Maldon District Community Safety Partnership

Report of the Domestic Homicide Review Panel into the death of Susan - July 2015

Overview report Executive Summary

Maldon District Community Safety Partnership

Report chair and author – Elizabeth Hanlon

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1.1 Executive summary

1.2 This overview report has been commissioned by the Maldon Community Safety Partnership concerning the death of Susan that occurred in 2015. Susan was killed by her ex-partner the father of her two children, Michael. The independent chair and report writer for this review is Elizabeth Hanlon, who is independent of Maldon Community Safety Partnership and all agencies associated with this overview report. She is a retired police officer who worked for Hertfordshire Constabulary for over 30 years. She retired 3 years ago. She is also currently the chair of the Hertfordshire Safeguarding Adults Board.

1.3 It is important to understand what happened in this case at the time, to examine the professionals' perspective at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

1.4 The death of any person in circumstances such as examined herein is a tragedy. Family members have been consulted during the review process and any of their views have been commented upon accordingly within the document. The panel wish to send their condolences to the family of Susan and would like to thank them and Michael's mother for their input into the review process. Pseudonyms have been used throughout this report. The family were spoken to regarding the anonymity of the report and stated that they were happy for the name Susan to be used for the report.

1.5 Reasons for conducting the review

1.6 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9(3)(a). Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. The Act states that a DHR should 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 person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or
A member of the same household as themselves, held with a view to identifying the lessons learnt from the death.

1.7 The purpose of a Domestic Homicide Review (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 upon, and what is expected to change as a result;

c) Apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.8 Details of parallel reviews/processes

1.9 Serious Incident Investigations were also undertaken by the North Essex Partnership University NHS Foundation Trust and the Mid Essex Hospital Services NHS Trust due to their involvement with Michael and Susan prior to Susan's death. These reviews have been shared with the panel. Susan was pregnant at the time of her death and therefore a referral was made to the Essex Safeguarding Children's Board for consideration to be made as to whether they wished to carry out a separate Serious Case Review. The ESCB decided that they would not conduct a review however requested that any identified learnings were shared with the board.

1.10 Subjects of the review

Name	Relationship	Ethnic Origin
Susan	Victim	White British

Michael	Ex-partner/perpetrator	White British

1.11 Susan and Michael were both from the travelling community. Michael's Grandfather and Susan's Grandmother were brother and sister. The families of both Susan and Michael were very close and both fathers had grown up together. Susan and Michael had been in a relationship for about four and a half years, although their relationship had been on and off. They had two children from their relationship. The relationship ended Christmas 2014. The children lived with Susan, although Michael would have one of the children at the weekends where he would take them to stay with his mother. Susan had stated a new relationship and her new partner had recently moved into the family home. Susan was 6 months pregnant at the time of her death. The father of the child is believed to be her new partner.

1.12 Objectives of the review

1.13 The purpose of Domestic Homicide Review (DHR) is to give an accurate as possible account of what originally transpired in an agency's response to Susan, to evaluate it fairly, and if necessary to identify any improvements for future practice. The full indepth purpose of the review is outlined above.

1.14 Scoping letters were send out to below agencies

Agency	Response
Braintree	No involvement with the family
Brentwood	No involvement with the family
Basildon	No involvement with the family
Southend	No involvement with the family
Colchester	No involvement with the family
Tendring	No involvement with the family
Uttlesford	No involvement with the family
Chelmsford	No involvement with the family
Maldon	No involveme... the family
Rochford	No involvement with the family
Castle point	No involvement with the family
Epping Forrest	No involvement with the family
Thurrock	No involvement with the family
Harlow	No involvement with the family
CCG	Received
Provide	Received
NHS England (GPs)	Received
Safer Places	No involvement with the family
Victim Support	No involvement with the family- supporting the family since the death
Police	Received

SERICC	No involvement with the family
MOAT	Received
YOT's	No involvement
Probation	No involvement with the family previous to murder
CAFCASS	No involvement with the family
Open Road (drug and alcohol service)	No involvement with the family
Westminster Drug Project	No involvement with the family
Essex County Council alcohol misuse service	No involvement with the family
Social Care	Received
Mental Health/NEHT	Received
MEHT/Midwifery	Received
Citizens Advice	Sent-unable to release info without permission from Michael/court order
CPS	Received
HMRC	Court order or permission from Michael to access info
HMPS	No involvement with the family previous to murder
Burnham Pre School	Nothing of any relevance

1.15 Chronologies and Internal Management Reviews were subsequently requested and received from: two GP practices, Mid Essex Hospital Services NHS Trust, Provide and North Essex Partnership University NHS Foundation Trust.

1.16 The aims of the Individual Management Reviews (IMRs) are to:

- Enable and encourage agencies to look openly and critically at individual and organisational practice and the context within which people were working;
- Identify whether the homicide indicates that changes to practice could and should be made;
- Identify how those changes will be brought about; and Identify examples of good practice within agencies.

1.17 IMR authors were informed of the primary objectives of the process, which is to give as accurate as possible an account of what originally transpired in the agency's response to Susan and Michael and to evaluate it fairly, and to identify areas for improvement for future service delivery. IMR authors were encouraged to propose specific solutions which are likely to provide a more effective response to a similar situation in the future. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of, or experiencing domestic abuse.

1.18 Agencies each prepared a chronology of their agency involvement and significant events during the specified time period. These chronologies were analysed by the Review Panel.

1.19 IMR authors produced a first draft of their reports which were quality assured within their own organisations through the signing-off process. These IMRs were then analysed by the Review Panel and discussed with the authors at meetings on the 11th October 2016. Copies of IMRs had been circulated to all the panel members prior to these meetings and panel members were able to cross-reference significant events and highlight missing information. Authors then reviewed their IMR's which were again supplied to the review panel for a further review meeting which was held on the 30th January 2017. Authors then produced final reports. The draft overview report was then discussed at a meeting on 9th March and again on the 30th June. The draft report was presented to the Maldon County Community Safety Partnership meeting on the 8th October 2017. The review fell out of the Home Office guidelines of completion within 6 months. This was partly due to awaiting the result of the court case but also that the panel wished to have family involvement and also for a discussion to take place with the offender regarding their relationship.

1.20 This overall report is based on the relevant information obtained from those IMR's. These reports were written by professionals who are independent from any involvement with the victim, family, friends or the perpetrators. Should actions be necessary by any of the agencies, the maintenance of, and strategic ownership of any action plan will be the overall responsibility of the Maldon Community Safety Partnership (CSP). It is essential that any resulting ownership and recommended activity is addressed accordingly.

1.21 Whilst key issues have been shared with organisations the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of this overview report are shared by the membership of the Review panel, commissioning officers and members of the Maldon Community Safety Partnership. The associated reports from agencies will not be individually published.

1.22 Relevant family members of the victim were briefed about the report in accordance with policy and practice of the CSP.

1.23 The review panel made the decision that family members of both Susan and Michael would be contacted and given the opportunity to contribute to the review. As such relevant family members were identified by the Police Family Liaison Officer.

1.24 The panel also wished to consider the impact of belonging to the travelling community might have had on Susan and her relationship with professional agencies and whether that restricted her from reporting domestic abuse. No instances of domestic abuse had been identified by agencies throughout their involvement with Susan and Michael.

1.25 An independent traveller liaison officer was invited to become a panel member and asked if she was able to contribute to the review process. She advised the panel that she did not feel able to become a panel member due to her relationship with the family. A

member of the Essex Countywide Traveller Unit was invited to become a member of the panel.

1.26 The panel wished to obtain some background information surrounding the traveller community and whether being a traveller would restrict the contact with professionals surrounding domestic abuse. The panel had been unable to identify any instances of abuse being reported to agencies and they wished to look further into this. As a result of this the Police member of the panel was able to arrange an interview with a female traveller who was willing to discuss her thoughts and views surrounding domestic abuse and the reporting of that abuse to professionals. These questions were not shared with the family of both Susan and Michael, although domestic abuse within the travelling communities was discussed.

1.27 **Diversity considerations**

1.28 All of the protected characteristics of the 2010 Equality Act were considered by both the IMR authors and the DHR panel.

1.29 Susan was a female from the travelling community and was also pregnant at the time of her death. Pregnant women are at an increased risk of domestic abuse, with prevalence rates of 5% to 21% during pregnancy and 13% to 21% in the postnatal period. There is a significant threat to the health and wellbeing of the mother and baby that may lead to potential morbidity and mortality.

1.30 Psychosocial, economic and cultural factors also interact in complex ways, placing minority groups at increased risk of domestic abuse (Allen, 2012).

1.31 Traveller women face numerous cultural barriers to accessing services, reducing their options to leave an abusive relationship. A lack of access to services and material resources has been acknowledged as an identifiable indicator of vulnerability to domestic abuse (West, 2005), inferring traveller women may be disadvantaged and more vulnerable to domestic abuse due to their culture than the settled population.

1.32 Domestic abuse is one of the most common causes of serious injury for women (Bowen, 2011) and on average two women are killed per week by a partner or ex-partner in England and Wales (ONS, 2015); a figure that is often quoted and has remained constant for a significant period of time (Smith et al, 2012, Department of Health, 2005, Home Office, 1999).

1.33 Terms of reference

The Terms of Reference for the review agreed by the CSP were as follows:

(1) In conducting the Domestic Violence review into the death of Susan, the Panel shall have regard to: -

(a) The Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews as revised and applicable from 1 August 2013; and

(b) The Essex Domestic Abuse Strategy Group - Domestic Homicide Reviews Guidance of September 2012;

(2) The Panel will operate on a presumption that Susan was killed by her previous partner Michael. Michael was convicted at Chelmsford Crown Court for the murder of Susan.

(3) Factual background as to the immediate relationship between Susan and Michael prior to her death, and the manner of her death will be sought. Reports shall be sought from relevant practitioners and agencies involved with Susan and Michael prior to Susan's death, and as to any actions taken or offered in relation to them. The Review shall consider whether such practitioners or agencies had any need to increase their own levels of awareness and information gathering, were sensitive to the needs of Susan and knowledgeable about potential indicators of domestic abuse, and were aware of actions they could take if concerns had arisen.

(4) Consideration shall be given to the role of any agencies that had not come into contact with Susan and/or Michael and which might have been expected to do so.

(5) A decision shall be taken as to which members of Susan's family or friends, and if appropriate family or friends of Michael, shall be asked to contribute to information gathering, and how that will be managed.

(6) In particular the Panel will try to ascertain whether Susan had made any disclosures about Michael to any practitioner, agency or individual, had any contact with a domestic violence or abuse organisation or helpline, had ever been subject of a Multi-Agency Risk Assessment Conference (MARAC) and whether drug or alcohol misuse by Susan and/or Michael could be of relevance. The panel also wish to ascertain whether Susan or Michael had any contact with mental health services. Any background in the lifestyle of Susan relevant towards understanding the events leading to her death shall be considered. Records of any disclosures made shall be sought.

