Epsom and Ewell
Community Safety Partnership

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Community Safety Partnership

Domestic Homicide Review
into the deaths of
Emma, Lettie & George

(All of whom died in February 2023)

Family members have expressly requested real names be used in this report.

Executive summary

Independent Chair & report author: Kevin Ball

Date: October 2024

1. The Review process:

1.1. This summary report outlines the process undertaken by Epsom & Ewell Community Safety Partnership having commissioned a Domestic Homicide Review Panel into the tragic deaths of a family, comprising two adults and one young child, all of whom died, by gunshot, in February 2023. This review was conducted under section 9 of the Domestic Violence, Crime & Victims Act 2004.

1.2. Family members have confirmed that they wish for the individual adults and children to being referred to as Emma, Lettie, and George. Given the circumstances of the deaths, there was a Police investigation, but not a criminal trial. A Coroner's Inquest concluded that Emma, and Lettie were unlawfully killed and that George, as the perpetrator, died by suicide.

1.3. The sudden and unexpected death of any individual family member can be shocking and traumatic; in these circumstances, the sudden and unexpected death of an entire family has had a profound impact on close family members plus former friends and work colleagues. The Epsom & Ewell Community Safety Partnership, and the Independent Chair of this DHR wish to extend their condolences to all family members.

2. Contributors to the review:

2.1. All agencies that had, or might have had, contact with members of the family were contacted in March 2023 to ask for preliminary information. This included over 10 separate agencies or service types that may have offered services.

2.2. From this original list and early contact, 10 agencies were asked to submit Individual Management Reports (IMRs). This included several educational establishments;

Table 1: Individual Management Reports submitted	
Surrey Police	East Surrey Domestic Abuse Service (ESDAS)
Surrey Children's Services	Surrey and Sussex Healthcare NHS Trust
First Community Health & Care[1]	School 1
GPs – via Surrey Heartlands NHS Integrated Care Board	School
Private Hospital	School 3
Additional information sought, and provided by one former employer of Emma (School 4) and one former employer of George.	

[1] First Community Health and Care is an employee-owned social enterprise, providing NHS community healthcare services to people living in East Surrey and parts of West Sussex.

3. The Review Panel members:

3.1. A Review Panel was established, and comprised of the following agency representation;

Table 2: Membership of the Review Panel

Name	Role	Agency
Kevin Ball	Independent Chair & author	Independent Chair & report author
Maggie Pugh	Partnership Development and Engagement Officer	Surrey Safeguarding Children Partnership
Jo Millward	Head of Domestic Abuse, Family Resilience and Adolescence Commissioning	Surrey County Council
Helen Milton	Designated Nurse for Safeguarding Adults	Integrated Care Board (ICB)
Andy Pope	Statutory Reviews Lead	Surrey Police
Nicola Eschbaecher	Designated Nurse for Child Death Reviews	Surrey Heartlands NHS Integrated Care Board (ICB)
Michelle Blunsom	Chief Executive Officer	East Surrey Domestic Abuse Service (ESDAS)
Patricia Denney	Director of Quality Assurance and Performance	Surrey Children's Services
Francesca Hyde	Community Safety Officer (Minutes)	Epsom & Ewell Borough Council on behalf of Epsom & Ewell CSP
Oliver Nelson	Public Protection Manager (Attending on behalf of CSP Chair)	Epsom & Ewell Borough Council on behalf of Epsom & Ewell CSP
Georgia Tame	DHR Coordinator	Surrey County Council
Kate Charles	Deputy Service Manager	School Relationships and Support for Surrey
Jane Stapleton	Adult Safeguarding Lead	NHS - First Community Health and Care

