DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

REPORT INTO THE DEATH OF VICTIM "SHARON" who died in January 2018.

Report authored by Mark Wolski

On behalf of North Somerset Community Safety Partnership

A Personal Tribute from Sharon's Parents

Sharon was a happy, outgoing, loveable girl and a strong character.

She had a real sense of humour, funny sarcasm and a general love of life. She would do anything for anyone.

She was so thoughtful and along with the sadness we feel losing her, we feel an enormous amount of pride.

Sharon was an amazing mother, daughter, sister and friend and we will never understand or get over the loss of our beautiful girl.

We will love and miss her forever

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1. INTRODUCTION

1.1 The primary purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse in order for the lessons to be learned as widely and thoroughly as possible, Professionals need to be able to understand fully what has happened in each homicide and, most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2 This Domestic Homicide Review was commissioned by North Somerset Community Safety Partnership following the death of Sharon on 8 January 2018. Her husband pleaded guilty to her murder on 8 March 2018 and sentenced to 16 years and 8 months.

1.3 This Report examines the contact and involvement that agencies had with the perpetrator, Sharon and her children between 1 January 2010 to 8 January 2018. In addition to agency involvement, this report also examines any relevant past history of abuse.

1.4 The report also reflects the views and thoughts of Sharon's parents who have been involved throughout the production of this report since the first panel meeting. The panel wishes to express their sincere condolences to Sharon's family and friends.

2. TIMESCALES

2.1 The Review Process began on 18 April 2018 and was concluded on 30th November 2018

2.2 North Somerset Community Safety Partnership was notified of Sharon's death on 8 January 2018. It reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and recommended to the Chair of the Community Safety Partnership that a DHR should be undertaken. The Chair ratified the decision and the Home Office was notified on 8th February 2018

2.3 The Initial Review Panel meeting took place on 18 April 2018. The Terms of Reference were agreed and matters of confidentiality were set out within a Confidentiality Agreement signed by all stakeholders.

3. CONFIDENTIALITY

3.1 Details of confidentiality, disclosure and dissemination were discussed and were agreed between panel member agencies at the first Panel Meeting on 18 April 2018.

3.2 All information discussed was agreed as strictly confidential and was not be disclosed to third parties without the agreement of the responsible agency's representative.

3.3 All agency representatives agreed to be personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

3.4 It was recommended that all members of the Review Panel set up a secure email system, eg registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents may be password protected.

3.5 To protect the identity of family members, the following anonymised terms and pseudonyms have been used throughout this Review. Ages are at the time of Sharon's death.

Sharon	- Victim	- 27
Tom	- Perpetrator	- 45
Jordan	- Eldest child of Sharon and Tom	- 6
Alex	- Youngest child of Sharon and Tom	- 3
Sam	- Tom's child from previous partner	- 16

4. DISSEMINATION

Helen Bailey	-	Chief Executive North Somerset Council (NSC)
Louise Branch	-	Domestic Abuse Co-ordinator NSC
Howard Pothecary	-	Community Safety Manager NSC
Mark Wolski	-	Independent Chair
Peter Stride	-	Vice Chair
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 North Somerset
Carol Sawkins	-	University Hospitals Bristol NHSF Trust
Tracey Wells	-	Children's Centres

5. METHODOLOGY - REVIEW PROCESS

5.1 Legal Framework

5.1.1 The Review has been conducted in accordance with Statutory Guidance under S9(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.

5.1.2 There were no other Reviews conducted contemporaneously that impacted upon this Review.

5.2 Methodology Overview, Panel Meetings, IMRs and Chronologies

5.2.1 Initial scoping of agencies involved was undertaken by North Somerset Community Safety Partnership and each agency was invited to the first Panel Meeting that took place on 18 April 2018. At this Panel Meeting the exact Terms of Reference were agreed as described at 5.8. Two further full Panel Meetings took place.

5.2.2 Six comprehensive chronologies and IMRs were requested, and received, from all appropriate parties and these enabled analysis of Agency contact and informed discussion at subsequent Panel discussions.

5.2.3 The Author expresses his thanks to all Agencies but, in particular, to Avon and Somerset Police who completed a detailed IMR and commentary on barriers to reporting Domestic Abuse.

5.3 Family Involvement

5.3.1 At the start of the review process, the criminal case was ongoing and the trial had not started. However, the Chair consulted with the Senior Investigating Officer and early contact was made with the assistance of the Homicide Support Service. The Chair wrote a letter that was followed up swiftly by personal contact explaining the DHR Process. This early contact ensured an open dialogue between the Chair and Sharon's parents throughout this DHR Although Sharon's family were offered additional or alternative support, they declined this and were supported by the Homicide Support Service throughout the DHR process.

5.3.2 Sharon's parents met the Chair on the date of each Panel Meeting and they were present through the entire third and final Panel Meeting that took place.

The Panel wish to thank the parents for their active contribution throughout the DHR process and their specific input at the final Panel Meeting.

5.4 Perpetrator Involvement

5.4.1 Following the trial, the Chair attempted to contact Tom via his solicitors. Following letters and a number of phone calls with no response, he wrote directly to the Prison Governor asking that a letter be handed to Tom inviting him to take part in the DHR process.

5.4.2 On 17 July the Chair and Deputy Chair attended Bristol Prison and were able to speak to Tom. They were able to talk to him about his life, his relationships and his account of the murder.

5.5 Friends of Sharon and Tom

5.5.1 The Chair interviewed two of Sharon's friends and was provided with access to anonymised statements that enabled the Chair and Panel to gain a comprehensive understanding of Sharon as a person and also her relationship.

5.5.2 Similarly the Chair was provided with access to statements from friends of Tom that informed the Chair and Panel of Tom's state of mind; in particular on the eve of the murder.

5.6 Terms of Reference

5.6.1 The Terms of Reference are summarised below:-

a) Domestic Homicide Reviews (DHR) place a statutory responsibility on Organisations to share information. Information shared for the purpose of the DHR will remain confidential to the Panel until the Panel agree what information should be shared in the final Report, when published.

b) To review the involvement of each individual agency, statutory and non-statutory, with Sharon and Tom during the relevant period of time from **1 January 2010 to 8 January 2018**.

c) To summarise agency involvement during that same period.

d) 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.

e) 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.

f) 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; and
- Produce the Overview Report and Executive Summary by critically analysing each Agency involvement in the context of the established Terms of Reference.

g) To conduct the process as swiftly as possible, to comply with any disclosure requirements, Panel deadlines and timely responses to queries.

h) On completion, present the full Report to the Local Community Safety Partnership.

The Terms of Reference were shown to Sharon's parents.

5.7 Contributors

5.7.1 Individual Management Reviews were requested and received from the following Agencies, all of whom were invited to form the Panel:-

- Children's and Adults Safeguarding, North Somerset Council
- Avon & Somerset Constabulary
- Clinical Commissioning Group
- North Somerset Community Partnership
- Bristol Royal Infirmary
- Citizens Advice North Somerset

5.8 Review Panel

5.8.1 The Review Panel consisted of:-

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 – a specialist domestic abuse service, then commissioned from Salvation Army Housing Association
Jos Grimwood	-	North Somerset Community Partnership
Fiona Cope	-	Manager, Citizens Advice North Somerset
Tracey Wells	-	Children's Centres
Carol Sawkins	-	Bristol Royal Infirmary University Hospitals Bristol Foundation Trust

5.9 Author and Independent Chair

5.9.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved training and has 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.

5.10 Equalities and Diversity

5.10.1 The nine protected characteristics as defined by the Equality Act 2010 have all been considered; they are age, disability, sex, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief and sexual orientation.

5.10.2 Sharon was of white British background as was Tom. There was no indication that Sharon's murder was motivated or aggravated by ethnicity, faith, sexual orientation or other diversity factors.

5.10.3 One of the protected characteristics considered to have relevance to this DHR was the sex of the victim. Domestic Abuse is a gender biased crime with the majority of victims being female. Research shows that women are disproportionately represented as victims of intimate partner homicides.

5.11 Parallel Reviews and Related Processes

5.11.1 There were no Reviews conducted in parallel.

5.11.2 The Inquest was adjourned pending trial and not resumed.

6. THE FACTS

6.1 The Events of the Murder

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

6.1.2 Police and Paramedics attended and found Jordan and Alex next to Sharon. Police found a knife had been stuck into the arm of an armchair next to Sharon's body.

6.1.3 At 07.17 am, that morning, Police received another emergency call from a member of the public at the local Railway Station. It was reported 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

6.2 The Investigation and Outcome

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

6.2.2 Police conducted thorough enquiries with friends and former partners. Her friends showed an awareness of the difficulties in the marriage between Sharon and Tom. They also recall having witnessed an attack on Sharon, when one of Sharon's friends intervened. Her friends were aware of Tom's drinking and the influence it had on his behaviour.

6.2.3 Former partners spoke about his alcohol consumption and one noted his volatile nature. She notes that in 2003/4 she attended hospital owing to how tightly he had held her hand. Whilst this is outside the scope of the timeframe set out in the Terms of Reference, there are no records of Police Reports regarding this incident or other domestic incidents. It is noted that one partner reported that Tom had proposed marriage but she had given him a condition of giving up cider and he refused to do this. This recollection was confirmed by Tom when he was spoken to in Prison.

