Domestic Homicide Review

Sarah/2013

Executive Summary

Author: Paul Pearce

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Intentionally Blank

Executive Summary

1. Introduction

This domestic homicide review (DHR) examines the circumstances surrounding the death of Sarah Taylor in Town B, Kent on 7 November 2013. Her estranged husband, Robert Taylor, was convicted of her murder and sentenced to life imprisonment with a recommendation that he serve at least 25 years.

This report has been anonymised and all the personal names contained within it, with the exception of members of the review panel, are pseudonyms.

2. The Review Process

The review began with an initial meeting held on 18 December 2013. Organisations that attended had indicated that they potentially had relevant contact and/or involvement with any or all of Sarah, Robert and their 15-year-old daughter Emma prior to Sarah's death.

As a result, the following organisations were requested to provide Individual Management Reviews (IMRs):

- Kent Police
- Kent Specialist Children's Services (KSCS)
- Education, Learning and Skills Directorate, Kent County Council
- Kent Community Health NHS Trust (KCHT)
- East Kent Hospitals University NHS Foundation Trust (EKHUFT)
- Kent & Medway NHS and Social Care Partnership Trust (KMPT)

IMRs include the following:

- a chronology of interaction with Sarah, Emma and Robert;
- what was done or agreed;
- whether internal procedures were followed; and
- conclusions and recommendations from the agency's perspective.

During the course of the review information came to light that suggested the following organisations also had relevant contact and/or involvement with Sarah, Robert or Emma:

- Education & Learning Services, Kent County Council
- The Crown Prosecution Service
- HM Courts and Tribunals Service

KCC Education & Learning Services provided an IMR. The CPS and HMCTS are not agencies that are required to participate in DHRs. Senior representatives of both organisations were interviewed by the Independent Chairman and provided information about their contact and involvement.

3. Terms of Reference

The Purpose of this DHR

a) Establish what lessons are to be learned from the death of Sarah Taylor in terms of the way in which professionals and organisations work individually and together to safeguard victims.
b) Identify what those lessons are, both within and between organisations, how and within what timescales that they will be acted on and what is expected to change as a result.
c) Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-organisation working.
d) Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-organisation working.

The Focus of this DHR

This review will establish whether any organisation or organisations identified possible and/or actual domestic abuse that may have been relevant to the death of Sarah Taylor.

If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

If domestic abuse was identified, this review will focus on whether each organisation's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other organisations.

Methodology

Independent Management Reviews (IMRs) must be submitted using the template current at the time of completion.

This review will be based on IMRs provided by the organisations that were notified of, or had contact with, Sarah, Robert or Emma Taylor in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Sarah, Emma or Robert Taylor, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the organisation submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual organisation and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

Each organisation required to complete an IMR must include all information held about Sarah, Robert and Emma Taylor from 1 January 2001 to 7 November 2013.

Information held by an organisation that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Sarah, Emma or Robert Taylor. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. in 2006, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, for example disability, cultural and faith matters should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

When each organisation that has been required to submit an IMR does so in accordance with the agreed timescale, each IMR will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chairman of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final agreed version will be submitted to the Chairman of Kent CSP.

<u>Specific Issues to be addressed</u>

Specific issues that must be considered, and if relevant, addressed by each organisation in their IMR are:

i. Were practitioners sensitive to the needs of Sarah, Robert and Emma Taylor, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
ii. Did the organisation have policies and procedures for the ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Sarah, Emma and Robert Taylor (as applicable)? Did the organisation have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Sarah Taylor subject to a MARAC?

iii. Did the organisation comply with information sharing protocols?
iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
vi. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Sarah, Robert or Emma Taylor (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
vii. Were senior managers or other organisations and professionals involved at the appropriate points?
viii. Are there ways of working effectively that could be passed on to other organisations or individuals?
ix. Are there lessons to be learned from this case relating to the way in which an organisation or organisations worked to safeguard Sarah and Emma Taylor and promote their welfare, or the way it identified, assessed and managed the risks posed by Robert Taylor? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other organisations and resources?
x. How accessible were the services to Sarah, Emma or Robert Taylor (as applicable)?
xi. To what degree could the death of Sarah Taylor have been accurately predicted and prevented?

4. Key Issues Arising from the Review

No evidence or information provided to the review has suggested that Sarah had been a victim of domestic abuse before 7 September 2013, although this cannot be ruled out. There is no evidence or information available to this review that Sarah was subjected to physical violence before the event that led to her death.

All contact that Sarah, Emma and Robert had with organisations between 7 September and 7 November 2013 was related to domestic abuse. The review focuses on that period.

Sometime in late August or early September 2013, before 7 September, Sarah and Robert separated after 17 years of marriage. On 7 September, Emma called Kent Police because Robert was threatening Sarah. Police officers went to the family home and this began an intense period of contact until 3 October. During that time Robert was arrested twice and convicted once of breaching a non-molestation order that Sarah had been granted. Six DASH risk assessments were completed with Sarah and two notifications were made to KCC Specialist

Children's Services (KSCS) because Emma had been present when police attended.

