



Bristol Community Safety Partnership

Domestic Homicide Review

Overview Report

14th January 2018

Victim, Adult Female, Susan Taylor (pseudonym)

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

Family Statement

Susan was a bright woman who endured adult decisions and sacrifices from an undeveloped age. Her life was a husk before she chose to end it in the manner she chose, and we seek solace in the fact she suffers no more. The events that led to the system lacking were due to legal oversight and sheer happenstance and we are happy that some insight can be given to address some failings in the system our society relies on. Susan's life has not been in vain as her children will endeavour to prove with the distorted imprint she has left being something of use to society and authorities.

Contents

1. Introduction
2. Circumstances leading to the review
3. Decision to undertake a review
4. Context and purpose of the Overview Report
5. Agencies involved in the review and Independent Chair
6. Involvement with family and associates of Susan Taylor
7. Background to the death
8. Circumstances of Susan Taylor's death
9. Review of agency involvement
10. Timescales for the review
11. Significant themes for learning from the review
12. Learning from previous Domestic Homicide Reviews
13. Conclusions
14. Learning for individual agencies involved in the review
15. Learning for Bristol Community Safety Partnership
16. Regional or national issues identified
17. Summary of Recommendations

Appendices

- A. Terms of reference
- B. List of agencies contacted for the review
- C. Glossary of terms
- D. Home Office Quality Assurance Feedback and Response
- E. Action plan for implementation of recommendations

1. Introduction

1.1 This review is into the death of Susan Taylor who died in September, 2016, in Bristol. Following a police investigation by Avon and Somerset police, and HM Coroner's Inquest, it was concluded that she killed herself.

1.2 Susan was a woman in her 30's who 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). It cannot be confirmed categorically that the relationship was ongoing at the time of her death. 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.

2. Circumstances leading to the review

2.1 Susan lived near to close family members. In the days leading up to her death, 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.

2.2 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.

2.3 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 did not cooperate fully with the police at the time but much later made disclosures to her Independent Domestic Violence Adviser that suggested she may have been sat on the sofa at the time and the white spirits may have also gone over her. However, that was not known at the time or prior to her partner being dealt with at court for it). 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. In the months before her death, it is believed she may have been seeing Simon Harper, but, as already described, keeping this secret from her family and those agencies that were providing her support. This cannot be confirmed.

2.4 In view of all the above circumstances, this review will focus on the agency involvement with Susan, and her relationship with Simon Harper, from 2009, though each agency has also looked back at all their involvement, where relevant, to understand her situation better. A significant amount of support had been given to her by the local authority Children's Services due to issues with her children. This work, though subject of an in-depth review as part of the Domestic Homicide Review process, will not feature in the overview report other than it relates to the history of domestic abuse, and the help it gives to provide insight into, and lessons learnt from, that abuse. A number of those lessons learnt in relation to the service provided to Susan and her children by Children's Services have been considered and acted upon already by the agency, outside of this report.

3. Decision to undertake a review

3.1 Susan Taylor was not murdered. She took her own life, though the reasons for that are unclear. Her mental health had suffered causing her to hoard, making her house uninhabitable and leading to concerns about her parenting, all of which had resulted in her children being cared for by other family members.

3.2 Work was to be carried out by the council to improve her house and was to start around the time she took her life. She had been told that she had to de-clutter her

house for this to take place. Due to her ongoing health problems, this tidying had not been completed. She did not leave a note or communicate her intention when she killed herself. It is therefore impossible to tell if she killed herself because of the various pressures she was under, or her inability to sort out her house and therefore get her children back, or some other reasons.

3.3 Her family are strongly of the opinion that she killed herself to protect them, as they believe that Simon Harper will have threatened to harm them if she did not let him back in to her life. Faced with having to see him secretly and keep it from her family they believe that she would not have been able to see an alternative other than to kill herself. It is known she had attempted to take her own life at other times of severe stress in the past. Since her death, they have taken steps and involved the police to keep him out of their lives.

3.4 Her death falls within the broader parameters for the requirement for a Domestic Homicide Review (DHR), given her death was recorded as suicide and she also had a history of being the subject of domestic abuse and was recipient of agency intervention. This is as set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016) and associated Home Office documents.

3.5 The circumstances were reported to the Bristol Community Safety Partnership for their meeting on 30th September, 2016. They agreed that Susan's death did meet the criteria, so a DHR would be carried out and they informed the Home Office of that decision. Terms of reference for conducting the review were also developed (See Appendix A). Initial scoping took place which identified significant involvement with Susan by a number of agencies. This was not just in relation to concerns for her welfare but more particularly that of her five children, particularly the four youngest.

3.6 The Independent Chair and author of this report, Ian Kennedy, was appointed to lead the review. He is a retired former senior Police Officer who has never been employed by, or worked with, any of the agencies involved in the review. The review entailed each agency reviewing their own practices to inform the creation of this

report by the Independent Chair. On completion, this report will be presented to the Bristol Community Safety Partnership for agreement and onward transmission to the Home Office.

4. Context and Purpose of this Overview Report

4.1 The purpose of any DHR is to examine agency responses and the support given to a victim of domestic abuse prior to their death. Lessons learnt, and a full understanding of what happened, can inform changes to practices and policies, to improve services to others and help reduce the number of avoidable similar deaths.

4.2 This report will have a number of potential audiences and readers, including agency managers and staff, the Home Office, press and media, the general public, academics, people involved, plus friends and family of the deceased. It must meet all their needs, so it is written in a style that will be accessible and informative to all parties in order to achieve its aim, to inform decision making and to ensure transparency. Whilst some anonymisation must take place to properly protect some individuals' confidentiality, it has been kept as open and direct as possible. Care will be taken to explain agency specific terms whenever possible. A glossary of terms will also appear at Appendix C for easy reference.

5. Agencies involved in the review and Independent Chair

5.1 All agencies who had, or may have had, an involvement with Susan in the years prior to her death were invited to be part of the Review Panel and to complete Independent Management Reviews (IMR's) of that involvement. These are reviews carried out by a senior manager or other qualified individual not involved with the direct delivery of service to the person whose death triggered the DHR. In smaller agencies where it is not possible to identify such an independent person, arrangements are usually in place for someone from another associated group to conduct the IMR for them. For example, in a GP's surgery every doctor may have seen the person at some point so an independent person from the local Clinical Commissioning Group may carry out the review for them.

5.2 Agencies and Lead Individuals involved in this DHR as members of the Review Panel were-

- Victoria Caple, Avon and Somerset Police, Manager, Bristol Safeguarding Coordination Unit
 - Lucy Watkins, Bristol City Council Early Help
 - Kate Mansfield, GP, Clinical Lead for Domestic Abuse for South Gloucestershire
 - Jill Chart, Named Nurse for Safeguarding, Sirona Care and Health
 - Be McCarroll, Head of Estate Services, Bristol City Council Housing Services
 - Krystal Presland, Policy and Projects Officer, Bristol City Council Housing Services
 - Sarah O'Leary, Service Manager, Next Link Domestic Abuse Services
 - Allason Hunt, Senior Probation Officer, National Probation Service
 - Mark Thompson, Contract Account Manager, Victim Support
 - Rick Cooper, Head of Service, AWP, Mental Health Services
 - Mark Dean, CAMHS, Mental Health Services.
 - Robyn Pickering, Bristol City Council Safeguarding Adults
 - Fiona Tudge, Service Manager Safeguarding and Change, Bristol City Council
 - Verity Felles, Bristol City Council Children's Services.
- (See also Appendix B).

The panel and Chair received excellent support and guidance throughout the review from Lynne Bosanko, Crime Reduction Project Officer (Domestic Violence & Abuse) at Bristol City Council. Their gratitude to her should be noted.

6. Involvement with family and associates of Susan Taylor

6.1 In her early teens, Susan Taylor was taken into care after allegations were made of sexual and physical abuse by an extended family member who was resident in her home. Whilst in care, aged 15, she became pregnant to a boy of a similar age who was in care at the same home. This led to the birth of her first child who through his life had periods when he was resident with, and separately cared for by, his mother, his father or his maternal grandmother. Susan did not have a lasting emotional relationship with the father of this, her first child, and went on in her late teens to have a relationship and child with a second man. The child was injured, allegedly by that partner, causing severe disabilities which require ongoing full time care, and she has been looked after for all her life by Susan's parents. The relationship with this partner broke up as a result, and prosecutions were taken by the police in relation to

the injuries caused and, for Susan, there was a finding of fact in a child care court that she had failed to protect her child.

6.2 Susan then met another man with whom she had a more stable relationship and they had two children together, prior to them breaking up due to alleged infidelity on his part. She then went on to have the relationship that continued until some point prior to her death. Her youngest child came from that relationship.

6.3 It was clear from an early stage of this review that Susan for much of her adult life had relied heavily on her close family for support, and to look after her children when she was going through difficult times physically and mentally. As a result, the review group were very keen to involve family members in their work.

6.4 At the second meeting of the group, Susan's eldest child came and spoke about his mother and the various agencies that supported her. He spoke for half an hour at the opening of the meeting in very moving and insightful terms. It was a great help to the various members present and allowed them the opportunity to contextualise their reviews.

6.5 To build on this, a meeting was arranged by the Chair with the same child again and also Susan's mother, separate to the formal review meetings. This was attended by review group members from the main agencies who worked with Susan and her children. Susan's mother and son spoke openly and bravely about Susan for several hours and gave a comprehensive perspective on her life, her relationships and the agency work carried out with her. It was invaluable to the completion of this review and the Chair and Review members are deeply grateful for the insight and honesty of Susan's mother and son.

6.6 Susan's family have been given access to this report to consider its content and findings prior to it being submitted to Bristol CSP. They were grateful to have seen it and welcomed its accuracy and findings. They described being involved in the process throughout as having been helpful for them as they continued to come to terms with Susan's death. They commented adversely on the inappropriateness of the word 'homicide' in the official title of the review process.

6.7 No contact has been made with the father of Susan's youngest child. Whilst it is strongly believed that he may have been secretly visiting her house in the months before her death, this has not been confirmed and they may have ceased their relationship over a year before, when she took out a non-molestation order against him and he was removed from their joint tenancy.

6.8 Susan's family had very strong feelings that he should not be involved in the review in any way. It was their first reaction when told about the review and their abiding strong feeling. He had caused such problems for them, and her, during Susan's life that they did not want him to cause more after her death, believing he would manipulate the process to hurt them or Susan's memory.

6.9 The Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016) is unclear on the need to speak with former partners in the case of a suicide that has led to a Domestic Homicide Review. There is reference to the 'perpetrator' being approached but this is in the context of homicide, not suicide. As such, the legality of accessing personal data, to establish where former partners are living, under the Data Protection Act 1998 has been questioned. This will be revisited in the conclusions at the end of this report.