6.2.4 Tom's friends gave details of his drinking on the day before the murder and also of comments he made about stabbing her, comments discounted by friends as "the alcohol talking".

6.2.5 Tom phoned Sharon's father at about 8.40 pm on the evening before she was found and said their relationship was over. Sharon took the phone from Tom and said everything was ok. Her father did attend the address and saw the lights were on and all was quiet. He returned home.

6.2.6 There was no history of Domestic Abuse reported to Police between Sharon and Tom.

6.3 Charging and Court Outcome

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

6.4 Coroners Report

6.4.1 The Inquest was adjourned pending trial and not resumed.

6.5 The Victim, Sharon

6.5.1 Sharon was White British.

6.5.2 She left school and went to college to pursue her passion of horse riding and her desire was to pursue a career related to her hobby. Ultimately acute allergies prevented this career choice being followed.

6.5.3 She was aged 27 when she died. She married the perpetrator in 2013 and was still married to him at the time of her death.

6.5.4 Sharon and Tom had two children, Jordan and Alex.

6.5.5 Sharon worked part time in a local pub.

6.6 The Perpetrator, Tom

6.6.1 Tom was White British.

6.6.2 He grew up with parents and an only sister.

6.6.3 Tom has one other child, Sam, from a previous relationship.

7. CONTACT WITH AGENCIES

1 January 2010 to 8 January 2018.

7.1 Avon and Somerset Police

7.1.2 Neither Sharon nor Tom were known to the Police as either suspects or victims of any crime.

7.1.3 During the period of the Terms of Reference, Police indices show Tom had two contacts, neither of which is relevant or reflect on Tom's character.

7.2 Clinical Commissioning Group

7.2.1 This Review was conducted by reference to clinical records obtained from the GP Surgery where both Sharon, Tom, Jordan and Alex were registered as patients and had attended for treatment.

7.2.2 Between the years 2010 and 2018 Sharon and her family attended their GP surgery and saw their GPs for various medical problems. There were a total forty five (45) log entries related to consultations. Twenty seven (27) of these entries relate to Sharon, three (3) to Tom and the remainder to the children.

7.2.3 This period covers the time when Sharon's two children were born. She appears to have seen the GP more often for ailments relating to childbirth and the impact of this on her life. Reasons for appointments included joint pains, advice on contraception and migraines. On one occasion, when Sharon reported "feeling tired", she mentioned that she was getting good support from mum who lived around the corner and her husband.

7.2.4 Tom rarely saw his GP. There are relatively few consultations that include; sustaining an injury whilst cycling, an injury whilst using tools related to his occupation and on occasion where he sought contraception advice. He was

referred for Vasectomy. It's unclear whether he took this up. The last recorded entry is when he attempted to take his life after murdering his wife.

7.2.5 Jordan was aged 6 years 9 months at the time of the death. Jordan had various consultations with the GP for a variety of medical issues. Two referrals were made to the Children's Hospital for knee pain not associated with any injury and the other for poor hearing. Jordan was assessed on both these referrals and subsequently discharged. Jordan was also referred to the Bowel and Bladder service (BaBs). Sharon failed to engage with Services and Jordan was discharged from the Service two months before this incident.

7.2.6 Alex was aged 3 years 10 months at the time of the death. There are few consultations recorded, most having been associated with common colds. This is described as not uncommon in this age group. One consultation of note is a fall from push chair when Alex would have been just two months old. Alex was seen promptly by GP and discharged home. The IMR Author discussed this particular consultation with Bristol North Somerset South Gloucestershire (BNSSG) CCG's Designated Nurse for Children and the response from the GP was deemed appropriate.

7.3 North Somerset Community Partnership (NSCP)

7.3.1 This review was conducted by reference to a review of the records relating to services offered to Sharon, Tom and their children in relation to the particular specialisms of; Specialist Community Public Health Nurses, Health Visiting and School Health Nursing, MSK Physiotherapy and the Bladder and Bowel Service (BaBS).

7.3.2 There were twenty-two (22) entries on the chronology provided by the NSCP.

7.3.3 It was reported that personal contact visits are subject to routine Family Health Needs Assessments. The latter are comprehensive assessments used by Health Visitors to determine health needs that may require further guidance/support. Additionally, the assessment aims to identify any risk factors that may impact upon a family's welfare. Such risk factors include proactive questioning about Domestic Abuse experiences. This aspect of the assessment includes framing questions such as: "have you at any time in your life ever felt unsafe or not safe. This could be while you were growing up or in relation to partners?" and "Do you feel safe now?". None of these occasions gave any indication of Domestic Abuse and there was no recommendation for anything beyond universal Service provision.

7.3.4 There were seven (7) such visits during the timeframe of this DHR, none of which resulted in concerns being raised. When Tom was present, this was recorded and specific note was made of his presence and not asking DA questions as on 18 June 2014 shown in the Schedule of Visits shown below.

09/06/11	Antenatal visit from HV to Sharon, no DA disclosed. Family Health Needs Assessment completed. Proactive questioning regarding DA.
03/08/11	Primary birth visit.
05/09/11	6 week review visit where Sharon declined to complete a Mood Questionnaire. This is usually completed to assess the impact of the arrival of a newborn on the family.
16/07/12	1 Year Health Review for Jordan.
18/06/14	New birth visit. It was recorded that DA question was not asked as Tom was present. This is noted as good practice and record keeping.
02/07/14	6 weeks visit for birth of HV.
23/07/14	HV visit for review of Sharon's mood, as above.
11/10/16	Home visit regarding Alex's behaviour, becoming angry and frustrated. Advice given re: frustration associated with limited vocabulary. Follow up was planned for 2 months and telephone records show this being done on 06/02/17 and it was reported Alex's behaviour had improved.

7.4 North Somerset Children's Centre

7.4.1 Over a period of 5 years, the family accessed Services provided, and supported, by Nailsea and Backwell Children's Centre on 25 occasions. 14 out of the 25 sessions were delivered by external partners. 11 out of the 25 were delivered directly by Children's Centre staff.

7.4.2 Attendance per year consisted of:-

- 7 – 2016
- 1 – 2015
- 3 – 2014
- 1 – 2013
- 1 – 2012
- 12 – 2011

7.4.3 The only targeted group that the family attended was the Young Parents' Group (x 2 in 2011) and the New Parents' Group (x 1 in 2011). Young Parents Group is a targeted group as young parents are identified as a group who may require additional support. Attendance is voluntary as consent is required from families who are not subject to Child Protection or Child in Need processes. All other Services that the family attended were open to every family who have a child under the age of 5.

7.5 Citizens Advice North Somerset

7.5.1 On 22 January 2014 Sharon visited Citizens Advice North Somerset and made enquiries, and received advice, in respect of statutory Maternity Pay and Maternity Allowance. This advice was given.

7.5.2 On 5 January 2018 Sharon attended Citizens Advice North Somerset to enquire about divorce and separation. She was asked about her safety and asked about Domestic Abuse. She did not disclose any personal safety concerns or worries about Domestic Abuse. She said that she was "just worried about telling him".

7.6 University Hospital Bristol NHS Trust

7.6.1 The University Hospital Bristol NHS Trust provides a range of medical care including Midwifery and Emergency Department Care.

7.6.2 There are forty-four (44) entries on the chronology relating to the family.

Sharon

7.6.3 On 12 July 2010 Sharon attended the Emergency Department (ED) following a reported fall from a trampoline/bouncy castle. It was noted that she may have aggravated an old injury incurred falling from a horse. There was no bone injury nor significant swelling. No indictors of concern in relation to Domestic Violence or Abuse were noted by staff at the time of this presentation.

7.6.4 Between 2 December 2010 and 20 July 2011 she attended hospital regarding routine maternity related matters, none of which recorded any concerns in respect of Domestic Abuse or other matters. Thereafter, two routine post-natal visits are recorded.

7.6.5 Between 23 October 2013 and 3 June 2014 she attended hospital on a number of occasions regarding routine maternity related matters. No concerns in respect of Domestic Abuse or other matters were recorded. Thereafter, a number of routine post-natal visits are recorded.

Tom

7.6.6 On 2 July 2010 Tom attended Accident and Emergency following a fall from his push bike. It was recorded that he was intoxicated on his way home from the pub.

Jordan and Alex

7.6.7 There are a number of entries for the children relating to their birth and matters not considered relevant to their home or family life.

7.7 Marriage Guidance Councillors

7.7.1 In April 2017 Sharon and Tom attended Marriage Guidance Counselling. No details or records were retained which detailed conversations held.

8. FAMILY AND FRIENDS

8.1 Information from Family

8.1.1 Sharon's parents have been involved and contributed to the DHR Process. ; meeting with the Chair after the first two Panel Meetings, as well as holding a number of conversations whilst the review was being conducted. They had a further private meeting with the Chair before attending the final Panel Meeting. This gave the panel information about Sharon's character and her parents' perception of Sharon and Tom's relationship and identified key points in the development of their relationship. The Chair showed her parents a copy of the draft overview report, with advocacy present.

8.1.2 Sharon is described by her parents as being a very strong character, very capable and very wilful. She was fun loving and used to say to her mum that "life's too short" as they went out to have fun.

8.1.3 Sharon's parents describe Tom as being her first proper relationship after college and say that she fell pregnant quite soon after they met.

