SAFER BARNSLEY PARTNERSHIP

Domestic Homicide Review into the deaths of S1 and S2

EXECUTIVE SUMMARY

Conducted using Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013

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November 2016

BARNSLEY Metropolitan Borough Council

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

Adult Female	S1	Subject of the report	White British
Adult Male	S2	Subject of the report	White British

1.2 In July 2015 South Yorkshire Fire and Rescue Service (SYFRS) received a call to a house fire in Barnsley. On their arrival at the scene SYFRS officers found a significant blaze and neighbours attempting a rescue of the occupants trapped inside. Firefighters deployed into the house in breathing apparatus but despite the best efforts of all involved it was not possible to save either of the occupants.

1.3 The subjects of this report both died in the house fire. The coroner found that whilst the fire was deliberate it was not possible to say which of the subjects had started the fire. The house was secure and there was no evidence of third party involvement. For that reason, there is no reference in the report to victim and perpetrator.

1.4 The coroner's narrative verdict states "The fire started in the rear bedroom, part way through the right hand side of the bed. The fire investigator can only conclude, by exclusion of all other causes, that the fire was started deliberately. The house was secure at the time, so it can only have been started by one or the other occupants. There is absolutely no evidence to tell me which one this might have been."

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 The Safer Barnsley Partnership [SBP] decided the deaths of S1 and S2 met the criteria for a DHR and appointed an Independent Chair. The Independent Chair is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews and Multi-Agency Public Protection Reviews. They have never been employed by any of the agencies involved with this DHR and were judged to have the experience and skills for the task. They were assisted by two additional independent practitioners, one of whom wrote the report. A DHR panel was assembled which represented local agencies and included members with detailed knowledge of domestic abuse. The Chair and Review Panel considered the scope of the review and drew up clear terms of reference, which they felt were proportionate to the nature of the homicides. Four panel meetings were held and attendance was good with all members freely contributing to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone. The panel held detailed discussions about the contents of the IMRs and ensured the Overview Report brought these together. The panel then drew together conclusions, lessons and recommendations.

2.2 Eleven agencies submitted written information. S1's daughter contributed to the review, providing important background information and acting as a voice for her mother. S2's son also contributed to the review provided important background information about S2 and his relationship with S1.

2.3 The purpose of a Domestic Homicide Review is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- apply these lessons to service responses including changes to policies and procedures as appropriate
- prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

3. BACKGROUND

3.1 Adult Female S1

3.1.1 S1 was born in the South of England and attended a number of state schools in the local area. She became pregnant when she was sixteen and had her daughter when she was seventeen. In her teens and twenties S1 had a number of jobs working in shops and restaurants. She started to misuse alcohol and developed associated mental health problems. S1 had a number of relationships and she was married four times. In 1998 she went to live abroad, initially in country A with her husband. That relationship broke down but she stayed in country A with her new partner until in 2005 when she went to live in country B with her daughter. Her daughter describes everything as being fine until around 2013 when following a change of medication S1 'hit rock bottom' again. This was a precursor to a move back to the UK and in February 2013, S1 moved to Barnsley where she met S2.

3.2 Adult Male S2

3.2.1 S2 was born in Leeds. His family know little of his early life except that he was brought up by his parents, together with a sister and two brothers. His family believe that one brother and S2's sister are still alive but have no contact with them. S2 formed a long term relationship and had two children with his partner whilst living in Leeds. His partner had a son when they met and all five lived together as a family. In his younger years S2 had sporadic employment including as a builder and a waiter in restaurants. However, he misused alcohol and this combined with mental health issues meant that he had not worked for many years. Following the breakup of that relationship, S2's former partner moved to Barnsley. S2 later moved to Barnsley to be nearer to his

children.

4. COMMENTARY

4.1 S1 and S2 met at a support group for people with substance misuse issues in June 2013. Their relationship progressed quickly and by August 2013 S1 had moved in with S2 at his then home. They were later to move together to address 1, the scene of the fatal fire.