6.10 For all these reasons, the Independent Chair decided that the father of Susan's youngest child will not be contacted. An indication of the negative response he may give, had he been approached, can be drawn from his attitude to work with CRC whilst on a suspended sentence order, saying he 'forgot it all as soon as he left the building'. The Chair can see the potential benefits of speaking to a former partner both to gain their insight and allow them to have their say, but in these specific circumstances believes the possible harm and upset outweighs any public interest even if the former partner's details were available.

7. Background to the death.

7.1 The main agency involvement with Susan was in relation to the care of her children, and her health. This had followed through from the birth of her first child to the time of her death and in recent years had seen some key events arising from her

personal circumstances, her deteriorating mental health and the impact of the relationship with her, apparently, coercive and controlling partner. Whilst this relationship appeared to have finished over a year prior to her death, there is a belief that it may have been ongoing. If so, this was a secret that she kept from her children, parents, and agency workers with whom she was engaged in the weeks before she took her own life.

7.2 The latter years of her life were also marked by significant though undiagnosed mental health issues when she began hoarding at her home. This was to the point of it being unsafe for children to live in, and she also suffered delusions that people were breaking in to the house through the attic and that her home was infested by insects, when neither was the case. Some of these psychoses are attributed by her family to her illicit use of 'speed' (amphetamine sulphate), traces of which were to be found in her blood, post mortem.

7.3 Having started the relationship with what was to be her final partner around summer of 2010, she lived together with him, on and off, in a house just across from Susan's parents. As well as providing full time care for Susan's second oldest child, they were to take care of her other younger children on an increasingly frequent basis following incidents involving her care and the breakdown of her relationship.

7.4 The focus of this overview report will be on actual or suspected domestic abuse that Susan suffered during her last relationship. The first significant incident in this regard was an event in late 2013 when her partner was arrested for causing damage and pouring white spirits over a sofa when Susan and her children were present in their house, and threatening to set it alight. Bristol City Council Children's Services were well represented on the review panel and conducted an in-depth review of their involvement with Susan which was quite rightly focussed on her children. This report will only refer to that analysis in so much as it relates to domestic abuse and protecting Susan from it. Any lessons learnt in relation to support for, and work with, Susan's children has been translated into an action plan which includes all relevant agencies. This is featured in Appendix D.

7.5 Susan's partner was arrested for the 'white spirits' incident in November 2013. The reported circumstances were that they had been arguing for a number of days over the breakdown of their relationship. This escalated and he damaged property at the house and carried out the acts that got him arrested. With police assistance, she removed herself and her children from the house.

7.6 Having been arrested, he was remanded in custody pending his eventual appearance at Bristol Crown Court in January 2014. At court, he was found guilty of causing damage with intent to endanger life and was given a Suspended Sentence Order (SSO) for Threats to Commit Criminal Damage and Common Assault. He received a 10-month custodial sentence suspended for 24 months. During this 24-month period, he had to complete two Requirements consisting of 24 months of Supervision and 24 sessions of the Building Better Relationships (BBR) Accredited Programme. He had previously not been known to the National Probation Service.

7.7 Initial safeguarding action by the police and other agencies immediately after this incident occurred was good, with warning markers being placed on Susan's address and the address where her children had been taken to. Specific Domestic Abuse, Stalking Harassment (DASH) risk assessments were carried out and information was passed to the joint Safeguarding Unit. Personal panic alarms were deployed to the addresses as it was not known initially if he would be remanded and all information was shared with First Response, CYPS and Safeguarding Children's team (this team includes representation from health visitors, GP service and the school nurse service). First Response are the local authority assessment team who decide what further action needs to be carried out and whether matters need to be passed on to Area Social Work teams. As Susan had gone to her mother's and was seen as being protective towards her children, it was not considered necessary for the Area Social Work teams to get involved. The response overall can be seen as supportive, comprehensive and focussed not only on Susan but also her children and close family members.

7.8 Susan did not necessarily welcome the involvement by "Social Services" (as she referred to Children's Services) with her children. She is quoted at the time as being unhappy with their involvement as she had suffered domestic abuse in previous

relationships, as a result of which, “Social Services make [made] her life hell”. These sentiments were to be repeated by her again over coming years and are a clear indication that “Social Services’ intervention” could have very negative connotations for her and was a cause of stress. It should also have been an indication to professionals involved with her that she may suppress information about domestic abuse to prevent further “Social Services” contact. It may explain to some extent why she later kept her resumed relationship with this partner secret, if it had indeed resumed.

7.9 When her partner, Simon Harper, was released from custody by the court in January 2014, the Safeguarding action was less comprehensive. He was joint tenant at the house where Susan was living and he was legally entitled to return there. There does not seem to have been the same multi agency activity. Police records show a Next Link IDVA had been engaged with Susan at the start of January 2014, ending their involvement because Susan ‘felt safe and had support in place’. The update from Next Link followed a referral to them, in December 2013, by the police to inform them of the ‘white spirits’ incident. It shows that appropriate action to support Susan had been taken following the original incident and this had not been continued due to Susan’s positive reaction when approached by Next Link.

7.10 Police records further show that a Witness Liaison person informed them that Susan’s partner had been sentenced and received a suspended sentence. This information appears to have been filed with no fresh risk assessment being carried out on the impact of his release from custody and being free to return to the communal home. There was no representation by the Court or Crown Prosecution service on the review panel for this DHR. The good inter-agency safeguarding work and management of risk that had been seen immediately after the ‘white spirits’ incident was not evident on this release from court. Whilst it is a one-off incident which did not lead directly to any adverse incident and therefore does not now justify any specific corrective action by the police, there may have been an opportunity here for the police to re-visit the risk assessment and ensure Susan’s well-being, rather than just filing the information.

7.11 The Suspended Sentence Order was supervised by Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company (BGSW CRC). They manage cases where the risk posed by the person, subject of the order, is assessed as medium or low. High risk cases are managed by the National Probation Service. Work under the order with Susan's partner was considered to have been successfully completed, in BGSW CRC's Independent Management review. This is despite the fact that he was not able to attend the Building Better Relationships Programme due to back logs, and a late referral, until February 2015 some thirteen months after his sentence. Further to this, he did not attend some appointments, arrived late for others and was disruptive in some group sessions. Due to the overly late start to the programme there was no time left at the end of it, while he was still subject of a probation order, to see if it had brought about positive change. Some of the delays and apparent shortcomings in service were as a result of major structural change in the probation services and have been improved since.

7.12 It is unclear exactly when Susan's partner returned to live at the address, but in April 2015, a Multi-Agency Risk Assessment Conference (MARAC) was held after concerns were raised by Susan's Nextlink IDVA that, *"whilst [partner] was in prison, he had been sending people to the address to keep an eye on her. Susan reported that he keeps calling her when he is out, asking how many people are in the house when he is out. The children are scared and do not want him in the house. The arguments, verbal abuse, constant calling is happening every day. The partner is making Susan tired by doing this so he can have full control over her. When he was released from custody following the court hearing, he went to Susan's home address as they have a joint tenancy. Susan was reported to be exhausted and would like him to move out of the address."* At the MARAC meeting, as 'no offences were disclosed', various markers were put in place to pick up any further issues or hospital A&E attendance, information was shared across relevant agencies and the Nextlink IDVA continued her work.

7.13 No action was taken in respect of the partner on receipt of this information. Since that time, the full criminal offence of Controlling and Coercive Behaviour (Section 76 of the Serious Crime Act 2015) has been created and it is the belief of the review panel that many of the actions of Susan's partner would amount to

evidence of that offence and in similar circumstances there would now be opportunities to consider prosecution for it. That was not available to the police at the time of this MARAC. The alleged elements of controlling and coercive behaviour will be highlighted and addressed later in this report. At the time of this MARAC meeting, Susan's partner was subject of his Suspended Sentence Order and still being supervised by CRC, and the MARAC minutes reflect that an update was reported from them. Despite this, the focus appears to have been on Susan as a victim, or her children, but the possible 'offender' element was not addressed by any agency other than the Probation Services. The provision of an update from CRC is however a good example here of multi-agency information sharing, albeit the focus of the meeting was on Susan and her children. It is believed, now that there is the specific offence of Controlling and Coercive behaviour, the police would not need to take a 'no offences disclosed' approach.

7.14 The next significant event was in January 2016 when police attended Susan's address at the request of her Nextlink IDVA, as she had concerns for Susan's welfare following a lack of contact. Due to the state of the house, when the police visited, it was considered unsafe for children as a result of the clutter created by Susan's hoarding. They also had difficulty waking Susan who was sound asleep whilst her youngest child roamed freely in the house. Due to the concerns these conditions raised, the police arranged for her children to be taken away and cared for elsewhere. They were subsequently put in the care of family members. Whilst this incident is primarily focussed on Susan's childcare, it is another example of the focus for agencies being on her and the children, probably quite properly. With the benefit of hindsight, the situation may have been a clear indication of her failing mental health, one cause of which may have been her on-off relationship with an abusive partner, as described to her IDVA in April the previous year (para. 7.11 above). No work or contact was made by any professionals with Susan's partner after these concerns about her parenting, no doubt because he was not resident at the address though it was suspected he may have been calling secretly to see his child and Susan.

7.15 A further very similar incident occurred in April 2016. Again, police attended, this time after concerns were raised by Susan's Family Intervention Team worker as

Susan was not engaging and contact had been lost. The police found the house to be once again in an unliveable state due to Susan's hoarding, and a criminal investigation was commenced by the police in respect of neglect issues by Susan. She was interviewed under criminal caution some weeks later in the presence of her solicitor. She described the house as a 'work in progress' and 'not too bad'. She blamed Children's Services and the council for not giving her enough support and recounted significant debt, personal problems and depression. Significantly, she said her former partner had not been at the house for over a year. She took no responsibility for the state of her house or showed concern for her young child roaming the house while she slept upstairs.

7.16 The police sergeant supervising the neglect investigation recorded on the file that there was clear evidence of child neglect and told the officer in the case to discuss the facts at an early stage with the Crown Prosecution Service (CPS). A facility called an Early Investigative Appointment is offered by the CPS to allow officers to do this. It is disappointing to note that an appointment was booked by the officer in the case on the 24th June but the earliest this could happen was going to be the 28th September 2016, three months later. In cases of Child Neglect, children will invariably be kept away from the family home until investigations are completed. It cannot be in the best interests of children who have been removed from a family home, to have their enforced absence extended by at least three months to allow an 'early' discussion between a CPS lawyer and an officer in the case.

7.17 Discussions took place between the Independent Chair and the police representatives on the panel on the police approach of investigating Susan criminally for the neglect issues involved. This was in the context that there was already Family Intervention Team/Children's Services involvement and the circumstances were largely known to their workers. It is the opinion of Avon and Somerset police that it was right and proper to investigate the matter criminally, and this would have identified it being down to Susan's mental health issues, if that was relevant. They do however accept that it took far too long and there was no effective liaison between the respective supervisors of this investigation and a concurrent one involving her partner for breach of a non-molestation order. They saw the neglect investigation as being necessary in relation to looking after the children who were

victims of it, and to meet the obligations of the police in relation to safeguarding and carrying out appropriate action when the investigation is concluded.