8.1.4 They are aware that Sharon had a good circle of friends with whom she socialised before, and during, her relationship with Tom.

8.1.5 Tom was described as being a husband who was always on best behaviour; who never swore.

8.1.6 Her parents became aware of the marriage difficulties and believe it was around August 2016 that Sharon explained to them that Tom had gone to his parents. Sharon had spoken to them about the possibility of Tom and her separating.

8.1.7 They were aware of Sharon, at some point, being concerned about money and wanting more. She was enrolled on a distance learning Course on dog grooming and had mentioned the cost of the books.

8.1.8 They were also aware that, whilst Tom's work had been seasonal, his business had been doing well with work being fully booked and not affected by the seasonal nature of tree surgery.

8.1.9 In June 2017 Sharon had spoken to her parents about renting a bungalow owned by them. Her father recalls that a prospective tenant had been working on the bungalow and that he was feeling a little guilty at the prospect of letting the bungalow to his daughter when there was a prospective tenant who had

been doing the work on the premises. Ultimately, Sharon did not move in as she was unable to secure the "benefits" she required.

8.1.10 Over the Christmas of 2017 they recall a wonderful relaxing Christmas and Boxing Day.

8.1.11 In the week before the homicide they had been aware that Sharon had been sleeping on the couch and that she had spent time at the pub when Tom was at home watching TV.

8.1.12 There is only one occasion when they saw any injury; a bruise to Sharon's arm. Her father asked her about this and she explained that the injury was caused by walking into a door and she did not want to talk about it

8.2 Information from Friends of Sharon

8.2.1 The Chair spoke personally to two of Sharon's friends and had access to statements which others had given to the police. This enabled him to gain information on some key events and gain insight into her friends' perceptions of her relationship with Tom.

8.2.2 Sharon had a close circle of girlfriends with whom she would regularly socialise, such as going out for coffee mornings and "Wine on Wednesdays".

8.2.3 The first disclosure of Domestic Abuse amounting to an assault relates to an incident in February 2015 when Sharon explained to a friend that Tom had punched her on the arm whilst she was holding Alex. She had said he was trying to push her down the stairs. She had also said that alcohol had been a factor.

8.2.4 One friend also witnessed Tom's aggressive behaviour when helping them to move. Tom had thrown a box at Sharon. He had made light of it but this had made the friend feel uncomfortable.

8.2.5 In March 2017 she confided to friends that she had been to Citizens Advice to seek advice on financial issues.

8.2.6 In April 2017 she had disclosed to a friend that she was at the point of a "make or break" decision and that financial issues were a big consideration.

8.2.7 In May 2017 a number of friends were present when Tom came into the kitchen where Sharon was drinking with friends. Tom had sworn, grabbed Sharon by the neck and another friend had intervened as Tom pulled his arm/hand back as if to strike Sharon. Friends spoke to Sharon about this incident and she said "I am not some sort of beaten woman". Friends who witnessed this incident describe themselves as being frightened and intimidated.

8.2.8 After this incident, Sharon travelled with friends for an evening out when she completely denied that anything actually happened and friends were very surprised by this.

8.2.9 In August Sharon told friends about an incident where Tom had thrown a television at her after she had gone upstairs to watch TV as she didn't want to watch football.

8.2.10 In September 17 there were exchanges of text messages about Sharon and Tom arguing and him taking her car keys.

8.2.11 In September 17 another friend was at the family home and Tom when been drinking. One of the children called for Sharon and Tom became very aggressive. The friend felt intimidated but Tom's mood quickly changed and nothing further was witnessed.

8.2.12 During the Summer of 2017 a friend had broached the subject of Sharon leaving Tom. Sharon had replied that she couldn't afford to as the Council wouldn't help her. The Chair spoke to the friend regarding this and Sharon had said that the Council couldn't help her as she was on the Deeds for her house and that she would be making herself intentionally homeless. The friend had asked whether Sharon had mentioned the abuse at home and she had said that she had not disclosed the abuse. It is not clear whether she had been asked.

8.2.13 In December 2017 Sharon confided in friends her intention to see Christmas through and then decide what they would do.

8.2.14 On New Year's Eve Sharon had texted a friend to say she was worried as Tom was out drinking.

8.2.15 On 4 January Sharon's friends recall receiving texts saying that she had told Tom about the end of their marriage and that he had responded by taking her car keys.

8.2.16 On the following date, 5 January, a group text was sent saying Tom was being very difficult.

8.2.17 Sharon was taken to the Citizens Advice office by one of her friends to seek financial advice.

8.2.18 The testimonies of friends report a consistent theme in the relationship between Sharon and Tom. He had such expectations of her that she felt restricted and put upon to keep the house tidy and have the meals ready. Sharon had felt the need to return home straight away if he phoned her.

8.2.19 It is observed by friends that Tom kept Sharon “under control” and, when asked by the Chair what they meant by this, gave an example of him treating her as a child, giving her “pocket money”.

8.2.20 The Chair asked the 2 friends he interviewed what may have made a difference and an opinion offered was of Sharon having options/choices or knowing where to go for advice.

8.2.21 The Chair asked whether the friends spoke about the situation when Sharon wasn’t present and the answer was “No”. They did discuss matters after the murder and it appears that Sharon confided elements of abuse and control separately to the friends. The Chair observes this is consistent with the testimonies provided separately.

8.2.22 The Chair explored awareness of Domestic Abuse amongst friends to consider what may have prompted an intervention or a report to the authorities. Notwithstanding evidence of friends’ own awareness of Domestic Abuse, they suggest that improved knowledge of where to turn may have prompted an intervention.

8.3 Friends of Tom

8.3.1 It has not been possible to secure a comprehensive view of Tom’s relationship with Sharon through witness testimony as it appears his friends knew little about her, one only having met her 5 weeks before the homicide even though he had known Tom for nearly a decade. It is, therefore, not possible to rely on any facts to form a sense of Tom as a person nor of his marriage to Sharon.

8.3.2 It is clear that Tom devoted significant time to playing pool with friends and that, on the day before the homicide, he attended a pool tournament with several of his friends. During that time, he was clearly drinking heavily and was heard to make a number of comments including comments about stabbing and killing her. During the day, he also pointed out to friends that he was no longer wearing his wedding ring. Testimony lacks further detail save for Tom drinking cider.

9. INFORMATION FROM TOM

9.1 The Chair and Co-Chair visited Tom in Bristol Prison in order to gain his perspective. The information provided summarises facts deemed pertinent to the review.

9.2 He described himself as a practical man who left school to study forestry at college. It was at college that he “found” cider and this gave him the confidence to go dancing.

9.3 He described having had six serious relationships and, when asked about whether there were any themes to his relationships, he described himself as a “boy scout”.

9.4 He was asked whether there had been any difficulties or violence in his relationships before Sharon; he said he had suffered a broken nose from a partner who suffered from substance misuse issues.

9.5 He spoke about a relationship with the mother of his first child, Sam, and acknowledged the relationship became difficult and that he drank more. He said that, at one point, he had declined to give up cider to save the relationship.

9.6 He said that he did a course to reduce his alcohol consumption but had not sought help from Alcoholics Anonymous or anyone else. He said that he did not see drinking as a problem.

9.7 He described his meeting with Sharon, having met in the pub and moving in within a few weeks.

9.8 He describes a wonderful start to the relationship but that about two years previously (July 2015) he suspected she was having a relationship with someone else. He said he bottled his feelings up and found it difficult to talk to Sharon. He says this caused him to become angry and frustrated.

9.9 He acknowledged that, in December 2017, they had agreed to separate and he had begun to drink more.

9.10 He stated they had paid for Marriage Guidance Counselling, one session only.

9.11 On being asked questions from the DASH Risk Assessment, he volunteered that he had contemplated suicide on one occasion but had not sought help, even though he had been to his GP at the time he was having suicidal thoughts.

9.12 Over the Christmas period prior to the homicide he said he became more and more frustrated and drank more.

9.13 On the day before the homicide he said that he had drank all day.

9.14 Tom states that, on the evening before the murder, he had phoned Sharon’s father and said the marriage was over and that Sharon had taken the phone from him and said to her father that everything was ok and that he had been drinking too much.

10 INFORMATION FROM SHARON

10.1 Domestic Homicide Reviews seek to learn from the past and identify learning to prevent future tragedies. The Chair is fortunate, in this particular case, to have been provided with insight directly from Sharon in the form of a letter. It is unclear when this letter was written.

10.2 An extract from Sharon's letter says:-

"I need some time out.

I feel taken for granted and unappreciated.

When I get annoyed about something - regardless of why… You get pissy with me.

As soon as we fight you try and lock me out of my own house. I know my name isn't on the paperwork but doesn't mean you can kick me out.

I let you do whatever you ask. I never kick up, but you always take the piss.

I feel we want different things all the time.

I've lost what it means to be me. I live how you want me to live or get told off!

And I've written all this and am telling myself how unfair I am being as you rarely stop me doing things, you pay for everything.

I'm fed up.

I don't want to spend evening on tablets phones anymore, I want to chat and cuddle and for you to be interested in me.

The only time you take notice of me is when you are horny.

Stop putting me down".