4.2 Both S1 and S2 were well known to mental health and substance misuse services in Barnsley. In July and August 2013 S1 underwent an inpatient detoxification programme. Both however continued to misuse a range of prescription drugs and other substances. S1 was admitted to hospital on a number of occasions having taken an overdose of various medications and self-harmed by cutting her arms. Some of this self-harm was said to be because she was upset that she had not been offered a bungalow in the couple's rehousing application.

4.3 Following the couple's move to address 1 on 6 May 2014 they continued to access a range of services. S1 and to a lesser extent S2 relied on mental health services for support but they were self-reliant in their day to day needs. On some occasions they did not make themselves accessible to support workers and a number of agencies worked hard to support them, for example by finding them through ringing friends and family.

4.4 S1 visited a childhood friend in the south of England periodically and once her relationship with S2 was established he accompanied her. Her friend states that S1 confided in her that on one occasion S2 had raped her. The friends discussed this and S1 did not want to report the matter or have it reported for her. Whilst her friend was concerned for S1 she did not feel it was her place to independently report things to the authorities that S1 had made a decision not to report.

4.5 On 30 January 2015 whilst being visited at address 1 by a social worker, S1 disclosed that S2 had physically assaulted and raped her. Immediate action was taken to safeguard S1 and she was removed from the address to hospital. Over the following weeks S1 reported the rape to the police and was accommodated in a women's refuge to protect her. This was not an easy process for S1 and at one point she withdrew her support from the investigation. However, when this was followed up she told other officers that S2 had threatened her and the investigation was reinstated.

4.6 Unfortunately whilst living at the refuge S1 caused a fire in her room on two occasions and after the second occasion was asked to leave as a result of concerns for other residents. This proved to be the catalyst for her to move back to address 1 with S2. Despite the concerted efforts of a number of professionals it was not possible to find accommodation that was acceptable to S1. She was advised that the decision to go back to S2 was not wise but she told her Independent Domestic Violence Advocate that S2 was now taking his medication and she thought things would be fine. On 9 April 2015, S1 moved back into address 1 with S2. There were no further indicators of abuse apparent after this.

5. CONCLUSIONS

5.1 S1 returned to the United Kingdom after living for many years abroad at least in part so that she would have better access to services. She knew that she needed support for her mental ill health and addictions and sought it out at the earliest opportunity. S1 was able to access an extensive range of services and it was whilst at one of those services that she met S2.

5.2 S2 also had mental ill health and addictions. The couple met at a support group. Whilst there are appropriate procedures in place to manage emerging relationships between service users a balance has to be struck. Professionals did intervene with advice and assistance, whilst at the same time recognising that both S1 and S2 had the capacity to make their own decisions. Ultimately there was no lawful way that the relationship between S1 and S2 could have been prevented from going ahead.

5.3 Both S1 and S2 were comfortable in accessing services and were able to find support. They engaged and sometimes disengaged with services as was their right. S1 made a decision to return to address 1 and resume her relationship with S2. Whilst this may have been in part because she found a potential offer of refuge accommodation in a different town unacceptable, it was a choice that she was capable of making whether professionals considered it wise or not.

5.4 Following the resumption of the relationship between S1 and S2 in May 2015 attempts continued to be made to ensure their safety. A fire safety check was completed on their home and the couple were given safety advice. S1's application for independent housing continued to be considered. The couple had not been forgotten.

5.5 At the time of their tragic deaths all outward indications were that S1 and S2 had entered a settled and stable phase of their relationship. They appeared to be reducing their dependency on services, although they were very much still in view. Based on the information known before the fire, the safeguarding meeting scheduled for later in July would have been very likely to have recommended that no further action was necessary.

