a causal connection based on prima facie evidence between any past violence, abuse or neglect by a person such as M and the death that objectively warrants such an appearance. The information before the Minister did not provide such a basis and in the absence of any prima facie evidence to establish such a link the Minister had no power to make the direction.
63. On **ground two** – misdirection/irrationality public law error allegations - the claimant argued that the Minister had failed to address the coroner’s verdict (ground 2(a)); was irrational at worst, or at best failed to explain how could conclude there had been “multiple domestic abuse incidents” when the police had only recorded two previous incidents (ground 2(b)); the Minister’s reliance on the pathology report as identifying “the possibility of inflicted injury” demonstrated a material misunderstanding of the pathologist’s findings and cherry picking. The fact the pathologist could not exclude the possibility of inflicted injuries as the cause of death was insufficient to conclude that the death appeared to have resulted from such inflicted injuries (ground 2(c)); it was too great a leap to rely on the limited recorded previous incidents of violence or abuse to conclude that the death appeared to have resulted from such violence or abuse as it was insufficient to establish the causal link (see ground one) (ground 2(d)); and, finally, reliance on controlling behaviour was misplaced since the Guidance cites coercive and controlling behaviour as relevant only if suicide is being considered, but there is no suggestion in this case that CB killed herself (ground 2(e)).
64. Overall the Minister made no attempt to grapple with the reasons given by the Police or the CRG/CSP as to why CB’s death was not considered to be a death that resulted from, or appeared to have resulted from, violence, abuse or neglect, at all and as to why the matters which he cites (and which they had considered) were not seen as establishing that the s.9(1) criteria were met.

65. **Ground three**, arises only if the claimant is unsuccessful in its preliminary point and the Court accepts that neglect formed part of the Minister’s reasons for his Decision and challenges the reasons given in the statement of case and PAP response on traditional public law grounds. Firstly it was submitted that the Minister applied the wrong threshold for probability, stating that the death could appear to have resulted from neglect which is not the same as it actually appearing to be so (ground 3(a)).
66. There is no consideration as to why M would or should have appreciated CB’s medical needs at the point when they both went to bed in the early hours of 5 June 2021 after they had both been drinking heavily. The coroner specifically found that M was unaware that CB had injured herself and no explanation is given as to how or why a contrary conclusion is reached. Nor is the issue as to whether M was under a duty to obtain medical treatment for CB at that point discussed or addressed (ground 3(b)).
67. Thirdly, there was a misdirection as to the nature of neglect as a one-off default in obtaining medical treatment for an adult lasting, at most, a few hours. While “neglect” is not defined in the 2004 Act, the Explanatory Notes to the Act or the Guidance, in the statutory context of s.9 it should be interpreted in the same way as “neglect” in other statutory contexts as concerned with more than a one-off neglect of duty and instead requiring continuous or non-transient neglect (e.g. in respect of coronial practice in finding a death results from neglect, see *R v HM Coroner for North Humberside and Scunthorpe, ex p Johnson* [1995] QB 1, per Sir Thomas Bingham MR at 25; in respect of child protection, see the statutory guidance, Working Together to Safeguard Children 2023 (definition of “Neglect” at p.160)) (Ground 3(c)).
68. Finally, even if neglect could be established, the Minister had no evidence on which to base a conclusion that CB’s death appeared to have resulted from such neglect. The Claimant is aware of no evidence as to whether delay in seeking medical treatment caused or contributed in any way to CB’s death. The conclusions were highly speculative.

Defendant’s submissions

69. The defendant’s position was straightforward. There was careful consideration of all the available evidence sufficient for the Minister to conclude that the death of CB appeared to have resulted from neglect by her partner which satisfied the low threshold set out in the statute to entitle the Minister to exercise his delegated responsibility to direct the CSP to establish a DHR to see if lessons could be learnt. The conclusions of the coroner and the police are not an end to the matter. The defendant does not suggest that this was a homicide. CB might have survived had she got medical help rather than being put to bed – because she is now dead it is impossible to know for certain, but the DHR may cast light on additional support that might have meant that her partner or social services could or should have had more input and support, or identify if there might have been other signs that were missed. GP records or social services or housing records may shed further light. The claimant has taken a deliberately narrow interpretation to a complex and multi-faceted issue and applied too high an evidential threshold.
70. There were no public law errors that vitiated the Minister’s decision. In answer to the third ground of appeal, the reasons set out in the PAP response letter on which the defendant now relies are not different to the earlier reasons set out in correspondence,

but merely more detailed and precise. Mr Keith accepted that if the Minister's reasons at the time had changed they could not be changed after the event, but there was now merely greater specificity, not substantive change.