11. ANALYSIS

The analysis of this Domestic Homicide Review explores the reasons why events occurred, how and whether information was shared and, subsequently, whether the sharing informed decisions and actions taken.

The analysis, initially, considers the findings of the IMRs and, where possible, triangulates this with information that presented itself subsequent to IMR submission, such as discussions with Sharon's parents, with Tom and also through the discussion and contributions of the Panel.

11.1 Domestic Abuse Definition

11.1.1 The Government definition of Domestic Abuse is:-

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality.

The abuse can encompass, but is not limited, to the following types of abuse: psychological, physical, sexual, financial, emotional.

11.1.2 Controlling behaviour is defined as:-

A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

11.1.3 Coercive behaviour is defined as:-

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim.

11.2 Avon and Somerset Constabulary (ASC)

11.2.1 There was no relevant contact between Sharon or Tom during the period noted in the Terms of Reference. There were only two contacts with Tom that were unrelated. Typically, limited contact with an Agency would result in a limited IMR.

11.2.2 The Chair consulted with ASC Policy Unit and, following discussion, ASC agreed to consider the information provided by friends regarding the relationship, previously undisclosed acts of violence and behaviour indicative of a controlling relationship as a basis for asking two questions:-

- What is stopping, not just victims, but friends, family and employers from reporting DA to Agencies?

- What can ASC do to improve current ways of working to break down barriers to reporting for victims of DA and third parties?

The findings from this IMR are referred to throughout the rest of this section. The Author and Panel wish to thank ASC for their pragmatism in agreeing to adopt this approach since the agency had no relevant contact until the trigger event, a circumstance in which most agencies would have declined to complete an IMR.

11.2.3 The IMR for ASC referenced recognised barriers for reporting and behavioural conditions that may affect a victim's response to Domestic Abuse and considered these against the information available from friends and family. It also considered ASC's own approach to third party reporting on the basis that several of Sharon's friends had witnessed an incident of violence and other incidents that may not have been recognised as Domestic Abuse.

11.2.4 **Barriers for Sharon**

(a) Financial Implications: ASC notes the significance of disclosures Sharon made to friends concerning financial difficulties which would ensue if she left Tom and the fact that she had sought advice from the Local Authority and Citizens Advice regarding housing and financial advice respectively. The link between financial security and housing is further highlighted within the IMR as it describes Sharon's mood as being "very positive" once she had arranged alternative accommodation with a friend. This illustrates that, once Sharon had the right support measures in place, worries about financial circumstances may have diminished and she felt confident enough to leave Tom.

(b) Fear: The IMR highlights a number of observed behaviours that make it reasonable to conclude that she was fearful for herself and, perhaps, for her children. In particular, she displayed a degree of urgency if Tom phoned or, if she knew he was coming home, needing to get Tom's dinner ready.

There were a number of physical assaults:-

- Several witnesses saw an assault which may have proved more serious had a friend not intervened, where Tom grabbed her around the throat and drew his hand back as if to punch her.

- Sharon's appearance and apparent fear were observed following an incident where Tom had reportedly punched her whilst she was holding Jordan.

- One example is highlighted when Sharon was assaulted by Tom in the presence of a friend which resulted in the friend being dismissive of Tom during unplanned encounters. This clearly caused problems to Sharon as she "pleaded" with her friend to treat Tom as she previously had in order to prevent Sharon being "hassled" by Tom.

(c) Psychologically worn down/conditioned: The IMR author calls attention to evidence of Tom belittling Sharon and making negative comments about her. She was someone who behaved differently in the presence of Tom, not displaying her normal confidence and "persona" as the life and soul of a party. The IMR Author questions whether her psychological state and her confidence had been so diminished that she didn't feel able to report or disclose the levels of abuse she was exposed to. Whilst this is acknowledged as being speculative, when explored in further detail, it was considered a valid factor through the analysis and cross referencing of testimonies that include:- unevidenced opinion of his being a "control freak", examples of controlling behaviour such as removal of her car keys and the impact of being subject to such "high expectations" in respect of housekeeping.

(d) Shame and opinion of family: Reference is made within the IMR to Sharon's having wanted the perfect family from a young age and worrying about disappointing her parents.

The Chair notes that, during subsequent conversations with Sharon's parents, they said that Sharon had joked with them about being the first member of the family to get divorced.

It is also reported that Tom's parents had purchased, or assisted with the purchase of, the family home and this may, therefore, be argued as adding an additional burden to Sharon's considerations when balancing her circumstances and any decision to disclose abuse or leave Tom.

(e) Isolation: The IMR draws attention to the impact of the abuse upon Sharon's friends. They acknowledged being fearful after witnessing incidents and this had the effect of reducing the level of contact with Sharon. For example, friends chose not to go to her house; particularly after an incident when he grabbed her around the neck.

It may be argued that the effect of Tom's behaviour was to insert emotional blocks between Sharon and her friends and family and this had the impact of reducing her opportunity to seek support.

The Chair also notes, from the analysis of witness testimonies, that Tom took Sharon's car keys away on more than one occasion, thereby, creating physical barriers that isolated her.

11.2.5 **Barriers for Sharon's Friends and Family**

(a) Perception of strength and choice: There was an overarching perception of Sharon's strength of character, described by a variety of friends as "bubbly and outgoing". The IMR suggests that the effect may have been that people assumed she was strong enough to deal with her situation. The Chair notes that her parents also considered her to possess strength of character. Her bubbly and outgoing personality was also apparent when Tom described how they met; she was serving in a restaurant/bar and treated him in a confident manner. The panel explored this and drew the inference that those who appear quiet and meek may be more likely to appear in need of help and so may be more likely to actually receive help.

(b) Fear of repercussions: Tom had been verbally aggressive and intimidating towards Sharon's friends and the IMR notes how swiftly his behaviour and mood could turn. The IMR outlines one particular example where a friend remained with Sharon and Tom following an incident for the sake of Sharon.

The IMR author considers that this was not an isolated example. Not only is there an example of Tom actually assaulting Sharon in the presence of friends, there are further examples showing his capacity to change mood and become aggressive. On one occasion, in the presence of a number of people, he became verbally threatening following an accidental injury to a friend in a pub.

(c) Not recognising domestic abuse: ASC considered that domestic abuse may not be recognised due to the perpetrator's practiced deception of being

"almost too nice" and also, if the domestic abuse includes emotional abuse, controlling and coercive behaviour rather than physical abuse

It is noted that friends recall how attentive Tom was to Sharon when in their presence; except for the instances of aggression. It is, therefore, considered highly likely that her family were completely unaware of the domestic abuse. Sharon's father, in conversation with the Chair, echoed this, describing Tom's angelic-like behaviour and the fact that he never ever swore in his presence. In hindsight, he finds this most unusual especially from a man such as Tom. It is clear to the author that Tom did not show his true character to Sharon's parents!

There was also a second element of failing to recognise the psychological abuse; including failing to note or consider the implications of how Sharon responded to text messages from Tom - she would drop everything, leave nights out early to return home. ASC cite a report entitled "Victims of Domestic Abuse, Struggling for Support"[i] which states: "civil society needs to be better equipped to recognise, support and refer victims of Domestic Abuse". This suggests that it requires significant effort to raise awareness of Domestic Abuse and the recent legislative changes regarding coercion and control, that would inform communities not just "professionals". Such endeavours may address further points noted within the ASC IMR which acknowledge the admitted lack of confidence of some of Sharon's friends. It may be argued that the adage "knowledge is power" could have encouraged reporting to agencies.

(d) Minimisation: It is noted that Sharon was dismissive of incidents or, on a number of occasions, changed the subject. She is quoted as saying "I am not some sort of beaten woman". ASC note that one friend had been told by Sharon that Tom had tried to push her down the stairs. The friend had wanted to appear shocked but wasn't as she already suspected there was abuse taking place.

Sharon's parents also recall her avoiding conversations about her relationship and also how, on one occasion, she was adamant that visible bruising had been caused by walking into a door.

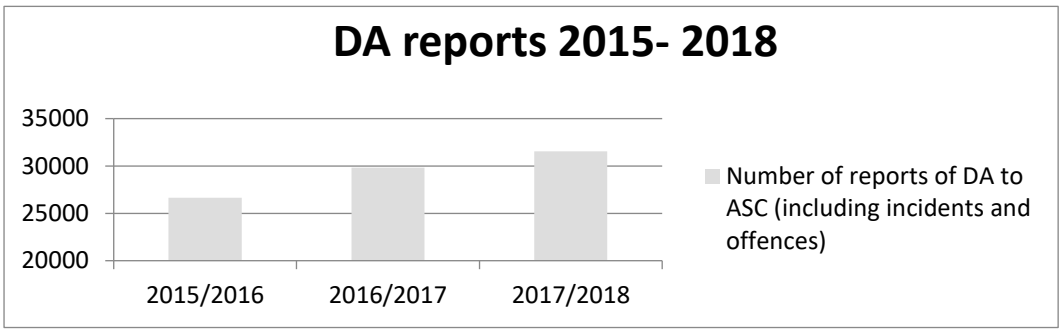
The Panel considered the level of abuse, not only in terms of Sharon, but also in terms of the children and drew the conclusion that friends accepted the "minimised" version of events.