7.18 Running in parallel to these incidents was the fact that Susan was doing her best to break off her relationship with her partner, and had fled her address after a domestic violence incident in mid-June 2015. There was no police involvement on that occasion, and the nature of the incident is unclear. She went on to have the partner removed from the joint tenancy, effectively making him homeless in late June 2015, and she also obtained a non-molestation order against him at that time. He was in breach of this by having been seen outside her house at 4am one morning in late April 2016 and an investigation was launched which was abandoned by the police in August 2016. They had not spoken to the partner but used the fact that he may have been calling for post at the former joint home address, among the reasons for taking no further action. This investigation was launched, and later abandoned, whilst the investigation into Susan's alleged neglect was ongoing. The two enquiries were not cross referenced and no contact seems to have been made between the separate investigators. The police have addressed this in the recommendations of their IMR.

7.19 Throughout the period under review it was noted that risk assessments had been completed by different agencies at various points. There was noted inconsistency in some of the rationales. There was also evidence that information held by each agency, or even within differing areas of the same agency, was considered in a silo approach by those competing the assessments. Consequently, they were by their very nature incomplete and risk was assessed on some, but not all, of the information that could have been considered. This was aggravated by over restriction of handling levels by some agencies or a misunderstanding of what could be shared on individual agency systems.

7.20 Without major investment in databases that search across all agencies, or specific agencies being given the lead role for individuals considered to be at higher risk and being the recipients of all their relevant intelligence, this will continue to be the case. The former approach may be beyond the limits of current austerity reduced public budgets but may be the only way the latter approach could be

achieved and time critical processes for sharing and accessing information put in place.

8. Circumstances of Susan Taylor's death

8.1 In early September 2016, Susan was living at home by herself. Her children were being looked after by, and resident with, her mother. Some work had been ongoing to make Susan's house habitable for her children, but she had continued to hoard and the house was still full of clutter. It was a dangerous environment for her children. The council had agreed to do work on the kitchen, a bannister, and bathroom. This was to commence the day after Susan was found to have killed herself. She had been told to have the house clear by then to allow the work to take place. There were concerns within the review group that this ultimatum to clear the house had gone further and may have been linked to the return of her children. No evidence was found of that in the end but it will never be known if it was a link that Susan made for herself, i.e., if she did not manage to clear her house, the work would not happen and her children could not return.

8.2 She did not leave a note or explain her plans prior to taking her own life. Her family believe that she may have taken her own life to protect them, after threats made by her former partner. For them, it may have been the only way she saw to get out of that situation. In any case, the reality was that she had various conflicting pressures in her life. These included her mental health, the housing situation, having her children live elsewhere, the legacy issues from various abusive relationships, and the pressures of maintaining a façade of not seeing her partner if indeed she had been seeing him in secret under duress. She had also been going through counselling sessions with her youngest child at CAMHS. Such therapeutic work can bring its own stresses and revive emotional incidents from the past, which can also have an effect on mental health by bringing past events back in to sharp focus.

8.3 What is known is that she had not been seen for three days by her family so they contacted the Children's Services social worker who was working with her. They shared their concerns and the social worker arranged to call the next day with the family. Prior to this visit happening, the next morning Susan's eldest son went to Susan's home and saw her inside, hanging from a ligature. He forced an entry and

having cut her down, tried to resuscitate her. This was not successful and on arrival of paramedics she was declared dead.

8.4 Susan had attempted suicide at other times in her life, the first when still a teenager. The incidents were at times of stress in her life, and it is only the benefit of hindsight that allows a view that it may have been predictable on this occasion. There were no indicators either to professionals or those close to her that it was her intention at that time.

9. Review of agency involvement

9.1 Each of the agencies represented on the DHR Panel prepared Independent Management Reviews (IMRs) of their involvement with Susan. The focus was on the period from the start of her relationship with Simon Harper in 2010 as this was her last close relationship and it was known to have included domestic abuse. It was also left open for IMR authors to look further back in to their records for any information that may be relevant outside that period.

9.2 Given the fact that Susan had been subject of agency involvement since her early teens there was a significant amount of information for some agencies to review. I will summarise the findings of each agency and lessons learnt in the following paragraphs.

9.3 Avon and Somerset Constabulary

9.3.1 A full review was carried out of police databases, and some key members of staff involved were interviewed. In keeping with the way that all single agency reviews were completed, the Independent review was conducted by a member of staff not involved with the case and signed off by a senior manager on behalf of the force. Again, as with all the reviews, this was then discussed at Review Panel meetings and specific points were challenged by the Chair or other panel members to reach final conclusions and Lessons Learnt/identify actions to improve service delivery.

9.3.2 The review concluded that Susan was a victim of domestic abuse, historically from a former partner and latterly from Simon Harper, with whom she was still

possibly continuing a relationship at the time of her death. If so, Susan kept this relationship secret from the authorities and from her family.

9.3.3 The review identified some areas of learning including-

- improvements in managing parallel investigations (as in this case with Susan as 'offender' in one investigation at the same time as being 'victim' in another linked one);
- information sharing and use of an anonymised version of this case to improve MARAC processes, and
- increase staff awareness of dealing with cases with a victim of domestic abuse who may have strongly held reasons why not to report, such as a fear of losing custody of her children.

As with all the reviews, the police created a single agency action plan which is included in the action plan and can be found at Appendix D.

9.3.4 Whilst the police have identified ways of improving their services and some failings in this case, it is not believed they could have foreseen or prevented Susan's death.

9.4 Bristol City Council Children's Services

9.4.1 A very comprehensive review was conducted by a member of staff from this agency. It was far reaching and looked at all aspects of their service provided to Susan not only specifically in relation to domestic abuse. They found some elements that could have been addressed better, an example of which was in relation to how a disclosure by one of Susan's children, of violence towards her, by her partner was dealt with. Susan had been asked about it and dismissed it, which was favoured over the child's account. This was at a time when she may have been seeing her partner secretly, under duress or otherwise. It may also tie in with earlier comments in this report of her disliking "Social Services" involvement in her life which would be a reason in itself for her to dismiss it. What was identified by this review, as with many of the other agencies', was that Susan did not maintain contact with them or make herself easy to contact. This may just as likely to have been due to her mental health issues, as her mistrust/dislike of 'Social Services' or other agencies.

9.4.2 Another issue that was highlighted by the review was the provision of information from Susan's GP to Child Case Conferences. It appeared at one, in July 2016, that none had been provided. Given the amount of background and current information held by the GP this was seen as a failing. On further investigation, it was ascertained that a report had actually been prepared and received by Children's Services but due to an administrative error had not been provided to the meeting. Whilst not primarily related to domestic abuse matters, this was highlighted as a significant issue and the process for managing child case conference information has been tightened up to prevent it happening again.

9.4.3 Suggested actions for this agency include-

- considering referrals to a GP in relation to: the mental health of a parent, with or without consent when appropriate rather than assuming self-referral;
- a review of Child Protection Conference arrangements to ensure they receive, consider and disseminate the best possible information and are capable of being attended by as many relevant people as possible, and
- training and reflection arising from identified issues.

9.4.3 The actions show that lessons have been learnt and reflect the desire to continue improving service provision. Whilst such changes may increase the possibility of a better outcome with cases in the future, this cannot be guaranteed, and if as in this case an adult with whom they are working either cannot or will not maintain an open and cooperative relationship.

9.5 Bristol City Council Early Help

9.5.1 The review by this agency showed that they had worked with Susan since late 2014 when information came from a family member that suggested she may be subject to domestic abuse from Simon Harper. There were some hold ups with this information not being addressed with Susan until early 2015, and the approach to her met with a negative response. Despite this, concerns were such that the MARAC referral by Susan's Next Link worker referred to above in this report was made after initial visits with her in April 2015.

9.5.2 Work with Susan and her family continued through to mid-2016, with 'stepping up and down' between Family Intervention Team and a Social Worker at various times when the need was seen to amend the level of intervention, or to involve social work intervention when the perceived risk to the children increased. The review concluded that whilst many visits were made to the family and a large amount of information gathered, there could have been greater resultant action, plus not enough time was spent analysing the information and the root cause of the issues, i.e. Susan's mental health difficulties and plans made to address these.

9.5.3 Lessons learnt were drawn up and these included-

- DASH assessments and the information that support them should be shared between the care professionals working with families;
- proper completion of assessment of risks prior to step up/step down processes being conducted to properly understand the situation and inform decision making at changes in level of service;
- where joint working takes place between Early Help and Children's Services there is clear demarcation of joint and individual responsibilities to avoid duplication or work being missed;
- too much time was spent gathering information and not enough time analysing it, which led to failure to address some issues such as Susan's mental health, though improved practices would now address this;
- work should be included with male 'perpetrators' to understand and reduce risk, despite the difficulties this can bring;
- broader engagement of agencies involved with families not just those that they work closely with all the time.

9.5.4 Good practice was identified in relation to periods of good relationships being maintained between their worker and Susan, a professional and committed approach by their worker which benefitted the care provided to Susan and her children, good record keeping (though this was tempered by less thorough supervision), some good inter agency work and continuity of worker through different roles.

9.5.5 In conclusion, the review showed that whilst there was a great deal of well-intentioned work, it lacked some focus, and subsequently action. There does appear

to have been a focus on Susan as a person, but the work lacked a similar focus on her hoarding issues which could have been indicative of her mental health issues and as such the root cause of her behaviours was not addressed. There may have been an opportunity for it to be addressed in the period when she appeared to be out of the influence of her abusive partner, the non-molestation order was in place and Susan had single tenancy of the house. This was a difficult time for Susan and whether or not she would have been willing or able to engage with a more focussed approach on her mental health and hoarding problems is of course unclear. As it was, Early Help put significant efforts in to trying to get her to engage despite the fact that this was not taken up by Susan. The lessons learnt are reflected in the recommended actions for Early Help- shared DASH assessments, Step Up/ Step Down protocols strengthened, and more focussed approaches to work.

9.6 GP

9.6.1 The review for GP services was carried out by South Gloucestershire Clinical Commissioning Group and included a review of all records for Susan and her children insofar as they related to domestic abuse issues for Susan. There was a great deal of contact with her GP by Susan down the years for a range of medical issues both for herself and the children. Most recently she had consulted with her GP about sleeping problems and her mental health. She had been referred on to Mental Health Services but had failed to return their contacts by phone and mail. This led to her referral for Mental Health Services being declined by the provider in August 2016. The mental health provider had discussed the difficulties over communication with Susan's GP. As the service which they could provide relied on a commitment and engagement with the patient, it was mutually decided that Susan was probably not ready for it at that time.

