REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire & Luton Coroner Service.
2.	**DATE OF REPORT** 14 September 2026.
3.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
4.	**THIS REPORT IS BEING SENT TO** 1. The [redacted] Secretary of State for Health & Social Care. You are under a duty to respond to this report within 56 days of the date of this report, namely by November 04, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN**

	There is no unified health record for individuals identified as at on-going risk of domestic abuse.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 03 March 2023 I commenced an investigation into the death of Sarah Marie ALBONE aged 38. The investigation concluded at the end of the inquest on 07 September 2026. The conclusion of the inquest was: **Unlawful Killing to which police failures in recognising and responding to the escalating domestic abuse materially contributed**
9.	**CIRCUMSTANCES OF DEATH** The Deceased was brutally murdered at her home by her Partner on 27 November 2022 as determined by Luton Crown Court on 11 September 2023. The Judge who presided over the criminal trial, described the Deceased as someone who "had faced many challenges in her life and…suffered from physical and psychological ailments – chief among them… Multiple Sclerosis (MS) and Functional Neurological Disorder" which meant she was "undoubtedly…a particularly vulnerable person (and) even more so around the time of her death". The Deceased had begun reporting concerns about her Partner to Bedfordshire Police from August 2021. Despite the fact that the Police DARA/DASH assessments and the Deceased's own statements included evidence of controlling or coercive behaviour, reference to this offence only appeared once in the many Crime Reports that were opened as a result of her concerns and both the criminal investigations into his alleged abuse, opened in September 2021 and December 2021 respectively, were subsequently closed with 'No Further Action'. This, coupled with failures to respond to some of her calls with the necessary urgency or understanding, resulted in a total breakdown of trust between the Deceased and Police, and by 21 December 2021 the Deceased was already expressing her decision not to contact them in the event of further incidents. Furthermore, the increased risks of the Deceased's Partner having moved into her home and appointing himself as her carer in the meantime were not properly considered by either Bedfordshire Police or other agencies and there was a lack of co-ordinated intervention to support the Deceased in effecting her Partner's removal from her home. Whilst the Domestic Homicide Review highlighted numerous multi-agency failures and a cross-agency lack of vigilance to safeguard the Deceased through adopting a 'trauma informed approach' to understand her disengagement from their services, there were a number of Police failures which materially contributed to her death: i. A failure properly to appreciate the risks the Deceased's Partner posed to her as evidenced by a lack of reference to her Partner's history of violent

	behaviour which was neither shared with MARAC nor the Deceased herself, despite her 'Clare's Law' Application; ii. A failure to pursue offences against the Deceased's Partner for coercive or controlling behaviour on their own merits, including considering an 'evidence-led prosecution' when the Deceased withdrew her evidence in September 2021; iii. A failure to continue the criminal investigations into the Deceased's Partner in January 2022 and/or to consider additional DVPN/DVOP protections; although the decision to close the criminal investigations was described by [redacted] as having been "certainly lacking in a few areas", there appeared to be a lack of reasonable grounds for this decision. The Deceased had provided compelling evidence to support charges and was in full support of Police action at that stage and, indeed, had expressed an understanding that, however difficult, this was, it was the only means she had of ending the control that her Partner had over her life. The effect of the investigation being closed in January 2022 was clearly devastating for the Deceased; prior to December 2021, the Police had been the main agency to whom she had been reaching out with regard to her Partner's behaviour but, after their apparent unwillingness to accept her account of his actions on 20 December 2021 and then their decision to drop all criminal action against him in on 7 January 2022, she clearly lost all confidence in the Police to help her ever again; iv. A failure properly to investigate the circumstances of the complaint raised by the Deceased's neighbour, including consideration of the previous Police contact, on 12 August 2022, which would have provided an opportunity for service recovery, to regain the Deceased's trust, and for appropriate safeguarding and/or criminal action to have been taken at that stage. As it was, the Police's attendance on the Deceased on 12 August 2022 likely reinforced her understanding that Police would never assist her which only allowed her Partner to have more control over her.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: • As highlighted by the Draft Domestic Homicide Review there is a need for essential clinical information, safeguarding indicators, and patterns of attendance to be visible across all settings involved in an individual's care to ensure timely identification of escalating risk and then effective protection of victims at risk of on-going domestic abuse; however, - although this there is a national shared IT system for child protection https://digital.nhs.uk/services/patient-flags-service/child-protection---information-sharing-cp-is - there is no national shared IT system for victims of on-going domestic abuse
11.	**COPIES AND PUBLICATION OF THIS REPORT**

	I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • Mother of the deceased • Sister of the deceased I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE**  **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**