3.2. Members of the Review Panel were independent of having any direct case management role or responsibility.

4. Author of the overview report:

4.1. The Chair of the Epsom & Ewell Community Safety Partnership appointed Kevin Ball as the Independent Chair and report author for this Domestic Homicide Review. He is an experienced independent Chair and report author, notably of cases involving the harm or death of children, but also Domestic Homicide Reviews. This is the second DHR he has undertaken which has examined familicide as a result of death by a licenced shotgun holder. He has a background in social work, and over 32 years of experience working across children's services ranging from statutory social work and management (operational & strategic) to inspection, Government Adviser, NSPCC Consultant, and independent consultant; having worked for a local authority, regulatory body, central Government, and the NSPCC. Over his career, he has acquired a body of knowledge about domestic abuse through direct case work, case reviews and audit, and research and training – all of which supports his work as a Chair and reviewer of Domestic Homicide Reviews. During his career, he has worked in a multi-agency and partnership context and has a thorough understanding about the expectations, challenges, and strengths of working across complex multi-agency systems in the field of public protection. In the last 10 years he has specifically focused on supporting statutory partnerships identify learning from critical or serious incidents and consider improvement action. He has contributed to the production of Quality Markers for Serious Case Reviews, developed by the Social Care Institute for Excellence & the NSPCC – which are directly transferable and applicable to the conduct of

Domestic Homicide Reviews. He has completed the Home Office on-line training for Domestic Homicide Reviews and the Chair training course provided by Advocacy after Fatal Domestic Abuse (AAFDA). He is a member of the national Child Safeguarding Practice Review Panel's pool of reviewers available for national reviews. In April 2024 he was appointed by the Home Secretary as the third Panel member for the new pilot Home Office Offensive Weapons Homicide Review Oversight Board established under the Police, Crime, Sentencing and Courts Act 2022. He has no association with any agencies involved and is not a member of the Surrey or Epsom & Ewell Community Safety Partnership, and has never worked for any agency in the local area, or been a part of either Partnership. As such, there was no conflict of interest.

5. Terms of Reference and lines of enquiry for the review:

1. Explore any information that was known by agencies, services, professional, family, friends, or work colleagues, that helps us understand the quality of the adult relationship between Emma and George, but also them as individuals and independent professional people. To consider any aspects of controlling or coercive behaviour that may have been present in the relationship.

2. Examine information that helps us understand the adults individual, and combined, parenting capacity.

3. Explore the quality and effectiveness of the shotgun licensing process e.g. initial application & assessment, renewals, weapon security, risk management, other relevant factors.

4. Examine whether the work undertaken by services in your contact was consistent with your organisation's a) professional standards, b) domestic abuse & violence policy, procedures & protocols, and c) safeguarding adults & safeguarding children's policy, procedures and protocols, d) staff welfare policy and procedures. This is applicable to universal services such as schools and health services, plus, any specialist or independent services that were used by either parent i.e. counselling services and mental health services.

5. To consider any barriers experienced by the victim or her family/ friends/ in reporting any abuse (including any aspects of coercive and controlling behaviour) including whether the victim knew how to report domestic abuse should she have wanted to. E.g. maternal and paternal sides of the family, close friends, work colleagues

6. Any issues that may be relevant arising from protected characteristics as set out in the Equality Act 2010 i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

7. Whether the impact of any organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively i.e., changes or the introduction of domestic abuse policies, training, Covid-19 etc.

6. Summary chronology:

6.1. Emma and George met and formed a relationship around 2006; they married in 2010. Both Emma and George, independently, had achieved successful professional careers. Emma had a successful career working in the teaching and education sector. George had a successful career working in the business sector.

6.2. Following his application earlier in 2012, George was granted a shotgun license in December 2012 for the purpose of clay pigeon shooting; this certificate was issued for a period of five years as per statutory guidance in place at the time. In December 2016 and then again in February 2022 George applied to renew his shotgun certificate; each time, this application which was granted for a further five-year period as per statutory guidance in place at the time.

6.3. Towards the end of 2013 Emma and George separated for a period of months, with Emma stating to a friend with whom she stayed with that she had experienced domestic abuse whilst living with George. Family members have confirmed that Emma refused to return until George's attitude changed and until he became more respectful towards her.