Analysis and conclusions

71. Before the defendant can require a relevant body to establish a DHR, five elements must be satisfied. In issue in this case is only whether the death had, or appeared to have, resulted from violence, abuse or neglect from M. All other elements were satisfied: CB was over 16, she was in an intimate personal relationship with M, the review was to consider the circumstances of her death with the purpose of identifying lessons that could be learnt.

Are the reasons advanced in these proceedings different to the Minister's Decision and, if so, with what consequence?

72. Mr Keith accepted in general terms that a decision-maker who gives one set of reasons cannot, when challenged, come up with another set – as per the reference in the claimant's submissions to *Bancoult* at paragraph [70] – but it is worth spending a little time on what amounts to a different set of reasons. Sedley LJ cites *R v Westminster City Council, ex p Ermakov* [1996] 2 All ER 302 as the source for his proposition in [70] of *Bancoult*. In *Ermakov* “fundamentally different” reasons “of the greatest significance” for why the defendant local authority had decided that Mr Ermakov and his family were intentionally homeless and refused them accommodation were put forward in the decision letter to those advanced in the defendant's evidence and in its defence of the claim. The evidence of the decision maker, Mr Lodge, evidence was that the decision letter and note taken by the homelessness officer inaccurately recorded his reasons. The issue in the case was whether it was reasonable for the Ermakov family to live in their home in Greece and were therefore intentionally homeless. The decision letter, compiled by a junior member of staff purportedly recording Mr Lodge's decision, said that the authority was not satisfied that the family had experienced harassment in their home in Greece and therefore it was reasonable for them to have stayed there. However, Mr Lodge's evidence sought to be put forward by the defendant contradicted the reason given in the decision letter – he said that he had accepted that the Ermakovs' account of harassment, but he had decided that the harassment described did not justify the family moving out of their house in Greece to live in London. As Hutchison LJ noted that “It is difficult to imagine a starker contrast” between the two sets of reasons and the reasons given in the letter were not the true reasons. In other places in the Court of Appeal's judgment the actual reasons given by Mr Lodge were described as entirely new, completely at odds with those given in the decision letter.
73. There were a number of factors of special importance that guided the court's decision: firstly that the Council's obligation to give reasons for refusing to house the Ermakov family was statutory; secondly the fact that entirely new reasons were put forward; and thirdly the idea that material gaps in reasons can always be supplemented *ex post facto* by affidavit or otherwise ought not to be encouraged. Relying on *R. v. London Borough of Croydon, ex p. Graham* (1993) 26 H.L.R. 286 per Sir Thomas Bingham M.R. consistent with a number of other first instance decisions, two further propositions were formulated: (1) If the reasons given are insufficient to enable the court to consider the lawfulness of the decision, the decision itself will be unlawful; and (2) The court

should, at the very least, be circumspect about allowing material gaps to be filled by affidavit evidence or otherwise.

