Domestic Homicide Review

EXECUTIVE SUMMARY

Report into the death of Sharon

Report produced by Mark Wolski – Foundry Risk Management Consultancy

On behalf of North Somerset Community Safety Partnership

March 2019

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1. THE REVIEW PROCESS

Pseudonyms are used throughout the report to protect individuals' identities. The pseudonym Sharon is used for the deceased and Tom for her husband, who pleaded guilty to her murder. Their two young children are referred to as Jordan and Alex.

The review was conducted in accordance with statutory guidance under s.9 (3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

There were no other reviews conducted contemporaneously that impacted upon this review.

The CSP was notified of Sharon's death on 8th January 2018, the date on which police were initially called to her death. The decision to hold a Domestic Homicide Review was made on 8 February 2018 and the initial review panel meeting took place on 18 April 2018.

All agencies that may have had contact with Sharon, Tom and/or their children prior to Sharon's death were asked to check their records and confirm whether they had any contact or not. Four agencies responded that they had had some contact and an Individual Management Review (IMR) and chronology was requested and received from each. Once received these were analysed.

2. CONTRIBUTORS TO THE REVIEW

Individual Management Reviews (IMRs) were requested from the following agencies, all of whom were invited to form the panel:-

- North Somerset Council
- Avon & Somerset Police
- Clinical Commissioning Group
- North Somerset Community Partnership
- Bristol Royal Infirmary
- Citizens Advice North Somerset

Further information and insight were provided by:

- Sharon's parents, who had discussions with the Chair on the date of each panel meeting and attended the final panel meeting.
- Tom who met the Chair and Deputy Chair at Bristol Prison
- Anonymised statements from friends of both Sharon and Tom.
- A letter written by Sharon before her death concerning her relationship.

THE REVIEW PANEL MEMBERS

Mark Wolski	-	Independent Chair
Peter Stride	-	Vice Chair
Louise Branch	-	Domestic Abuse Co-Ordinator NSC
Howard Pothecary		Community Safety Manager NSC
Lucy Muchina	-	Clinical Commissioning Group
David Deakin	-	Avon and Somerset Police
Anjalee Joglekar	-	Avon and Somerset Police
Heather Stamp	-	Gemini Services Manager
Jos Grimwood	-	North Somerset Community Partnership
Fiona Cope	-	Manager Citizens Advice Bureau
Tracey Wells	-	Children's Centres
Carol Sawkins	-	Bristol Royal Infirmary University Hospitals Bristol Foundation Trust

AUTHOR OF THE OVERVIEW REPORT

The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training and attended subsequent Training by Advocacy After Fatal Domestic Abuse. He completed 30 years exemplary service with the Metropolitan Police Service retiring at the rank of Superintendent. During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding.

The Vice Chair was Peter Stride. Peter has completed his Home Office approved training and received subsequent training by Advocacy After Fatal Domestic Abuse. Peter has over 30 years detective experience in the field of Domestic Abuse, Public Protection and Safeguarding in London.

Neither Mark or Peter have any connection with the North Somerset area.

3. TERMS OF REFERENCE FOR THE REVIEW

The Terms of Reference are summarised below:-

The purpose of this DHR is:

- To review the involvement of each individual agency, statutory and non-statutory, with Sharon and Tom during the relevant time period from 1 January 2010 to 8 January 2018.
- To summarise agency involvement during that same period.
- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify, and respond to, disclosures of domestic abuse.

- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
- To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
- To commission a suitably experienced and independent person to:
    - Chair the Domestic Homicide Review Panel;
    - Co-ordinate the review process;
    - Quality assure the approach and challenge agencies where necessary;
    - Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established Terms of Reference.
- To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
- On completion, present the full report to the Local Community Safety Partnership.

It is not to seek to apportion blame to individuals or agencies

4. SUMMARY CHRONOLOGY

At 6.43 am on Monday 8 January 2018 the police received an emergency call from Jordan stating that their mum was dead. During this call Jordan said that Alex was also there.

Police and paramedics attended and found Jordan and Alex next to Sharon. Sharon had multiple stab wounds to her body and, sadly, was later declared dead.

Police found a knife had been stuck into the arm of an armchair next to Sharon's body.