6.4. In early January 2014 George disclosed having marital problems to his GP. His GP referred George to a Consultant Psychiatrist, who met with him twice in 2014 and found no psychosis or psychiatric problems, just relationship problems. The outcome of these two meetings with the Psychiatrist was that a referral was made for George to have some cognitive therapy from a Therapist, who met with them four times. Emma and George also had 12 sessions with a private Psychologist between January and May 2014, plus sessions with a local Relate service.

6.5. Also, in January 2014 Emma contacted the East Surrey Domestic Abuse Service (ESDAS), having been provided their contact details by her GP. Concerns raised included having recently move out of living with George, and indications about financial and emotional abuse. This referral resulted in Emma meeting with a worker from ESDAS, Emma disclosing being called names by George, being pushed by him, and efforts by him to try to isolate her from friends. She shared that she realised that she was spending a lot of time in the spare room, crying, explaining how she had tried to tell George how she felt, but he just told her that she was being 'too sensitive'; The ESDAS worker offered ongoing support and provided her with the Surrey 24-hour helpline number, as she worked long hours which made it more difficult for her to call in 'office hours' however this was not taken up.

6.6. In 2015 Lettie was born. Emma had attended all her routine antenatal care appointments and routine questions about domestic abuse were asked – no information of concern was provided by Emma. Routine Health Visiting appointments were attended and again, no issues of concern were noted. George was not recorded as being present during any of these appointments however it is not necessarily unusual for father's to be absent from these appointments. The attachment between Emma and Lettie was noted as warm and loving. A Universal[2] level of service was offered, as no unmet needs were identified.

6.7. In May 2016 Emma is recorded as assaulting George. The Police attended the incident having been called by George. George stated that they had been arguing over Emma's work, but also mentioned marital problems and counselling. George did not want the Police to take any further action and made it very clear that had he known what the Police response would involve he would not have called them. The attending Officers completed a Domestic Abuse, Stalking, Harassment & Honour Based Violence Assessment tool (DASH)[3], form with George and save for two questions, he answered 'no.' The first 'yes' question asked about children and at that time Lettie was 12 months old. The second question asked about other relevant information and George stated he held two shotguns. The risk level for this incident was rated as 'standard', which is defined as '*… current evidence does not indicate the likelihood of causing serious harm …*'[4]. Although Lettie was only 12 months old, she was awake and being comforted by her mother. The Officers completed a Child at Risk Form (now known as a Single Combined Risk Assessment - SCARF), a requirement when a child comes to the attention of the police. On completing this form, the Officers described both Emma and George as respectable professional individuals with no concerns about their ability as individuals to care for Lettie, who appeared healthy, well dressed, and cared for. The Officer did however express concern about the potential emotional impact on Lettie following this incident and recorded this on the multi-agency referral form, and giving it a grading of 'Amber'[5]. In this case a power of arrest did exist,

[2] A universal service from health visitors and their teams, providing the full Healthy Child Programme to ensure a healthy start for children and family, support for parents and access to a range of community services/resources.

[3] The DASH tool (Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment) is part of the Multi Agency Risk Assessment Co-ordinator (MARAC) referral - a risk assessment form to help you work out the risk level for the victim.

[4] College of Policing, Risk-led policing of domestic abuse and the DASH risk model, 2016.

[5] MASH process guidance, Surrey County Council, March 2017.

and the Officers chose to arrest Emma in accordance with the policy. Upon release Emma was driven home by the Officers and it was recorded that she would be given advice about Outreach domestic abuse services that provides support services for victims of domestic abuse. It is offered to all victims regardless of whether the risk is Standard, Medium, or High.