During that period, KSCS Social Workers telephoned Sarah twice and spoke to her about the notifications. No further action was taken and Emma was not spoken to. On 16 September, Emma told her school that her parents had separated and although she did not mention domestic abuse specifically, the school was contacted by KSCS on the same day and told it was a factor.

Sarah next contacted Kent Police on 2 November, although it is now known that Robert had continued to stalk and harass her following his conviction. All contact between then and her death was by telephone; police officers were never deployed to visit her.

Following Sarah's death Kent Police identified that there were issues about the protection, safeguarding and support given to her, both by individuals and the organisation. A number of staff were initially suspended and the force voluntarily referred the case to the Independent Police Complaints Commission (IPCC). The IPCC have carried out an investigation and have made recommendations to Kent Police about individuals.

This DHR has found organisational issues relating to Kent Police and has made recommendations accordingly. Recommendations are also made in respect of KSCS.

5. Conclusions and Recommendations from the Review

Conclusions

The conclusions from this review are:

1. None of the organisations involved in this review had evidence or information that Sarah Taylor was a victim of domestic abuse prior to 7 September 2013.
2. None of the organisations involved in this review had evidence or information that Sarah Taylor was a victim of physical violence prior to the incident that led to her death. Family and friends who have been spoken to as part of this review support this.
3. The safeguarding, support and victim care that Kent Police provided to Sarah fell below the standard that its policies aspired to.
4. Kent Police did not fully implement aspects of its Domestic Abuse Policy and Sarah did not receive the service she was entitled to.

5. Kent Police did not keep Sarah updated with the work they were doing in response to her concerns and therefore failed to provide reassurance that action was being taken.
6. Kent Police did not appreciate that the history of domestic abuse must inform risk classification and management.
7. Kent Police dealt well with the aspect of victim safeguarding that comes from taking positive action against perpetrators.
8. Kent Police and KSCS paid insufficient attention to the safeguarding of Emma Taylor.
9. Kent Police and KSCS missed opportunities to gain information from Emma Taylor about the domestic abuse that she and her mother were subject to.

Recommendations

The recommendations from this review are:

	Recommendation	**Organisation**
1.	Kent Police must examine its initial response to calls made by Sarah between 2 November and 7 November and amend policies and guidance in order to ensure that the lessons learned from this review are incorporated.	Kent Police
2.	Kent Police must ensure that the importance of keeping domestic abuse victims informed of police action is seen as a priority.	Kent Police
3.	Kent Police must review its domestic abuse policy regularly to ensure that it describes the service that victims can expect. Having done so it must ensure that the policy and associated guidance are complied with.	Kent Police
4.	Kent Police must be open and transparent about the minimum level of service that domestic abuse victims will receive from each of the three DASH risk classifications.	Kent Police
5.	If a victim has previously received a 'High' or 'Medium' DASH risk classification, Kent Police must ensure there is additional scrutiny of any subsequent 'Standard' risk classification to ensure that the history of the abuse has been taken into account when making that classification.	Kent Police

6.	When training staff in how to deal with DANs, KSCS should clarify that being a first notification should not in itself be a reason for taking no further action.	KSCS
7.	When KSCS staff make contact with adults or children following a DAN, there should be a workable process that enables them to pass back to Kent Police any new information that they gather from the contact which may be relevant to the way Kent Police deal with future incidents involving that victim.	Kent Police KSCS
8.	When a decision about child safeguarding is taken, which appears to be contrary to policy and/or guidance, the rationale for the decision must be recorded.	KSCS
9.	When KSCS staff speak to a child's parent(s) about domestic abuse they should ask for consent to talk to the child, if the child is old enough to speak for themselves. Where a request is not made, the reason why should be recorded.	KSCS
10.	When KSCS staff speak to a child's parent(s) about domestic abuse and the parents have separated, they should query child access arrangements.	KSCS
11.	NHS England should consider whether there is a need to check the quality of records made by the GP visited by Sarah following her overdose.	NHS England
12.	Kent Police, in consultation with KSCS, should review the domestic abuse child referral matrix to ensure that there are no anomalies and that it provides the right criteria for safeguarding children who are living in households where domestic abuse is taking place.	Kent Police KSCS
13.	When training officers and staff in dealing with domestic abuse incidents, Kent Police should emphasise the importance of speaking to children who are old enough to speak for themselves.	Kent Police
14.	The Kent Criminal Justice Board (KCJB) should consider whether there is any way in which the facilities available in an SDVC could be provided in cases where the defended appears having been remanded in custody.	KCJB

15.	The Department for Constitutional Affairs (DCA) should consider whether domestic abuse should be excluded from the general principle of cases being disposed of at first hearing following a guilty plea, when this means that offenders are less likely to appear before SDVCs.	DCA
16.	The training given to professionals who come into contact with domestic abuse victims must emphasise that control and behaviour (such as stalking and harassment) suffered by victims, other than through physical violence, must be carefully considered when assessing the risk to domestic abuse victims.	All Organisations