KENT & MEDWAY

DOMESTIC HOMICIDE REVIEW

Rosemary/2017

Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership
Review Completed: 14th June 2018

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EXECUTIVE SUMMARY

1. The Review Process

1.1 This summary outlines the process undertaken by the Domestic Homicide Review panel in reviewing the homicide of Rosemary Taylor, who lived in Kent.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family members:

Victim	Rosemary Taylor
Perpetrator	Simon Vincent

1.3 Rosemary was a white British woman, who was 23 years old at the time of her death on 29 June 2017. Simon was a white British man, who was aged 25 then.

1.4 Criminal proceedings were completed on 6 February 2018, when Simon was sentenced to life imprisonment for murdering Rosemary. The trial judge recommended that he should serve at least 26 years in prison.

1.5 The DHR Core Panel met on 17 July 2017 and agreed that the criteria for a DHR were met. The Chair of the Kent Community Safety Partnership then made the formal decision that a DHR would be conducted. All agencies that potentially had contact with Rosemary and/or Simon prior to Rosemary's death were contacted and asked to confirm whether they had contact with them.

1.6 Those agencies that confirmed contact with the Rosemary and/or Simon were asked to secure their files.

2. Contributing Organisations

2.1 Each of the following organisations were subject of an IMR:

- Kent Police
- Kent & Medway NHS and Social Care Partnership Trust
- GP Practice 1 (Rosemary's GP) *
- GP Practice 2 (Simon's GP) *

* To protect the anonymity of Rosemary and her family, GP practices are not named.

2.2 In addition to the IMRs, Staffordshire Police provided a chronology and supporting documents about an incident that involved Simon.

3. Review Panel Members

3.1 The Review Panel was made up of an Independent Chairman and senior representatives of organisations that had relevant contact with Rosemary and/or Simon. It also included a senior member of Kent County Council Community Safety Team.

3.2 The members of the panel were:

Simon Brownsword	Staffordshire Police (Final meeting)
Kate Bushell	NHS Clinical Commissioning Group
Jackie Hyland	Choices Domestic Abuse Service
Susie Harper	Kent Police
Catherine Collins	Kent County Council Adult Social Services
Richard Hill	Medway Council
Paul Pearce	Independent Chairman
Shafick Peerbux	Kent Community Safety
Jen Sarsby	NHS Clinical Commissioning Group
Cecelia Wigley	Kent and Medway NHS & Social Care Partnership Trust

3.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Rosemary or Simon. The panel met on three occasions during the DHR.

4. Independent Chairman and Author

4.1 The Independent Chairman and author of this overview report is a retired senior police officer who has no association with any of the organisations represented on the panel and who has not worked in Kent. He has experience and knowledge of domestic abuse issues and legislation, and an understanding of the roles and responsibilities of those involved in the multi-organisation approach to dealing with domestic abuse.

4.2 The Independent Chairman has a background in conducting reviews (including Serious Case and Safeguarding Reviews), investigations, inquiries and inspections. He has carried out senior level disciplinary investigations and presented at tribunal. He has completed the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports.

5. Terms of Reference

These terms of reference were agreed by the DHR Panel following their meeting on 17 August 2017.

Background

On 29 June 2017, Rosemary Taylor, aged 23 years, was attacked by her ex-boyfriend, Simon Vincent, aged 25 years, as she got into her car following a visit to a gym. He stabbed Rosemary numerous times and she died subsequently of her injuries.

Simon remained at the scene and was arrested on suspicion of causing Rosemary's death. He was later charged with her murder and remanded in custody.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 28 July 2017. It agreed that the criteria for a DHR have been met and, the Chair of the Kent and Medway Community Safety Partnership confirmed that a DHR would be conducted.

That agreement has been ratified by the Chair of the Kent & Medway Community Safety Partnership and the Home Office has been informed.

The Purpose of a DHR

The purpose of a DHR is to:

a) 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;

b) 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;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

The Focus of the DHR

This review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Rosemary 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 DHR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. 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 consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

The full subjects of this review will be the victim, Rosemary Taylor, and the alleged perpetrator, Simon Vincent.

DHR Methodology

The DHR will be based on information gathered from IMRs, chronologies and reports submitted by, and interviews with, agencies identified as having had contact with Rosemary and/or Simon in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. The DHR Panel will decide the most appropriate method for gathering information from each agency.

Independent Management Reports (IMRs) and chronologies must be submitted using the templates current at the time of completion. Reports will be submitted as free text documents. Interview will be conducted by the Independent Chairman.

IMRs and reports will be prepared by an appropriately skilled person who has not any direct involvement with Rosemary or Simon, 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 and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency 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 agency required to complete an IMR must include all information held about Rosemary or Simon from 1 January 2013 to 29 June 2017. If any information relating to Rosemary being a victim, or Simon being a perpetrator, of domestic abuse before 1 January 2013 comes to light, that should also be included in the IMR.