(7) The panel should consider the appropriateness of agency responses to Susan both historically and immediately prior to her death, to establish how well agencies worked together and to identify how inter-agency practice could be strengthened.

(8) Establish if and how agencies assessed risk within all the family households to include contact with the children. This is to include family members who were caring for the children during contact issues following separation. The panel also wish to consider agencies response to the assessment of risk to others within the dynamics of the wider family.

(9) To identify good practice that was in place.

(10) Information about the background and convictions of Michael shall also be sought, and as to whether or not he had ever been subject to Multi-Agency Public Protection Arrangements (MAPPA) or Domestic Violence Perpetrator Programme (DVPP), or under the supervision of the Probation service.

(11) To consider the impact, if any, regarding agencies responses where Susan and Michael were from the travelling community. The panel also wish to look at the broader issue of contact with the travelling community with agencies and access to support surrounding domestic abuse.

(12) The Overview Report shall be written by the Chair of the Panel who shall submit a draft to the whole Panel for their consideration prior to its submission to the Community Safety Partnership, and then to the Home Office. The report shall address the issue as to whether there are improvements that could be made in the way in which relevant agencies can work to safeguard potential victims;

(14) Individual Management Reviews undertaken by relevant practitioners and agencies will be required to cover the time spanning at least between 1st January 2011 to 17th July 2015. If practitioners or agencies consider that events outside of this time frame are significant and of relevance to the Review, then they should include that information setting out the date involved.

1.34 The panel also wished to consider the impact of belonging to the travelling community might have had on Susan and her relationship with professional agencies and whether that restricted her from reporting domestic abuse. No instances of domestic abuse had been identified by agencies throughout their involvement with Susan and Michael.

1.35 Chronologies and Internal Management Reviews were subsequently requested and received from: two GP's and Essex Partnership University NHS Foundation Trust (EPUT), Provide and Mid Essex Hospital Services NHS Trust, Broomfield Hospital.

2.0 The Facts

2.1 Case specific background

2.2 Michael and Susan had been in relationship for some years and had two children together. Both Michael and Susan were from the travelling community and had been living together until December 2014 when Susan ended their relationship. Susan had complained to neighbors' and family that Michael was lazy and refused to work. She had further expressed views that Michael didn't help enough at home or with their children and would instead play computer games.

2.3 Michael moved back to his mother's address when the relationship ended. An informal child access arrangement begun between Michael and Susan that Michael would collect the children alternately every weekend.

2.4 It is clear from witness accounts that Michael was suffering emotionally due to the end of his relationship with Susan. On one occasion Michael had the access to his children removed. It also appeared that Michael was still suffering from the suicide of his father.

2.5 On the day of the murder, Michael was seen by his mother at her home prior to her leaving for work. She describes him as acting perfectly normal.

2.6 Susan spent the morning with her new partner who was collected at lunchtime by his grandfather with plans to attend a local public house. Susan was left in her flat with her two children alone.

2.7 A witness describes hearing a male she believed to be Michael arrive at the house and then describes hearing Susan and the male have 'harsh words' as they were walking towards the entrance of the flats. Within about 2 minutes she describes hearing muffled noises coming from Susan's flat. She heard Susan's voice shouting out louder but she could not make out what was being said. Both parties had raised voices. This went on for about 10 minutes. She then heard the engine of a car start and drive away and she believes it is the same car as she heard arrive earlier. She seems to be the last person to hear Susan alive. It appears that Michael took his youngest daughter to his mother's house and then returned. The eldest child was in the house at the time of the murder.

2.8 Later that afternoon Susan's sister and boyfriend arrived at the flat and entered the block of flats and knocked at the front door. They got no reply, so she went to the kitchen window at the front of the block and opened the window which was regularly left on the latch as a means of access. Upon entering the flat Susan was discovered deceased in the bathroom. The emergency services were called.

2.9 Michael was found guilty of Susan's murder on 29th February 2016 at Chelmsford Crown Court. He was sentenced at Chelmsford Crown Court to a life sentence with a minimum of 18 years' imprisonment

3.0 Family involvement and perspective

3.1 Michael was sent a letter to prison advising him of the review process and asking whether he wished to be spoken to as a part of the review process. Contact was received from the prison stating that Michael had received the letter but had not indicated either way as to whether he wished to be spoken to. Letters were sent to both Susan's and Michael's family advising them of the Domestic Homicide Review and asking if they wished to participate in the process

3.2 A meeting took place between the independent chair and Susan's mother and father. They were advised of the purpose of the review. They described Susan as a very happy go lucky, cheerful person who didn't let things get her down. They described a very close family relationship between themselves and Susan and her siblings. They went into detail regarding Susan and Michaels's relationship stating that they had had an on/off relationship.

3.3 They stated that during the relationship there was no suggestion of any domestic abuse happening within the family. Susan's parents stated that they would have arguments 'like other couples' but that they were not aware of any forms of abuse taking place within the home. Susan's mum described them as having a very close knit relationship and stated that Susan would have told her if there had been any form of abuse.

3.4 Susan's parents said that they understood that the relationship between Susan and Michael appeared to end around December time and Michael moved back in with his mum. Their relationship split appeared to be amicable with arrangements put in place for Michael to have the children at the weekends. He would have one of the children at a time. Susan started a new relationship around Christmas time and her new partner later moved into the family home. The relationship between all three of them appeared to be amicable and Susan believed that Michael had accepted that their relationship had ended and that he had moved on. They would meet up on several occasions as the children went with their dad. Susan advertised that she was pregnant with her new partner and again it appeared that this had been accepted by Michael.

3.5 The independent chair discussed with Susan's parents their traveller background and their views of being a part of the travelling community and contact with professional agencies. They expressed their concerns regarding any impact or importance being put on the fact that Susan was from the travelling community and felt that had there been any issues surrounding domestic abuse within the household then firstly Susan would have spoken to them but that also she would have reported it to the authorities. They stated that the only agency Susan had contact with were health professionals. They spoke highly of this contact with no concerns being raised.

3.6 The chair also met up with Michaels's mother. The relationship between Michael and Susan was discussed. Michaels's mother stated that they had been in a relationship for about four and a half years and that most of the time they were happy together. She stated that their relationship ended just before Christmas, although Michael was still living at the home address, before moving out on Christmas day. Michael knew that Susan had started another relationship and although he initially wasn't happy about it he had accepted it. She described how the family had been close when the children had been young and that both Susan's father and Michaels's father had been friends.

3.7 She stated that she wasn't aware of any violence taking place within the household but that she knew that they had a volatile relationship on occasions but no different than other people's relationship. She described the death of Michaels's father and the big impact this had on Michael. She stated that after the relationship broke down, Michael suffered from mental health problems and ended up being taken to hospital. She described having a good relationship with Susan and described her as a very loving and caring person. She stated that Michael was aware of Susan's new relationship and that he was also aware that she was pregnant with the new partner's child. She described Michael as being fine about the relationship and new pregnancy and appeared to have moved on with his life. He appeared to be relieved that their relationship had moved on and that he could now get on with his life. He had just passed his driving test, had gotten a job and had made new friends.

3.8 She felt strongly that the doctors within the mental health services should have spoken to Michael more whilst he was in hospital to try and get him to open up to them. She stated that he still kept things bottled up and that he needed to get it out. Michael received one follow up visit which she described as being a waste of time with Michael only being asked if he was 'ok'. This wasn't delved into by the worker and then they only received a further letter.

3.9 She also stated that being a member of the travelling community would have had no impact on reporting any instances of domestic abuse and that she felt that both Susan and Michael would have either told her or Susan's parents if something had happened within the household.

3.10 The chair visited the parents of both Susan and Michael and shared the report with them. They stated that they were happy with the report and that they agreed with the recommendations.

3.11 The chair also visited Michael in prison and read the report through with him. He agreed with the report and the recommendations. He spoke about his relationship with Susan and the children and the breakdown of their relationship. He stated that there were no instances of domestic abuse within their relationship. He believed that they had a good relationship until Susan had started to see someone else and that they had both agreed that the split was the best for both of them. Michael did however state that he felt that Susan would have changed her mind later on down the line and that they would have gotten back together again. He described his dealings with the mental health services are being very limited and that he felt isolated upon being back home. He did not feel that he was offered a great deal of support after leaving the hospital and can only remember one short visit by the community mental health services.

4.0 Agency involvement.

4.1 There was no multi agency involvement with Susan and Michael which required any response from both the MARAC or the MAPPA process.

4.2 Since 2012 agencies involved with Susan, Michael and their children have been notified of six different addresses where the family have lived.

4.3 Provide

4.4 Provide Health Visiting service have allocated health visitors for each of the traveller sites in Mid Essex. Susan and Michael and the children were offered a Universal health visiting service following an initial assessment at the primary contact (New Birth Visit). A New Birth Visit is completed at 10-14 days post-delivery to complete health needs assessment and introduce health visiting and local supportive services, including children's centre activities and child health clinics.

4.5 The Health visitor who completed the new birth visit for Susan's second child, explained in interview that she had extensive experience of working with traveller families both

settled and on traveller sites. She met with Susan and Michael both at Susan's mother's home and in their trailer on the traveller site. She described them as welcoming and engaged with the health visitor service and Healthy child programme. Both children were fully immunised.

4.6 The family were registered with local GP's and although they did use the local Emergency services. This was appropriate due to the severity of the children's illnesses; they were mostly out of hours visits and resulted in admission.

4.7 The Health Visitor had recorded that the family tended to move often and have lived in the Maldon and Burnham areas, sometimes staying with maternal family. Families moving in and out of the area are picked up through notifications by the family of movement, registering with a GP in the new area, attending a clinic in the new area or notification of attendance from a walk in centre or Emergency Services with a new address.

4.8 A good level of support was offered to the family throughout their dealings. The majority of missed appointments were picked up and acted upon. The missed appointments were followed up with the family by the Health Visiting team and did not meet the criteria for the "Missed appointments Monthly reports" as they were usually followed up in a timely manner with staff diligently pursuing a positive outcome.

4.9 Attempts were made by Health Visitors to follow up all emergency services attendances and missed appointments. Several, despite reporting staff shortages during this time, have persisted until successful contact was made using various means of communication including telephone, letter and opportunistic home visits. There were no documented issues surrounding domestic abuse within the relationship, nor any suspicions raised.

4.10 North Essex Partnership University NHS Foundation Trust.

4.11 The trust had no dealings with Susan. They first became involved with Michael following the separation when Michael presented at emergency service with his mother and brother in early 2015 with suicidal thoughts.

4.12 It would appear that a loss of relationship with possible delayed bereavement led to the informal admission of Michael. There was no previous contact with mental health services. The admission was very brief with short term follow-up from the supported discharge team indicating that a good and speedy recovery had been made. There is documented evidence that Michael was involved in decisions made around his discharge.