9.6.2 The review otherwise showed that GP's had made time for Susan and were aware of domestic abuse and child protection issues, being recipients of information from other agencies. They had provided all relevant information to multi-agency meetings but had not been able to attend any of these due to late notice and clashes with surgery commitments. There was evidence that the GP's surgery was not always updated after the meetings were held. Such lack of consistency in the

provision and feedback of information can only lead to imprecise or ill informed decision making and planning.

9.6.3 Consideration has been given by the review panel as to whether having a single point of contact at GP surgeries, to handle and provide information to multi agency meetings, would improve information sharing. The practicalities of the situation would generally not allow for this to be anything other than an aspired for position. Taking this case as an example, there are actually 29 part-time GP's in the surgery where Susan was registered making identifying an available single person difficult, and, whilst there is a GP Lead for domestic abuse, they are also lead for safeguarding children/adults. They will have their own surgery appointments to keep and may be on call out.

9.6.4 This GP lead role is a feature of IRIS (Identification and Referral to Improve Safety) which is the domestic abuse training and advocacy service that has been delivered to all South Gloucestershire and a large proportion of Bristol practices, and is be seen as good practice. The usual point of contact for seeking information as a matter of urgency is likely be an on-call GP who would not be doing a planned surgery but will also be dealing with a large number of urgent calls. The lead for domestic abuse would provide support and guidance to their colleagues. Fortunately, the evidence available to the panel is that where GP practices are asked for reports for MARAC then in the majority of cases the information is provided ahead of the meetings.

9.6.5 It concluded that the GP practices involved in Susan's care appear to have been aware of her previous history of abuse in childhood and were made aware of the domestic abuse she suffered. This together with her mental health difficulties ensured that they recognised her as being in need of more consistency of care to support her and her family.

9.6.6 In terms of recommendations to address the findings-

- a review is ongoing of scanning and coding sensitive information;

- a need is identified for awareness raising across GP staff of the need for the fullest information sharing about all family members to help inform Child Protection and Domestic Abuse issues;
- a similar awareness raising is required in relation to perinatal;
- mental health problems and a review of how information is sought from GP services. This latter element ties in with the proposed review of how information is sought for Child Protection meetings.

Whilst practices could be improved by these measures, it is not believed that any further or different action by the GP's surgery would have changed the outcome for Susan.

9.6.7 Children's Nurse. The community health services in South Gloucestershire are provided by Sirona. This covered the health visitor working with Susan and her family. The review showed good linking in with other agencies particularly the Social worker, a supportive approach towards Susan and some good engagement by Susan.

9.6.8 There were questions raised however about the level and commitment of her compliance, given later information that Susan may still be seeing her former partner in secret. It was also identified that communication could be improved across local authority boundaries. Training in the extent and pressures of domestic abuse for practitioners was seen to be appropriate. Also, proper understanding of dealing with children and the importance of what they say is an area where improvements were seen to be necessary both in Sirona and across other agencies. This followed an incident when one of Susan's children made a disclosure about violence and it was too easily discounted by Susan as having been invented by the child.

9.6.9 There was also an issue with late invitations to joint agency meetings and minutes not being circulated afterwards which ties in with similar finding in Children's Service IMR. Improvements by closer working between nursery settings and health visitors against a context of partnership with families was another area for development.

9.7 Bristol City Council Housing Services

9.7.1 This agency was the housing provider to Susan throughout the period under review. They conducted their review of that interaction and identified that whilst their primary focus is on the housing needs, some areas for improvements around domestic abuse are possible for the service, to meet the needs of some of their vulnerable tenants. It was found that information was shared with them by other agencies about domestic abuse from 2013, though full details were not kept on their systems due to some misunderstanding about what they could do with information received and its dissemination.

9.7.2 They had assisted Susan removing her partner from the joint tenancy and in creating a sole tenancy, in June 2015. This was in support of her trying to move on from the abusive relationship. As part of this it would be fully explained to Susan's partner that he would have to seek private rented accommodation as his circumstances would not qualify him to be entered on the Housing Register. After this at the end of 2015 and into early 2016, Susan was actively engaging with Next Link and Bristol City Council Housing's Estate Management seeking support to make steps to prevent her former partner from accessing the home. This engaged and proactive approach between agencies is positive in light of her lack of engagement with agencies documented in March and April 2014.

9.7.3 Lessons learnt including-

- better storage of information on their databases in relation to domestic abuse;
- better dissemination of information generally and post MARAC meetings to Housing department workers engaged with the person/address;
- a follow up meeting with tenants who change from joint to sole tenancy of an address to assess their needs, which does happen with new tenants but could be missed with such continuing tenants;
- how to better access police security provision in domestic abuse cases
- internal arrangements over repayment of rent to joint tenants who cease to be so, to avoid financial issues for the person left in the property.

Good practice was found in the joint working between Housing Officers and Nextlink IDVA, attempts to make the property more secure, and the victim focused approach by the Housing Officer.

9.8 CAMHS

9.8.1 CAMHS started working with the family in June 2016 three months after the children had been removed due to alleged neglectful parenting. The referral explained domestic abuse between the parents had been witnessed by the children. There were five sessions completed over nine weeks until the case was closed.

9.8.2 The emphasis of the work was on establishing and maintaining a safe and supportive environment for the youngest child and to help him understand what had been happening in the family. There is good evidence throughout the record of the voice of the child and some evidence of Susan's feelings. There is no reference to discussing the impact of the domestic abuse on Susan or of engaging her with any work to recognise and address this. However, in explaining the impact of the domestic abuse on her child, this would have also helped Susan to understand the emotional impact on her.

9.8.3 The DASH risk checklist can help to assess risk to a victim of domestic abuse and whether the threshold is met to refer to the Multi-Agency Risk Assessment Conference (MARAC) which supports victims at high risk of murder or serious harm from domestic abuse. However, the North Bristol NHS Trust Domestic Abuse Policy also states that the DASH risk assessment tool is for 'current rather than historic domestic violence and abuse'. It was not clear to the reviewer when and to whom the disclosure of domestic abuse had been made or whether a DASH had been carried out.

9.8.4 There was however evidence found of good multi-agency working. There is a brief note that the CAMHS worker contacted both the Health Visitor and Social Worker after her initial visit to the family and the third session included the social worker. More than one summary of her work and recommendations for future input were also sent to Susan and copied to the GP and Health Visitor.

9.8.5 The CAMHS worker is not included in the attendance list for the Child Protection Conference which took place on 5th May 2016, which would have been

post-referral to CAMHS but prior to meeting the family. Inviting her to this meeting would have been a way of introducing her to the family at an earlier date and understanding the background more fully before commencing her work. However, minutes were sent to her to inform her work. She attended and provided a report for the First Review Conference on 19th July 2016.

9.8.6 The CAMHS worker directed Susan to her GP to continue to seek support for her own mental health and because she was sleeping during the day without explanation which affected her ability to be a safe carer for her child. The counsellor appropriately located the child's behaviour in the domestic abuse and helped Susan to understand that. She also made plain to the family and other agencies that the exclusion of the perpetrator was central to that work, which helped to locate the problem with the perpetrator rather than focusing on Susan's inability to protect or provide adequate care for her children.

9.8.7 The intervention by the CAMHS worker was a specific piece of work allocated to her within the context of the multi-agency plan. There is no record of other agencies contacting her during this time, apart from at the first child protection review conference but she communicated with the social worker, health visitor and nursery. She has noted core group dates but there is no record of her attendance at these.

9.8.9 Recommendations from this review were-

- Use of holistic assessment framework to support work in CAMHS. This is an ongoing piece of work in conjunction with implementation of the electronic record system (IAPTUS).
- LSCB level 3 Domestic abuse training to be prioritised for staff who have not received it. CAMHS will need to map training need against places available.

9.9 Mental Health Services- AWP

9.9.1 The review for this agency focussed primarily on provision of mental health services and this report will only deal with this in relation to any domestic abuse issues. They had three clear periods of engagement with Susan, 2002-2005, 2010

and then 2015 into 2016. The first stemmed from problems caused by her struggling to manage emotions and her past failed abusive relationships. The second saw her complain of coping, depression and sleep problems when she self-referred. In 2015, she again self-referred and went for a course of counselling. The period in later summer 2016 records the referral by her GP and the difficulty the service had in getting a response from her prior to them declining service after a discussion with her GP in August 2016.

9.9.2 There is an overall pattern of Susan struggling to engage with the support and therapy that was offered to her over the years by AWP. There were consistent problems with Susan not attending booked appointments and it seems that this was due to a variety of factors including difficulties in relationships, difficulties with childcare, problems with practical issues such as debt and housing and, latterly, problems with chronic tiredness.

9.9.3 The review showed Susan was a woman with a demanding life and a complex, difficult and traumatic history. She was known to services from a very early age, and took her first overdose at age 12. It is clear that over the course of her life a lot of different services were involved in trying to help her on therapeutic, medical and practical levels. There were also clearly complex issues around the safety and wellbeing of her children as well as herself, and choices around relationships that led to these becoming problematic.

9.9.4 As far as treatment in AWP goes, Susan falls into a category of people who present with complex trauma, and for whom psychotherapy and other talking therapies would be the recommended treatment. Between 2002 and 2016, Susan engaged with various talking therapies, including two years of psychotherapy with Secondary Care and input from IAPT and other services. Latterly, Susan had identified that, for her, talking about her difficulties was unhelpful and this was validated by the results of her self-assessment forms from her treatment, which showed that her anxiety and depression had not improved following the intervention but had in fact got worse.

9.9.5 Given that a psychological approach would be the recommended intervention for someone with Susan's difficulties; it is difficult to conclude what else could have been offered in this case after she did not engage with communications aimed at getting her in to service. Susan was offered appropriate treatment/services and when relevant referred on to other caring agencies to help address her needs- Next Link, Womankind, Mental Health Matters etc.

9.9.6 The review concluded that Susan had a history of significant childhood trauma, which had caused her difficulties as an adult, and she found it hard to engage with services. Susan's death occurred following recent significant life events including the breakdown of her relationship, her children being taken away and problems with chronic tiredness and falling asleep which were impacting her ability to care for her children. Given her history it is understandable that these recent significant life events would potentially raise the risk of self-harm or suicide, though as the service was not actually treating her at that time they were not in a position to foresee it. No issues for a Single Agency Action Plan were identified but the service welcomes ongoing work to better share information between NHS Trusts/GP surgeries/Council Services etc. which will address any issues that were highlighted by their review.