6. LESSONS IDENTIFIED

1.	**Narrative:** Both S1 and S2 suffered from forms of mental illness and substance misuse. They were at times high intensity users of a range of services and were able to freely access those services when they wished to do so. **Lesson:** Information about S1 and S2 was appropriately shared on many occasions between professionals in order to assist in the provision of services to S1 and S2. To that extent the review highlights good practice.
2.	**Narrative:** Despite what was undoubtedly effective information sharing between professionals there was no overall oversight or ownership across the partnership of the issues and risks arising from the relationship between S1 and S2 until a Safeguarding Strategy meeting was prompted by the events of 30 January 2015. The case was then considered by Multi - Agency Risk Assessment Conference (MARAC) and a Safeguarding case conference took place on 7 April 2015. **Lesson:** People with complex needs who are not offered services under a coordinated strategy may be denied the best opportunity to support their needs and ultimately reduce their dependence on services. **(Panel Recommendation 1)**
3.	**Narrative:** S1 presented serious risks to other residents at the refuge she was living in by twice creating a fire risk. She then stayed briefly with a relative before returning to address 1. Attempts were made to find alternative refuge or hostel accommodation for her but were unsuccessful due to the perception of risk from fire to other residents. S1 was left with Hobson's choice[1] and returned to address 1 to live with S2. She described herself as happy and all indicators right up until the time of the fatal fire were that S1 and S2 had entered a settled phase of their relationship. **Lesson:** Stable accommodation is almost essential to manage people with complex needs and the lack of suitable housing for people who pose a fire risk provides an additional obstacle and leaves them vulnerable. **(Panel recommendation 2)**

[1] A free choice in which only one thing is offered.

4.	**Narrative:** Personal risks to professionals were considered to be heightened to an extent that computer systems were flagged by two agencies but the information was not shared with other agencies. **Lesson:** Not sharing risk information with all agencies supplying services could endanger staff providing those services. **(Panel Recommendation 3)**

7. RECOMMENDATIONS

7.1 The DHR Recommendations appear at Appendix B.

Appendix A

Terms

Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) was: "Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14 February 2013 is: "Any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional, Controlling behaviour is: 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. Coercive behaviour is: 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."

3. Therefore, experiences in S1 and S2's relationship fell within the various descriptions of domestic violence and abuse.

DASH risk assessment model

4. Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment form (DASH) is the risk assessment model currently by the Safer Barnsley Partnership

5. DASH is an essential element to tackling domestic abuse. It provides the information that would influence whether or not to refer the victim to a Multi - Agency Risk Assessment Conference [MARAC].

6. There are three parts to the DASH risk assessment model:

    1. Risk identification by first response police staff
    2. The full risk assessment review by specialist domestic abuse staff
    3. Risk management and intervention plan by specialist domestic abuse staff

7. The definitions of risk used by the Safer Barnsley Partnership are:

- **Standard**: Current evidence does NOT indicate likelihood of causing serious harm.

- **Medium**: Identifiable indicators of risk of serious harm. Offender has potential to cause serious harm but unlikely unless change in circumstances.

- **High**: Identifiable indicators of risk of imminent serious harm. Could happen at any time and impact would be serious. All high risk cases go to MARAC.

Appendix 'B' **Action Plans**

	Safer Barnsley Partnership				
	Recommendation	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	Safer Barnsley Partnership and Barnsley Safeguarding Adult Boards should consider the feasibility of developing a coordinated case management/information sharing approach to the care of high intensity service users, who for whatever reason engage in risky behaviours, that are not captured by other safeguarding processes.	1. Multi-Agency Information Sharing Agreement. 2. Case Management System across DV service and Multiple Need Service. 3. Vulnerable Adult Risk Management system (VARM)		Barnsley Council Barnsley Council Barnsley Safeguarding Adult Board	April 2017 April 2017 Nov 2016
2	In developing their new commissioning strategy, the Safer Barnsley Partnership should give consideration to how refuge places can be commissioned for people who although vulnerable themselves may present a variety of risks to others.	1. Commission new Domestic Violence Service with single point of entry. 2. Extend efficient Refuge offer to include home protection and promote exclusion of offender. 3. Based on Recommendation 1 whole system approach agreement		Barnsley Council	April 2017
3	The Safer Barnsley Partnership should give consideration to how its partners can share information about perceived risk to staff in a way that respects the needs and rights of service users.	Based on above agreement and having shared information manage low and medium level risk by coordinated response.		Barnsley Council	