11.2.6 **Barriers for Third Parties in General**

ASC recognises that Domestic Abuse represents 12% of all its crime compared to the figure of 8% nationally, quoted by the Authorised Professional Practice on Domestic abuse[ii] but is unable to identify the proportion that is reported by third parties. It is suggested that analysis of crime statistics on third party reporting is, therefore, not possible and barriers and, conversely, incentives to third party reporting cannot be clearly understood.

ASC reports a steady increase in reported domestic abuse for the past three years. It attributes this, in part, to actions following an HMRC Inspection.

At the outset of this inspection ASC had 64% compliance, this has now increased to 95%. The IMR Author also notes a number of awareness campaigns that ASC ran between 2015 to 2017 with one specific campaign aimed at third party reporting.



ASC also examined the volume of Multi-Agency Case Reviews currently being undertaken. There are 27 such Reviews, of which 13 relate to domestic abuse. It further comments that 8 are typified by very limited contact with the Police.

The Chair and Panel have considered these findings and agree that the issue of third party reporting requires further exploration in terms of:-

(a) Encouraging third party reporting via universal awareness raising; and

(b) Developing effective systems for capturing third party reported crimes as this would help to understand barriers and opportunities to encourage third party reporting.

Whilst increased reporting is encouraging, ASC, like many Forces, is not able to analyse the effects of particular campaigns.

The inference being drawn is that the true crime rates are starting to be reflected. It notes that approximately 47% of domestic abuse is reported directly but does not report whether the remainder can be attributed to third party reports by friends and family rather than reports from professional agencies.

11.2.7 Sharon's parents made the observation that the range of options for reporting abuse against children is generally well known but that, although they were aware of Crime Stoppers as a means of reporting crime anonymously, they were unaware of any specific means of reporting any form of adult abuse, including domestic abuse. This was explored and it is recognised that there is a need to highlight means of reporting domestic abuse and ways to find out options for supporting anyone experiencing it; including the National Domestic Violence Helpline which provides advice and information and operates 24 hours a day, 7 days a week.

11.2.8 Sharon's parents also observed that there is a significant focus upon raising the awareness of victims and they suggested that there is also a need to direct information towards the wider friendship groups of potential victims and

perpetrators. The panel concurred and noted that information on domestic abuse may be placed in hidden areas, such as on the back of toilet doors! This report was identified by the panel members as an opportunity to be more proactive and they acknowledged that the district's Children's Centres had already ensured that highly visible information was available at all their centres as a result of this case.

11.3 Clinical Commissioning Group

11.3.1 The panel considered the volume of contacts that the family had with their GP and noted that the majority (27 of 45) of these related to Sharon; only three entries related to Tom and the remainder related to the children.

Sharon

11.3.2 It was noted that the most contact between Sharon and the GP related to pregnancy and childbirth. There was not any disclosure of domestic abuse; physical or otherwise. Nor was there evidence of Sharon being routinely asked screening questions to determine if there were any issues. This was explored and such questions would only be asked if issues such as anxiety, depression or other concerns were apparent.

11.3.3 There were two entries, dated October 17 and October 15, that were explored by the IMR Author and the panel as they may, on face value, be symptomatic of stress. These had been explored by the GP and the detailed records showed that issues of stress and anxiety had been explored and it was reported that she had good support from her husband and mother who lived close by.

Alex

11.3.4 It was noted that Alex had fallen from their pushchair aged 2 months. This incident was explored by the IMR Author, along with the Bristol North Somerset South Gloucestershire CCG, and the response was deemed appropriate, not requiring any referrals regarding concern for the child's overall welfare. It was, however, noted that the Health Visitor had not been notified, as per policy. This may have prompted an additional enquiry by the Health Visitor.

Jordan

11.3.5 Jordan was seen by the GP (25/05/17) and referred to the Bowel and Bladder Service (BaBs). This was explored by the panel and it was apparent that Jordan was prescribed medication. The panel enquired whether the cause of the symptoms which led to this referral would have been explored and, in particular, whether stress in the family environment had been explored. It was not possible to draw any conclusion to this line of enquiry.

11.3.6 Whilst there appear, on face value, to be a significant volume of contacts with the GP, given that the average number of attendances at a GP for a patient per annum is 5.16[iii], it is concluded that the overall volume would not have triggered any additional concerns.

11.4 North Somerset Community Partnership (NSCP)

11.4.1 NSCP provide services which include Specialist Community Public Health Nurses such as Health Visiting and School Health Nursing, Physiotherapy and the Bladder and Bowel Service.

11.4.2 An analysis of the twenty entries on NSCP Systems shows that seven resulted from visits to the family address. Whilst these were mostly routine, visits which related to three matters were further explored by NSCP and the Panel.

11.4.3 In September 2011 Sharon declined to complete a Mood Questionnaire. This was explored at the Panel Meeting. Completion is entirely voluntary and mothers may decline to complete for a variety of reasons. It is therefore, difficult to draw any conclusion as to why she declined on this occasion.

11.4.4 In October 2016 Alex was reported as becoming angry and frustrated. This was explored at the time and it was concluded that this was associated with the development of the child's vocabulary. It appears that by February 2017 this behaviour had improved.

11.4.5 Between May and August 2017 notes were made regarding Jordan and the referral to the Bladder and Bowel Service. Sharon had been asked to complete diary sheets regarding Jordan's bowel and bladder routines and Jordan was discharged from the service without receipt of the diaries or responses to the requests for follow up, in accordance with policy. Having been discharged on 30 August, cross referencing with GP records shows that GPs were notified of this on 11 October.

11.4.6 The panel explored the discharge procedure and it is noted as good practice that they checked for changes of address and any alerts such as Child Protection and Child at Risk. NSCP have full access to such information via shared electronic records.

11.4.7 Further NSCP good practice is noted and evidence found of policy being implemented within the chronology of contact with Sharon. Comprehensive policies and training regimes in respect of Domestic

Abuse include:-

- All Health Visiting students receive structured sessions with regard to understanding domestic abuse and violence: how to recognise/suspect it and how to raise a concern.

- All NSCP staff have received instruction and support with regards to proactive questioning in respect of Domestic Abuse with questions such as “have you at any time in your life ever felt unsafe or not safe?”

- Staff are trained, and supported, with respect to identifying/suspecting and managing domestic abuse concerns within statutory single agency training which they must repeat every two years.

11.4.8 Evidence of training being put into practice is to be found when the Health Visitor Record highlights that Sharon was proactively asked about Domestic Abuse at the antenatal contact. At a subsequent contact, the practitioner chose not to ask questions relating to domestic abuse when Tom was present.

11.4.9 It is, therefore, considered appropriate that targeted services were not considered as appropriate as there was no observed domestic abuse or disclosure of domestic abuse.

11.5 North Somerset Children’s Centres (NSCC)

11.5.1 NSCC offers support services for parents and children. The only targeted attendances by Sharon were two occasions in 2011 when she attended a group that is offered to young parents identified as having higher need for general support.

11.5.2 The volume of contacts was explored by the panel. The IMR Author reports that all Children’s Centre Family Support Workers and Children Centre’s Leaders access mandatory training which supports their knowledge and understanding of how to recognise the signs of domestic abuse and use of routine screening questions when working with adults where domestic abuse may be suspected.

The IMR Author suggests that North Somerset Children’s Centres would benefit from developing further training and awareness for their Early Years Workers who also support service delivery to ensure that they are enabled to recognise Domestic Abuse and also to consider the appropriateness of these staff asking screening questions. North Somerset Children’s Centres could also, within their buildings, raise awareness of assistance for victims, as well as friends and family members of victims.

11.6 Citizens Advice North Somerset (CANS)

11.6.1 Sharon visited the local Citizens Advice Office on two occasions, the first in January 2014 regarding statutory Maternity Pay and Maternity Allowance, the second in January 2018, a few days before the homicide. On neither occasion was domestic abuse disclosed. The advisor for Citizens Advice did explore with Sharon whether she was worried about domestic abuse and was reassured that there was none; Sharon stated that she was "just worried about telling him". In the context of the interview, Sharon did not give the Advisor a reason to follow up.

11.6.2 The panel explored the issue of asking "screening questions" and ensuring recognition of an opportunity to ask "follow up" questions in response to statements such as the one above. It was noted that the IMR Author acknowledged that there is currently a reliance upon those approaching Citizens Advice offices to disclose domestic abuse, as opposed to advisers routinely asking questions. A view expressed by the IMR Author, and agreed by the panel, was that individuals may not be able to identify that they are suffering from domestic abuse.

11.6.3 During panel discussions, it became apparent that Citizens Advice Bureaux nationally have conducted significant research regarding clients attending the service for information, ostensibly for advice on issues such as finance or housing, when there is an underlying issue that may relate to an abusive relationship.

11.6.4 The Citizens Advice report entitled "Victims of domestic abuse: struggling for support?"[iv] reported findings of a pilot conducted across a small number of Citizens Advice Services across the country. This involved advisors proactively asking clients questions about whether, or not, domestic abuse is present in their lives. During this pilot the number of clients independently disclosing abuse rose from 0.8% to 7%. Citizens Advice Services are now rolling out the process of routine enquiry across all its services.

11.6.5 Upon reviewing its overall local response to domestic abuse, CANS identified opportunities to develop knowledge of, and integrate with, local domestic abuse service providers and recognised that this may improve local referrals to such organisations.