9.10 Next Link

9.10.1 The review by this agency was given great consideration as they had been engaged very recently with Susan prior to her death and since early 2015, specifically in relation to the domestic abuse issues. Next Link is commissioned by Bristol City Council to provide domestic abuse services for women and children across the city. Their review concluded that there was need for improvement in a number of areas-

- when more than one worker was engaged with a family more sharing of information and meetings between workers would be beneficial;
- risk assessment processes to be reviewed;
- where one worker performs one role for Next Link and then another for a different agency, there is a better review process to ensure that the two changing services get proper review and re-assessment.

9.10.2 Despite the worker remaining the same, as in this case with the worker concerned actually performing two separate paid roles and having been chosen to provide continuity and consistency, 'handovers' should be approached as if a new professional had been allocated the case each time. The summer of 2016 saw little engagement by Susan with Next Link despite their efforts to contact her. The Next Link worker had seen Susan at a child protection conference in July 2016. Susan was physically improved and maintained she was content with her children being at her parents', which allowed her more space and time to herself. She felt better able to cope and was not pressing for contact.

9.10.3 If there were other, less positive, reasons for Susan's apparent non-engagement these will not now be known and can only be speculated at- too unwell/ concerned that a secret relationship may become known/ worries for her children being taken from her/coercion by her partner, etc. Nothing was found during the review that suggested a different outcome could have been achieved for Susan rather than her decision to take her own life.

9.11 Probation Services

9.11.1 The review has already mentioned the work carried out by BSGW CRC with Susan's partner under the Suspended Sentence Order (SSO). Current working practices which were in the process of being introduced at the time as part of major organisational transformation caused significant disruption at the time of the order. Both BGSW CRC and the National Probation Service conducted reviews of their work with Susan's former partner.

9.11.2 The National Probation Service had limited involvement with Susan's partner as the work under his suspended sentence order was carried out by BGSW CRC. They did however review practices and found that greater consideration needed to be accounted to domestic abuse issues and child safeguarding when working with offenders. This has been reflected on with the relevant professionals and action taken. Good practice was also identified in relation to the risks identified by the Pre-Sentence Report writer when Susan's partner appeared at court and his referral to the Building Better Relationships by a second Offender Manager after it was earlier unacceptably delayed.

9.11.3 Recommendations included better safeguarding awareness across all professionals in their agency and proper multi-agency information sharing to ensure all agencies are aware of who else is working with an individual or family. This is an aspired for situation with most of the reviews that were conducted.

9.11.4 BGSW CRC found that the Building Better Relationships (BBR) programme took too long to provide a place for Susan's partner, due to backlogs at that time. The time delays were further adversely affected in their effectiveness by the length of time made by the court for the order. This has been addressed by the National Probation Service (NPS) and the courts, to ensure work such as the Building Better BBR work here can be properly delivered and their effects assessed before the period of the supervision order finishes. Though individual sentencing courts will still impact on the situation.

9.11.5 The situation with Court Orders as it applied to this case, and therefore any other similar ones, is this. The courts can only make a Suspended Sentence Order for 2 years, but can make a Community Order for 3 years. The latter 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, NPS could propose a Community Order to allow more time to complete the Programme but it clearly needs to take into account proportionality. Whilst the NPS can propose to a court, it is down to the court to make the decision. If the court does decide to make a Suspended Sentence Order then the CRC delivering the programme need to escalate the start of it. This will ensure it is completed and there is also a period post-programme when change can be monitored and addressed if necessary. In this instance, the Officer proposed a Community Order, but the court chose to make a Suspended Sentence Order.

9.11.6 The review also found evidence of insufficient information sharing and contact with partner agencies. This is to be addressed in relation to more systematic recording of contact details and improved risk related information.

9.11.7 The late referral seen in this case to the Partner Link Worker, who works with any supervised offender's partner, meant that Susan was not contacted to find out about her partner's behaviour in the relationship. This could have helped inform his BBR programme and also to provide feedback to see if change had come about. Good practice was identified in Simon Harper being given 1 to 1 meetings by his probation worker prior to the very delayed BBR sessions he completed, and also in the challenges to Simon when he behaved inappropriately during group sessions.

9.11.8 Actions recommended include-

- raising knowledge of Partner Link worker role;
- better and more timely updates of systems;
- improved records of communications with other agencies about domestic abuse risk so that it can be clearly seen what has been done.

9.12 Victim Support

9.12.1 This agency had no involvement with any of the parties mentioned in this review, but their Lead Review member provided valued critical challenge at review meetings and in reply to circulated documents.

10. Timescales for the review

10.1 Susan died on the 6th September, 2016. Her death was brought to the notice of Bristol CSP who decided that the conditions for a formal review were met and therefore to run a Domestic Homicide Review, at their meeting on the 30th September, 2016.

10.2 The need for an Independent Chair was advertised and Ian Kennedy was appointed to that role on 19th December 2016. He was briefed by Stuart Pattison and Lynne Bosanko, on behalf of Bristol CSP on the 11th January 2016. Statutory and relevant agencies were identified by scoping and they attended their first DHR meeting on Tuesday the 28th February, 2017. At that meeting, they were tasked to assess their agency's involvement with Susan and her partner, and children, in so far as that related to domestic abuse and commence their IMR's. Further agencies involved with Susan were identified at the 2nd Panel meeting on Tuesday the 16th May, 2017, and IMR's were requested from them.

10.3 The delay caused by the late identification of these agencies, and the time to complete IMR's generally, led to the 3rd planned Panel meeting being moved from Wednesday the 9th August, to Tuesday the 26th September to allow the completion of the IMR's.

10.4 The re-scheduled 3rd meeting took place on 26th September, when cross cutting issues were identified and the first draft Overview Report discussed. Subsequent to that meeting Single Agency Action Plans were created and the draft Overview Report was further amended, then re-circulated. This allowed a final version to be produced of the overview report, circulated once more to the group for final comment, prior to presentation to the CSP. After this, it is to be shared with Susan's family to update them on its findings, prior to being forwarded to the Home Office.

11. Significant themes for learning from the review

11.1 Risk assessments

11.1.1 It was highlighted by reviews that on a number of occasions, risk assessments were completed on incomplete information. This was due to problems in sharing and accessing information between agencies, rather than it being received and not recognising its significance. Risk should be reviewed after a significant event or when cases are transferred. Clearly any risk assessment will only be as good as the information on which it is based, so completing a risk assessment on less than the full picture is less than ideal.

11.1.2 As well as assessments being completed on incomplete information, there was also some lack of consistency in their completion. For example, one risk assessment was set at Medium Risk due to Susan's partner not being resident at the address and yet, another one by a different worker in the same agency a week later still assessed the risk as Medium even though the partner had moved back in. It raises the questions as to whether risk assessments drive activity or are they made to fit the preferred activity, and separately, whether workers actually understand how to complete them.

11.2 Work in silos

11.2.1 Each agency involved with Susan had their own priorities; be it her children, her housing, her mental health etc. That is understandable but there also needs to be a focus on domestic abuse or other areas that cut across all agencies. There was some good practice identified in all of the agencies, but it may have been helped by a specific agency taking on the Lead role and coordinating the efforts of all agencies. It may be that such an approach could actually reduce work overall, by avoiding duplication and ensuring best use of the information available. Individuals in each agency performed good work but the benefits of this could have been increased if one agency had 'ownership' to ensure that the work was all necessary and mutually complementary.

11.2.2 There was good evidence found of multi-agency work taking place in and around Child Protection Conferences. A Lead worker, a social worker, was identified in relation to Susan's children, but that person understandably did not have domestic abuse as a primary focus. It may have benefitted Susan and others in similar situations, if a separate professional had been identified for her as Lead worker for domestic abuse issues. By identifying such a lead role for Domestic Abuse, it may also result in key events being identified and planned for, to prevent high risk situations when, as in this case, partners are released from court and are free to return to the communal home with no risk assessment or service support being in place.

11.3 Information sharing

11.3.1 Again, this tended to happen in silos but was also aggravated within agencies when information was not shared with frontline workers either through a misunderstanding of what to do with it or because it had been over protected in its handling codes.

11.4 Conflicting pressures leading to non-referral by a victim

11.4.1 Susan was a very vulnerable woman with complex needs. She had a distrust and dislike of "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. Work to help her view engagement as beneficial and supportive may have built trust and improved this situation. There were opportunities to do this at the time when she was living in her house alone, her partner having been removed from the joint tenancy and she had taken out a non-molestation order against him.

11.5 Work with perpetrators

11.5.1 Throughout the period covered by the review it is clear that Simon was a threat to Susan. The only specific work which seems to have been carried out with him by any agency was by the BGSW CRC under the court order and even that had its shortcomings. A victim centred approach to domestic abuse does not preclude work with perpetrators. They pose the risk to current and future partners, so, reducing that risk, protects victims. Recent work by the University of Cambridge and Hampshire Police, as presented in Cambridge Journal of Evidence-Based Policing, September 2017, Vol 1, *“Reducing the Harm of Intimate Partner Violence: Randomized Controlled Trial of the Hampshire Constabulary CARA Experiment”*, has shown that work with offenders can reduce offending. Offenders who admitted domestic abuse attended a set number of workshops run by professionals, on behalf of a charity. The study showed they reduced their rate of re-offending and those that did re-offend caused less harm to their victims.

11.5.2 The majority of the current funding for domestic abuse services in Bristol relates to supporting victims but not working with offenders. Currently the only funding targeted towards perpetrators, is the Resolve to Stop Violence Programme (RSVP) and is short term funded. It is a *“specialist perpetrators of domestic abuse service run in Bristol. The service supports those willing to take responsibility for aggressive, controlling or violent behaviours through an established evidence based 1:1 behaviour changing programme. During one to one sessions, the service supports perpetrators to learn non-abusive ways of behaving within a relationship and learn new techniques and strategies to make changes”*.

11.5.3 The programme ensures the needs and safety of victims are embedded in all aspects of service delivery. This programme provides places for 60 males per year and works 1:1 with them to take them through a 10-week programme. They liaise monthly with Next Link who work with their female partners (if they are happy to be referred).

11.5.4 Support for male victims of domestic abuse is provided in Bristol by Victim Support in line with their work nationally. Their work is in the 'Bristol Male Domestic Violence Service', which provides support and advocacy for male victims of domestic abuse. The work is funded by Bristol City Council.

11.5.5 There can sometimes be a noticeable trend of public funding for domestic abuse services to focus on services for victims, and particularly female victims. The University of Cambridge/Hampshire Police study outlined above gives empirical evidence of the benefits (to victims) of addressing offending behaviours with the perpetrators. A full review of the RSVP programme locally to identify its success rate at dealing with re-offending would be timely to see if it also is achieving similar successes. Based on such a review, considerations around funding, on a more long-term basis could be properly considered and put in context against monies being made available elsewhere in the system to domestic abuse services. Dealing with offending behaviour will reduce risk for victims.