At 07.17, that morning, police received another emergency call from a member of the public at the local railway station reporting that a male was on the track attempting suicide. On arrival of police, they found Tom who had sustained a significant injury to his right hand. He was taken to a local hospital under arrest and detained there until 31 January. The injury to his hand had been sustained from a moving train

The Investigation and Outcome

A Post Mortem was carried out. Sharon had suffered multiple stab wounds to her body and had also suffered some wounds to her wrists consistent with defensive wounds.

Charging and Court Outcome

Tom was charged with the murder of Sharon and pleaded guilty to this at the Crown Court. On 10 April, 2018 he was sentenced to life with a minimum tariff of 16 years and 8 months.

5. KEY ISSUES

The following issues were identified as key to the review:

- **Perceptions of victims:** Sharon was seen as strong and outgoing.
- **Barriers to reporting domestic abuse**: Sharon was in a complex situation: She was subject to coercive and financial control, may have been afraid of the consequences of asking for help and may have started to see the situation as "normal".
- **Risk identification and assessment:** although there were a number of factors in Sharon's situation which, in retrospect, could have helped identify the risk she was subject to; these were not recognised at the time. This was primarily due to Sharon not disclosing the abuse and agencies not screening for abuse.
- **Third party reporting:** some of Sharon's and Tom's friends were aware of abuse within their relationship but they did not take any action about this. Reasons for this may have ranged from being intimidated by Tom, respecting her "choices", believing that she was strong enough to cope or the fear of making things worse.
- **Partnership working:** although there was limited contact with partner agencies, the review gives partners an opportunity to improve their integrated response to domestic abuse; in particular joining-up responses from non-statutory sector agencies such as specialist counselling services.

6. CONCLUSIONS

The Chair and panel concluded that Sharon's murder was not predictable, it could not have been prevented as she did not disclose the abuse to professionals and that, although it is evident in hindsight that Tom's drinking played a part in the murder, there was no agency awareness at the time of an escalation in this behaviour.

7. RECOMMENDATIONS

Recommendation 1 - Governance

The recommendations below should be actioned through a Partnership owned Action Plan that is subject to the Governance and oversight of the Local Community Safety Partnership and Safeguarding Boards. These overarching recommendations and individual IMR recommendations should be reported on within six months of this review being approved by the Partnership.

Recommendation 2 - Perception of Victims and Barriers to their Reporting

The Community Safety Partnership raises awareness across Agencies and Partner Front Line Practitioners in respect of the learning from this particular DHR that would include:

- How a victim presents as having strength of character may hide true vulnerability.
- The phenomena of "minimisation"' and "normalisation".
- The considerations of a victim when reaching a decision to report abuse, leave an abusive relationship or to take further positive steps to take control. In this DHR these considerations included financial constraints and housing.

Recommendation 3 – Risk Identification

The Community Safety Partnership reviews the policies and practices regarding the use of screening questions for domestic abuse, determining how widespread their use is, how this is tested and the efficacy of asking those questions.

In particular, the council to consider their policy when dealing with members of the public seeking advice on housing and ensure that the Home Choice Policy specifically references the "priority needs" of domestic abuse victims.

Recommendation 4 – Risk Identification

The CCG reviews and reports how its GP Practices are able to screen patients who may be suffering from domestic abuse and/or actively encourage patients to report domestic abuse to those practices.

Recommendation 5 – Public Awareness

The Community Safety Partnership further develops its programme of awareness raising regarding domestic abuse to enable the community to identify unhealthy behaviours in relationships and that also signposts the role of "friends" and wider community and where to seek help and advice or where to report abuse. In developing the approach to raising awareness it needs to:-

- Be forward facing, not hidden and target wider friendship circles.
- Highlight the assistance available via the National Domestic Violence Helpline.
- Develop a practical guide to those leaving abusive relationships that is identified as a time of increased risk.
- Include the learning from this review in respect of how victims may present as being strong and independent whilst being a victim of abuse.

Recommendation 6 – Third Party Reporting

The Community Safety Partnership to conduct research into the barriers to reporting domestic abuse for third parties, to seek ways to overcome these barriers and ensure findings inform future strategy, policy and practice regarding domestic abuse.

Recommendation 7 – Partnership Working

The Community Safety Partnership identifies and seeks to involve all existing services who are likely to deal with victims of domestic abuse in North Somerset, in the development of strategy, policy and practice thereby ensuring consistency of practice.

Recommendation 8 – Partnership Working

The Home Office reviews the licensing and accreditation of registered counselling services to ensure their continued awareness, development and potential contribution to combatting domestic abuse.