11.6.6 The panel welcomed the national research by Citizens Advice, the roll out of "ASK"' as a routine enquiry and recognition of opportunities to integrate further with local DA Service Providers.

11.6.7 The issue of specialist domestic abuse advice was explored and the local Citizens Advice Office is fortunate enough to have a domestic

abuse specialist Family Advisor available. This is seen as good practice and, whilst the Panel recognises the limitations and availability of volunteers, it also considers it advisable to strengthen the overall knowledge of CAB Advocates regarding domestic abuse

11.6.8 The IMR Author suggested strengthening local partnership working concerning domestic abuse and clarifying the pathways for accessing support for clients. The panel considered that, given the national research by Citizens Advice, it is considered highly desirable that CANS are involved in further development of local responses to domestic abuse.

11.7 University Hospital Bristol NHS Trust

11.7.1 The Hospital Trust provides a range of medical care and there are forty-four entries regarding the family. A high proportion of these entries relate to Sharon's attendance in respect of pregnancy/maternity issues.

Sharon

11.7.2 In accordance with policy, Sharon was asked questions regarding Domestic abuse during visits related to pregnancy. Questions were not asked when Tom was present.

11.7.3 It is noted within the IMR that an Annual Assurance Audit is carried out to ensure that questions regarding domestic abuse continue to be asked. This is noted as effective practice.

Tom

11.7.4 The only entry for Tom was following an accident on his bike on the way home from the pub where it was noted that he was intoxicated.

11.7.5 The analysis of the Trust's IMR reassures the panel in respect of routine questions regarding domestic abuse during pregnancy and of a Quality Assurance Process that will ensure this is maintained.

11.7.6 The IMR and chronology develops the theme of alcohol as a feature of Tom's behaviour.

11.7.7 The panel explored the working practices of the Emergency Department at Bristol Royal Infirmary. It has a well-established Independent Domestic and Sexual Violence Advisers Service (IDSVAS) in place, supported by Domestic Violence and Abuse Policies and Procedures. Staff within the Department receive Adults and Children Safeguarding

Training and additional Specialist Domestic Abuse Training, provided by the IDSVAS. The specialist training includes recognising possible indicators of domestic abuse and neglect and additional screening for all presentations which may be concerning.

The department has an additional safeguarding process in place for instances where there are concerns about a potential risk of domestic abuse and further information or assessment is required. In such cases, overnight admission to the Observation Unit can be arranged, with the consent of the patient. This is noted as good practice.

11.8 Marriage Guidance Counsellors

11.8.1 Sharon and Tom visited counsellors in April 2017 and it was reported that no records had been retained.

11.8.2 The Chair spoke to the Counselling Service and it was reported that all records in the relevant period had been shredded.

11.8.3 The Counselling Service spoke in general terms about the Service provided and noted a degree of expertise in respect of domestic abuse and sexual abuse counselling.

11.8.4 The Chair explored what the service's response would be in respect of any disclosures and was informed that the policies would dictate a course of action dependent upon the risk to self or others. This was explored, and the Chair was reassured of considerations including disclosure to statutory agencies.

11.8.5 The Chair explored overall awareness of Risk and Risk Assessment Tools. The Counselling Service Representative was unaware of the DASH Risk Assessment Model.

11.8.6 The DASH Risk Assessment Model was introduced in March 2009 and is the nationally accredited Tool for Risk Assessment of domestic abuse.

11.8.7 The Panel consider that counsellors ought to have an awareness of Risk Assessment Models and, with regard to domestic abuse, this should be the DASH Model.

11.8.8 There are currently no laws in the UK regarding counselling and psychotherapy quality of service. Instead, current requirements for registration relate to the volume of hours training and the volume of hours of supervised Clinical Practice. The Counselling Service in question is registered.

11.8.9 The Chair and panel consider that organisations responsible for registering counsellors should consider that the prevalence of domestic abuse and, in particular, the frequency that those receiving counselling are likely to experience it, demonstrate a compelling need to ensure specific training regarding the identification and responses to domestic abuse.

11.8.10 The panel also noted and cross referenced two Citizens Advice recommendations as pertinent to Independent Counselling Services:-

(i) To develop greater interaction and referral pathways between CANS and Domestic Abuse Services; and

(ii) To ensure CANS has greater integration within local Domestic Abuse Services. These recommendations are seen as being transferrable to work with Private Counselling Services and other NGOs.

11.9 Family

11.9.1 Sharon's mother and father were kind enough to engage with the DHR process from the start and were able to provide significant insight into the relationship between Sharon and Tom that affirms observations made through friends' testimonies, IMR Summaries and panel discussions. In isolation, the Chair and Panel conclude that it would not have been possible for them to predict the tragic events of 8 January 2018.

11.9.2 Whilst Sharon's parents were aware of the age difference between Sharon and Tom and were aware that he had been in a previous long-term relationship, they felt that they appeared to be a happy couple. Tom's first child would stay over and Sharon was a brilliant mum to all the children.

11.9.3 The parents, on describing Tom, recall a man who never swore, who was always on his best behaviour. It is only with hindsight that they believe this was part of an act. Whilst they cannot evidence this feeling, Sharon's father said that, for a man doing the type of manual work Tom was doing, never to swear in front of him seemed really unusual.

11.9.4 They do describe one isolated incident where dad noticed a bruise. Sharon quickly shut the conversation down, claiming it was an accidental bruise from bumping into a door. This adds credibility to the notion of her being in denial and/or minimising any abuse she was suffering.

11.9.5 They did become aware of Sharon's desire to increase her income as she was training to be a dog groomer. This was surprising as they were

also aware of the Tree Surgery Business having a more stable cash flow. It had, at one point, been very seasonal, with peaks in the Summer and quiet in Winter. They were aware this income had become more stable and, once again upon reflection, are, therefore, surprised that Sharon made comments about money and the costs of the books for studying.

11.9.6 In the Summer of 2017 Sharon had spoken to her parents about renting the bungalow the parents owned but she was of the opinion that she would not be able to afford to pay the rent, nor get help from the Council. When asked "how things were", she merely replied that "all was OK".

11.9.7 Whilst the isolated examples presented to the parents could not reasonably draw anyone to predict the tragic outcome, they do add weight to the pressures that securing financial and housing assistance may put on a victim weighing up options of how, and when, to leave.

11.9.8 Efforts have been made to determine whether Sharon attended the Council Offices to seek advice and support but this can neither be confirmed or denied. The Housing Advice Manager reports that, had Sharon been seen by Housing Staff, this would have been recorded. However, she reports that Sharon may have spoken to front-of-house Reception and been referred to the Home Choice Policy which states that Home Owners are not eligible. The Panel explored this point and, whilst there is no formal record of contact with Sharon, they agree a need to ensure that the Home Choice Policy references that domestic abuse would attract "Priority" consideration.

11.9.9 The Chair has explored the reasons why Sharon did not speak to her parents about the assaults and controlling behaviour. Whilst there is no definitive answer, they have considered a number of options. Potentially, she may have, in some way, been trying to protect them from embarrassment or she may have been worried about what her parents' reaction may have been. If it were the latter, she would have been worried about matters being made worse.

11.9.10 When the Chair further explored the time when the marriage breakdown became clear, Sharon's parents said that they were not told until the Saturday before the homicide.

11.9.11 The proximity of this disclosure to the murder was discussed by Panel members and it is recognised that such decisions do change risks in volatile relationships. Had such a decision been made known, in a relationship already subject to professional domestic violence advocacy, the Panel consider this may have merited a revised Risk Assessment. The simple fact is, however, that Sharon and Tom were not known to

agencies. The proximity of decisions to leave, to tell people and the murder merely adds weight to commonly held professional views.

11.9.12 On the evening before Sharon was found, her father recalls Tom phoning him and saying that "he didn't want to upset him but it's not working out, you should have her back"'. Sharon took the phone from Tom and explained that Tom was drunk and everything was ok. Her father did go around but, upon seeing the lights on and that everything appeared ok, he returned home.

11.10 Friends of Sharon

11.10.1 It is clear from the testimonies of friends that Sharon was fortunate to have a

close circle of friends with whom she enjoyed an active social life. As a result, these friends were aware of, and also witnessed, some of Tom's aggression and controlling behaviour as well as the impact upon Sharon. Therefore, their testimonies provide a unique insight into Sharon's marriage and barriers to her leaving the relationship and also raise the questions of why the friends did not report their concerns individually or collectively and what may have encouraged them to report what was occurring. These questions were explored and an explanation is offered that Sharon confided individually with friends and asked each to keep any disclosures confidential.

11.10.2 Tom's aggression and violent nature is apparent through witnessed behaviour as well as by what Sharon told her friends. She told her friends about Tom trying to push her down stairs. Friends witnessed violence on a number of occasions and also intervened on one particular occasion. Sadly, the first sign of difficulty was apparent on their wedding day when Sharon had confided to friends that he had "started on her", though detail was not elaborated upon.

11.10.3 His controlling nature and impact on Sharon was typified by how she reacted when she received calls or texts or knew Tom was due home. In these circumstances, there appeared to be a sense of urgency in Sharon's reaction with a need to get home. It is considered reasonable to assume that there was a degree of fear or intimidation involved.