74. It is important to note that in this case, unlike in *Bancoult*, there was no statutory obligation on the defendant to issue reasons with the decision.
75. The other case relied on by Mr Cornwell, *Caroopen*, also repays close attention. In it Underhill LJ reminds us at [48] that it is important to pay close attention to the kind of subsequent letter or decision with potentially different reasoning to those set out in an initial decision, in any particular case. Underhill LJ was also careful to note that in the decisions under appeal in *Caroopen* the defendant was not under a statutory obligation to provide reasons with its decision. He identifies four conceptually different types of purpose that a supplementary letter may serve: firstly further reasons cases where there is no explicit statutory duty to give reasons when courts should still approach attempts to rely on subsequently provided reasons with caution, especially where important human rights are concerned; secondly a supplementary letter which may be effective, not by retrospectively curing the original decision, but by prospectively filling the gap which would arise if the original decision were to be held to be invalid, which certainly in the Upper Tribunal of the Immigration and Asylum Chamber may be relevant to the relief granted (if any); thirdly a “new material” case where new material requires a decision maker to reconsider their original decision; and fourthly where the decision maker acknowledges the original decision is wrong, effectively makes a fresh decision superseding the original decision where the tribunal has to decide whether to allow the validity of the fresh decision to be determined in the context of the existing proceedings ([30]-[33]).
76. I now return to the contents of the Decision and the PAP response to apply the legal principles to the facts of this case. In the Decision the Minister accurately set out the statutory test and the criteria giving him the power that has been delegated to him by the Secretary of State to direct the claimant to establish a DHR – that the death has, or appears to have resulted from violence, abuse or neglect, by, in this case, M. The letter does not expressly state that CB’s death was or appeared to have been caused by M. Nor does it identify which of the three possible matters – violence, abuse or neglect - had, or appeared to have resulted in her death, but cites the multiple domestic abuse incidents, possibility of inflicted injury, screenshot messages showing CB’s intention to leave, patterns of coercive and controlling behaviour and disclosure of domestic abuse to friends. However the Submission from the QA Panel states that the AAFDA believe from the additional information that they had obtained that CB was in a vulnerable state and neglected which led to her death and referred to the specific information of specific incident of domestic abuse, including disclosures to her employer and that CB had stated she was planning to end the relationship. It also identifies the claimant’s objection to a DHR on the ground that there was no evidence to suggest a causal link between past domestic incidents and CB’s death on 5 June 2021. It goes on to say that it would be pertinent to conduct a review to understand CB’s life and examine the circumstances which led to her death to ensure that lessons can be learnt.
77. In the PAP response letter, challenging what the defendant considers to be the claimant’s too narrow view of the legislation that the conclusions of the coroner and the police are the end of the matter, it states

“All that is required is that the death appears to have resulted from neglect. The facts surrounding the death, including the failure to call for medical assistance in a timely manner, can have that interpretation. There is on any view of the facts, circumstances that suggest that the death could appear to have resulted from neglect.”

78. On the face of it, the reasons in the PAP response letter are not different to those in the Decision letter, but a more precise, refinement of the earlier reasons. In reaching my conclusion that the reasons are not different per se, I have taken into account the wording of Ms Patel’s statement that the QA Panel after its September 2023 meeting “also” considered the death could be attributable to neglect, but I interpret this as mere infelicitous wording, not a different set of reasons. The AAFDA view had always been that it appeared that M’s neglect of CB was the cause of her death as explained in their careful letter. Neglect is also identified in the Submission to the Minister by the QA Panel. The fact that the Minister highlights some of the previous domestic abuse incidents and other matters in the Decision in explanation of his direction is not inconsistent with CB’s death having resulted from neglect by M. As the Submission accurately summarised the AAFDA position – there was a history of domestic violence in line with para 15 of the Guidance, CB was in a vulnerable state and neglected. The further reasons do not contradict the earlier ones. So I conclude that since it is not different, the PAP response letter may be relied on in this litigation as further explanation of the Minister’s reasons for his decision and do not amount to prohibited ex post facto rationalisation.
79. But if I am wrong about that and the failure in the Decision letter to mention the neglect referred to in the PAP response amounts to a material difference of some sorts between the two documents, let us consider the consequences. It would fall into category one of Underhill LJ’s categories and the further reasons should be approached with caution. This is an entirely different case to *Ermakov* where the actual decision maker, Mr Lodge, said that the reasons given in the reasons letter by the more junior member of staff were plain wrong and Mr Lodge’s reasons had been entirely different to those given. Here, the PAP response letter, if it is different at all, does not contradict the Decision. The human rights of the claimant are not engaged and the Minister was not under a statutory duty to give reasons (unlike in *Caroopen*). Even on the most cautious of approaches the reasons in the PAP response letter do not constitute an impermissible ex post facto rationalisation and may be relied on in defence of these proceedings.

