# Domestic Homicide Review
# Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Jonathan
which occurred in January 2017

Report Author: Christine Graham
December 2018

## Preface

The Keeping Bristol Safe Partnership wishes at the outset to express their deepest sympathy to the family of Jonathan. This review has been undertaken in order that lessons can learned to better protect others in the future. We appreciate the engagement from families and friends throughout the process. Our understanding of the circumstances that preceded the incident resulting in Jonathan's death has been helped enormously by the engagement of those involved.

This review has been conducted in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by Bristol's Community Safety Partnership on receiving notification of the death of Jonathan in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

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# Section One – The Review Process

## 1.1 Introduction and agencies participating in the Review

1.1.1 This Domestic Homicide Review relates to a set of circumstances that are unique and have presented a number of legal and procedural challenges. The death upon which the review is predicated is that of the victim in this case, Jonathon. Jonathan was a Dutch national who had lived and worked in Bristol for around five years. He died by means of euthanasia in Belguim in January 2017. In certain circumstances euthanasia is legal in Belgium.

1.1.2 Jonathon decided to end his life as a result of horrific injuries he received following an incident at the home address of an ex-girlfriend in late September 2015. In that incident his ex-partner threw 99% pure sulphuric acid over him whilst he was lying unclothed in bed.

1.1.3 As a direct result of the attack Jonathan sustained serious and life changing injuries. He was in a coma for several months and was paralysed from the neck down. Burns from the acid affected approximately 25% of his body. His lower left leg was amputated just below the knee, he lost sight in his left eye, severe damage to the sight in his right eye. On moving out of his coma he was only able to move his face and tongue and was barely able to speak for many months. He underwent several operations including a substantial number of skin grafts and endured significant muscle weakness.

1.1.4 His ex-partner, Frances, was a South African national who had lived in the Bristol area for several years. She was initially arrested and charged with the criminal offence of 'to throw/cast corrosive fluid with intent to burn/maim/disfigure/disable/do grievous bodily harm'. She was remanded in custody to await trial.

1.1.5 Jonathan remained in hospital until November 2016 when he was moved to a care home. His condition required full-time care. In the December of that year he moved by private ambulance, to a hospital in Belgium.

1.1.6 On 2nd January 2017 Jonathan's life ended in Belgium as a result of legal euthanasia[1].

1.1.7 At the time of Jonathan's death Frances was still awaiting trial. As a result of his passing she was additionally charged with his murder on the basis that her attack upon him directly led to his death.

1.1.8 On 23rd May 2018 Frances was found guilty of 'applying a corrosive substance' with intent to cause injury and found not guilty of both manslaughter and murder. She was sentenced to life imprisonment with a minimum term of 12 years.

1.1.9 The manner of Jonathan's death and the nature of the weapon used in the attack upon him are both somewhat unique and require special mention within this report. However, this review is about what can be learned from the circumstances of the relationship between Jonathan and Frances in order to better protect others in the future. It is in this context that this report is written.

[1] Euthanasia is legal under Belgian law but remains illegal under UK law.

1.1.10 The following agencies contributed to this Review:

- Bristol City Council
- Avon and Somerset Police
- NHS England
- Bristol, North Somerset and South Gloucestershire CCG
- Next Link
- WomanKind
- Victim Support

In addition the review interviewed the victim's father, the perpetrator and a woman with whom the victim had begun a new relationship.

## 1.2 The Review Panel Members

The Panel was comprised the following members:

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| Gary Goose MBE | Independent Chair | |
| Christine Graham | Overview Report Author | |
| Stuart Pattison | Community Safety Manager | Bristol City Council |
| Lynne Bosanko | Domestic Abuse Officer | Bristol City Council |
| Cherene Whitfield | Equalities Officer | Bristol City Council |
| Jackie Beavington | Public Health | Bristol City Council |
| Paul Bolton-Jones | Inspector | Avon and Somerset Constabulary |
| Anjalee Joglekar | Policy, Support & Review Officer | Avon and Somerset Constabulary |
| Paulette Nuttall | | BNSSC CCG |
| Andrew Sutherland | | NHS England |
| Kyra Bond | | Womankind |
| Allason Hunt | | National Probation Service |
| Dawn Harding | | Next Link |
| Mark Thompson | | Victim Support |

## 1.3 Domestic Homicide Review Chair and Overview Report Author

1.3.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.3.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Healthchecks which provide an independent view of partnership arrangements. Christine is also a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.3.3 Working together, Christine and Gary have completed four reviews, with thirteen reviews (excluding this one) currently in progress. In addition, Gary has completed a further six reviews.

1.3.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[2]

1.3.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event (Bradford September 2018)

## 1.4 Purpose and Terms of Reference for the Review

1.4.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.4.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.4.3 In this case, Jonathan chose to end his life by way of euthanasia in Belgium. His decision to take his own life was based upon the quality of life he was to endure as a direct result of

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

the attack upon him. Frances has been found guilty of throwing the corrosive substance with intent to cause him injury. Therefore, the criteria set out at 1.2.2 above, and further explained with the Statutory Guidance for the Conduct of Domestic Homicide Reviews (Reviews to include suicide), has been met.