11.10.4 His controlling nature is further illustrated by his removal of her car keys at various points. This act having an effect of isolating Sharon. Further examples appear to be the close control of money in the household. Friends described in conversation with the Chair that she was given "pocket money".

11.10.5 His intimidating nature is further illustrated as Sharon's friends have been

frightened by his behaviour. Not only during the example where they witnessed the assault on Sharon, but also on other occasions in the home, when his mood changed, such as when responding to the children calling for their parents.

11.10.6 It is also apparent, from the testimonies, the part that alcohol played in their lives. Tom's behaviour was often associated with alcohol. Friends describe that, even at their Wedding, he had promised not to drink. He did and, at one point, Sharon became upset and asked friends to collect her from the Hotel.

11.10.7 Whilst the friends provide an insight into the relationship, they also illuminate
barriers that Sharon was facing in determining her decision to leave.

11.10.8 Sharon had confided in more than one friend about some of the financial barriers she faced. In March 2017 she confided that she was going to seek advice from the Citizens Advice Bureau regarding financial matters. In April of that year she had confided to another friend that she was aware of the financial difficulties associated with leaving. In the summer of 2017 she had said that she could not afford to leave as the Council wouldn't help her. Having spoken to friends of Sharon, it appears that the fact she was on the deeds of the house acted as a barrier to getting help from the Council. Equally, she told a friend that she did not disclose Domestic Abuse when she spoke to the Council. It is not clear if she was asked about whether she was a victim. This has been explored by council authorities and there are no records of contact being made.

11.10.8.1 Sharon's parents explored the visit to the Council premises and, whilst accepting that it may not be practicable to record every visitor's encounter with reception staff, this encounter may have provided an opportunity to explore why Sharon had attended beyond advice on housing. The Chair notes a potential parallel with the approach of Citizens Advice and the roll out of the "ASK" Programme.

11.10.9 It is reasonable to assume that, during the Spring and Summer of 2017, the chronology of events indicates Sharon was actively considering her options in respect of leaving Tom.

11.11 Friends of Tom

11.11.1 It is not possible to draw any conclusions as to Tom's character, nor of his relationship with Sharon. A point of note is that one friend who had known Tom for ten years had only met Sharon 5 weeks before the murder.

11.11.2 In the events running up to the homicide, it is clear that alcohol featured when Tom played in a pool tournament with friends. During that day, it is clear that his failing marriage was on his mind and he was angry, as expressed through threats he made. It is felt these were considered by his friends as “the drink talking”.

11.12 North Somerset Domestic Abuse Strategy 2016 - 2019

11.12.1 Reference is made to this Strategy as it sets out the overall aims and priorities for North Somerset at the time of Sharon’s homicide. Of the seven priorities, the Chair considers that three provide a useful backdrop to consider the circumstances against which (a) Sharon suffered from domestic abuse apparently without reporting it or accessing Services, (b) those in the community who had witnessed or knew did not report and (c) practitioners were not able to identify the abuse which friends did not report it.

Priority 1: Access - We want to ensure that adults and children affected by domestic abuse are able to access appropriate support when it is first needed. They need to know what help is available, and where to get it, and they should feel confident enough to ask for support and be able to trust that it will be both appropriate to their needs and sensitively provided.

Priority 3: Community - We want North Somerset to be a place where domestic abuse is not tolerated. We want all people living and working in the area to have an understanding of domestic abuse so that they know how to recognise when it might be happening and how to help anyone experiencing it.

Priority 4: Practitioners - We will aim to ensure that all workers in the district who may come across anyone experiencing domestic abuse can identify this and know how to respond.

11.12.2 The Chair explored the broader question of raising awareness and was reassured that the partnership was able to detail a programme of multi-agency awareness raising that includes a number of downloadable guides such as: Domestic Abuse Handbooks for professionals, Survivors’ Handbooks and a number of other guides. The Partnership was also able to provide documentary evidence in support of their efforts since 2010. This includes a social media campaign in 2017. The Chair acknowledges these efforts and the comprehensive nature of its Domestic Abuse Handbook 2017/2018.

11.13 Summary of Analysis

(a) Sharon lived in an abusive and volatile relationship where she was subject to a variety of controlling behaviours. These included financial control as apparent from the thoughts expressed in her letter as well as incidents described by friends. Her efforts to find a way out are evidenced by seeking advice from CANS, training for a new career, speaking to her parents and, reportedly, to the Council about housing.

(b) It is apparent that Sharon was subject to a number of assaults, some witnessed, others that arose in conversation with friends. It does not appear that any of these were reported to authorities by Sharon or a third party.

(c) Tom portrayed an angelic character to Sharon's parents, always being on best behaviour. This is considered by the panel as a practiced deception of appearing angelic to conceal his character. This is seen as further evidence of his controlling nature.

(d) Alcohol played a key role in the formation of Tom's character giving him confidence at an early age. Whilst not untypical, his reliance on alcohol was damaging in a number of ways, such as convictions for drink driving as well as in his behaviour to Sharon.

(e) Barriers to Sharon reporting the abuse included intimidation and fear. Whilst fortunate to have a close circle of friends, there is evidence of her becoming isolated owing to Tom's behaviour keeping friends away. Along with the financial control, this weighed in favour of her remaining in an abusive relationship until the point when she made arrangements for alternative accommodation. The panel also consider that Sharon sought to protect her family and reputation not wanting to be the first family member to divorce.

(f) The panel found that there was a degree of minimisation by Sharon who had said "I am not some beaten women" and changed the subject in conversation. It is also probable that a degree of conditioning contributed to her failure to recognise the abuse she was suffering. On being asked by her parents in 2017 how things were, she merely replied "all is ok".

(g) Barriers to friends reporting the abuse included their perception of her as being a very strong character. This was also reflected by her family's perception. It may be argued that they may not have recognised the assaults and behaviour as amounting to domestic abuse although, on balance, the panel considered this unlikely as

some friends were clearly intimidated.

(h) Analysis of third-party reporting is not possible owing to "flagging" limitations. This also limits analysis of the success, or otherwise, of campaigns to raise awareness and encourage third party reporting.

(i) Risk identification via routine screening questions is apparent with Health Visitors and University Hospitals Bristol NHS Trust. It has been identified by Citizens Advice as best practice and the ASK Programme will be rolled out nationally. Routine screening is not apparent across all organisations.

(j) Partnership working was identified by CANS as an opportunity to be involved with wider partnerships to combat domestic abuse. The benefits of this also became apparent during conversations with a local marriage guidance counselling service who would benefit from awareness training in respect of DASH.

(k) Risk Escalation - the proximity of a decision to leave, and of making this decision known, to the homicide supports professional opinion regarding the elevation of risk at this critical time.

12. CONCLUSIONS AND RECOMMENDATIONS

12.1 Preventability

12.1.1 Given the information presented in the Review, the Chair and Panel conclude that Sharon's murder could not have been prevented and was not predictable. Responsibility for this tragedy rests with Tom. This conclusion is based upon a number of factors:

12.1.2 There is no evidence that Sharon reported the abuse to police or trusted professionals; although she had confided in friends separately and there are witnesses to assaults and aspects of coercive and controlling behaviour.

12.1.3 It could be argued that, had Sharon expressed the thoughts within her letter to a trusted professional, this may have prompted the professional curiosity required to delve further into the relationship; either through a routine encounter with a medical professional, or with a specialist advisor from whom she sought advice such as Citizens Advice North Somerset.

12.1.4 Tom was an individual who had relied on alcohol in his teens and who arguably developed a dependency. This impacted on his work life through drink driving and also through an accident. It is also apparent

that alcohol impacted upon his overall demeanour. However, there are no Police Intelligence or Crime Reports that would indicate the potential escalation in violence that resulted in murder. And yet it is clear that alcohol played a significant part in the day before the murder.

12.1.5 None of Sharon's discussions with her parents, or their questioning about a bruise, would have indicated to them the potential for this extreme event. Whilst Tom had phoned Sharon's father on the evening of the murder and her father had gone around to the address, there had been no other examples of extreme behaviour that would have given them cause for concern.

12.2 Issues Raised by the Review

12.2.1 <u>How Sharon and Victims are perceived</u>

(a) Friends and family's overarching perception is of Sharon having a very strong character and of being "bubbly and outgoing". It may be argued that those who appear meek and mild may be more likely to receive help than those who appear strong.

(b) Sharon did not disclose the assaults or the degree of coercion and control that was apparent in her marriage to professionals, notwithstanding the significant levels of contact with partnership agencies. There is evidence of good practice in asking screening questions across such agencies and, given the nature of her character, it is considered unlikely that she presented as somebody in need of help.

(c) There is also evidence to suggest that Sharon was "minimising" the behaviour, actually declaring that she was "not some sort of beaten woman" and she avoided conversations such as when her dad asked about the bruise to her arm.

(d) Furthermore, it may be contended that friends who knew about the domestic abuse considered and respected the "choice" that Sharon was making to remain in the relationship as opposed to recognising that she was subject to a degree of psychological conditioning.

(e) Putting ourselves in Sharon's shoes, it could be that there were a number of reasons why she did not report the abuse relating to the issue of "perception":-

- To prevent embarrassment to her family as she had made comments about being the first in the family to get divorced.

- Her embarrassment as she was a person recognised as being a strong character who was bubbly and full of life.