Ground one

80. Ground 1 is that on a natural reading of the Minister’s decision, he implicitly misdirected himself in law that it was sufficient for a DHR to be established if there were lessons to be learnt from a death, without any express finding that the death appeared to have resulted from domestic violence, abuse or neglect. I have noted above, that the Decision does not, in terms, state that it appears that CB’s death was caused by M’s violence, neglect or abuse. Mr Cornwell also made much play of what he said was the somewhat speculative wording in the PAP response letter that the facts surrounding the death, including that the failure to call for medical assistance in a timely manner, could appear to have resulted from neglect. His criticism was the use of the word “could” have resulted in her death, rather than “did” or “appeared to have” done so.

81. But I read the letter and the PAP response differently. The Decision accurately cites and sets out the statutory test of whether the death has or appears to have, resulted from violence, abuse or neglect by, inter alia, a person with whom CB had been in an intimate personal relationship and the purpose of conducting a DHR.
82. It is implicit from a balanced reading of the Decision and PAP response that the Minister had a clear understanding from accurately citing the legislation that he was both aware that he could only direct a DHR if CB's death had, or appeared to have, resulted from violence, abuse or neglect of her by M. It goes without saying from his recitation of the statutory test that CB's death was in scope and he then quite properly went on to consider whether to exercise his discretion to direct a DHR and if lessons could be learned from it, and he concluded that they could. Self-evidently the Decision/PAP response is not predicated on the actual fact of a causal link between M and CB's death given the outcome of the police investigation and the coroner's report. The Minister correctly understood that that was not the end of the matter and he could consider the appearance of CB's death.
83. So far, so good, but what is a death which "has, or appears to have, resulted from violence, abuse or neglect" by a relation, or a person with whom they had been in an intimate personal relationship, or a member of the same household (s.9(1) of the 2004 Act)? In its challenge, the claimant focused on the meaning of the words "appear", "resulted from" and "neglect".
84. It was agreed that the evidential threshold for an appearance is lower than a balance of probabilities test. The OED definition is appropriate as it is an ordinary word with a natural meaning: "seem to the mind, be perceived as, be considered". Little, if any, benefit is derived from trying to define it further and the parties did not seek to argue otherwise. As for "result from", here there was a clear distinction between the parties' respective positions. For the claimant it was said that the violence, abuse or neglect must be the primary and direct cause of death whereas the defendant submitted that the wording was deliberately open textured and although there must be a direct cause, it need not be the sole cause. Some time was also spent in the hearing on the meaning of "neglect" in s.9(1). The claimant submitted that a one off failure to call 999 was not capable of amounting to neglect, although Mr Cornwell accepted that the threshold was not as high as for gross negligence manslaughter. Mr Keith suggested the ordinary civil meaning of the word applied. Both agreed there must appear to be a causal connection between the violence, abuse or neglect and the death.
85. I find that the section is deliberately open textured, using non-legalistic language, and requires a low evidential threshold, below a balance of probabilities test. "Looks like" is a useful synonym for "appears". Again, it is not a fruitful exercise to try to define it further. I agree it must be an objective test. The appearance will be based on the information known to the decision maker, which may include inferences to be drawn from any gaps in the information.
86. For something to result from something else there must be a causal connection, but I do not find that it must be the primary or sole cause. A looser connection, a material or sufficient contribution is sufficient. The defendant conceded that there must be a direct cause, but the suicide example in the Guidance would suggest that the term may bear a wider interpretation, but on the facts before me and in light of the defendant's

concession, it does not require a determination in this case. I have proceeded on the basis of the parties' agreed position.