4.13 A reactive diagnosis was given that required no medication as treatment either during admission or following discharge. The diagnosis reflected Michael's difficulty in managing social situations which led to high expressed emotions necessitating an informal admission to manage suicidal ideation at the time.

4.14 There was no indication of any risk posed towards his ex-partner, Susan, during this period. There was no indication of violence or aggression, either towards himself or directed at others documented, that could be highlighted as leading to future risk. However, there

has been no information received which showed that any specific questions were asked of Michael regarding any risk to others. It appeared that the risk identified was one to himself and not others. This however should have been explored further. There is no evidence that a risk plan was considered or completed prior to discharge.

4.15 There was no additional cause for concern, other than suicidal thoughts, identified during and around admission or on discharge from in-patient care and Home Treatment.

4.16 On discharge from Home Treatment it was documented that his relationship with his ex-partner had improved and that he was in a new relationship about which he felt positive. During the interview with Michael's mother, she stated that she did not feel that the follow up service offered to Michael had been sufficient and did not delve into any issues. A discharge letter was sent to Michael's GP highlighting his admission, however no additional follow up treatment was identified.

4.17 Administration staff checked Michael's new GP details and sent on any letters pertaining to Michael's time under their care and treatment ensuring that the new GP had all documentation relating to presenting problems, diagnosis and treatment and this was done in a timely manner.

4.18 It is recorded that Michael had an out-patient appointment of which he did not attend. There is nothing documented on electronic records that Michael either received the letter or rang to say whether he would be attending or not.

4.19 There was a procedure to offer a further appointment following missed appointments, however, this was at the time of Journeys, a computer management system, and names were being added to lists of who would move to what team, rather than offering new appointments, because of the consultants moving to different teams.

4.20 The Appointments policy incorporating non-attendance procedure indicates that where a person misses' appointments the clinical team must make a decision based on discussion with referrer and consideration of clinical risk. Risk assessment is key in determining how many offers of appointment are made. It is normal practice to offer at least two appointments ensuring that choice is offered.

4.21 The expectation would have been for a letter to have been sent to Michael to either offer a new appointment or advise of the decision by clinical team regarding discharge and also to the GP to inform that he had missed his appointment. That this did not occur and that his subsequent discharge was not until 22nd July 2016, following a review of all clients, would indicate that despite mechanisms in place to support a smooth and safe transfer of care with Journeys, the follow up for Michael following discharge from home treatment team 'slipped through the net'.

4.22 Whilst on the ward Michael had commented that he found the psychology session helpful and a recommendation was made that he continue with this following discharge. If still appropriate, this may have been provided through secondary mental health service or

GP. Unfortunately, due to his missed appointment, this did not occur and thus an opportunity to review the benefit of this was missed.

4.23 Doctors Surgery 1

4.24 Primary care records have been reviewed from birth to the date of arrest. There is nothing significant that relates to the Terms of Reference of this review. There appear no difficulties in Michael accessing primary care services. The discharge letters for Michael did not action the GP to undertake any follow-up activities following his discharge from mental health services.

4.25 Doctors Surgery 2

4.26 Primary care records have been reviewed from birth to the date of Susan's death. There is nothing of significance to the review identified.

4.27 Mid Essex Hospital Services NHS Trust, Broomfield Hospital

4.28 Susan had nine attendances at the hospital throughout the review, mainly for maternity reasons. Within maternity services current routine enquiry asks expectant mothers about Domestic Abuse within their current relationship. Without disclosure from the woman herself the service would not necessarily be aware of any previous abusive relationships that may still currently pose a threat to the woman and her family. There is nothing to suggest that Susan had been subjected to any domestic abuse within her relationship. It is however not documented that Susan was asked about domestic abuse during her last pregnancy. If she had have been this would have been around her new partner and not her previous relationship.

5 Conclusions and Recommendation

5.1 Conclusions

5.2 Domestic abuse within Gypsies and Travelling communities.

5.3 The family of both Susan and Michael stated that they were not aware of any domestic abuse taking place within the family and Susan's mother felt strongly that if there had been then Susan would have told her or reported it to professionals. It does not appear that any issues of possible domestic abuse were considered by agencies involved with both Susan and Michael, however there does not appear to have been any reason for any concerns that domestic abuse was taking place within their relationship.

5.4 There are cultural expectations that are documented that sometimes make it difficult for domestic abuse to be challenged within the travelling community. Families from the travelling community often live closely with their extended family, are often male and elder dominated, adhere to gender specific roles with men as the head of the family and women at its heart, and may have concerns about living in houses. There are many barriers that

prevent women from accessing domestic abuse services and fear of prejudice from police and other professionals may inhibit this further. Leaving a community that is based around the extended family means that women may end up not only losing their home and partner, but also the community, culture and way of life. They may also have a lack of knowledge of mainstream services, mistrust of authority, and may not be able to access refuge space if another traveller family is already placed there or if they have a large number of children. The nomadic pattern of living for some families makes it difficult to develop trusting relationships with professionals from the settled community and some services designed for the settled community will not adequately cover the needs of the traveller community (Friends, Families & Travellers 2009)

5.5 It has also been acknowledged by the Friends, Families and Travellers Outreach team in Sussex, that Traveller families can experience prejudice and discrimination when accessing Primary health services. Many use out of hours' service providers and A&E departments when in crisis rather than local GP services as they find them more welcoming, accessible, and friendlier and believe that they get a more thorough examination. There are many complex barriers for travelling families accessing health care services, including racism, social and cultural barriers including the family culture and lack of a fixed address (Fair Access for All? 2010 – Annex B). Provide in Essex has a very robust policy in relation to working with the traveller community particularly in relation to those families who are frequent movers and as a result have a tendency for non-attendance at appointments.

5.6 Essex County Council has an Essex wide Traveller unit who manage all the sites throughout Essex. There does not appear to be a bespoke domestic abuse policy regarding the Gypsy and Traveller community published on their website. It is widely published that the Gypsy and Travelling community may find it difficult to report either acts of abuse within their community, or acts happening within their own household, to professionals. They therefore would prefer to allow these to remain hidden, although identified by the traveller lady spoken to, if the abuse became serious it is felt they then would involve professionals. Provide have an excellent policy regarding the travelling community and have liaison staff within their agency who receive specific training. It has been identified throughout the Provide IMR, their strong relationships with the travelling community. It also appears that both Susan and Michael had a good relationship with their health visitor who visited them at their home addresses.

5.7 During the visit with Susan's mother she talked about domestic abuse within the travelling community and the issues surrounding any reports of abuse being reported to the authorities. She believed that Susan had a close relationship with her Health visitors and that these agencies would have been looked upon as the first port of call. She stated that if young generation traveller women were subjected to abuse within the family then they would have no means to report this. They would often be without phones and transport so would not be able to leave the site to report. The main time that they would be able to report would be through their GP but mainly through their pre-natal and post-natal services. She encouraged the usage of the domestic abuse sticker system but stated that this would require verbalisation to encourage usage and that just having stickers or forms within toilets were of some use but restricted those who could not read. She believed that a DA sticker should be placed on the females file, accessible to the female at any point so she could just

take it off and place it in a prominent position i.e. urine sample, so the professional would be highlighted to the need of help and support at any point of her care.

5.8 It has also been reported that victims of domestic abuse would not necessarily consider themselves to be a victim if the abuse was believed to be minor. It was discussed that if abused was serious then the travelling community would consider reporting the matter to the police or other professionals. What level of abuse would be considered as serious by the travelling community? Education is required for the travelling communities, to identify domestic abuse and that an estimated 1.9 million adults aged 16 to 59 years experienced domestic abuse in the last year, according to the year ending March 2017 Crime Survey for England and Wales (1.2 million women, 713,000 men). The police recorded 1.1 million domestic abuse-related incidents and crimes in the year ending March 2017 and of these, 46% were recorded as domestic abuse-related crimes; domestic abuse-related crimes recorded by the police accounted for 32% of violent crimes. all abuse is serious and needs to be reported. Domestic abuse is more likely to begin or escalate during pregnancy (Department of Health 2005) with more than 30% of cases of domestic abuse starting during pregnancy (Lewis and Drife 2001).

5.9 Susan's mother also stated that other travelers would not intervene if they felt that a female within another family was being abused as this would cause a considerable rift within families that could last for years.

5.10 The mental health assessment which took place regarding Michael appeared to concentrate on self-harm and his suicidal thoughts. There does not appear to be a full risk assessment surrounding his family and children and any discussions regarding any indications of harm towards them. The Serious Incident investigation noted that it is documented that Michael's relationship with his ex-partner had improved and he was in a new relationship which he was feeling positive about. Michael did appear to have received two calls and two visits from the Community Mental Health Team upon being discharged into his mother's care. A further appointment was sent to Michael which did not appear to take place and there is nothing documented to show that this had been followed up.

5.11 Recommendations

Recommendation 1 Essex Partnership University NHS Foundation Trust (EPUT).

North Essex Partnership University NHS Foundation Trust to reinforce the importance of risk assessments surrounding patients presenting with suicidal concerns, upon discharge, regarding possible harm to children and other family members, whether within the same household or estranged.

It is also recommended that this recommendation is submitted to NHS England for wider dissemination and learning opportunities.

Recommendation 2 – Essex County Council Traveller Unit

Educational campaign is to be developed and implemented surrounding the Traveller community regarding domestic abuse and identifying that all levels of abuse are serious and levels of support available.

The Essex Traveller Unit is to proactively raise awareness surrounding Domestic abuse within the community and to 'sign post' appropriate areas of support.

Recommendation 3 - Essex County Council

Essex County Council to include coverage of Gypsy, Roma, Traveller (GRT) culture within the development of the domestic abuse strategy in Essex.

Recommendation 4 – Virgin care

The Domestic Abuse Sticker system was started by the safeguarding team in the spring of 2011. New Birth Visit Template to be amended to include a box for recording that the domestic abuse sticker system was discussed. (Annex B)

Recommendation 5 – Mid Essex Hospital Services NHS Trust

Mid Essex Hospital Services NHS Trust staff are to be reminded of the significance of possible domestic abuse within families, especially during pregnancy, and to discuss such possibilities during appointments. Staff are also to be reminded to document that domestic abuse has been discussed with the patient.

National recommendation – NHS England

To consider widening the usage of Domestic Abuse stickers to all health professionals for the inclusion onto the patient's paperwork so that any potential victims of abuse could access the sticker and place it in a prominent position, whichever health agency they are visiting and which every area they have moved into.

6 Judges Summing up

'You were convicted by the jury of the vicious killing of Susan. She was 23 years of age, and your former partner, the mother of your children. She was, as you yourself described her, lively, nice to be around, and generally a happy person.

The relationship between you and her broke down, as this court heard, and she and you had separated and she had commenced a new relationship with David, by whom she was pregnant. It is quite clear that you had difficulties in accepting that the relationship was over.