- Her concerns about involving statutory agencies and the impact this might have upon her children.

(f) Sharon's case highlights that, regardless of how a victim is perceived, they are vulnerable and that perceptions ought not to cloud any identification of risk. It appears that she did not present or disclose domestic abuse to professionals.

12.2.2 Barriers to Reporting

(a) It is reasonable to conclude that "fear" of further abuse played a part in Sharon not reporting the Domestic Abuse. She had been a victim of assault on a number of occasions and, moreover, appeared fearful of how friends behaved to Tom once they had witnessed his behaviour. Sharon asked her friends to treat him as usual after one particular incident. Friends had described him as intimidating and the effect of this was isolation of Sharon.

(b) It is clear that, in addition to having been assaulted, she had been subject to other controlling and coercive behaviour.

(c) It is argued that financial control as opposed to financial management was exercised as part of overall controlling behaviour. Sharon was seeking to enhance her own financial independence through training to be a dog groomer, notwithstanding the tree surgery business doing well. Sharon clearly identified a lack of financial independence as a constraining factor when seeking advice from Citizens Advice and speaking with her parents in respect of her own housing situation.

(d) Putting ourselves in Sharon's shoes, it is considered possible that other barriers played on her mind that may have included the reaction of her's and Tom's parents. In particular, her father felt that she may have been worried that any disclosure would have made matters worse.

(e) Again, looking at matters from Sharon's perspective, there are events that indicate denial and minimisation. It may, reasonably, be put forward that the unhealthy behaviours may have become normalised over time and, as such, she may not have recognised the option of reporting the crimes being committed against her.

(f) There have been various articles in respect of normalization; Kohlman et al. (2014) investigated the cultural mechanisms of domestic violence normalisation. The tendency for many cultures to value family privacy and prioritise the "good of the family" above

that of the individual (referred to as familism) contributes to continued acceptance of abusive behaviour. It is argued that familism can facilitate physical and emotional abuse within families by effectively preventing victims from seeking outside help or even perceiving their treatment as abusive.

(g) This same article comments on the effects of the media and the normalisation of violence in a domestic setting. It also notes the potentially positive contributions of the media and this is regarded by the panel as an opportunity to be considered in the future.

(h) It is argued that this case demonstrates the complexity of issues and the dilemmas and decisions that victims have to balance before reaching a decision to deal with the abuse by leaving, reporting or otherwise. The opportunity facing the Community Safety Partnership in addressing this balance may, in part, be achieved through ensuring access to services and making domestic abuse unacceptable in the community.

12.2.3 Risk Identification and Assessment

(a) Whilst Sharon is not known to have reported domestic abuse to the authorities, she faced multiple risk factors that are worth repeating here. Whilst the onus is put upon professionals to recognise risk, it is put forward that wider community recognition may have enabled professional interest from statutory agencies:-

(i) Escalation of behaviour.

(ii) She had been assaulted in the presence of friends.

(iii) She had previously been assaulted and brought this up in conversation with friends.

(iv) He drank alcohol to excess.

(v) He had controlled her to the extent that she was on edge whenever he contacted her whilst she was out.

(vi) He financially controlled her, paying for everything.

(vii) He had removed her car keys to control and isolate her.

(viii) He verbally put her down in the presence of friends.

(ix) He isolated her by making friends feel uncomfortable.

(x) Her friends felt intimidated having witnessed violence and mood changes.

(b) Despite this list of behaviours, Sharon managed these risks alone, not reporting to the authorities, not disclosing when asked as part of routine screening for domestic abuse by professionals and also not benefitting from a third-party report being made.

(c) The panel heard details from stakeholders of a variety of contacts with professionals. Abuse was not disclosed, despite there being clear evidence presented of questions having been asked, such as at the antenatal contact. The policy in respect of health visitors, midwifery services and the emergency department is particularly clear and the panel learned of questions not being asked when Tom was present. This is noted as good practice.

(d) Sharon's GP did not ask questions with regards to domestic abuse and wouldn't unless specific issues came to light such as anxiety or depression. The panel explored the barriers to general screening approaches and reported that the IRIS Project, that operated locally until 2017, had shown promising signs in the early identification of domestic abuse. The panel considered that the learning from this approach should be considered to reinforce the benefits of screening questions by healthcare professionals within GP Practices.

(e) The case highlights the necessity for practitioners to be able to recognise DA and to apply professional curiosity to determine whether abuse is occurring. The roll-out of the ASK Approach by Citizens Advice bureaux across the United Kingdom is acknowledged by the panel as good practice. It demonstrates a culture of continued organisational learning that is to be encouraged to enable the identification and assessment of risk. Given the specific approach of Citizens Advice to "ASK" screening questions when advice is being sought regarding finance and housing, it may be argued that a similar approach should be adopted across agencies; including the council.

(f) Sharon's case also raised an issue in respect of the role of "trusted professionals" not subject to such strict regulation as required for statutory authorities. Sharon and Tom attended a private Marriage Guidance Consultation. Such Counsellors are able to become registered through numbers of hours training and/or supervised counselling. The Chair spoke to the counselling service and was informed of their expertise in respect of relationships and domestic abuse. They were asked about incidents where concerns were raised and the Chair was reassured that there were policies that dictated alerts to agencies where there were causes for concern.

However, when asked about “Risk Assessments” and DASH, the term was not recognised. The panel consider that this as an opportunity to involve other agencies in the local development of the domestic abuse agenda that may ensure shared learning and best practice.

(g) This case shows that there remains significant work in respect of ensuring that victims have “access” to support when it is needed, that they are informed enough to recognise unhealthy relationship behaviours and have the trust to ask for support.

(h) This case further demonstrates the part that the “community” has to play in recognising domestic abuse and some of the behaviours/risks that typify it.

(i) The proximity of the homicide to the decision to leave, and telling Tom of this, supports professional opinion in respect of the escalation of risk at the point of separation and for a time afterwards. The panel considered whether there was specific practical advice available to those about to leave an abusive relationship. Notwithstanding a number of publications, the panel agreed there was an opportunity to signpost, and develop, such advice.

12.2.4 Third Party Reporting

(a) Sharon’s friends had witnessed assaults and the coercive/controlling behaviour by Tom. They had been informed of other incidents.

(b) Action could have been taken to alert the authorities butit does not appear that anyone did this, perhaps because members of the community were not aware of when, and how, to help victims of domestic violence. The analysis also suggests a number of other reasons that vary from respecting Sharon’s choice, believing she was a strong enough character, not recognising the controlling nature of the situation, fear of making matters worse, through to a degree of intimidation of those friends.

(c) Avon and Somerset reports that 12% of its overall crime relates to domestic abuse against a national average of around 8%. The IMR Author conducted further research in relation to Force multi-agency case reviews and found that, of 27 ongoing reviews, 13 related to domestic abuse of which 8 were typified by limited contact with Police. The IMR Author further reported that flagging issues limited the ability of analysing third party crime reporting trends and, therefore, the analysis of the success of domestic abuse awareness raising campaigns is limited.

(d) This case, therefore, suggests that that the Partnership needs to do more to raise awareness in respect of Domestic Abuse and the need to report it.

(e) The review also shows a need to research and alleviate the reasons for not reporting abuse. Part of this would require ASC considering how it captures third party reporting data to facilitate analysis.

12.2.5 Partnership Working

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(a) Whilst Sharon and Tom had very limited contact with partner agencies, the Chair agrees with the recommendation of Citizens Advice for their closer integration with the wider Strategic Partnership to tackle Domestic Abuse.

(b) Citizens Advice North Somerset has identified the link between those seeking advice with respect to housing and finance and domestic abuse,

(c) This case also demonstrates the potential for even wider involvement of agencies such as Specialist Marriage Guidance Counselling Services to ensure the sharing of developments in respect of risk identification.

12.3 Recommendations

12.3.1 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.

12.3.2 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 as a misrepresentation of 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 take further positive steps to take control; in this DHR these included financial constraints and housing.

12.3.3 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 its policy for 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.

CSP agencies to ensure that staff who work with families, but who do not currently receive mandatory training on domestic abuse, are trained and provided with guidance on how to identify and ask about domestic abuse and how best to provide support. This should include early years workers based in children's centres

12.3.4 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.

12.3.5 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 so that people know what to say and how to broach the issue as well as 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 to target wider friendship circles.

- Highlight the assistance available via the National Domestic Violence Helpline.

- In this case developing 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.

- Give friends and family guidance on how to raise the issue of domestic abuse with a victim and how best to support them.

- Encourage and support small businesses to provide support for any staff who may be experiencing domestic abuse.

12.3.6 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 that the findings inform future strategy, policy and practice regarding domestic abuse.

12.3.7 Recommendation 7 – Partnership Working

The Community Safety Partnership to identify and seek 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.

12.3.8 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.

[ii] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/introduction/

[iii] Hobbs, F.D., Bankhead, C., Mukhtar, T. et al,.(2016) *Clinical Workload in UK primary care: a retrospective analysis of 100 million consultations in England 2007014* The Lancet, Volume 387 Issue 10035, p 2323 – 2330

[iv] Citizen's Advice Bureau, 2015 available at https://www.citizensadvice.org.uk/about-us/policy/policy-research-topics/justice-policy-research/domestic-abuse-policy-research/domestic-abuse-victims-struggling-for-support/