12. Learning from previous Domestic Homicide Reviews

12.1 A review of the actions from previous DHR's in Bristol as published on the Bristol CSP website show that the majority of recommendations over the last five years has related to training and information sharing. This is not surprising as that matches figures from around the country. In the review carried out by the Home Office of all 33 DHR's completed nationally between 2011 and 2015, communication and information sharing was identified as an issue in 76%. These figures are shown in the document, "Domestic Homicide Reviews- Key Findings from Analysis of Domestic Homicide Reviews (December 2016)". Single Agency Action Plans (SAAP's) have been created where appropriate by all agencies involved in this DHR and included in an overall action plan. Where training, communication and information sharing are issues they have highlighted those.

12.2 Recommendations will be made later in this report for the Bristol CSP to deal with broader issues, over and above the SAAP's, to bring about a step change in domestic abuse services rather than having a focus on the finer detail of this or that individual event.

13. Conclusions

13.1 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. She died at her own hand, and it cannot be established what affect the abuse from this and previous relationships brought to bear on her decision to do that.

13.2 The Crown Prosecution Service guidance in relation to prosecuting cases under the new Act lists relevant behaviours which could constitute evidence of such offending. They are listed below. Included in brackets after each element is an indicator as to whether or not those factors are suspected to have been present and suffered by Susan in her relationship with Simon. This is based on information provided by statutory agencies and charities working with Susan and information from friends and relatives.

- Isolating a person from their friends and family (suspected)
- Depriving them of their basic needs (suspected)
- Monitoring their time (suspected)
- Monitoring a person via online communication tools or using spyware (not suspected)
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep (suspected)
- Depriving them access to support services, such as specialist support or medical services (not suspected)
- Repeatedly putting them down such as telling them they are worthless (suspected)
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim (not suspected)

- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities (not suspected)
- Financial abuse including control of finances, such as only allowing a person a punitive allowance (suspected)
- Control ability to go to school or place of study (not relevant)
- Taking wages, benefits or allowances (not suspected)
- Threats to hurt or kill (suspected)
- Threats to harm a child (suspected)
- Threats to reveal or publish private information (e.g. threatening to 'out' someone) (not suspected)
- Threats to hurt or physically harming a family pet (suspected)
- Assault (suspected)
- Criminal damage (such as destruction of household goods) (suspected)
- Preventing a person from having access to transport or from working (suspected)
- Preventing a person from being able to attend school, college or University (not suspected)
- Family 'dishonour' (not suspected)
- Reputational damage (suspected)
- Disclosure of sexual orientation (not relevant)
- Disclosure of HIV status or other medical condition without consent (not relevant)
- Limiting access to family, friends and finances (suspected)

13.3 The number of elements, shown as 'suspected', which feature in the list show the true nature and seriousness of abuse that is believed to have been the case towards Susan in the last relationship she had. Had the Controlling and Coercive Behaviour offence been in existence at the time, and, importantly, all the circumstances known, it would clearly have been one that could be considered to deal with Simon. A conviction for it may have allowed further opportunity for working with him to address his behaviour and help protect Susan or other future victims.

13.4 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. 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. Due to the number and complexity of issues affecting her life it is not possible to establish whether having her former partner dealt with for a criminal offence of Controlling and Coercive behaviour would have helped her circumstances or even be a course of action that she would have supported. At least it would now be an option, but it was not for Susan.

14. Learning for individual agencies involved in the review

14.1 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.

14.2 Information sharing

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

14.3 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.

15. 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 that has made.** Do the same lessons continue to be learnt? If so, is there a need for a broader review and focus for services? In coming years, agencies which have reduced significantly in size due to austerity funding cuts will not be able to provide the same level of service. It is therefore imperative for **the CSP to have evidence based data on where to best apply limited resources.**

- 2) The work by the University of Cambridge and Hampshire Police set out above shows the benefits of working with perpetrators, to reduce the risk to victims. **The RSVP work locally with perpetrators of domestic abuse is limited in the number of people it can work with 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.

- 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. If their use is mandated in different agencies, are they completed to reflect work that will take place otherwise, to drive essential work or to (wrongly) show that no further work is necessary? Also, are they accurate, based on all the information that could have been available and did the person completing them have that access? 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 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 that 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.

16. Regional or national issues identified

- 1) This review was initiated on Home Office Guidelines despite the fact that it was a suicide, rather than a homicide. It is running in parallel with another unconnected review by the same independent Chair into another suicide locally. If reviewing suicides where there is some history of domestic abuse is to be continued practice, **it is requested that the Home Office review both the title of such reviews and the content of its Guidance document.** The title *Domestic Homicide Review*, suggests a third-party involvement in the death when that is clearly not the case with suicide and may suggest a conflict

with the findings of HM Coroner. 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 to ‘perpetrator’, relate to a domestic abuser who may or may not have been involved in the death. It would also clarify whether a review should include a partner, or former partner, at the time of the death even though they played no part in the death. This could also include clarity about the legality of releasing information on their contact details to a DHR Chair to facilitate contact with them. The current guidance fails in this regard leading to the difficulties identified with this review of contacting the former partner, had the family not been so opposed to such contact and if it could have been shown to be a benefit.

- 2) 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, NPS 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. This is particularly relevant when, as in this case, the programme was late commencing due to shortfalls in the system. 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 best chance of succeeding, in the best interests of victims of domestic abuse.

17. Summary of Recommendations

1. A review of the running of meetings by Children's Services
2. Each agency involved in information sharing from multi agency meetings to dip sample a small number of cases to identify how the information gets shared and whether it is readily available to frontline workers to enable and inform operational activity
3. 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
4. Review not only what recommendations have been made and completed by DHR's in Bristol, but also what difference that has made
5. The CSP to have evidence based data on where to best apply limited resources
6. The RSVP work locally with perpetrators of domestic abuse is limited in the number of people it can work with and is short term funded. A proper review of the performance of this scheme in reducing re-offending should be undertaken
7. 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
8. 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
9. It is requested that the Home Office review both the title of such reviews and the content of its Guidance document
10. The Home Office, with the National Probation Service, should review current practices in sentencing to establish whether best practice is being followed to allow proper time to provide effective rehabilitation.

14th January 2018

Appendix A

Bristol DHR Terms of Reference

The Terms of Reference

1. The purpose of this review of the death of Susan:

- 1.1 Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- 1.2 Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- 1.3 Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.
- 1.4 Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- 1.5 Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- 1.6 Highlight any fast track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

2. Overview and Accountability:

- 2.1 Following the consideration of a DHR by the DHR Advisory Panel, the decision was taken by the Chair of the Bristol Community Safety Partnership on the 18/11/16 and the Home Office informed on 15/12/16.
- 2.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.
- 2.3 This Domestic Homicide Review is committed to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner, within the spirit of the Equalities Act 2010

3 The Domestic Homicide Review will consider:

- 3.1 Each agency's involvement with Susan from 2010 and the date of her death, except for any other relevant information relating to domestic abuse prior to this date. Whilst checking these records we may identify any other significant individuals who may be able to help the review by providing information, in particular:

Family members – Susan’s eldest son, Mother, other children.

- 3.2 Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or her children, prior to the homicide (any disclosure, not time limited).
- 3.3 In relation to the family members, whether there were aware if any abuse and of any barriers experienced in reporting abuse? Or best practice that facilitated reporting it?
- 3.4 Could improvement in any of the following have led to a different outcome for Susan by considering:
 - Communication and information sharing between services with regard to the safeguarding of adults.
 - Communication within services.
 - Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services.
- 3.6 Whether the work undertaken by services in this case are consistent with each organisation’s:
 - Professional standards.
 - Domestic abuse policy, procedures and protocols.
- 3.7 The response of the relevant agencies to any referrals relating to Susan concerning domestic abuse or other significant harm from (to be confirmed at first review panel meeting). It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
 - Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim, perpetrator or her children.
 - Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
 - Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
 - The quality of any risk assessments undertaken by each agency in respect of, her children or the perpetrators
- 3.8 Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

- 3.9 Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.
- 3.10 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.
- 3.11 Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
- 3.12 Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.
- 3.13 Keep these terms of reference under review to take advantage of any, as yet, unidentified sources of information or relevant individuals or organisations.

4. Media Strategy

- 4.1 A single point of contact has been identified to field all media enquiries in relation to this DHR and a position statement of “no comment” will be offered until the conclusion of the DHR process and sign-off of the overview report by the Home Office Quality Assurance Panel.

Appendix B

Agencies contacted for the review.

- Avon and Somerset Police

- Bristol City Council Early Help

- South Gloucestershire Clinical Commissioning Group on behalf of her GP

- Sirona Care and Health

- Bristol City Council Housing Services

- Next Link Domestic Abuse Services

- National Probation Service and BSGW CRC

- Victim Support

- AWP, Mental Health Services

- CAMHS, Mental Health Services.

- Bristol City Council Safeguarding Adults

- Safeguarding and Change, Bristol City Council

- Bristol City Council Children's Services.

Appendix C

Glossary of terms

A&E	Accident and Emergency
AWP	Avon and Wiltshire Partnership
BBR	Building Better Relationships
BSGW	Bristol, Somerset, Gloucestershire and Wiltshire
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CRC	Community Rehabilitation Company
CSP	Community Safety Partnership
CYPS	Child and Young Person Services
DA	Domestic Abuse
DV	Domestic Violence
DASH	Domestic Abuse, Stalking and Harassment
DHR	Domestic Homicide Review
DPA	Data Protection Act 1998
FIT	Family Intervention Team
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IAPT	Improving Access to Psychological Therapies
IMR	Independent Management Review
IRIS	Identification and referral to improve safety
MARAC	Multi Agency Risk Assessment Conference
NPS	National Probation Service
RSVP	Resolve to Stop Violence Programme
SSO	Suspended Sentence Order

Appendix D Home Office Quality Assurance Feedback and CSP Response



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Stuart Pattison
Crime Reduction Manager
Crime Reduction Team
Bristol City Council
P.O. Box 3176
Bristol
BS3 9FS

26 July 2018

Dear Mr Pattison,

Thank you for submitting the Domestic Homicide Review (DHR) report for Bristol (Susan) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 23 May 2018. I apologise for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel commended the decision to carry out a review in this case of death by suicide which they felt had identified useful learning. The Panel concluded that, whilst this is a good review as far as it goes, it has no terms of reference and it is, therefore, difficult to gauge how wide-ranging the review was and the extent to which all appropriate lessons have been identified.