6.8. The Child at Risk Form completed by the attending Officers was sent into the Multi-Agency Safeguarding Hubs[6] (MASH). On receipt of the Child at Risk notification, Surrey Children's Services Social Worker completed a check of the Surrey Children's database to confirm if the family were previously known to Surrey Children's Services – no information was found indicating no previous involvement. A decision was made that threshold was not met for further intervention from Surrey Children's Services and a single letter was sent to Emma and George highlighting the impact of parental acrimony on children; there was no further contact from Surrey Children's Services with the family. At the time of this incident, Emma worked at a school.

6.9. Following the assault allegation where George was recorded as the victim Police seized both his shotguns and he surrendered his certificate at the time. This was in accordance with the Domestic Abuse policy. A home visit was made to both George and Emma in June 2016 by a Firearms Enquiry Officer where both adults were spoken to separately. Emma told the Officer she was surprised her husband called the Police over such a trivial matter and stated their relationship was now good and she had no safety concerns relating to the return of her husband's shotguns. George told the Officer the reason he called the Police was to impress upon his wife that she should not resort to violence to resolve matters and he only wanted to frighten her. He stated if he knew she would have been arrested he would not have called the Police. A report was submitted to the Superintendent responsible for the Firearms Licensing Unit in Surrey Police recommending the return of the shotguns based on the assessment of the circumstances, no previous domestic abuse history or antecedent history or other significant risk to public safety or the peace justifying a revocation. The shotguns were returned.

6.10. Emma visited her GP in March 2019, again with stress and anxiety related symptoms, detailing a high alcohol intake of 2-3 drinks per night and stress at work. Similar circumstances were described later in September 2020 and March 2021, and included a specific reference to her husband struggling at home due to the Covid-19 restrictions.

6.11. In February 2022 Emma attended a local Minor Injuries Unit with a face injury, recorded as caused by a dog bite to her upper lip. Records state routine enquiry of domestic abuse was not made, and no safeguarding issues were identified. Emma reported she was accidentally bitten by her friend's miniature dog.

6.12. In March 2022 work colleagues of Emma noted tensions in Emma's relationship with George during conversations in which she described of unrest which appeared to focus around the issue of the family home – notably about George not wanting to move house closer to Emma's forthcoming new job with a school 2, but wanting to remain in the current family home where he had completed a lot of work over a number of years.

6.13. In May 2022 Emma attended the Minor Injuries Unit alone with pain in her lower leg – recorded as being from playing netball an hour previously. Medical assessment confirmed a muscle tear and she was provided with pain relief and advice. No routine enquiries were made at this time. One-week later Emma attended the Minor Injuries Unit alone stating she would be going away soon and wanted to know what she should/not be doing with her leg injury from last week. Following assessment, advice was given – again, there is no reference to routine enquiries being made which was in line with the standard operating procedure in place at the time.

[6] The Surrey Multi-Agency Safeguarding Hub (MASH) is the single point of contact for reporting concerns about the safety of a child, young person, or adult. It aims to improve the safeguarding response for children and adults at risk of abuse or neglect through better information sharing and high-quality and timely responses.

6.14. Between May and September 2022 Emma received private medical treatment following a referral from her GP. The details of this episode are not relevant to the review however what is relevant is George's response to Emma's situation; members of Emma's family have confirmed that George showed no sympathy or care towards her symptoms and often cited these as being the cause of their relationship difficulties.

6.15. In August 2022 Emma moved job to take up the role of Headteacher at a school 2. In September 2022 Lettie started at a new school – no concerns were identified and Lettie was observed to be happy, and steadily settling into a new school with a new group of friends.

6.16. In December 2022 another former colleague of Emma had a conversation with her, during which Emma stated that she wanted to leave George and divorce had been discussed.

6.17. In February 2023 Emma, Lettie and George were found dead at the family home. They all died by gunshot. Police investigations have confirmed that George was responsible for killing Emma and Lettie, before taking his own life.