1.4.4 The purpose of this DHR 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 and homicide and improve service responses to 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 possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

The Terms of Reference specific to this Review are appended to this Executive Summary.

## Section Two -
## Agency contact and information learnt from the Review

2.1 The couple in this case had been in a relationship for around 5 years. Frances had moved to the UK from South Africa with her then husband, who was English. She and her husband divorced in 2005 but she remained friends with him and he became a friend of Jonathan's. Frances moved to the address in Bristol in 2007 when she split from another boyfriend and was engaged on a fashion course in the city.

2.2 Jonathan and Frances met on line in 2010. Jonathan visited her in England in 2011 and, apart from going home to Holland for a week, he then remained in the UK. The couple moved to the Netherlands temporarily in 2012 but returned to the UK in 2013.

2.3 A small number of agencies and individuals had minimal information that could suggest significant difficulties within the relationship. This review has considered whether information was appropriately shared between professionals. We have come to the conclusion that given the level of disclosure, the balance between the confidentiality of individuals and safeguarding, that it was. In the context of what was known at the time professionals acted reasonably. The true nature of the difficulties within the relationship and the pressures and stresses encountered by the individuals was not known to agencies.

2.4 It is right that this review explores the evidence that has been made available to it and makes comment upon its relevance and its ability to allow us to learn from it. This review has access to material that was available during the criminal process but was not heard in the public trial; in particular the account of Frances. We seek to avoid a 'hierarchy of testimony' subject to one caveat, that being that the perpetrator in this case provided an explanation that the Jury rejected and thus found her to be dishonest in that respect.

2.5 **Evidence of domestic abuse**

There is evidence to suggest that there was domestic abuse in Jonathan and Frances' relationship. Both Jonathan and Frances made specific reference to abuse to different agencies at different times. As we consider this in more detail, it is important that we remember that Frances was found guilty of throwing the noxious substance. The Jury rejected her assertion that she threw what she thought was water and came to the conclusion that she knew what she was doing. During her trial, evidence was presented that showed that she had researched the use of sulphuric acid and had purchased it, a fact that she does not deny.

2.6 There are a number of potential scenarios:

- Frances was violent and controlling towards Jonathan and she was the only perpetrator of violence
- That Jonathan and Frances were both, at times, violent and controlling towards each other in a relationship that was volatile and turbulent
- Frances had been a victim of domestic abuse from Jonathan and responded with violence towards him

This element is explored fully within the overview report. There is, though, evidence that enduring male attitudes to domestic abuse were a factor in this case. Jonathan is described as someone who 'laughed off' previous injuries to the woman with whom he was involved in a new relationship. He also spoke of being ashamed when attending the

police station to report harassment by Frances as he spoke to a female police officer. Work needs to continue at a local and national level to change male attitudes to being victims of domestic abuse.

## Section Three –
## Key issues arising from the Review

3.1 The key issues arising from this Review are reflected within the recommendations that follow its conclusion.

3.2 This Review rightly centres upon the relationship between Jonathon and Frances. It is clear that it was a relationship where coercion and control and violence was, at times, prevalent. The perpetrator had been prone to self-harm and at times had previously scratched and attacked her boyfriend, in turn she has said that he taunted her and tried to strangle her.

3.3 It is also clear that relationship's breakdown led to a deterioration in the mental health of the perpetrator of the acid attack. She had been engaged previously with mental health services and could have sought more help by disclosing the true extent of her anguish and turmoil.

3.4 The review identifies again that the ending of a relationship is a time of high stress, anxiety and tension. It also identifies that men are still more reluctant to report domestic abuse than women, in this case the victim told the woman with whom he was embarking upon a new relationship that he felt 'ashamed' and 'humiliated' when reporting the issues with Frances to police. More work needs to be done within society to ensure that male victims don't feel less able to report abuse than women.

3.5 This review also has to tackle the issue of the availability of acid and the lack of current controls over its purchase. Acid was the weapon used to inflict the injuries in this case, the perpetrator could easily have used a knife or other implement; it is for that reason that this review must concentrate on the reason for the attack and not necessarily the attack itself. However, all involved in the review question whether it is reasonable for a person to be able to purchase 99% pure sulphuric acid over the internet with no seeming restrictions whatsoever. We ask the Home Office to look again at their proposals for the control of acid purchases in the light of its use in many well publicised attacks in recent history.

## Section Four – Conclusions

4.1 The way in which the victim died, the weapon used to inflict the injuries that resulted in that death, and the fact that this is female on male violence, have the capacity to mark this review out as somewhat unique and notable. Whilst both the weapon and manner of death are deserving of special attention, this review is ultimately about a domestic homicide and the circumstances that lead to the passing of a young man with his whole life ahead of him.

