



Bristol Community Safety Partnership

Domestic Homicide Review

Overview Report, Executive Summary

14th January 2018

Victim, Adult Female, Susan Taylor (pseudonym)

Author, and Independent DHR Chair,
Ian Kennedy BA (Hons)

1. Introduction

This Domestic Homicide Review examines the circumstances surrounding the death of Susan Taylor (pseudonym), a woman in her 30's, in Bristol.

1.1 Susan had struggled with mental health issues for some years, and she had been subject of Social Care support since her early teens when she was taken into care following allegations of physical and sexual abuse in her home. There was also a history of her being a victim of domestic violence from a number of partners but most recently from her last partner prior to her death, Simon Harper (pseudonym). She had told friends, family and agencies, that she had ended the relationship the previous year but she may have been seeing him secretly in the months prior to her death, and keeping this from her family and agency workers.

1.2 Susan lived near to close family members. In the days leading up to her death, in September 2016, they had not seen her and had failed to get access to her house. As concerns increased, her son went to the house and through a window could see his mother inside, hanging by a ligature. He forced entry and alerted the emergency services and other family members, but unfortunately, despite his best efforts, it was too late to save his mother's life.

1.3 A police investigation took place in to Susan's death on behalf of HM Coroner. The full circumstances were reported at an inquest where it was concluded that she had taken her own life.

2. The Review Process

This summary outlines the review undertaken on behalf of Bristol Community Safety Partnership (CSP) into Susan's death. She died as a result of her own actions. Her death falls within the broader parameters for the statutory requirement for a Domestic Homicide Review (DHR), given she killed herself and also had a history of being the subject of domestic abuse and recipient of agency intervention. This is as set out in the Home Office document; Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016).

2.1. The decision to hold a review was made at a meeting of the Bristol CSP on the 30th September 2016, and the Home Office was informed. The Independent Chair and report author, Ian Kennedy, a former senior police officer, was appointed to lead it.

2.2 Susan had lived all her life in the Bristol area. She had five children (ranging from 5 to 17 years old at the time of her death) by four different partners. There was a history of her being a victim of domestic abuse from at least two of these partners. Her most recent partner prior to her death had been convicted of offences arising out of an incident in 2013 when he damaged items in their house during an argument between them and poured white spirits over a sofa and threatened to set light to it. Susan and her children were present in the house at the time. The review panel also identified a series of suspected behaviours and actions towards Susan by this partner that would now fall to be considered under the Controlling and Coercive Behaviour criminal offence but which all pre-date it becoming statute, as part of the Serious Crime Act 2015.

2.3 There had been multi-agency discussions and work, on and off, to safeguard Susan in the last several years leading up to her death. Some of these took place at Child Protection meetings where several agencies were present, as were Susan and members of her family.

2.4 The agencies participating in this review are-

- Avon and Somerset Constabulary
- AWP, Mental Health Services
- Bristol City Council Early Help
- Bristol City Council Housing Services
- Bristol City Council Children's Services.
- Bristol City Council Public Health Services
- Bristol City Council Safeguarding Adults
- CAMHS, Mental Health Services.
- Next Link Domestic Abuse Services
- National Probation Service and BGSW Community Rehabilitation Company

- Sirona Care and Health
- Victim Support
- South Gloucestershire Clinical Commissioning Group on behalf of her GP

2.5 The Independent Chair met with nominated professionals from each agency on a number of occasions to properly consider all the facts. All the agency involvement with Susan was discussed and work continued between meetings, communicated by secure e-mail to complete the work in a timely and appropriate manner (see Terms of Reference in Appendix A). Each agency that had had dealings with Susan completed Independent Management Reviews (IMR's), covering the period from 2010 when her relationship with Simon Harper is believed to have commenced. It was also left open to agencies to look further back beyond that period for any information that may be of relevance.

2.6 The purpose of Domestic Homicide Reviews is as set out in the Home Office document but in simple terms is to carry out effective reviews, to identify learning and suggest improvements within and between agencies to prevent future domestic abuse deaths and improve safeguarding for service users.

3. Findings of the IMR's

3.1 Susan was a very vulnerable woman with complex needs, who did not keep in contact with, or make herself easily contactable by, professionals from the agencies working with her. She also had a distrust and dislike of what she termed "Social Services" and the disruption they had caused to her life and her children after domestic abuse from previous relationships. This, and the associated fear of losing her children, may well have been the primary reasons for her not engaging with agencies and her non-disclosure of the resumed relationship with her last partner, if indeed it had resumed.