The court is prepared to accept that you didn't go there intending to kill her, but once you arrived there, an argument started, and that is supported by independent evidence, between you, which culminated in you attacking her and finally strangling her.'

Maldon District Community Safety Partnership

Report of the Domestic Homicide Review into the death of Susan - July 2015

Maldon District Community Safety Partnership

Report chair and author – Elizabeth Hanlon

April 2018

Main overview report

Section 1: Introduction

1.1 Background

1.2 The Commissioning of the review

1.2.1 This overview report has been commissioned by the Maldon Community Safety Partnership concerning the death of Susan that occurred in July 2015. The independent chair and report writer for this review is Elizabeth Hanlon, who is independent of Maldon Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective from Hertfordshire Constabulary who has several years' experience of partnership working and involvement with several previous domestic homicide reviews, partnership reviews and serious case reviews. She has just completed writing a Domestic Homicide Review for Watford District Council, Hertfordshire and Tendring District Council, Essex. She is also chairing and writing four further domestic homicide reviews for Essex and Hertfordshire. She is also the current independent chair for the Hertfordshire Safeguarding Adults Board.

1.2.2 It is important to understand what happened in this case at the time, to examine the professionals' perspective at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximized both locally and nationally.

1.2.3 The death of any person in circumstances such as examined herein is a tragedy. Family members have been consulted during the review process and their views have been commented upon accordingly within the document. The panel wish to send their condolences to the family of Susan and would like to thank them for their input into the review process. Pseudonyms have been used throughout this report. The family were spoken to regarding the anonymity of the report and stated that they were happy for the name Susan to be used for the report.

1.2.4 The Home Office were notified by Maldon Community Safety Partnership (CSP) on 11th September 2015 of their intention to carry out a Domestic Homicide review. The Essex Coroner was also notified that a Domestic Homicide Review was taking place. The inquest into the death of Susan had already been opened and subsequently closed prior to the first DHR panel meeting. The Domestic Homicide Review was started on the 19th May 2016 when the first meeting took place. A press statement was produced by the chair of the Maldon CSP following consultation with other partner agencies. This will be amended prior to any publication of the report.

1.2.5 The court case surrounding Susan's death had already taken place and Michael had been found guilty of Susan's murder on 29th February 2016. He was sentenced at Chelmsford Crown Court to a life sentence with a minimum of 18 years' imprisonment. There were therefore no issues regarding disclosure in relation to running the review in conjunction with the court case.

1.2.6 The findings of each individual IMR are confidential. At the beginning of the meetings of the review panel, attendees were asked to sign a confidential agreement.

1.3 The Review Panel

Name	Position/Organisation
Elizabeth Hanlon	Independent chair and report writer
Spencer Clarke	Community Safety Partnership, Maldon District Council
Fiona Marshall	Maldon District Council
Richard Holmes	Maldon District Council
Caroline Venables	Detective Inspector, Essex Police Public Protection Command
Janette Rawlingson	Detective Inspector, Essex Police Public Protection Command (from September 2015)
Jane Reeve	Provide

Alice Burlington	Community Safety Partnership
Paul Secker	Essex County Council Children's Social Care
Tracy Kinton	Moat housing
Steven Andrews	Essex Countywide Traveller Unit
Rachel Thomas	Safer Places
Sarah Robinson	NHS England
Jackie Wilson and Leila Francis	Mid Essex Clinical Commissioning Group
Clive Gibson	Mid Essex Hospital Services NHS Trust
Lisa Gunn	Mid Essex Hospital Services NHS Trust
Tendayi Musundire	NE Partnership NHS Trust
David Messam	National Probation Service

1.4 Reasons for conducting the review

1.4.1 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9(3)(a). Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. The Act states that a DHR should 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 person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or
A member of the same household as themselves, held with a view to identifying the lessons learnt from the death.

1.4.2 The purpose of a Domestic Homicide Review (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 upon, and what is expected to change as a result;
c) Apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.5 Terms of Reference

The Terms of Reference for the review agreed by the CSP were as follows:
(1) In conducting the Domestic Violence review into the death of Susan, the Panel shall have regard to: -

(a) The Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews as revised and applicable from 1 August 2013; and
(b) The Essex Domestic Abuse Strategy Group - Domestic Homicide Reviews Guidance of September 2012;

(2) The Panel will operate on a presumption that Susan was killed on the 17th of July 2015 by her previous partner Michael. Michael was subsequently convicted at Chelmsford Crown Court for the murder of Susan.

(3) Factual background as to the immediate relationship between Susan and Michael prior to her death, and the manner of her death will be sought. Reports shall be sought from relevant practitioners and agencies involved with Susan and Michael prior to Susan's death, and as to any actions taken or offered in relation to them. The Review shall consider whether such practitioners or agencies had any need to increase their own levels of awareness and information gathering, were sensitive to the needs of Susan and knowledgeable about potential indicators of domestic abuse, and were aware of actions they could take if concerns had arisen;

(4) Consideration shall be given to the role of any agencies that had not come into contact with Susan and/or Michael and which might have been expected to do so;

(5) A decision shall be taken as to which members of Susan's family or friends, and if appropriate family or friends of Michael, shall be asked to contribute to information gathering, and how that will be managed;

(6) In particular the Panel will try to ascertain whether Susan had made any disclosures about Michael to any practitioner, agency or individual, had any contact with a domestic violence or abuse organisation or helpline, had ever been subject of a Multi-Agency Risk Assessment Conference (MARAC) and whether drug or alcohol misuse by Susan and/or Michael could be of relevance. The panel also wish to ascertain whether Susan or Michael had any contact with mental health services. Any background in the lifestyle of Susan relevant towards understanding the events leading to her death shall be considered. Records of any disclosures made shall be sought;

(7) The panel should consider the appropriateness of agency responses to Susan both historically and immediately prior to her death, to establish how well agencies worked together and to identify how inter-agency practice could be strengthened.

(8) Establish if and how agencies assessed risk within all the family households to include contact with the children. This is to include family members who were caring for the children during contact issues following separation. The panel also wish to consider agencies response to the assessment of risk to others within the dynamics of the wider family.

(9) To identify good practice that was in place.

(10) Information about the background and convictions of Michael shall also be sought, and as to whether or not he had ever been subject to Multi-Agency Public Protection Arrangements (MAPPA) or Domestic Violence Perpetrator Programme (DVPP);

(11) To consider the impact, if any, regarding agencies responses where Susan and Michael were from the Travelling Community. The panel also wish to look at the broader issue of contact with the Travelling Community with agencies and access to support surrounding domestic abuse.

(12) The Overview Report shall be written by the Chair of the Panel who shall submit a draft to the whole Panel for their consideration prior to its submission to the Community Safety Partnership, and then to the Home Office. The report shall address the issue as to whether there are improvements that could be made in the way in which relevant agencies can work to safeguard potential victims;

(14) Individual Management Reviews undertaken by relevant practitioners and agencies will be required to cover the time spanning at least between 1st January 2011 to 17th July 2015. If practitioners or agencies consider that events outside of this time frame are significant and of relevance to the Review, then they should include that information setting out the date involved.

1.5.2 **Any additional information considered relevant:**

1.5.3 If any additional information becomes available that informs the review this should be discussed and agreed by the independent chair and the review panel and confirmed by the chair.

1.5.4 Unless specifically indicated all agencies have current Safeguarding and Domestic Abuse policies and procedures in place within their organisations. They also carry out relevant training for all relevant staff within their organisations.

1.6 Details of parallel reviews/processes

1.6.1 Serious Incident Investigations were also undertaken by the North Essex Partnership University NHS Foundation Trust and the Mid Essex Hospital Services NHS Trust due to their involvement with Michael and Susan prior to Susan's death. These reviews have been shared with the panel. Susan was pregnant at the time of her death and therefore a referral was made to the Essex Safeguarding Children's Board for consideration to be made as to whether they wished to carry out a separate Serious Case Review. The ESCB decided that they would not conduct a review however requested that any identified learnings were shared with the board.

1.7 Subjects of the review

1.7.1 Susan and Michael were both from the travelling community. Michael's Grandfather and Susan's Grandmother were brother and sister. The families of both Susan and Michael were very close and both fathers had grown up together. Susan and Michael had been in a relationship for about four and a half years, although their relationship had been on and off. They had two children from their relationship. The relationship ended Christmas 2014. The children lived with Susan, although Michael would have one of the children at the weekends where he would take them to stay with his mother. Susan had stated a new relationship and her new partner had recently moved into the family home. Susan was 6 months pregnant at the time of her death. The father of the child is believed to be her new partner.

1.8 Objectives of the review

1.8.1 The purpose of Domestic Homicide Review (DHR) is to give an accurate as possible account of what originally transpired in an agency's response to Susan, to evaluate it fairly, and if necessary to identify any improvements for future practice. The full indepth purpose of the review is outlined above.

1.8.2 Scoping letters were send out to below agencies

Agency	Response
Braintree	No involvement with the family
Brentwood	No involvement with the family
Basildon	No involvement with the family
Southend	No involvement with the family
Colchester	No involvement with the family
Tendring	No involvement with the family
Uttlesford	No involvement with the family
Chelmsford	No involvement with the family
Maldon	No involvement with the family
Rochford	No involvement with the family
Castle point	No involvement with the family
Epping Forrest	No involvement with the family
Thurrock	No involvement with the family
Harlow	No involvement with the family
CCG	Received
Provide	Received
NHS England (GPs)	Received
Safer Places	No involvement with the family
Victim Support	No involvement with the family- supporting the family since the death
Police	Received
SERICC	No involvement with the family
MOAT	Received

YOT's	No involvement
Probation	No involvement with the family previous to murder
CAFCASS	No involvement with the family
Open Road (drug and alcohol service)	No involvement with the family
Westminster Drug Project	No involvement with the family
Essex County Council alcohol misuse service	No involvement with the family
Social Care	Received
Mental Health/NEHT	Received
MEHT/Midwifery	Received
Citizens Advice	Sent-unable to release info without permission from Michael/court order
CPS	Received
HMRC	Court order or permission from Michael to access info
HMPS	No involvement with the family previous to murder
Burnham Pre School	Nothing of any relevance

1.8.3 Chronologies and Internal Management Reviews were subsequently requested and received from: two GP practices, Mid Essex Hospital Services NHS Trust, Provide and North Essex Partnership University NHS Foundation Trust.

1.8.4 This overall report is based on the relevant information obtained from those IMR's. These reports were written by professionals who are independent from any involvement with the victim, family, friends or the perpetrators. Should actions be necessary by any of the agencies, the maintenance of, and strategic ownership of any action plan will be the overall responsibility of the Maldon Community Safety Partnership (CSP). It is essential that any resulting ownership and recommended activity is addressed accordingly.