7. Key issues arising from the review:

7.1. The following key issues arise from this review:

- Emma and George had long standing relationship difficulties; attempts to resolve these do not appear to have been successful despite individual and joint counselling sessions some nine years earlier in 2014. Relationship difficulties persisted until their deaths in 2023.
- Emma experienced persistent emotional abuse from George, most often privately and away from the public view. This steadily and negatively impacted Emma, making her question her own perceptions about the relationship. It also resulted in her adapting her lifestyle, and parenting of Lettie, to accommodate around George.
- Lettie was loved and well cared for – there were never any concerns about safety or welfare. However, Lettie is likely to have witnessed her parents' relationship difficulties and the way her father treated her mother.
- From an outside view, George was seen as professional, friendly, sociable, and competent; this appears to contrast with his behaviours within the family home. He did experience mental distress and mental health difficulties.
- Emma held senior professional roles in educational settings. She had a good working knowledge and was able to advise other's about safeguarding related matters; she recognised domestic abuse as a safeguarding issue.
- Emma was on the cusp of leaving George, and taking Lettie with her. She had sought legal advice and was also seeking help from friends and family to make this transition possible.
- George accessed a private GP and an on-line prescribing service to gain medication for several years to help him manage his mental health; this meant that his NHS GP was not aware of the issue or prescription, and this could not therefore be disclosed to the Police when renewing the gun license.
- Emma's role and status often made it challenging for her to seek the right help at the right time; she carried a perception that if her relationship difficulties became public knowledge then it would impact on her work.
- George exhibited coercive and controlling behaviour over Emma for a number of years.

8. Conclusions:

8.1. This Domestic Homicide Review has examined the contact and involvement of professionals and agencies with all members of a family, who died in February 2023 as a result of gunshot by the licensed gun holder, who then took his own life. The review has benefitted from the contributions of all agencies and professionals that came into contact with family members, a Review Panel, plus members of the extended family, from both the maternal and paternal sides.

8.2. Incidents of familicide – the murder and suicide within a nuclear family – are rare. Data from other homicides and case reviews confirms that mental ill health, drug use, relationship difficulties and stress are often cited as contributory factors to such tragedies. The review has identified that illicit drug use did not feature as an issue, but alcohol use was common; the licensed gun holder suffered with, what one close family member has described as 'mental distress', but which can also be described as mental health difficulties (no diagnosis ever given). Medication, privately sourced and prescribed, was used by the licensed gun holder as a way of helping with the symptoms of this mental health difficulty, and relationship difficulties alongside stress were also present.

8.3. The review has examined the process of gun licensing and noted that there are a small number of deaths each year connected to licensed gun holders; however, in most cases, licensed gun holders behave responsibly and do not represent a danger to themselves or others. In this case, no concerns about the issuing of a gun license have been identified.

8.4. The review has captured a number of learning points; four significant points being; firstly, for those victims leaving an abusive relationship, it can often be the riskiest of times; secondly, perceptions about professional role and status can inhibit a victim from making timely decisions to leave abusive relationships; thirdly, children can be victims of domestic abuse; and finally, the use of private doctors and on-line prescribing services for medication can circumvent information sharing protocols with NHS GPs, and used, potentially, as a pathway to conceal the use of medication.

8.5. The Independent Chair would like to thank members of both maternal and paternal sides of the family for their contributions to the review, their patience in seeing the process through despite other challenges they faced, and their desire to seek some positive greater change out of such awful circumstances and personal tragedy.

9. Lessons to be learned:

9.1. Based on analysis of chronological information, the submission of information and research, the contribution of family members, findings from the Police investigation, there are several points captured that translate into lessons to be learnt from this tragedy.

- An eight-stage homicide timeline model has been developed following extensive research by Dr Jane Monkton-Smith[7]. This helpfully sets out different stages which might assist with the identification and prevention of homicides. It is useful to reflect on this when examining this case. No explicit information of concern has been put forward to this review to indicate any significant concern in terms of stages 1, 2 and 3 (pre-relationship history, early relationship, and relationship) in terms of there being a dysfunctional, abusive, or controlling relationship at any point. Emma and George started their relationship in 2006. It is acknowledged that George was suffering with work related stress in 2009, but it was not until 2014 when the first recorded difficulties arise with there being a trial separation, references to relationship difficulties and help seeking behaviours by both adults. The absence of information about these earlier stages of the relationship does not mean that factors were not present – it just means that they were not identified or observed. Stages 4, 5, 6 and 7 appear more relevant (triggers, escalation, change in thinking, planning).