3.2 The criminal offence of Controlling and Coercive behaviour in domestic circumstances was brought in by the Serious Crime Act of 2015. That was too late for Susan and the behaviour believed to be exhibited towards her by her partner Simon. The Crown Prosecution Service guidance in relation to prosecuting cases

under the new Act lists relevant behaviours/actions which could constitute evidence of such offending. Of the 25 examples of behaviours within the list which may be considered evidence of Controlling and Coercive Behaviour, 13 are suspected to have been present in the actions of Simon Harper towards Susan, though these were not fully known to the agencies sitting on this review panel until after her death.

3.3 This is based on information provided by statutory agencies and charities working with Susan together with information from friends and relatives. Susan was the subject of service provision from a number of agencies for the different and conflicting complex issues in her life. She did not always engage fully with those services, either because of legacy issues from previous dealings or because of her mental and physical health or other issues going on in her life. She was an adult and was fully aware of what was available to her, with some professionals going out of their way to provide her with help. The review panel were very grateful to members of Susan's family who engaged fully with the review and met with panel members to discuss Susan's experiences of services delivered and give an invaluable insight into the complex issues facing her and how agency service delivery addressed those, or otherwise.

3.4 Her suicide was not foreseen and this review has not identified any action or shortfall in service provision that would have brought a different outcome for her. Agencies were still keen to learn whatever lessons they could from Susan's death, to improve their services. These are as set out in the Single Agency Action Plans combined in an overall Action Plan in the Overview Report (see Appendix E of the report).

4. Key Issues

4.1 A number of issues that cut across a number of agencies were identified-

4.2 Meetings

A review of the running of meetings by Children's Services as included in their Single Agency Action Plan is ongoing to ensure best gathering, consideration and sharing of information and attendance by all those involved or best able to assist. This is

specifically in relation to child issues but, as in this case, can be a place where domestic abuse information is raised and shared.

4.3 Information sharing

There was some evidence of information not being shared between and within agencies, sometimes due to systems that do not communicate with each other and sometimes due to over restrictive access levels. Where appropriate, these issues have either been addressed directly or feature in the all agency Action Plan in the Overview Report. There would still be merit for each agency involved in information sharing from multi agency meetings to dip sample a small number of live cases to identify how the information gets shared in their agency and whether it is readily available to frontline workers to enable and inform operational activity.

4.4 Lead agency/professional and ownership

The review identified shortcomings in risk assessments and consequently domestic abuse service provision due to the people completing them not having access to all relevant information. With single-agency stand-alone computer systems this will always be more likely than not to happen. Having an identified single individual/agency who can act as 'Lead' for certain domestic abuse victims may result in better assessment and therefore management of risk towards them. Such 'ownership' could only be achievable for a limited number of people but may be seen as good practice for particular medium or high risk victims, identified through the MARAC process. The MARAC meetings go some way towards drawing together information but the onus then returns to individual agencies to complete the work, often in silos.

5. Learning for Bristol Community Safety Partnership

- 1) Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. It may now be timely to review not only what recommendations have been made and completed by DHR's in Bristol, but also what difference those have made. In keeping with national research (Domestic Homicide Reviews- Key Findings from Analysis of Domestic

Homicide Reviews (December 2016)) the individual agency recommendations in this case mainly focus on improving training, communication and information sharing. It has been so with all the DHR's in Bristol to date, and also nationally. This may indicate that there will always be shortcomings in knowledge and information sharing, in which case processes must be developed to protect against any failings these may cause. A review that looked at all DHR findings to date, and the change that has been brought about by them, could inform decision making on the robustness of Domestic Abuse services locally. It would indicate whether future reviews will continue to find the same shortcomings and could highlight the need to approach Domestic Abuse issues in a different way, for example by having a lead agency as above for better risk assessment or increasing work with offenders as below. A comprehensive review on how current services are actually performing now, may be more productive in protecting victims than historical scrutiny, post homicide/suicide, of systems that have already changed and improved.

- 2) The recently published work by the University of Cambridge and Hampshire Police, as set out in the report, shows the benefits of working with perpetrators, to reduce the risk to victims. The Resolve to Stop Violence Programme (RSVP) work commissioned locally to work with perpetrators of domestic abuse is limited in the number of offenders it can include and is short term funded. A proper review of the performance of this scheme in reducing re-offending, together with the results of the University of Cambridge/Hampshire Police model may point towards the benefits of finding ways to broaden out the programme to a greater number of people and those lower level offenders before their behaviour becomes ingrained and more serious. Working with perpetrators to change their behaviours can reduce risk to victims and should be seen as a positive way of supporting current, or preventing future, victims.
- 3) The current practice of risk assessment completion showed some failings in relation to accuracy and access to information on which it should be based. A review of current practice by dip sampling of a number of risk assessments

across all agencies to assess accuracy, necessity and what was changed as a result would be worthwhile. A proper independent review that cuts across all agencies is the only way of ascertaining whether the significant amount of work that goes in to their completion achieves the intended outcomes.