1.8.5 Whilst key issues have been shared with organisations the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of this overview report are shared by the membership of the Review panel, commissioning officers and members of the Maldon Community Safety Partnership. The associated reports from agencies will not be individually published.

1.8.6 Relevant family members of the victim will be briefed about the report in accordance with policy and practice of the CSP and such consultation will take place prior to the publication of the report.

1.8.7 The review panel made the decision that family members of both Susan and Michael would be contacted and given the opportunity to contribute to the review. As such relevant family members were identified by the Police Family Liaison Officer.

1.8.8 The panel also wished to consider the impact of belonging to the travelling community might have had on Susan and her relationship with professional agencies and whether that restricted her from reporting domestic abuse. No instances of domestic abuse had been identified by agencies throughout their involvement with Susan and Michael.

1.8.9 An independent traveller liaison officer was invited to become a panel member and asked if she was able to contribute to the review process. She advised the panel that she did not feel able to become a panel member due to her relationship with the family. A member of the Essex Countywide Traveller Unit was invited to become a member of the panel.

1.8.10 The panel wished to obtain some background information surrounding the traveller community and whether being a traveller would restrict the contact with professionals surrounding domestic abuse. The panel had been unable to identify any instances of abuse being reported to agencies and they wished to look further into this. As a result of this the Police member of the panel was able to arrange an interview with a female traveller who was willing to discuss her thoughts and views surrounding domestic abuse and the reporting of that abuse to professionals. These are some of the views of the female spoken to and cannot be taken as the views of all of the travelling community. These questions were not shared with the family of both Susan and Michael, although domestic abuse within the travelling communities was discussed.

1.8.11 "Regarding school, male and female children will generally attend infant and junior schools until the age of 10 years. They will not attend secondary school education because it is believed within the traveller community that the children are exposed to sex education, the temptation of drugs and boys become very aware of girls. From this age, the boys will go to work with their Dads and learn their jobs.

As far as the girls go, they will stay at home and help with cleaning the caravans and looking after the younger children in the family.

The family network is very close amongst travellers. All of the family spend lots of time together and would all generally live on the same site. Brothers, sisters, aunts, uncles, grandparents etc.

There are more and more traveller families moving into houses now. This is because it is more difficult just to pull up on a piece of land with your trailer and stay for a while. The councils keep moving travellers on. So, they live more in houses.

Domestic abuse does happen on occasions within the community. In the main, such incidents are not reported to the Police or anyone else if it's considered to be minor.

However, if it were to be more serious then it would be reported to the Police. Most women would not think they are victims and would just accept the situation as part of day to day life. Most other traveller women would support a victim of domestic violence should they report the incidents to the police. Most would think that the victim should have done something about it sooner. Such matters would not be generally spoken about openly, until things got so bad it would have to be reported to the Police.

Women are in general well respected within the traveller community as they give birth to children, look after them and raise them. Keep the site and trailers clean and tidy, look after their men and cook.

Separation and divorce is not viewed well within the traveller community, especially for a woman, as they are meant to be married only once and be with the same man for life. For the men, it is a different story. They can pretty much do as they please, but they would not normally separate or divorce. If such a thing were to happen, the person at fault and their family would pretty much be disowned by the other travellers in the community.

New relationships would be viewed badly. The male partner would feel that if there were young children involved from the previous relationship his kids would not be bought up and looked after in the ways he would wish. The children would not be subject of any harm"

1.9 **Diversity considerations**

1.9.1 All of the protected characteristics of the 2010 Equality Act were considered by both the IMR authors and the DHR panel.

1.9.2 Susan was a female from the travelling community and was also pregnant at the time of her death. Pregnant women are at an increased risk of domestic abuse, with prevalence rates of 5% to 21% during pregnancy and 13% to 21% in the postnatal period. There is a significant threat to the health and wellbeing of the mother and baby that may lead to potential morbidity and mortality.

1.9.3 Psychosocial, economic and cultural factors also interact in complex ways, placing minority groups at increased risk of domestic abuse (Allen, 2012).

1.9.4 Traveller women face numerous cultural barriers to accessing services, reducing their options to leave an abusive relationship. A lack of access to services and material resources has been acknowledged as an identifiable indicator of vulnerability to domestic abuse (West, 2005), inferring traveller women may be disadvantaged and more vulnerable to domestic abuse due to their culture than the settled population.

1.9.5 Domestic abuse is one of the most common causes of serious injury for women (Bowen, 2011) and on average two women are killed per week by a partner or ex-partner in England and Wales (ONS, 2015); a figure that is often quoted and has remained constant for

a significant period of time (Smith et al, 2012, Department of Health, 2005, Home Office, 1999).

Section 2: The Facts

2.1 Case specific background

2.1.1 Michael and Susan had been in a relationship for some years and had two children together. Both Michael and Susan are from the travelling community and had been living together until December 2014 when Susan ended their relationship. Susan had complained to neighbours and family that Michael was lazy and refused to work. She had further expressed views that Michael didn't help enough at home or with their children and would instead play computer games.

2.1.2 Michael moved back to his mother's address when the relationship ended. An informal child access arrangement begun between Michael and Susan that Michael would collect the children alternately every weekend. This arrangement had relied on the collection and drop off of the children by their paternal grandmother but in recent months Michael was able to do this himself having passed his driving test and having purchased a vehicle. It is known by both family and friends that Michael would only ever have care of one child at a time.

2.1.3 It is clear from witness accounts that at the beginning, Michael did not want the relationship with Susan to end and had suffered emotional strain causing him to receive psychiatric care in January 2015 as an in-patient.

2.1.4 A letter dated July 2015 addressed to Michael, later found by police during the search of his car, detailed that he was no longer entitled to receive family tax credit and owed HMRC a significant amount of money.

2.1.5 In mid-July 2015 Michael attended the flat and was handed items of his property including DVD's and CD's by Susan. She is understood to have told Michael that her new partner was moving in with her and that she was pregnant with his child.

2.1.6 In recent months Michael had gained temporary employment via a recruitment agency.

2.1.7 On the day of the death, Michael was seen by his mother at her home prior to her leaving for work. She describes him as acting perfectly normal.

2.1.8 Michael had agreed to work that day but later sent a text to the agency stating that he couldn't come into work.

2.1.9 Susan spent the morning with her new partner who was collected at lunchtime by his grandfather with plans to attend a local public house. Susan was left in her flat with her two children.

2.1.10 Susan posted a facebook message which read 'Time to get my daughter ready she's off to her Dad's then just me and my handsome little munchkin and David for the weekend, take me baby out tomorrow if weather is good Mummy's special boy x'.

2.1.11 A witness described, sometime during the afternoon, whilst sitting in the home of her friend seeing Susan sitting on a green garden chair on the grass. The two children were playing close by. The witness heard the engine of a car pull up and heard Susan say "OH LOOK, DADDY'S HERE". She saw the children run up to a male on the grass and heard Susan say "GIVE DADDY A HUG".

2.1.12 The witness described hearing Susan and the male have 'harsh words' as they were walking towards the entrance of the flats. Within about 2 minutes she described hearing muffled noises coming from Susan's flat. She heard Susan's voice shouting out louder but she could not make out what was being said. Both parties had raised voices. This went on for about 10 minutes. She then heard the engine of a car start and drive away and she believes it is the same car as she heard arrive earlier. She seems to be the last person to hear Susan alive. It appears that the car heard driving away was Michael taking his younger child to his mother's address before returning. The oldest child appears to have been present at the time of the murder.

2.1.13 Later that afternoon Susan's sister and boyfriend arrived at the flat and entered the block of flats and knocked at the front door. They got no reply, so she went to the kitchen window at the front of the block and opened the window which was regularly left on the latch as a means of access. Following a search of the flat Susan was found deceased in the bathroom. The emergency services were contacted.

2.1.14 The Police have identified several possible risk factors for Susan's murder, including;

- Relationship breakdown in December 2014 between Susan and Michael, a decision made by Susan who then asked him to move out of their home.
- The separation between Michael and his two children.
- The news, learnt by Michael on his last visit to Susan, that she was now in a serious relationship with another man and that they were to move in together.
- News learnt by Michael that Susan was pregnant with the child of her new partner.
- This news and the request by Susan to remove the last of his belongings from the flat confirmed to Michael their relationship could not be saved.
- The knowledge that another man would be living with his children.

- Michael had received a letter, confirming that as a result of this relationship ending, he would no longer be in receipt of tax credits and in fact owed HMRC a substantial amount of money in overpayment. It is known that the letter received from HMRC was discussed by Michael and Susan when he arrived to her home in mid- July 2015 because Susan texted her new partner saying that Michael had received the letter.
- DVD's and CD's still in the car from 12th July 2015 acting as a constant reminder of his separation with Susan and the loss of his home with her.

2.2 Family Composition

Name	Relationship	Ethnic Origin
Susan	Victim	White British
Michael	Ex-partner/perpetrator	White British

2.3 Individual Management Reviews

2.3.1 The aims of the Individual Management Reviews (IMRs) are to:

- Enable and encourage agencies to look openly and critically at individual and organisational practice and the context within which people were working;
- Identify whether the homicide indicates that changes to practice could and should be made;
- Identify how those changes will be brought about; and Identify examples of good practice within agencies.

2.3.2 The independent chair and overview report writer guided the IMR authors through the process for the development of each IMR, as follows:

- Securing agency records;
- Commissioning IMRs;
- Gaining consent to view records;
- Drawing up a chronology;
- Conducting a desk-based review which investigated the agency's involvement relative to the agency's policies and procedures; relevant partnership / multi-agency policies and protocols; professional standards and good practice; and national and local research and evidence-based practice;
- Conducting interviews with relevant staff;
- Writing the IMR including analysing the information and making recommendations;
- Ensuring the report is quality-assured through the process of counter-signing by a senior accountable manager; the same guidance includes advice on:
- Conducting parallel investigations of disciplinary matters and complaints which will not be reported which are internal agency matters;
- Providing feedback and debriefing to relevant staff;

2.3.3 IMR authors were informed of the primary objectives of the process, which is to give as accurate as possible an account of what originally transpired in the agency's response to

Susan and Michael and to evaluate it fairly, and to identify areas for improvement for future service delivery. IMR authors were encouraged to propose specific solutions which are likely to provide a more effective response to a similar situation in the future. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of, or experiencing domestic abuse.

2.3.4 Agencies each prepared a chronology of their agency involvement and significant events during the specified time period. These chronologies were analysed by the Review Panel.

2.3.5 IMR authors produced a first draft of their reports which were quality assured within their own organisations through the signing-off process. These IMRs were then analysed by the Review Panel and discussed with the authors at meetings on the 11th October 2016. Copies of IMRs had been circulated to all the panel members prior to these meetings and panel members were able to cross-reference significant events and highlight missing information. Authors then reviewed their IMR's which were again supplied to the review panel for a further review meeting which was held on the 30th January 2017. Authors then produced final reports. The draft overview report was then discussed at a meeting on 9th March and again on the 30th June. The draft report was presented to the Maldon District Community Safety Partnership meeting on the 8th October 2017. The review fell out of the Home Office guidelines of completion within 6 months. This was partly due to awaiting the result of the court case but also that the panel wished to have family involvement and also for a discussion to take place with the offender regarding their relationship.