87. I find that the word neglect in s.9(1) bears its natural and ordinary meaning, which is the fact of not giving enough care or attention to something or somebody. Nothing more technical or sophisticated is required. It is not to be confused with the term gross negligence manslaughter and as the Guidance emphasises, DHRs are not about who is culpable or how a victim died (para 11) so definitions from the criminal law are not helpful.
88. I also reject the claimant's submission that one incident would never be sufficient to amount to neglect. Again a non-technical, commonsense approach to the language is called for. It is worth remembering that the purpose of the legislation is to learn lessons to prevent future deaths that have or appear to have resulted from violence, abuse or neglect by intimate partners (and specified others). The Guidance explains the meaning of domestic violence in paragraph 15.
89. Applying that definition to the information before the Minister, based on the Submissions from the QA Panel, a specialist panel with particular expertise from a wide range of sources in the field of domestic abuse, he was entitled to conclude that, as identified by the family, it appeared that CB's death resulted from M's neglect of her. She was in a vulnerable state and neglected when she fell down the stairs several times fatally injuring herself and M failed to get help. This was against a troubling background of specific incidents of domestic abuse and her plans to end the relationship which would have made her especially at risk.
90. True it is that it would have been preferable if the Minister's Decision letter had expressly stated that CB's death appeared to have resulted from M's violence, abuse or neglect and specifically referred to the incidents of his neglect of her and his failure to call for help for her after she had kept falling down the stairs on their return that night. But that was not necessary when it was implicit from the letter and the defendant was writing to the CRG which was also familiar with the statutory test and there was no statutory duty to provide reasons. But the further reasons in the PAP response letter spell it out more precisely and there is no error of law or misdirection in law as to the causal link. Ground 1 is dismissed. There appeared to be a causal link between M's neglect of CB over the night of 4-5 June 2021 which resulted in her death as identified by the QA Panel in its Submission which the Minister accepted. Furthermore, the underlying material on which the QA Panel submission was based from the AAFDA, amply justified the conclusion that CB's death appeared to have resulted from M's neglect of her culminating in her death that night.

Ground 2

91. Since I have found against the claimant on the preliminary point, the criticisms of the initial Decision letter can be dealt with briefly. There are a number of specific overlapping points raised in the allegations of traditional public law errors in the decision. Before diving into the detail a few general points are worth making. The nature of the decision under challenge is a direction to a council to conduct a DHR. It is not a determination of civil rights but involves conducting a multi-agency review and paying for an independent chair and the parties were agreed that the direct costs were

approximately £10,000 although there would be the indirect costs of the police and others' time and work.

92. It is important to bear in mind the purpose and context in which a decision on directing a DHR is made as set out above. A DHR may be conducted on the basis of appearances, if there is a proper basis for that appearance and cases which do not result in criminal convictions or civil proceedings may be in scope.
93. I now turn to each of the specific points raised by the claimant. In 2(a) the defendant is criticised for not explaining how the coroner's verdict of accidental death can be squared with CB's death appearing to have resulted from violence, abuse or neglect of her by M. But the Guidance states that the DHR is not a re-run of the coronial process and it is not inconsistent for a coroner's verdict to be accidental death and yet there still be an appearance that the death resulted from another's violence, abuse or neglect. The law was drafted intentionally to enable reviews into deaths such as CB's with the appearance of having resulted from neglect from a relevant other to be reviewed. It is not a criminal or coronial investigation. The coroner's verdict that the death was accidental is not impugned by the establishment of a DHR. The defendant did not need to spell all that out to the claimant in the Decision letter.
94. In ground 2(b) the Minister is criticised for concluding that there had been multiple abuse incidents, when the police had only two filed reports of domestic abuse. There are two problems with the claimant's argument. Firstly as confirmed in the PAP response the defendant relies only on neglect and the past domestic abuse incidents are therefore only relevant background and context. Secondly, in any event, the Minister was entitled to conclude that there appeared to have been incidents of domestic abuse as reported by CB to her family, friends and her employer which had escalated in the months leading up to her death.
95. Grounds 2(c) and (d) fall away with my conclusion on the preliminary point that the defendant may rely on the PAP response and the reasons set out in that letter. The defendant is not relying on CB's death resulting from domestic violence by M in the early hours of 5 June 2021. It is not suggested by the defendant that M assaulted CB and caused the abdominal injuries from which she died, but that is not the question that the Minister was required to ask himself in deciding whether to direct the claimant to establish a DHR.
96. Ground 2 (e) also falls away in light of my conclusion on the preliminary point. However it is not clear to me that para 18 of the Guidance bears the meaning suggested by the claimant. Whilst paragraph 18 refers specifically to suicides, it is an example of the breadth of the scope of the meaning of s.9(1) and when a DHR may be appropriate and support the defendant's arguments in ground 1, supported by the definition of domestic abuse as defined in para 15.
97. I find that the Minister did not need to grapple any more than he did with the reasons given by the police or pathologist as to why CB's death was not considered to be a homicide at all. He was not looking at the matter as a review of the police charging decision. He was not looking at culpability but applying the statutory test in s.9(1). Although CB's family were raising issues about the adequacy of the police inquiry and the evidential leads that they considered had not been explored, it was not necessary, or even desirable, for the Minister to engage with those criticisms in his Decision. His