There were also some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The Panel felt further exploration of the most recent partner in the events leading up to her death and how he was never the focus of interventions may have been useful;
- Substance misuse is alluded to in the review but has not been examined in any detail;
- It would be helpful if the review could clarify the basis for the assumption that the victim was seeing her former partner;



- You may wish to review the narrative as some of the language used could be perceived as victim-blaming. The Panel felt the review could focus more on what might have helped the victim engage with services given her compromised situation rather than holding her responsible for not engaging;
- The Panel felt it would be helpful if the review explored the cause of the backlog and the reason for the late referral that resulted in a 13-month delay in the perpetrator attending the Building Better Relationships programme and whether a recommendation is required to address the findings;
- Similarly, exploration around the reason for the 3-month delay in the Crown Prosecution Service offering the police an Early Investigative Appointment and whether an action to address this finding would be appropriate;
- It was unclear whether the family were offered specialist advocacy services and the Panel reiterated the importance of offering specialist advocacy services to families when inviting them to engage in reviews;
- The Panel felt that the executive summary is missing key sections and has been redacted to such a level that it does not adequately convey the deceased's life to enable the reader to understand the basis for the key findings;
- Equality and diversity issues are not considered as part of the review;
- The action plan is missing key milestones and only contain national and multi-agency recommendations. The Panel suggested single agency recommendations should also be included;
- Please review the report for errors. For example, IRIS is incorrectly named both in paragraph 9.6.4 and the glossary, and 'Department for Justice' in paragraph 16(2) should be 'Ministry of Justice'.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Hannah Buckley

Acting Chair of the Home Office DHR Quality Assurance Panel



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17 September 2018

Dear Hannah,

Thank you for the comprehensive Quality Assurance panel feedback dated 26 July following your meeting on 23 May 2018.

The CSP has shared your feedback, which we considered to be thorough and considered, with the independent DHR report author. We sought their response before giving further consideration to the DHR reports at the Community Safety Partnership Executive Board meeting on Friday 14 September.

I write to provide you with information on the outcome of that meeting:

The CSP was pleased you considered the report to be good. We have added the terms of reference of the review to add further clarity post publication.

We note your comments about the victim's former partner and references to substance misuse within the report. It was felt both issues were well considered through the DHR process and this was reflected in the report and resultant action plan.

With regard to your request for clarity around the assumption that the victim was in an on-going relationship we felt the report was clear in that this had not been confirmed.

The CSP takes on board your feedback around the language and narrative of the report and on reflection consider it to be balanced and proportionate. We are pleased to confirm this is also the view of family members consulted through the review process.

The CSP agree with your observations around the operational challenges highlighted through this report and can confirm these were indeed raised and address during the review process by those agencies concerned. The CSP is

satisfied therefore that learning has been identified and actioned as a result of this review.

We can confirm the family of the victim were indeed offered specialist support by the CSP at the outset of the review process. This offer was remade by the Independent Chair during the review.

The CSP is happy with the content and format of the executive summary and confirms this will be published alongside the more detailed overview report on the City Council's website for those wishing to consider both the full report and the abridged headlines set out in the executive summary.

With regards to consideration of equalities issues within the report we are sure you will agree these issues are woven throughout the overview report and clearly considerable consideration was given to equalities issues by the panel members and agencies providing IMRs for the review. We do however take on board your comment that in future it would help to bring these considerations together in a summary chapter within the overview report for ease of reference. This learning has also been welcomed by the author of this report.

The further typographic amendments and completion of the action plan have been undertaken and will be reflected in the final report on publication.

The CSP is now liaising with family members to work towards publication of the report. We anticipate the report being published before the end of the year and will be available via the following link: <https://www.bristol.gov.uk/policies-plans-strategies/domestic-homicide-reviews>.

Thank you once again for your time and consideration of this report.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Stuart Pattison', with a large, stylized initial 'S'.

Stuart Pattison
Crime Reduction Manager

**Appendix E
Action Plan – Susan Taylor**

Recommendation	Scope of recommendation i.e. local/ regional/ national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
The Home Office reviews both the title of Domestic Homicide Reviews and the content of its Guidance document in the context of deaths occurring from suicide	National	CSP to write to Home Office to request consideration of: a. A more neutral title for domestic abuse related death reviews and b. Revised national guidance to reflect this and clarify references to involved parties and disclosure of appropriate information in the circumstance of death by suicide.	Home Office	Letter from CSP Chair to Home Office Nov 2018	November 2018	
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	National	CSP to write to Home Office and NPS to request consideration of where reasonable and proportionate, in line with Sentencing guidelines, NPS should propose a Community Order to allow more time for offenders to complete a	Home Office with Ministry of Justice and National Probation Services	Letter from Chair of CSP to Home Office and NPS Nov 2018 National guidance for NPS now means that only Community Orders are proposed (not Suspended Sentence	November 2018	

		perpetrator programme		Orders which cannot be longer than 2 years). Rehabilitation considered in proposals but proportionality needs to be considered in sentencing		
The CSP to undertake a review of recommendations and learning from DHRs across Bristol to ascertain what difference has been made	Cross-Agency	The CSP to commission a learning review of all recommendations from DHRs across Bristol and identify what difference has been made to local systems and multi-agency practice	Safer Bristol	<ul style="list-style-type: none"> - Commission a learning review by March 2019 - Receive review findings and recommendations July 2019 	July 2019	
The CSP to evaluate the impact and effectiveness of the RSVP perpetrator programme	Cross-Agency	The CSP to undertake an evaluation of the RSVP programme with a view to recommissioning appropriate perpetrator interventions (informed by this review and other national research) from 2019	Safer Bristol	<ul style="list-style-type: none"> - Evaluation report commissioned by CSP from provider of RSVP programme - CSP to undertake evidence based recommissioning of perpetrator provision from 2019. 	June 2018 September 2019	
The CSP to review current risk assessment practice in relation to accuracy and access to information	Cross-Agency	The CSP to undertake a dip sample of risk assessments across all agencies to assess accuracy, necessity and what was changed as a result of those assessments having	Safer Bristol	MARAC reform implementation group to review DASH risk assessment practice as part of the review and implementation of new	October 2018	

		been undertaken – to feed into the ongoing force wise review of MARAC arrangements		ways of working from October 2018		
The CSP to consider the benefits of implementing a concept of lead agency/ professionals for certain individuals based on level of risk or case complexity	Cross-Agency	Safer Bristol to consider this concept in its VAWG service needs assessment and recommissioning with a view to procuring appropriate services from 2019 onwards	Safer Bristol	CSP to identify benefits and practicalities and oversee implementation	December 2018	
Single Agency Action Plans for local agency actions.	Local	To be monitored by the Bristol Domestic and Sexual Abuse Strategy Group (BDSASG) Progress to be reported to CSP Board by exception	Safer Bristol	- Action plans and progress reviewed and monitored at each BDSASG meeting - Exceptions reported to the CSP Board	To commence on publication of the DHR	
Refer this DHR case to the current force-wide MARAC review process as a learning point to be taken forward as appropriate.	Local	Force Lead for DA to make the referral	Avon and Somerset Constabulary	- This DHR case is referred and considered, along with the learning as part of the MARAC Review	September 2017	
Think Family’ to provide full information to the police when a decision is	Local	Force Lead for DA to make a formal request to ‘Think First’	Avon and Somerset Constabulary	Protocol set up and implemented	September 2017	

made to enter/remove a family as being a troubled family, this to include the rationale behind the decision. Information received to be entered upon Niche, as intelligence.						
When a DA victim presents as not complying with agencies as they may remain at risk referral to SCU and onward referral to Adult Safeguarding may will be considered	Local	Force Lead Officer - Vulnerable Adults to instruct Safeguarding Co-ordinating Units to consider a referral to Adult Safeguarding	Avon and Somerset Constabulary	Procedures updated and implemented	September 2017	
Create a case study, using this incident to demonstrate where the new offence of Controlling or Coercive Behaviour in an Intimate or Family Relationship may be used (Section 76 of the Serious Crime Act 2015). Case study to be made available to police	Local	Force Lead for DA to ensure that a case study is written and disseminated effectively to police officers and staff	Avon and Somerset Constabulary	<ul style="list-style-type: none"> - Case study developed - Case study and learning formally shared force wide 	September 2017	

officers and staff via a training bulletin/an appropriate DA event						
Develop a tool to assist police supervisors to achieve timely and proportionate management of investigation. Including training/guidance on how to use Niche to flag diary dates and set reminders to individual and/or team members.	Local	Force Digital Policing Manager to write and publish tool for use on Niche	Avon and Somerset Constabulary	Tool developed and implemented force wide	September 2017	
Amendment of the ‘initial occurrence enquiry log’ template to include a requirement for setting automatic diary prompts on Niche as part of the initial record of an investigation strategy.	Local	Force Digital Policing Manager to write and publish tool for use on Niche	Avon and Somerset Constabulary	The initial occurrence enquiry log’ template is amended and diary prompts added	September 2017	
Refer this DHR case to the current force-wide MARAC review process, as a learning point to be taken forward as appropriate.	Local	Sarah Omell, Business Development Manager Partnerships, together with Force Lead Officer – Vulnerable Adults to make the referral	Avon and Somerset Constabulary	Referral made and learning taking forward	September 2017	

<p>Parents involved in child protection enquiries is known to have a history of mental health problems, self-harming or suicidal ideation, ensure current guidance is implemented</p> <p>ie. encouraging the parent to notify their GP or mental health service provider that they may be vulnerable to added stress because of the child protection enquiries/proceedings.</p> <p>If a parent refuses to seek such medical support consideration of sharing information without consent will be considered on a case by case basis.</p>	<p>Local with recommendation Nationally</p>	<p>Review of multi-agency guidance to ensure adult health service engagement and support of adult parents during Child Protection Processes.</p>	<p>BCC Children Services</p>	<p>Review of South West Child Protection Procedures to ensure that engagement with adult mental health and health services is mandated as part of Child Protection processes.</p> <p>Launch of the BSCB Guidance 'Think Family Approach to Supporting and/or Safeguarding Children whose parents have support needs'</p>	<p>November 2017</p>	
<p>Bristol's Child Protection Conference service to undertake a review of</p>	<p>Local</p>	<p>Child Protection Manager and ABS Business Manager to review existing systems,</p>	<p>Children and Families Services</p>	<p>Approval by Service Manager for system</p>	<p>December 2017</p>	

<p>processes and procedures and provided a refresher session to all relevant staff. This includes booking conferences; ensuing attendees are sent invites and reports to complete pre conference. Returned completed reports are forwarded to the CP chair and note taker and added to LCS the same day. Post conference the documents will be sent to all professionals involved, within statutory timescales. Reports to GPs are sent via secure email.</p>		<p>identify improvements needed to ensure compliance and implement changes.</p>		<p>changes Implementation by the Child Protection Manger and ABS Team Leader Monitoring by BSCB Quality Assurance Sub Group through auditing.</p>		
<p>Develop reflective practice guidance for Social Work practitioners in developing awareness of key areas to consider when devising ‘safety plans’ with families to ensure safe and appropriate care of the child (ren).</p>	<p>Local</p>	<p>Signs of Safety Steering to develop standards for Family Safety Planning and Next Steps as part of the Signs of Safety England Innovations project</p>	<p>Children and Families Services</p>	<p>Signs of Safety Steering Group to develop and share across the profession The revised reflective practice to be approved by CMT and SOS steering group</p>	<p>January 2018</p>	