2.3.6 The final report has been shared with both Susan's family and Michael's family and any comments they have made about the review have been added to the report. The report was also shared with Michael in prison.

2.4 Key event analysis of involvement from the Internal Management Reviews.

Key timeline of events.

11/10/2011	Maternity admission for delivery. Normal vaginal delivery of a male infant. Antenatal care non eventful, low risk, no concerns identified. Postnatal care routine. Father of baby noted to be Michael.
23/03/2012	Susan has been feeling depressed for about 8 weeks, gets panic attacks, had baby in October, split from father. Examination: looks upset, low mood, poor eye contact, rational, no obvious psychotic symptoms, no obvious suicidal ideation.
07/04/2012	Viral infection. Noted to have consulted with GP regarding her mental health the previous week

19/06/12	Health visitor plans to make visit to traveller site for transfer in visit. Informed by colleague that family have moved on.
21/12/2012	Home visit (Specialist Nurse Practitioner @ Provide - Maldon) post-natal assessment lives with maternal parents in their housing association, rented house of good order in the downstairs rooms seen. Susan and her partner not working, in receipt of benefits due, partner trying to get work as recently became unemployed. Excellent support network established. Family history: nil of note. Discussed family support - excellent. interpersonal relationships observations - mutually close and loving bond observed to be forming between during my visit. Obstetric history - second baby delivered at 39 weeks' gestation. General wellbeing - stated is enjoying her new baby and has excellent support from her partner and her mother and father with whom she lives.
18/02/2013	Home visit by health visitor, Mothers Assessment Outcome: seen at home with both children for reviews of each. Susan stated she is really happy now settled into trailer on traveller site where her partner's family live and where her parents lived in the past, has many friends to add support from that provided by families. Her parents moving but will visit regularly. Susan also now has a car so not isolated or dependent on others. Enjoying being a mum to both her children. Recently suffering with a stiff mid/lower back and finding it uncomfortable first thing in the morning. Seen by GP and prescribed Codeine and Paracetamol which appear to alleviate discomfort at times. awaiting outpatient appointment for further assessment. Nil similar in family known.
04/08/2013 28/08/2013	Susan moved with son and daughter Michael moved into the property.
04/01/2015	ED attendance: Michael presented due to suicidal intent. Mother and brother in attendance. Mother reports he split up from his girlfriend 2 weeks before Christmas. Patient reported to mother that his life is no longer worth living and told his brother he wanted to hang himself. Reports that his girlfriend will not allow him to see his children. Patient not making eye contact, crying and hitting his head. Referred to mental health. Seen by mental health. Plan- high suicide risk, requires period of assessment- admit to inpatient psychiatric unit.
04/01/2015	Referral to Crisis Resolution and Home Treatment (CRHT) from ED to assess. Referral picked up at 23.12

05/01/2015	Michael was assessed in ED by a member of the CRHT. Michael presented with suicidal ideation. There had been a recent break-up of his long term relationship and Michael had been denied access of his 3-year-old child. Michael had been found in graveyard by his dad's gravestone. Michael had been drinking the previous day. Michael had stated that he wanted to hang himself. Recommendation from assessment was for informal admission.
05/01/2015	Admission to an in-patient unit, accompanied by mum and brother. No prior history identified. Risks on admission listed as suicide triggered by a break-up of relationship. Dad hung himself in 2003 and family are frightened that he will do the same. Placed on 6 checks per hour observations. 72 hour care plan completed to monitor physical and mental health and remove items of risk.
06/01/2015	Letter sent from CRHT to GP – assessment details from 4th January.
06/01/2015	Michael referred to psychology team. Attended a psychology group and spoke about the impact that taking his life would have on his child. He also spoke about the impact on himself when his dad committed suicide. Documented as visited by mum.
07/01/2015	Ward notes document that Michael had minimal interaction with other patients, was feeling better within himself and was wanting transfer to a ward nearer home. Observations reduced to level 1.
08/01/2015	Ward review – Michael was asking for transfer to a ward nearer home. Appeared calm. Spoke about work in a chicken factory and not getting much sleep. Michael assessed himself a 2/10 on a suicide risk. Michael said he is now speaking to ex- partner and has been using time in hospital to reflect. Michael stated that he would like a few more days in hospital. Plan to transfer nearer home when bed becomes available, refer to psychology on an out- patient basis once discharged and to give information on CRUSE for support with his dad's death.
08/01/2015	Ward entry – Michael appeared irritable in mood and expressed frustration at being so far from home. Michael stated that he no longer presented as a risk to self and could keep safe. Michael said he was willing to receive home treatment if discharged. Seen by ward doctor who advised him to stay but mum agreed to him going home with a view to discharge tomorrow and follow up by Home Treatment team in Chelmsford. Mum stated that she had a crisis card and contact numbers if she needed support. CRHT in Tendring was contacted.
09/01/2015	Ward rang Michael and his mum to check mental state and inform him that he was now discharged and under the services of Chelmsford CRHT. Michael stated that he was happy with the decision and was doing well. Ward also referred to Maldon Community Mental Health team.

11/01/2015	Ward rang as part of 48 hour follow up. Michael stated that he was doing well, sleep is good and he is eating well. Also stated that mental health were to visit tomorrow.
12/01/2015	Michael had first visit from. Michael presented as bright and positive in thinking. Michael said he had returned to work and booked a driving test. Michael had made an agreement with ex-partner to visit children at weekend. Sleeping well, diet good. Michael said that he had visited dad's grave and had had no negative thoughts about this. Discussed plans for discharge on 15th if all goes well.
15/01/2015	Home visit by CRHT. Michael had been shopping with mum and said things were going well. Stated that he is seeing children, is on good terms with his ex-partner and is in a new relationship. Sleep is perfect, eating very good. No suicidal ideation, plan or intent. No thoughts of self- harm. Michael had a crisis card and said he would use this if he needed support. Discharge agreed.
15/01/2015	Letter sent from mental health services to GP with discharge summary. Advising of a diagnosis of Adjustment reaction with depressive symptoms and suicidal thoughts following relationship breakdown, with no medication as treatment. Letter discussed a referral to psychology upon discharge.
20/01/2015	Letter sent from CRHT to GP at Medical Centre advising of discharge from Home Treatment.
04/02/2015	Letter to Michael offering an out-patient appointment with Maldon Community Health Team at Cherry Trees in Maldon.
04/02/2015	Letter from CRHT to GP – assessment details from 4th January 2015
04/02/2015	Letter from CRHT to GP Surgery advising of discharge from Home Treatment.
14/03/2015	Daughter attended ED accompanied by mother and boyfriend, David (mother's boyfriend)
10/04/2015	Susan booked for antenatal care with 3rd pregnancy at 9 weeks' gestation. Father of baby noted to be David. No concerns identified, booked for low risk care. Routine Enquiry for Domestic Abuse not recorded as being done. This enquiry would have been regarding current partner David.
13/04/2015	Development assessment for daughter. Mother reported that father no longer resident in the family home due to relationship breakdown. He is reported to have contact with children fortnightly.

July 2015	Essex Police received a 999 call from Ambulance control. This was in response to ambulance personnel attending a report that the occupant, Susan, has been found deceased. Susan was reported as being currently in a relationship with a male named David with whom she was expecting a child but had two other children with her previous partner, Michael. Michael was reported to have been with his children at this time. Both Susan and Michael are from a travelling background and they had been living together at the above address until December 2014 when Susan decided to end the relationship and Michael moved out. Michael moved back to his mother's. When told of the pregnancy Michael did not react well and was suffering emotionally from the break up.

Section 3: Analysis

3.1 Family involvement and perspective

3.1.1 Michael was sent a letter to prison advising him of the review process and asking whether he wished to be spoken to as part of the review. Contact was received from the prison stating that Michael had received the letter but had not indicated either way as to whether he wished to be spoken to. Letters were sent to both Susan's and Michael's family advising them of the Domestic Homicide Review and asking if they wished to participate in the process

3.1.2 A meeting took place between the independent chair and Susan's mother and father. They were advised of the review process and the purpose of the review. They described Susan as a very happy go lucky, cheerful person who didn't let things get her down. They described a very close family relationship between themselves and Susan and her siblings. They went into detail regarding Susan and Michaels's relationship stating that they had had an on/off relationship. They described Susan's frustration with Michael not getting a job and that she felt she had to be the bread winner. This appears to have caused issues within the relationship resulting in some friction. They described the relationship as breaking down on a few occasions due to this but that they would get back together again for the children. The first split came when their first child was 6 months old but they renewed their relationship resulting in a further child. The family stated that finally Susan realised that Michael would not change and that she had asked him to leave the family home resulting in him moving back in with his mother. They state that during the relationship there was no suggestion of any domestic abuse happening within the family. Susan's parents stated that they would have arguments 'like other couples' but that they were not aware of any forms of abuse taking place within the home. Susan's mother described them as having a very close knit relationship and stated that Susan would have told her if there had been any form of abuse.

3.1.3 They did however state that Michael had threatened to 'kill himself' during their arguments and separations, and their belief that this was as a way of manipulating Susan to take him back or for them to stay together. These instances of suicidal threats do not appear to have been reported to any agencies until after the relationship had ended.

3.1.4 Susan's family said that they understood that the relationship appeared to end around October time and later Michael moved back in with his mum. Their relationship split appeared to be amicable with arrangements put in place for Michael to have the children at the weekends. He would have one of the children at a time. Susan started a new relationship around Christmas time and her new partner later moved into the family home. The relationship between all three of them appeared to be amicable and Susan believed that Michael had accepted that their relationship had ended and that he had moved on. They would meet up on several occasions as the children went with their dad. Susan announced that she was pregnant with her new partner and again it appeared that this had been accepted by Michael. Susan had encouraged Michael to move on and find new relationships.

3.1.5 The independent chair discussed with Susan's parents their traveller background and their views of being a part of the travelling community and contact with professional agencies. They expressed their concerns regarding any impact or importance being put on the fact that Susan was from the travelling community and felt that had there been any issues surrounding domestic abuse within the household then firstly Susan would have spoken to them but that also she would have reported it to the authorities.

3.1.6 The chair also met up with Michaels's mother at her sister's home address. The relationship between Michael and Susan was discussed. Michaels's mother stated that they had been in a relationship for about four and a half years and that most of the time they were happy together. She stated that their relationship ended just before Christmas although Michael was still living at the home address, before moving out on Christmas day. Michael knew that Susan had started another relationship and although he initially wasn't happy about it he had accepted it. She described how the families had been close when the children had been young and that both Susan's father and Michaels's father had been good friends.