Decision fell into two parts: were the s.9(1) criteria met, and if so, should he exercise his discretion to direct a DHR so that lessons could be learnt. He is neither himself conducting a criminal enquiry or deciding if the police failed in theirs. A DHR, if established, may in appropriate cases consider best practice in policing and if there are lessons to be learnt in future cases, but that was not part of the defendant's remit or his decision making at this stage. He was looking at the summary of the police report and the summary of the family's concerns to make his decision set out in the Submission and was not required to say more than he did. Given his conclusion on the first part of the question it goes without saying that lessons could be learnt from a DHR in this case.

98. Ground 2 is dismissed.

Ground 3

99. Ground 3 challenges the reasons in the PAP response. Once again a few general preliminary observations are necessary. This was a case with a number of red flags. CB lived in a relationship in which there was some evidence that she had been subject to domestic violence in the past, including reports to the police. There was evidence of injuries sustained three and a half months earlier and photographs of CB with a black eye from which it could reasonably be inferred from contemporaneous text and WhatsApp messages had been caused by M, and accounts in her messages to friends and family consistent with controlling and coercive behaviour by M. There was also information that CB wanted to leave M which it is well recognised would make her more vulnerable. There was some evidence of financial abuse. The QA Panel is made up of specialists in the field of domestic abuse who had considered the information that they had received extremely carefully and the Minister had been appropriately briefed in the Submission.
100. Turning to the specific grounds. I reject the claimant's linguistic analysis and parsing of the use of the word "could" in the PAP response. It is nit picking. It is obvious that the PAP response uses the word "could" to explain how it is that it appears that CB's failure to get medical help for CB would on its own amount to neglect causing her death. It does not mean that the Minister had failed to make a decision about how her death appeared, as is obvious from the context. It is used to assist the claimant to understand the scope of the section and to correct the misconception that appears in some of the documents that a domestic homicide was required. The point the letter is trying to make is that the use of the word homicide in s.9 is subject to its own definition which is much wider and more expansive than the word might otherwise suggest. It is interesting to note that the Home Office is updating the legislation and replacing the term "domestic homicide review" with Domestic Abuse Related Death Review to avoid exactly the sort of confusion that arose in this case. The defendant's invitation to the claimant in the PAP response to work with it to gain a better understanding of the facts around CB's death was a genuine attempt to assist them.
101. Grounds 3(b), (c) and (d) apply too stringent a test to the defendant's decision-making exercise, bearing in mind it was based on appearances. At the risk of repetition, as noted above, the Minister was not required to conduct a full investigation and reach conclusions before directing a DHR. The submission misunderstands the purpose of a DHR. The point is that M went home with CB knowing that she drunk to the point of having trouble staying upright. Her friend was so concerned about her she rang twice in 4 minutes and could hear CB sounding upset in the background. The noise of her

falling down the stairs was so loud that it woke up the next door neighbours. The injuries she suffered repeatedly falling down the stairs were so serious that they killed her. There was a background of earlier abuse, reports of gaslighting behaviour and CB's deteriorating low self-esteem in the months before her death and M had failed to summon any help that night. He made a surprising comment to the paramedics about her weight.

102. Against the limited information available of the history of CB and M's relationship and the account of what happened on the night of CB's death, there was sufficient information for the Minister to conclude, and it was perfectly reasonable and rational for him to decide that it appeared that neglect by M resulted in her death. Medical treatment may or may not have saved CB, but the Minister did not need to consider medical evidence on causation along the lines of a clinical negligence trial to make the decision that he did. It is interesting to note that the Home Office suggested at an early stage to the claimant that they could consider obtaining wider information prior to deciding whether to establish a DHR, but they chose not to do so. They also chose not to take the Home Office up on their similar offer in the PAP response. If those steps had been taken they may have provided a clearer picture that would have supported the claimant's position.
103. I have disregarded the information that the Minister did not have before him. Had he known of the discrepancies in M's witness statement with the 999 call and the paramedic evidence from which inferences could have been drawn he would no doubt have been reinforced in his conclusions.
104. Ground 3 is also dismissed.
105. It follows that the claim is dismissed and the DHR should now be established by the claimant.