[7] Dr Jane Monkton-Smith, Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide, August 2019, University of Gloucester.

Perpetrators feeling or perceiving that they are losing control is a dominant feature during these stages. Research has noted the following possible triggers; separation, threat of separation, imagines a separation, bankruptcy or financial ruin, physical health deteriorates in perpetrator or victim, mental health deteriorates in perpetrator or victim, redundancy, retirement, event which prompts retaliation or revenge on victim. Information points towards a steady increase in Emma's dissatisfaction and unhappiness in the relationship, and George making attempts to assert himself in the relationship. There is, of course, an added level of complexity to keep in mind – the Covid-19 affect – and that, due to lockdown restrictions, time together was forced onto the family, and it potentially having a deleterious affect rather than positive. Speculating about motive is unhelpful but it does leave one wondering what triggered George (stage 8, the homicide). The learning from this, for agencies and professionals, especially when working with known victims of domestic abuse and coercive control, is to be alert to significant life events, change of routine or references about separation, and how this might impact on the victim's safety.

- Research[8] reminds us that leaving relationships is often the riskiest time for victims of domestic abuse. It is often very difficult for victims of domestic abuse to leave an abusive relationship; this can be made even more difficult if the victims have parenting and caring responsibilities to children who live in the same house, and who are clearly totally reliant on the care they receive i.e. Lettie. All professionals need to be aware of the often-conflicting demands and dilemmas faced by victims and support them to find a safe route out of an abusive relationship. In this case, the impact of Covid-19 made separation even more challenging, and Emma had articulated her concerns about who might be given custody of Lettie had separation been successful; Emma was explicitly concerned about Lettie's welfare sufficiently so for it to be a factor in her decision making.

- Those professionals with responsibility for assessing incidents of domestic abuse should remain alert to unconscious bias – forming either a positive or negative bias, often unwittingly, about someone or something due to difference. Professional status or role does not exclude someone being either a victim of domestic abuse or a perpetrator of abuse.

- Children are victims of domestic abuse too; they can see, hear, or experience the effects of domestic abuse - this is now recognised in legislation through the Domestic Abuse Act 2021. Research[9] supports the view that providing safe space and opportunity for children to speak about their home life is important for all professionals to be mindful of. All professionals that work with children need to remain mindful of this, but especially those professionals that have opportunities to build trusting relationships and who can provide the time and space to speak about their home life.

- For those holding professional roles, finding a safe channel to discuss worries that are perceived as something that cannot be discussed as part of an employment relationship, is important.

- Given Emma's work role, it is evident, through information provided, that Emma was aware of how domestic abuse can impact relationships and actions that can be taken for victims of abuse to seek support. However, having a working knowledge about domestic abuse and sources of support Emma still felt unable to leave the relationship most likely due to the factors already outlined above. Barriers remained and assumptions should never be made about the levels of support those in positions of trust and authority may need.

[8] Why don't women leave abusive relationships? Women's Aid

[9] Izaguirre, A., Cater, A., Child witnesses to intimate partner violence: Their descriptions of talking to people about the violence, 2016, Journal of Interpersonal Violence.

- GPs considering alcohol as a relevant factor re suitability, and including this information in medical reports for new issues or renewals of gun licensing.

- The use of private GPs and online prescribing services can mean that NHS GPs are not fully informed or updated about a patient's health and medical history; whilst this may not necessarily pose a problem for most of the population, for those adults that are licenced gun holders it can mean that their full medical and health history is not disclosed or evaluated by an NHS GP when contacted by the Police to comment on suitability to own a lethal weapon. There appear to be no control measures in place to prevent this from happening.