Information held by an agency 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 Rosemary and/or Simon. 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 2014, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, for example disability, sexual orientation, cultural and/or faith 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 agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Independent Chairman. 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 Chair of Medway CSP.

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

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

i. Were practitioners sensitive to the needs of the Rosemary and Simon, knowledgeable about potential indicators of domestic violence and 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 agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Rosemary and Simon? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency forums?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any 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. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiv. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training,

management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to the Rosemary and Simon?

6. Summary Chronology

6.1 Rosemary was born in 1994 and lived with her parents in Kent throughout her life. At the time of her death she was a student at a university in the county.

6.2. Rosemary and Simon met each other through the social media application Tinder in July 2016, but they did not meet until November that year. Rosemary took Simon to meet her parents and apart from some apprehension when she told them he had bi-polar disorder, they had no concerns about him then.

6.3 In April 2017, while staying in a hotel, a disagreement took place between Rosemary and Simon. Her mother witnessed part of this, and Rosemary told her that Simon had been recording and videoing her.

6.4 They went on holiday abroad together in May 2017 and shortly afterwards, on 17 June, she told him that their relationship was over. Following this he posted messages on Facebook about their break up and made false allegations about her drug taking. She blocked him on Facebook, after which he posted derogatory messages about her to her family and friends.

6.5 On 22 June 2017, Rosemary and her mother went to their local police station and reported the social media harassment by Simon. By this time, he had bought the knife he used to kill Rosemary. He was spoken to by a police officer and agreed to remove the social media posts. On 25 June, Rosemary again contacted Kent Police to say that Simon had put further posts on social media, stating he had been cleared by police and no further action was being taken. When contacted by the police officer two days later, he agreed to remove these.

6.6 On the evening of 28 June 2017, Rosemary saw Simon in a public house. He was with another girl. The following day, Rosemary was at a gym when Simon came in and spoke to her. She sent a text to her mother and a WhatsApp message to a friend telling them that he had been there. When she left the gym and got into her car in the car park, Simon came up to it, opened the door and attacked her. He stabbed her fatally and then waited for police to arrive.

6.7 Simon had a history of using texts and social media to harass women who no longer wanted to see him. In 2013 he did this to a woman called Sally, who he had been out with on one occasion in Staffordshire, where he was then living. No further reports were made to the police and contact stopped following a holiday she took in July 2013. The messages he sent to Sally were sinister and threatening, but the information about this incident was not known to Kent Police when Rosemary reported harassment to them.

6.8 In May 2016 in Kent, he harassed a woman he had a short relationship with. He stopped when she told him if he came to her flat again, she would report him to the police. This victim did not report the harassment to the police or other agency.

7. Conclusions

7.1 None of the organisations subject of this review had evidence or information that Rosemary was a victim of domestic abuse prior to the end of her relationship with Simon. At the time, her parents did not have concerns about the relationship, beyond some apprehension about her entering a relationship with someone who said he was suffering from bipolar disorder when she had struggled for some years with bulimia.

7.2 With hindsight, Rosemary's parents can identify potentially controlling and coercive behaviour by Simon. Rosemary was studying at home during evenings for her final year exams and she refused Simon's requests to see him. He would then come to the house unannounced. Rosemary let him in, and he would sit on her bed watching her study. He knew that after her exams she was intending to take the summer off, so he gave up his job to be with her all the time. Rosemary was angered by this and told him they would not spend all their time together and he should get another job, which he did. Controlling and coercive behaviour is a key element in many cases of domestic abuse. This is something that people, including those who are close to victims, may not identify at the time.

7.3 The Home Office should lead a campaign to educate the public about coercive and controlling behaviour and the role it plays in domestic abuse. **(Recommendation 5)**

7.4 These indications of potentially obsessive behaviour did not cause undue concern at the time and were not the cause of Rosemary ending the relationship, which she felt had run its course.

7.5 When their relationship ended, Simon attempted to use coercion to persuade Rosemary to resume it. She and her mother did the right thing in reporting this to Kent Police at an early stage. This did not prevent her death, but it must not deter other victims from reporting behaviour they are being subjected to as soon as it causes them concern.

7.6 When Rosemary was asked by the police officer dealing with her report if Simon has been violent towards her during their relationship, she said he had not. He stalked and harassed her using text messaging and social media after their relationship ended. His social media posts were an attempt to coerce her into resuming their relationship and although he did not threaten violence, she was frightened by them. An indication of this is that when her parents were intending to go on holiday, they gave neighbours copies of a photograph of Simon, so they might recognise him if he turned up at Rosemary's home. This reaffirms how frightening stalking and harassment can be, even without any threat of violence.