<p>Children Services to:</p> <p>a). share the learning from this DHR and disseminate to Child Care Social Work staff.</p> <p>b). Consider the benefit of a case audit. Focusing upon three main areas; 1) Ensuring effective communication with health professionals where there are worries about parental mental health and stability. 2) Developing and utilising tools to undertake specific work with children and hear their voice, and ensure it is heard, and that this formulates part of the overall planning, safety and care arrangements for children. 3) Assessment of parent (where there have been allegations / convictions</p>	<p>Local</p>	<p>a) Dissemination of the DHR Learning via the Quality Assurance Service briefing on publication</p> <p>b) Auditing partnership communication and engagement and use of tools to capture the Voice of the Child to be embedded into every case audit undertaken in the service as part of the Quality Assurance framework</p> <p>c). Audit of domestic abuse cases including parenting assessment as part of the MARAC Review</p>	<p>Children and Families Services</p>	<p>Agreed at Service Manager Level</p> <p>Updated Quality Assurance Framework</p>	<p>a).Within 3 months of the completion of the DHR</p> <p>b).July 2018</p> <p>c).February 2019</p>	
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for domestic abuse), to ensure that they can safely care for their child.						
Formalise joint working supervisions between the adult and children's support workers in Next Link.	Local	<p>Draw up Think Family joint supervision template to be used by team leaders.</p> <p>Initiate 3-way case reviews with relevant workers and relevant team leader. This includes support planning sessions with both workers using a think family approach, in line with Next link policy and procedures.</p> <p>Think family refresher training for support workers and managers to understand the family as a system</p>	Next Link Domestic Abuse Service	<p>A template produced</p> <p>Procedure integrated into the Next Link supervision matrix.</p> <p>Training of Team Leaders to use the template</p> <p>Joint Think Family supervisions commenced</p>	<p>January 2017</p> <p>October 2018</p>	
Restating and training all staff that all referrals are treated as new referrals	Local	Refresher training at team meetings to ensure that all staff understand that the Next Link Policy on Risk	Next Link Domestic Abuse	Refresher training taken place at all team meetings.	January 2018	

<p>requiring a new risk assessment based on change of circumstances in line with Next Link policy.</p>		<p>Assessments and reviews applies in all circumstances</p> <p>To ensure audits of case work by managers to evidence the new risk assessments are taking place</p>	<p>Service</p>	<p>Audit demonstrates staffs are following risk assessment policy.</p>		
<p>Improve safe guarding awareness and appropriate multi-agency information sharing</p>	<p>National and local</p>	<p>Ensure that all staff complete mandatory training</p> <p>SARA</p> <p>Safeguarding adults</p> <p>Safeguarding children</p> <p>Safeguarding children and domestic abuse</p>	<p>National Probation Service</p>	<p>Introduction of Guidance for practitioners issued 2016</p> <p>Circulation of survey of staff confidence in dealing with Domestic abuse cases</p> <p>New quality assurance of risk management plans tool in use 2016-2017</p> <p>Update Nov 18 – Mandatory Training remains in place. As well as this Child Safeguarding briefings have taken part locally and Adult Safeguarding briefings are planned</p>	<p>January 2018</p>	

Ensure that Officers are aware of appropriate action to take following a significant event. in this case learning that offender has returned to home of partner	Local	SPOT check Asked officer involved in early stage of case and peers what they would do during this enquiry	Bristol and South Gloucester LDU	Regular spot checks are embedding in procedures Awareness and learning disseminated to officers Update Nov 18 – ongoing monitoring of cases through supervision and Performance Improvement Tools which will include consideration of these issues.	April 2018	
a). Introduce a ‘follow up’ process or new tenancy visit for Housing Officer (HO) to compete to recognised potential risk in domestic abuse victims ending a joint tenancy and resigning a new sole tenancy at the same address (although they are not a new tenant as such they begin a new	Local	BCC Housing Services to create and implement new policy/ process for HO to complete within service. Process to be created, training delivered and performance monitored	Bristol City Council- Housing Services	Introduce a ‘follow up’ process or new tenancy visit for Housing Officer. Housing Officers formally notified and embed good practice of completing tenancy checks with tenant,	November 2018	

<p>tenancy with a risk posed from ex- joint tenant therefore it is important for</p> <p>b). HO to complete a tenancy check with the tenant. This will give the victim a clear channel to communicate with BCC Housing Services any continued DA to which Housing Services can seek multi-agency support for the victim in line with their wishes.</p>						
<p>a). Review internal information sharing between Housing Representative for MARAC cases and the patch HO for MARAC process to ensure relevant information is shared with patch officers to safeguard the individual tenant discussed even when no actions recorded.</p>	<p>Local</p>	<p>Internally change current process whereby a representative from Housing Services attends and information is not shared to the patch officer unless there is a specific action to complete. Process revision, training and implementation. Record/ coding to be designed and implemented by ICT and training on change delivered</p>	<p>Bristol City Council- Housing Services</p>	<p>a). Review undertaken and changes implemented</p>	<p>November 2018</p>	

<p>b). Consideration to be given to confidential nature of information and data sharing.</p> <p>C). Coding system to be explored on Housing Management System to record attendance at MARAC</p>				<p>b). Confidential information sharing considered and embedding in practice</p> <p>c). Coding system explored and CSP updated on the outcome</p>		
<p>a). Refresher domestic abuse training for Housing Services Estate Management i.e. HO's.</p> <p>To include:</p> <p>-the necessity of timely recording of domestic abuse case management and the importance of cases being logged on Housing Management System to store case progress and provide full records.</p> <p>b). HO's are reminded of Housing Services expectations of HO's when information is</p>	Local		Bristol City Council- Housing Services	<p>a). Training designed and delivered to Estate Management Services</p> <p>b). Formally reminded through appropriate Housing staff communications and</p>	<p>November 2018</p> <p>November 2018</p>	

<p>received in respect to abuse a tenant may be experiencing to ensure consistently proactive response to this information and to contact victim on receipt. It is not acceptable to 'wait' on any such information irrelevant on the uncertainty of its meaning; clarity should be proactively to contact the victim.</p> <p>-Readily seek to clarify via evidence of any legal orders that 'ban' a joint tenant from returning to the property e.g. occupation orders, injunctions etc. so that there is a record of this information on the file to legally justify actions taken by Housing Services in line with this information</p>				training		
<p>a). Housing Services Rent Management to reconsider its refund</p>	Local	Policy reconsidered and revised and training on change implemented and	Bristol City Council- Housing	a). Housing Services Rent Management to review its refund	November 2018	

<p>request process to ensure all checks are made effectively e.g. check housing management system for records of domestic abuse reports to safeguard for potential financial abuse victims and a reminder that written evidence is a requirement for a payment to be authorised to a sole account for a joint tenant.</p> <p>b). Rent Management Service liaise with the patch HO to confirm there is no known DA to ensure that the request does not have the potential to be made against the wishes of the other party e.g. form of financial abuse.</p> <p>Bristol City Council to explore if checks can be set at a financial sum, in</p>		<p>performance monitored</p>	<p>Services</p>	<p>request process to ensure all checks are made effectively</p> <p>b). Awareness and safeguarding of financial abuse procedures put in place and routinely implemented</p>		
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this case over £1000 was refunded which is a significant financial amount.						
Refresher Training for Housing Repairs Service for Customer Advisor and Response Surveyors to share correspondence/ information internally with Housing Officer (HO) within Estate Management where information is alluding to a tenant struggling to maintain their tenancy so that the HO can follow up on this so that tenancy sustainment support can be offered.	Local	Processes checked, refreshed training designed and delivered to repairs services CA and surveyors	Bristol City Council- Housing Services	Refresher training completed with all staff	June 2018	
Clarity to be sought on police process on requesting additional security for DA victims. Is it possible for a Housing Officer to request a 'bobby van service' or does this have to come from the police dealing with the case? Clarity on	Local	BCC gain clarity from Avon & Somerset police on process for requesting additional security for domestic abuse victims and survivors. Process created and HO trained on this process for improvement	Multi-agency work together- Avon & Somerset police, BCC	Information confirmed and formally disseminated to all practitioners	October 2018	

whether the process is akin to anti-social behaviour victims whereby HO makes a referral for additional security measure via multi-agency coordinators within Avon & Somerset Police.						
MARAC steering group to consider how information is shared following MARAC attendance to safeguard individuals.	Local	MARAC Steering Group to check with all partner agencies how they share information in their organisation and consider how they wish this information to be shared to ensure safeguarding the individual is maximised whilst considering the confidential nature of the information being discussed	MARAC Steering Group- multiagency consideration	MARAC Steering Group contacts partner agencies and receive their feedback	November 2018	
Improve operational links between social worker(s) and housing officer(s). Social Workers to diarise and remind or where possible attend scheduled appointments they make on behalf of	Local	Strategic discussion between Adult Care/ Housing Services to provide a better link to operational staff for HO and S/W to work together to support tenants/ clients in need to achieve outcomes e.g.to ensure successful visits scheduled to aid welfare and	Adult Care Services and Housing Services BCC	Mangers to review, improve and implement current procedures	November 2018	

client to ensure attendance is successful or work collaboratively with Housing Services to support the attendance of tenants to assist with tenancy and welfare issues of tenants.		tenancy sustainment rather than missed visits (in this case over several months)				
Consideration to be given to the need for more work to be done on listening to the child's voice, demeanour and daily life experience, recording it and acting on it, particularly in relation to the possibility of domestic abuse	Local CCHP	<ul style="list-style-type: none"> a. Map present understanding of Voice of the child. b. Collect examples of good practice and tools for different age groups. c. Hold voice of the child workshops in public health nursing. d. Audit in all children's services. e. All audits will show voice of the child in 90% of records where there has been active work with the child. 	Sirona	CSP updated when complete	September 2018	
Consideration to be given to communication across local authority borders.	Local CCHP	<ul style="list-style-type: none"> a) To share electronic South Glos Post code/ HV base look-up with bordering Local Authorities. b) To encourage practitioners to use the Resolution of Professional Difference: 	Sirona	CSP updated when complete	April 2018	

		Escalation when there is persistent difficulty contacting Social care.				
Check that multi agency training in relation to domestic abuse helps practitioners further their knowledge and understanding of the issues highlighted in the review.	Local CCHP	To check whether the new Domestic violence and abuse training within South Gloucestershire covers the following: a. Practitioners to be helped to develop an understanding of the pressures parents can be under when experiencing extreme domestic violence and abuse, and the difficulty in being open with agencies especially when the children are subject to a Child Protection Plan or Child in Need processes. b. Practitioners to be given practice in asking the questions relevant to domestic violence in a non-judgmental and competent way so that the likelihood of disclosure is maximised and children are protected	Sirona	Checks to made and the CSP updated when complete	November 2018	