South Yorkshire Fire and Rescue						
	Recommendation	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	SYFR Managed Pathway for MARAC information Sharing Referrals	1. Identified SYFR Coordinators 2. Visual Pathway Flow Chart 3. Referral Forms 4. Secure emails 5. Admin support	1.SYFR Safeguarding Board and Reference Group Minutes 2.Copies of documents under Key Actions	Managed process for High Fire Risk MARAC Case Referrals Secure and Confidential referral and feedback	Community Safety Team Leader Safeguarding Officer Equality and Inclusion Officers	Oct 2016
2	Route for all other referrals linked to Domestic Abuse i.e. those not reaching the threshold for MARAC	1.Safe and Well Partnership Referrals 2.Partnership Codes – Monitoring 3.Referrals 4. Secure Portal	Safe and Well Partnership Policy and Process	Managed process for High Fire Risk MARAC Case Referrals Secure and Confidential referral and feedback	Equality and Inclusion Officers Partnership Officer	Nov 2016
3	MARAC Training for key staff	1.Identify appropriate external Training Providers 2.Identify relevant staff to attend	Training records	All Community Safety staff attend MARAC/ Domestic Abuse Training	Community Safety Team Leader Station Manager Safeguarding Officer	Nov 2016

4	Secure recording system	1.Restricted access to confidential, sensitive and high risk information 2.High Risk People rather than premise based (may be linked to multiple premises) 3.Fields for capturing additional information not captured in an HSC Questionnaire	1.Meetings with Data Team/CFRMIS 2. Vulnerable CFRMIS Person Module and/or High Risk Access Database	1.Sensitive and Confidential Case information restricted to relevant staff 2.SYFR able to record and store detailed case information linked to a person as opposed to a single property	Community Safety Group Manager Station Manager Team Leader	Oct 2016
5	Support and Supervision for SYFR staff managing High Risk cases	Management Oversight	Safeguarding Board and Reference Group Minutes Supervision meetings for key staff - already in HSC3 and Safeguarding Policy	Ongoing support, guidance, development and improvement for Prevention and Protection 2. Individual support on high risk decision making	Community Safety Group Manager Station Manager Team Leader Equality and Inclusion Officers	July 2016
6	Debriefing for SYFR personnel who have had prior involvement with a Fire Fatality case	Debriefing to be included in the Fire Death and Serious Injury Review process	Debriefing written into FD and SI policy and learning reviews	Staff involved in a case feel supported and are included in any learning review	Community Safety Group Manager Station Manager Team Leader Area Watch Managers	Oct 2016

Agency Recommendations: South West Yorkshire Partnership Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	To improve liaison between mental health services and the Fire and Rescue Service	1. To contact Vulnerable Adult Fire Officer to arrange training sessions across CMHT's, Early Intervention, Assertive Outreach Team, SPA, Intensive Home Based Treatment Team and Mental Health Liaison Team 2. To confirm Referral Pathway and ensure referral paperwork identifies possible past and current drug use history.	To show evidence of training and to confirm the availability of the pathway and the availability of the referral form	To improve communication between mental health and Fire Service and identify possible vulnerable service users and to ensure that referrals and access to the service is improved	Community Mental Health (CMHT) Team in conjunction with Team managers across teams and High Risk Coordinator Community Safety South Yorkshire Fire and Rescue	Dec 2016
2	To improve knowledge around the MARAC process	To arrange updates / information regarding the MARAC process and training re completion of the DASH Risk Assessment Domestic Abuse training to be delivered November 2016	Provide evidence that training has occurred and that staff have attended these training sessions and ensure that the Policies and the referral forms are available to all staff on the appropriate drive.	To ensure there is an increased awareness of the MARAC system and how referrals can occur.	CMHT Manager in conjunction with MARAC coordinator and Safeguarding Team	Dec 2016

Agency Recommendation: South Yorkshire police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	South Yorkshire Police to reinforce the use of DVPO's and DVPN's to officers dealing with DA incidents, to encourage greater use in incidents of DA, to better support and protect, those victims where they are unwilling/ unable to support other criminal justice outcomes	DVPO/DVPN included on street skills training Autumn 2016/ Spring 2017. Masterclass to be presented. New posters and intranet entries to be completed.	Training schedules. Presentations, posters and intranet entries	Increase in applications for DVPO/DVPN	Detective Chief Inspector	April 2017

End of Executive Summary