7.7 Simon cooperated with Kent Police on both occasions when they spoke to him, although it is now known that he had bought the knife used to kill Rosemary before she first reported him. Her tragic death shows how the end of a relationship can trigger obsessive behaviour, with a rapid escalation to stalking, harassment and violence.

7.8 The stalking and harassment that Simon subjected Sally to in 2013 became explicitly threatening and sinister, but it did not escalate to physical violence against her.

7.9 The use of social media whether by 'private' messaging apps or public posting on sites such as Facebook and Instagram, is the main means by which many people communicate with their family and friends. Social media has become an integral part of many people's lives; they use it to share their activity and events in their life. This is particularly so for those who have grown up since the inception of mobile devices, which are used for most messaging and social media posts. For the majority, this brings social benefits, but as Rosemary's case shows, it can be a vehicle for more sinister activities, including stalking and harassment.

7.10 Stalking and harassment by a party to a relationship that has ended happened before the advent of messaging and social media. However, these forms of communication allow the perpetrator to maximise the likelihood of immediate engagement. In addition, the stalker has access to their victim without the need to plan or reflect. As well as targeting the victim directly, the perpetrator may be

able to communicate easily with their relatives and friends using social media. This can result in the fear of embarrassment or social rejection, which can be distressing and as pernicious than the fear of violence. Cyberstalking has become the widely used term for stalking using social media or other technology.

7.11 There is very little empirical research available worldwide about the specific effects of cyberstalking, perhaps because it is a different means to the same end. Research (*conducted by Jane Monckton-Smith, Karolina Szymanska, and Sue Haile for the Suzy Lamplugh Trust*) suggesting that there is a link between stalking and domestic homicide is available here. Cyberstalking is a subset of the wider behaviour, and this case shows the link to domestic homicide.

7.12 The website of Get Safe Online highlights the risks of cyberstalking, how users can protect themselves and contacts for organisations that can provide advice for those affected by it. Within Kent and Medway, Community Safety Partnerships should ensure that member organisations know where victims of cyberstalking can be signposted. **(Recommendation 6)**

7.13 It is important that when stalking and harassment by messaging and social media is reported, the professional who deals with it has a clear understanding of how the medium works. This is not achieved from a learned knowledge of the technical aspects of messaging apps and social media platforms; it must be an understanding gained from using them as part of life. The best people to educate those who use social media about its risks and dangers are those who use it themselves as part of their way of life.

7.14 There is no record that Rosemary discussed her relationships with her GP, who would have had no reason to have safeguarding concerns about her. Simon did not give health professionals reason to be concerned that he would harm others. There is no record that he discussed his relationships with them.

7.15 The end of a relationship, followed by stalking and harassment, has been the precursor to previous domestic homicides. However, such was the speed at which the escalation to extreme violence took place in this case that even with hindsight, the likelihood of such a tragic outcome could not have been identified.

14. Lessons Identified

14.1 The end of a relationship can be an event that results in the start or escalation of domestic abuse, stalking and harassment

14.1.1 Separation may not be the ‘solution’ to domestic abuse; it may increase the risk to the victim.

14.2 Physical violence is not the only precursor to domestic homicide.

14.2.1 Rosemary's death confirms that physical violence is only one indicator of the risk of a domestic homicide. After their relationship ended, Simon attempted to coerce and control her using social media. It is therefore important that all indicators of potential serious harm are identified.

14.3 Social media has become a method of stalking and harassment, which can result in coercion and control even if the victim and perpetrator do meet or speak to each other.

14.3.1 Professionals should treat cases of stalking and harassment by social media as seriously as those which involve direct contact between the parties.

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9. Recommendations

9.1 The Review Panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1.	Staffordshire Police must submit a report to the Kent and Medway Community Safety Partnership detailing how, if this case was reported today, the degree of victim focus would be greater, based on their revised stalking and harassment policy.	Staffordshire Police
2.	Kent Police and Staffordshire Police should give victims of stalking and harassment details of a domestic abuse or specialist stalking support organisation local to the victim.	Kent Police Staffordshire Police
3.	KMPT must ensure that their DNA policy applies to, and is implemented by, the PCMHS.	KMPT
4.	KMPT must ensure that handover of a case to the PCMHS is managed in a way that ensures PCMHS is able to deliver the required level of treatment and service following it.	KMPT
5.	The Home Office should lead a campaign to educate the public about coercive and controlling behaviour and the role it plays in domestic abuse.	The Home Office
6.	Within Kent and Medway, Community Safety Partnerships should ensure that member organisations know where victims of cyberstalking can be signposted.	Kent and Medway Community Safety Partnerships