4.2 This review has no reservation in saying that the injuries inflicted upon Jonathan in September 2015 directly led to his decision to end his life in January 2017. That is a natural conclusion to arrive at; there can be no other. There is nothing to suggest that Jonathan, a man in his late-20s at the time of the attack, had anything other than a full life to live. It is important to say that this review is not at odds with the verdicts reached as a result of the criminal process. That is a very different process under, rightly, very different rules.

4.3 A relatively small number of agencies and individuals had any prior information that would suggest difficulties within the relationship. This review has considered whether information was appropriately shared between professionals. We come to the conclusion that given the level of disclosure, the balance between individual confidentialities and safeguarding, that it was. It would take a 'sea-change' in the interpretation of current legislation to suggest that those who received information from Frances to the effect that she 'sometimes attacked her boyfriend' when she was suffering from acute anxiety and stress, was something that should have triggered a referral. In the context of what was known at the time professionals acted reasonably.

4.4 This review has looked at the Government's approach to the control of acid and it is clear that none of the proposed changes would have prevented an adult from purchasing the 98% pure sulphuric acid used in this attack. We would urge Government to look again, in the light of all of the information that they have to hand, at the controls in place and consider whether controls only of young people are sufficient.

4.5 There is evidence that enduring male attitudes to domestic abuse were a factor in this case. Jonathan is described as someone who 'laughed off' previous injuries to the woman with whom he was involved in a new relationship. He also spoke of being ashamed when attending the police station to report harassment by Frances as he spoke to a female police officer. Work needs to continue at a local and national level to change male attitudes to being victims of domestic abuse.

4.6 Finally, the circumstances of this case also identify that work carried out in society to improve our understanding of relationships and, importantly, how to act when relationships come to an end, is never wasted.

## Section Five – Recommendations

5.1 That the Safer Bristol Partnership reviews the services to male victims of domestic abuse in the locality to ensure that, as far as is possible, services are available.

5.2 That the Safer Bristol Partnership reviews its publicity and information available to male victims of domestic abuse to ensure that they are providing information to men in the most appropriate places.

5.3 That all public facing agencies in the partnership review their training for staff and volunteers to ensure that appropriate responses are given to men reporting domestic abuse.

5.4 It is recommended that in light of this case and others, government review its controls over the sale of acid to consider whether they should be extended to adults as well as young people.

5.5 That Avon and Somerset Constabulary raises awareness with officers about what they are expected to do when a victim declines to engage with a DASH and that they are assured that the appropriate rationales are recorded.

5.6 That Avon and Somerset Constabulary should ensure that officers are following best practice by clearly recording that they have spoken to both parties separately when attending domestic abuse incidents, even where the Body Worn Video Camera footage shows that this has taken place.

5.7 That Avon and Somerset Constabulary takes further steps to raise awareness of male victims of domestic abuse and makes officers aware of their own possible unconscious bias in circumstances involving male victims.

5.8 That Avon and Somerset Constabulary undertakes checking and testing to see whether male victims of domestic abuse are currently receiving expected standards of service by the force.

5.9 That all GPs in the area sign up to the IRIS project so that relevant prompts are provided to remind staff to ask about domestic abuse and support provided if domestic violence or abuse is disclosed.

# Appendix One –
# Terms of Reference

**SAFER BRISTOL PARTNERSHIP**

**Terms of Reference for the Domestic Homicide Review into the death of Jonathan**

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Safer Bristol Partnership in response to the death of Jonathan which occurred on 11th January 2017.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the Safer Bristol Partnership has appointed Gary Goose MBE to undertake the role of Independent Chair. Mr Goose will be supported by Christine Graham, who will author the overview report. Gary and Christine will work together on the investigations. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the incident on 23rd September 2015 which led to Jonathan's death on 2nd January 2017 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family;

2.2 Establish whether the agencies or inter-agency responses were appropriate leading up to and at the time of the incident on 23rd September 2015; suggesting changes and/or identifying good practice where appropriate;

2.3 Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together safeguard victims;

2.4 Identify what those lessons are, how they will be acted upon and what is expected to change as a result;

2.5 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

2.6 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;

2.7 Contribute to a better understanding of the nature of domestic violence and abuse; and

2.8 Highlight good practice.

## 3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with, the on-going criminal justice investigation.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for the criminal courts.

## 4. Scope of the review

The review will:

4.1 Seek to establish whether the events of 23rd September 2015 could have been reasonably predicted or prevented.

4.2 Consider the period up to five years prior to the events (or other timescales as appropriate, to be confirmed at the first Review Panel), subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

4.3 Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.4 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.5 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

4.6 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

## 5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 Arrangements will be made to support the family to engage with the review which is not in their first language.

5.4 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

## 6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Safer Bristol Partnership will be the first point of contact.

## 7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel. A single point of contact will be identified to receive media enquiries and a position statement of 'no comment' will be offered until the conclusion of the review and sign off of the overview report by the Home Office Quality Assurance Panel.