- Societal expectations and gender stereotyping has influenced the way in which the emotional and mental health of men has been viewed, often resulting in issues and difficulties being undiagnosed, remaining hidden and support not being sought. In situations where emotional and mental stress may be affecting any individual (regardless of gender) it is important that all individuals are encouraged to seek support without fear of stigma.

- Notification about someone that works in the children's workforce, who is either a victim of domestic abuse, or is an offender of domestic abuse, should always go to the local authority designated officer (LADO) for assessment. Whilst in no way a reflection about Emma posing a risk to children, an opportunity did exist for another professional to view the domestic assault incident in 2016 between Emma and George from a different perspective. The role of the LADO is to consider information or incidents which may indicate that someone who works with children has;

    - behaved in a way that has harmed a child, or may have harmed a child.
    - possibly committed a criminal offence against or related to a child.
    - behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
    - behaved or may have behaved in a way that indicates they may not be suitable to work with children.

9. Recommendations

9.1. As part of the reporting process for this review, those agencies that have contributed have identified actions for themselves and these are contained in their own single agency action plan. Responsibility for implementing, embedding, and monitoring these remains with each agency. The following additional recommendations arise out of this review:

1. The Home Office guidance Firearms Licensing: Statutory Guidance for Chief Officers of Police, February 2023, should be strengthened to include the need for applicants to declare the use of private GPs or medical consultants, and the use of on-line medication prescribing services. The strengthened guidance should then translate to Police authorities amending their application/renewal forms.

2. The Home Office guidance Firearms Licensing: Statutory Guidance for Chief Officers of Police, February 2023, should be strengthened to specifically ask applicants to declare the number of units of alcohol they consume per week (with accompanying guidance that assists the application – see, for example the NHS website: NHS Alcohol units). Where information is either provided by the applicant, or by the GP, which indicates high usage, the licensing Police authority should examine this further to assist their decision making.

3. The Home Office guidance Firearms Licensing: Statutory Guidance for Chief Officers of Police, February 2023, should be strengthened to allow licensing Police authorities the option, based on the particular

circumstances of the applicant, the option to seek the views of other adult members of the applicant's household about the licence application, the holding of weapons in the home, any relevant medical conditions i.e. alcohol consumption, or additional issues including the presence of domestic abuse, coercion and control. The views of other adult members of the applicant's household should be sought separately, and not in the presence of the applicant, to avoid any fears or concerns about disclosure.

4. The Home Office guidance Firearms Licensing: Statutory Guidance for Chief Officers of Police, February 2023, should be strengthened to explicitly require an assessment of the suitability of the location of where any weapons are to be held that goes beyond assessing the arrangements for the secure physical storage of any shotgun or firearm e.g. in a property on an educational establishment grounds.

5. Following steps already taken by the Independent Schools Bursar's Association, which has introduced a new clause in the Service Occupancy Agreement that expressly prohibits an employee (or any persons occupying any accommodation provided to them) from being in possession of, or storing, an offensive weapon and/or ammunition, the Association should formally promote annual reviews of the Agreement to check on any change to circumstances.

6. The Home Office & the Domestic Abuse Commissioner's Office should promote the Public Health England & Business in The Community Domestic Abuse Employer Toolkit. This toolkit helps employers of all sizes and sectors make a commitment to respond to the risk of domestic abuse and build an approach that ensures all employees feel supported and empowered by their workplace to deal with domestic abuse. Alongside this, the Partnership should raise the profile of this toolkit and the Employers Initiative on Domestic Abuse (http://eida.org.uk/) across all partner agencies, to raise awareness that supports all employees, regardless of role, status and position held, seek help if they are a victim of domestic abuse.

7. The Epsom & Ewell Community Safety Partnership should work with relevant agencies and other strategic partnerships to examine methods for reaching into local communities that encourage adults (particularly adult males) to seek support about emotional or mental health worries or any mental distress they may be troubled by.