3.1.7 She stated that she wasn't aware of any violence taking place within the household but that she knew that they had a volatile relationship, although she did not feel that this was any different than most relationships. She described the death of Michaels's father and the big impact this had on Michael. She stated that after the relationship broke down, Michael suffered from mental health problems and ended up being taken to hospital. She stated that she contacted the police to ask for advice as she was very worried about Michael and didn't know what to do. The police advised her to take Michael to the hospital and arranged for the mental health team to be present. She stated that at the time Susan was still telling him that once he came out of hospital and got a job then he could move back home with her and the children. She described having a good relationship with Susan and described her as a very loving and caring person. She stated that Michael was aware of Susan's new relationship and that he was also aware that she was pregnant with the new

partner's child. She described Michael as being fine about the relationship and new pregnancy and appeared to have moved on with his life. He appeared to be relieved that their relationship had moved on and that he could now get on with his life. He had just passed his driving test, had gotten a job and had made new friends.

3.1.8 She described Susan as a caring mum but someone who was looking forward to her new relationship and new baby more. She stated that Susan was the dominant force in their relationship.

3.1.9 She felt strongly that the doctors within the mental health services should have spoken to Michael more whilst he was in hospital to try and get him to open up to them. She stated that he still kept things bottled up and that he needed to get it out. Michael received one follow up visit which she described as being a waste of time with Michael only being asked if he was 'ok'. This wasn't delved into and then they only received a further letter.

3.1.10 She described Susan as a lovely person but someone who didn't know what she wanted out of life. She also stated that being a member of the travelling community would have had no impact on reporting any instances of domestic abuse and that she felt that both Susan and Michael would have either told her or Susan's parents if something had happened within the household.

3.1.11 The chair visited the parents of both Susan and Michael and shared the report with them. They stated that they were happy with the report and that they agreed with the recommendations.

3.1.12 The chair also visited Michael in prison and read the report through with him. He agreed with the report and the recommendations. He spoke about his relationship with Susan and the children and the breakdown of their relationship. He stated that there were no instances of domestic abuse within their relationship. He believed that they had a good relationship until Susan had started to see someone else and that they had both agreed that the split was the best for both of them. Michael did however state that he felt that Susan would have changed her mind later on down the line and that they would have gotten back together again. He described his dealings with the mental health services are being very limited and that he felt isolated upon being back home. He did not feel that he was offered a great deal of support after leaving the hospital and can only remember one short visit by the community mental health services.

3.2 Agency Involvement

3.2.1There was no multi agency involvement with Susan and Michael which required any response from both the MARAC or the MAPPA process.

3.2.2 Since 2012 agencies involved with Susan, Michael and their children have been notified of six different addresses where the family have lived.

3.2.3 Provide

3.2.4 Provide Health Visiting service have allocated health visitors for each of the traveller sites in Mid Essex. Telephone discussion about the role was completed with an allocated health visitor for a Traveller site in Mid Essex.

3.2.5 One health visitor reported that she had been the link health visitor for traveller sites in the Maldon area and had worked with the site warden and traveller liaison to engage with the community and had developed services with the local children's centre for the families with young children on the site. She reported a good relationship with the site residents, had always found them welcoming, and that they did engage with local health services. She reported that it was usual for the families on this site to attend local child health clinics, and for children to attend nursery and to have their immunisations. Susan's children were both up to date with immunisations and although there were some missed appointments Susan was welcoming when health visitors attended her property unannounced.

3.2.6 Susan and Michael and the children were offered a universal health visiting service following an initial assessment at the primary contact (New Birth Visit). A New Birth Visit is completed at 10-14 days post-delivery to complete health needs assessment and introduce health visiting and local supportive services, including children's centre activities and child health clinics.

3.2.7 The health visitor who completed the new birth visit for Susan's second child, explained in interview that she had extensive experience of working with traveller families both settled and on traveller sites. She met with Susan and Michael both at Susan's mother's home and in their trailer on the traveller site. She described them as welcoming and engaged with the health visitor service and Healthy child programme. Both children were fully immunised.

3.2.8 The family were registered with local GP's and although they did use EDs this was appropriate due to severity of children's illnesses, visits were mostly out of hours and resulted in admission. There were several identified occasions of missed appointments by Susan and the children, however these do not appear to have had any impact and were acted upon by agencies.

3.2.9 The process of following up missed appointments is a requirement under CQC (2009) and came in response to the Protection of Children report by Lord Laming (2009) it is also a significant factor in many Serious Case Reviews. Missed appointments may be an indication that the parents or carers are failing to engage with professionals and can be an indication that they are not meeting the health needs of the children. Following a child's missed appointment, it is the responsibility of the practitioner to attempt further contact with the family, check that the demographic details are accurate, ascertain why the appointment was not kept and offer another. Practitioners are advised to contact the safeguarding team for advice if there are any safeguarding concerns and liaise with other professionals working with the family who may be able to clarify the situation.

3.2.10 Provide have a Policy and processes in place for managing missed appointments. Monthly reports are run from the electronic records, identifying children who have missed 5 or more appointments within Provide services and any children who are on a Child Protection or Child In Need plan or Looked After Children who have missed one. The practitioner who is the case-holder for the family is then notified and needs to formulate an action plan to address this appropriately.

3.2.11 The Health Visitors made 3 attempts to make contact with Susan to complete a transfer in visit when the family moved from Maldon area to Burnham and were successful having phoned and left a phone message on the 4th occasion. This shows that despite only working 2 days per week the health visitor had persisted until a favourable result was obtained.

3.2.12 The referral to Speech and Language Therapy made by Health Visitors was not accessed by Susan who did not reply to the letter sent from the department requesting that Susan make an appointment with the therapist for an initial assessment. The Health visitor, as the referrer was notified that Susan had not contacted the department to make an appointment and the case was closed by Speech and Language Therapy. Several attempts to contact Susan were made to review her decision not to go ahead with the referral and when unable to get a response by phone made an opportunistic visit to the home and was told that her son's speech had now improved and that he was attending Preschool. The health visitor had acted diligently to follow up the missed appointment and discuss current health needs. It is not unusual for children's development to appear delayed and then show marked improvement in a short period of time particularly with the addition of external influence such as nursery placement.

3.2.13 Health Visitors also made three attempts to see Susan following a referral by the GP. Susan would have been aware of the referral and know that the Health Visitor was trying to contact her. It was reported that Susan was always welcoming when she attended the property and had no reservations in inviting her in even when attending opportunistically. It was felt that Susan didn't see a Health Visitor visit as a priority and therefore was often not in for appointments and failed to remember that she was coming around.

3.2.14 The Health Visitor had recorded that the family tended to move often and have lived in the Maldon and Burnham areas, sometimes staying with maternal family.

3.2.15 Families moving in and out of the area are picked up through notifications by the family of movement, registering with a GP in the new area, attending a clinic in the new area or notification of attendance from a walk in centre or ED with a new address. The Burnham Health Visitor attempted to make contact with Susan immediately following receipt of a transfer in notification when Susan moved to that last recorded address in Burnham. Health Visitors recorded that this was a travelling family with frequent moves

3.2.16 A good level of support was offered to the family throughout their dealings. The majority of missed appointments were picked up and acted upon. The missed appointments were followed up with the family by the Health Visiting team and did not meet the criteria

for the "Missed Appointments Monthly Reports" as were usually followed up in a timely manner with staff diligently pursuing a positive outcome.

3.2.17 Attempts were made by Health Visitors to follow up all ED attendances and missed appointments. Several, despite reporting staff shortages during this time, persisted until successful contact was made using various means of communication including telephone, letter and opportunistic home visits.

3.2.18 North Essex Partnership University NHS Foundation Trust.

3.2.19 The trust had no dealings with Susan. They first became involved with Michael following the separation when Michael presented to the ED with his mother and brother on the 5th January 2015 with suicidal thoughts.

3.2.20 It would appear that a loss of relationship with possible delayed bereavement led to the informal admission of Michael. There was no previous contact with mental health services. The admission was very brief with short term follow-up from the supported discharge team indicating that a good and speedy recovery had been made. There is documented evidence that Michael was involved in decisions made around his discharge.

3.2.21 A reactive diagnosis was given that required no medication as treatment either during admission or following discharge. The diagnosis reflected Michael's difficulty in managing social situations which led to high expressed emotions necessitating an informal admission to manage suicidal ideation at the time.

3.2.22 There was no indication of any risk posed towards his ex-partner, Susan, during this period. There was no indication of violence or aggression, either towards himself or directed at others documented, that could be highlighted as leading to future risk. However, there has been no information received which showed that any specific questions were asked of Michael regarding any risk to others. It appeared that the risk identified was one to himself and not others. This however should have been explored further. There does not appear to have been any questions asked regarding why Michael had stated that he felt responsible for the break up of their relationship. This could have indicated the potential for domestic abuse either as a perpetrator, victim or both.

3.2.23 There was no cause for concern, other than suicidal thoughts, identified during and around admission or on discharge from in-patient care and Home Treatment. A discharge letter was sent to Michaels GP highlighting his admission, however no additional follow up treatment was identified.

3.2.24 Administration staff checked Michael's new GP details and sent on any letters pertaining to Michael's time under their care and treatment ensuring that the new GP had all documentation relating to presenting problems, diagnosis and treatment and this was done in a timely manner.

3.2.25 It is recorded that Michael had an out-patient appointment on 20th March 2015 of which he did not attend. There is nothing documented on electronic records that Michael either received the letter or rang to say whether he would be attending or not.

3.2.26 There was a procedure to offer a further appointment following a missed appointment however, this was at the time of Journeys and names were being added to lists of who would move to what team, rather than offering new appointments, because of the consultants moving to different teams.

3.2.27 The Appointments policy incorporating non-attendance procedure indicates that where a person miss appointments the clinical team must make a decision based on discussion with referrer and consideration of clinical risk. Risk assessment is key in determining how many offers of appointment are made. It is normal practice to offer at least two appointments ensuring that choice is offered.

3.2.28 The expectation would have been for a letter to have been sent to Michael to either offer a new appointment or advise of the decision by clinical team regarding discharge and also to the GP to inform that he had missed an appointment. That this did not occur and that his subsequent discharge was not until July 2016 following a review of all clients would indicate that despite mechanisms in place to support a smooth and safe transfer of care with Journeys, the follow up for Michael following discharge from home treatment team 'slipped through the net'.

3.2.29 Whilst on the ward Michael had commented that he found the psychology session helpful and a recommendation was made that he continue with this following discharge. If still appropriate, this may have been provided through secondary mental health service or GP. Unfortunately, due to missed appointment, this did not occur and thus an opportunity to review the benefit of this was missed.

3.2.30 On discharge from Home Treatment it was documented that he told the worker that his relationship with his ex-partner had improved and that he was in a new relationship about which he felt positive. During the interview with Michael's mother, she stated that she did not feel that the follow up service offered to Michael had been sufficient and did not delve into any issues.