- 4) The concept of having a lead agency/professional for certain individuals based on the risk to them or the complexity of issues affecting their lives is one that is recommended for consideration by the CSP. Having “Ownership” in one professional or agency could allow better understanding of risk and also allow a focus on what services are necessary for such individuals. It may actually allow for a reduction of the agencies working with an individual by removing duplication, which can only be of great benefit to agencies whose staffing levels have been reduced significantly by the funding cuts of recent years. It would allow a more intelligent, focussed and proportionate service delivery for those individuals who have most agency involvement.

6. Regional/ National Issues identified

6.1 This review has been running alongside another, totally unconnected, DHR which had very similar aspects and also arose from the suicide of a woman locally who had suffered domestic abuse at the hands of a number of partners in her lifetime. Recommendations from that review, in relation to national and regional issues, are mirrored by those identified in this review. Those recommendations for consideration were-

- 1) This review was initiated on Home Office Guidelines despite the fact that it was a suicide, rather than a homicide. If this is to be continued practise, it is requested that the Home Office review both the title of such reviews and the content of its Guidance document. A more fitting title, such as “Domestic Abuse Related Death Review” would be more accurate and also prevent the situation of raising doubt in the minds of the deceased’s family who, having come to terms with the suicide of their loved one, are informed that a review is to be carried out of the ‘homicide’. Such a change in title could be mirrored in a Guidance Document that makes it clear that references,*

contained within it, to 'perpetrator', relate to a domestic abuser who may or may not have been involved in the death.

2) As part of the consideration of the DHR process, greater flexibility could be given to Community Safety Partnerships to only review those suicides where Domestic Abuse appears to have been a significant and primary influencing factor on the decision of the person to take their own life. This may require some initial scoping work in establishing motivation, but would fall short of the sometimes cumbersome, time consuming and financially challenging processes of a full DHR review. This would allow a focus for DHR's only to be conducted for those most troubling of deaths where there is most likelihood of, and need for, significant learning. It would also mean that time and money that could be devoted to supporting current victims of Domestic Abuse and not being unnecessarily devoted to costly and time consuming historical reflection that will produce little learning.

3) The Guidance also includes direction for Chairs/Panels to contact the perpetrator. Whilst the benefit of the insight they could provide may be very valuable, it is difficult in the case of suicide, where the perpetrator in the death of the deceased, is the deceased. To seek out and engage with a perpetrator responsible for the domestic abuse of the deceased during their life is made difficult by Data Protection legislation as in this case, where there was a reluctance to release details to the Independent Chair, of the new address for the partner who played no part in the death.

The Chair asks that they also be considered by those deliberating on the findings of this review.

6.2 Separately, this review identified one issue for national consideration-

- There was an issue in this case with the decision by the court to give a Suspended Sentence Order rather than a Community Order. The former can be for a maximum of two years and the latter a maximum of three. The longer period of a Community Order clearly makes it more effective by giving the time to run a programme and then monitor the change/impact afterwards. Where reasonable, in line with Sentencing guidelines, the National Probation Service could propose a Community Order to allow more time to complete the

Programme but it clearly needs to take into account proportionality. The Independent Chair understands that there have been discussions at a national level between the National Probation Service and the Ministry of Justice to ensure that courts in carrying out their sentencing powers consider the benefits of using Orders with longer time frames in cases of domestic abuse to not only allow programmes of rehabilitation to take place but also to monitor their impact afterwards. Delays were seen in this case when Susan's partner received a suspended sentence order that was to include completion of a Building Better Relationships (BBR) programme for the 'white spirits' offence. As a result, it took some significant time to commence and there was no period afterwards to monitor if there was a positive change. It may have been that the unacceptable delays in this case in the commencement of the partner's BBR programme were in part due to changes within the Probation Services at the time or staffing difficulties. In any case, the panel recommends that the Home Office, with the National Probation Service, reviews current practices in sentencing to establish whether best practice is being followed to allow proper time to provide effective rehabilitation. If there are found to be similar failings, the guidance for sentencing bodies should be reviewed and amended to give the system the likeliest chance of succeeding, in the best interests of victims of domestic abuse.