3.2.31 Doctors Surgery 1

3.2.32 Primary care records have been reviewed from birth to the date of arrest. There is nothing significant that relates to the Terms of Reference of this review. There appear to have been no difficulties in Michael accessing primary care services.

3.2.33 The discharge letters for Michael did not action the GP to undertake any follow-up activities following his discharge from CRHT.

3.2.34 Doctors Surgery 2

3.2.35 Primary care records have been reviewed from birth to the date of Susan's death. In April 2014, the GP appropriately considered an eating disorder for Susan and referral and spoke with her about the impact of her restrictive diet. A referral was made but Susan declined the appointment. By July 2014, Susan was reporting a more varied diet and her weight had increased. This period of care seems appropriate. The impression of an "eating disorder" was more reflective of phobic and restrictive diet due to fear of hair in food and choking as opposed to an eating disorder due to pre-occupation with body image. This would explain a quicker improvement in eating patterns.

3.2.36 There were many references to Susan not attending appointments and the following inferences have been made:

- March 2011 cluster of 2 missed appointments: around a period where she moved between GP surgeries
- There was another cluster of missed appointments for her post-natal check and it is unclear from the records whether this took place (Nov/Dec 2011).
- In March 2012 she had a consultation about "feeling depressed for about 8 weeks". Citalopram was commenced (she was prescribed enough for 4 weeks) and a review was planned for 7 days later. She did not attend this appointment and moved again in the period of time that a follow-up would have been appropriate.
- In April 2012, her new GP surgery offered her a newly registered appointment which she did not attend. The next appointment in which she attended May 2012 was because she was pregnant.
- In mid-November there were two appointments missed. It does not appear that the surgery was proactive in offering follow-up consultations. However, for future consultations the surgery phoned to remind her of the appointments.

3.2.37 Mid Essex Hospital Services NHS Trust, Broomfield Hospital

3.2.38 Susan had nine attendances at the hospital throughout the review, mainly for maternity reasons. Within maternity services current routine enquiry asks expectant mothers about Domestic Abuse within their current relationship. Without disclosure from the woman herself the service would not necessarily be aware of any previous abusive relationships that may still currently pose a threat to the woman and her family. There is nothing to suggest that Susan had been subjected to any domestic abuse within her relationship. It is however not documented that Susan was asked about domestic abuse during her last pregnancy. If she had have been this would have been around her new partner and not her previous relationship.

Section 4: Conclusions and Recommendation

4.1 Conclusions

4.1.1 The family of both Susan and Michael stated that they were not aware of any abuse taking place within the family and Susan's mother felt strongly that if there had been then Susan would have told her or reported it to professionals. It does not appear that any issues of possible domestic abuse were considered by agencies involved with both Susan and Michael. No questions were asked or if they were they were not documented.

4.1.2 There are cultural expectations that are thought to sometimes make it difficult for domestic abuse to be challenged within the travelling community. Families from the travelling community often live closely with their extended family, are often male and elder dominated, adhere to gender specific roles with men as the head of the family and women at its heart, and may have concerns about living in houses. There are many barriers that prevent women from accessing domestic abuse services and fear of prejudice from police and other professionals may inhibit this further. Leaving a community that is based around the extended family means that women may end up not only losing their home and partner, but also the community, culture and way of life. They may also have a lack of knowledge of mainstream services, mistrust of authority, and may not be able to access refuge space if another traveller family is already placed there or if they have a large number of children. The nomadic pattern of living for some families makes it difficult to develop trusting relationships with professionals from the settled community and some services designed for the settled community will not adequately cover the needs of the traveller community (Friends, Families & Travellers 2009).

4.1.3 It has also been acknowledged by the Friends, Families and Travellers Outreach team in Sussex, that Traveller families can experience prejudice and discrimination when accessing Primary health services. Many use out of hours service providers and emergency departments when in crisis rather than local GP services as they find them more welcoming, accessible, and friendlier and believe that they get a more thorough examination. There are many complex barriers for travelling families accessing health care services, including racism, social and cultural barriers including the family culture and lack of a fixed address (Fair Access for All? 2010 – Annex C). Provide in Essex has a very robust policy in relation to working with the Traveller community particularly in relation to those families who are frequent movers and as a result have a tendency for non-attendance at appointments.

4.1.4 Essex County Council has an Essex wide traveller unit who manage all the sites throughout Essex. There does not appear to be a bespoke domestic policy regarding the Gypsy and Traveller community published on their website. It is widely published that the Gypsy and Travelling community may find it difficult to report either acts of abuse within their community, or acts happening within their own household, to professionals. They therefore would prefer to allow these to remain hidden, although identified by the traveller lady spoken to, if the abuse became serious it is felt they then would involve professionals. Provide have an excellent policy regarding the travelling community and have liaison staff within their agency who receive specific training. It has been identified throughout the Provide IMR, their strong relationships with the travelling community. It also appears that

both Susan and Michael had a good relationship with their health visitor who visited them at their home addresses.

4.1.5 During the visit with Susan's mother she talked about domestic abuse within the travelling community and the issues surrounding any reports of abuse being reported to the authorities. She believed that Susan had a close relationship with her Health visitors and that these agencies would have been looked upon as the first port of call. She stated that if the younger generation traveller women were subjected to abuse within the family that they would have no means to report this. They would often be without phones and transport so will not be able to leave the site to report. The main time that they would be able to report would be through their GP but mainly through their pre-natal and post-natal services. She encouraged the usage of the domestic abuse sticker system but stated that this would require verbalisation to encourage usage and that just having stickers or forms within toilets were of some use but restricted to those who could not read. She believed that the DA sticker should be placed on the females file, accessible to the female at any point so she could just take it off and place it in a prominent position i.e. urine sample, so the professional would be highlighted to the need of help and support at any point of her care.

4.1.6 Susan's mother also stated that other travelers would not intervene if they felt that a female within another family was being abused as this would cause a considerable rift within families that could last for years.

4.1.7 It has also been reported that victims of domestic abuse would not necessarily consider themselves to be a victim if the abuse was believed to be minor. It was discussed that if abused was serious then the travelling community would consider reporting the matter to the police or other professionals. What level of abuse would be considered as serious by the travelling community? Education is required for the travelling communities, to identify domestic abuse and that an estimated 1.9 million adults aged 16 to 59 years experienced domestic abuse in the last year, according to the year ending March 2017 Crime Survey for England and Wales (1.2 million women, 713,000 men). The police recorded 1.1 million domestic abuse-related incidents and crimes in the year ending March 2017 and of these, 46% were recorded as domestic abuse-related crimes; domestic abuse-related crimes recorded by the police accounted for 32% of violent crimes. all abuse is serious and needs to be reported. Domestic abuse is more likely to begin or escalate during pregnancy (Department of Health 2005) with more than 30% of cases of domestic abuse starting during pregnancy (Lewis and Drife 2001).

4.1.8 Essex undertook a Serious Case Review in 2015 involving adults from a travelling background in which domestic abuse was a feature. One of the recommendations from the review was the importance of professionals always considering the cultural background and expectations within the travelling communities. Contained within the specific recommendation was that the Essex Strategic Domestic Abuse Board should include coverage of Gypsy, Roma, Traveller (GRT) culture within the further development of the domestic abuse strategy in Essex. This does not appear to have taken place within the

council and therefore the panel felt that a recommendation should be made for this work to be completed.

4.1.9 The mental health assessment which took place regarding Michael appeared to concentrate on self-harm and his suicidal thoughts. There does not appear to be a full risk assessment surrounding his family and children and any discussions regarding any indications of harm towards them. The serious incident investigation noted that it is documented that Michaels relationship with his ex-partner had improved and he was in a new relationship which he was feeling positive about. Michael did appear to have received two calls and two visits from the Community Mental Health Team upon being discharged into his mother's care. A further appointment was sent to Michael which did not appear to take place and there is nothing documented to show that this had been followed up.

4.2 Recommendations

Recommendation 1 Essex Partnership University NHS Foundation Trust (EPUT).

North Essex Partnership University NHS Foundation Trust to reinforce the importance of risk assessments surrounding patients presenting with suicidal concerns, upon discharge, regarding possible harm to children and other family members, whether within the same household or estranged.

It is also recommended that this recommendation is submitted to NHS England for wider dissemination and learning opportunities.

Recommendation 2 – Essex County Council Traveller Unit

Educational campaign is to be developed and implemented surrounding the Traveller community regarding domestic abuse and identifying that all levels of abuse are serious and levels of support available.

The Essex Traveller Unit is to proactively raise awareness surrounding Domestic abuse within the community and to 'sign post' appropriate areas of support.

Recommendation 3 - Essex County Council

Essex County Council to include coverage of Gypsy, Roma, Traveller (GRT) culture within the development of the domestic abuse strategy in Essex.

Recommendation 4 – Virgin

The Domestic Abuse Sticker system was started by the safeguarding team in the spring of 2011. New Birth Visit Template to be amended to include a box for recording that the domestic abuse sticker system was discussed. (Annex B)

Recommendation 5 – Mid Essex Hospital Services NHS Trust

Mid Essex Hospital Services NHS Trust staff are to be reminded of the significance of possible domestic abuse within families, especially during pregnancy, and to discuss such possibilities during appointments. Staff are also to be reminded to document that domestic abuse has been discussed with the patient.

National recommendation – NHS England

To consider widening the usage of Domestic Abuse stickers to all health professionals for the inclusion onto the patient's paperwork so that any potential victims of abuse could access the sticker and place it in a prominent position, whichever health agency they are visiting and which every area they have moved into.

Judges summing up

'You were convicted by the jury of the vicious killing of Susan on the 17th of July of last year. She was 23 years of age, and your former partner, the mother of your children. She was, as you yourself described her, lively, nice to be around, and generally a happy person.

The relationship between you and her broke down, as this court heard, and she and you had separated and she had commenced a new relationship with David by whom she was pregnant. It is quite clear that you had difficulties in accepting that the relationship was over.

The court is prepared to accept that you didn't go there intending to kill her, but once you arrived there, an argument started, and that is supported by independent evidence, between you, which culminated in you attacking her and finally strangling her.'

Annex A– Glossary

CSP	County Safety Partnership
IMR	Internal Management Reviews
Journey	New computerised patient management system for Mental Health
ED	Emergency Department
GP	General Practitioner
CRHT	Community Health Team

Annex B

Provide sticker system. This responsibility has now been taken over by Virgin Care.

Domestic Abuse Within Provide
Provide have had a Specialist Practitioner for Domestic Abuse since 2009. This post was introduced following recommendations from a Serious Case Review. The post was commissioned to improve domestic abuse awareness with the Children's Community Public Health Teams including health visitors and school nurses. The role included training, supervision and support for staff around Domestic abuse and representing the organisation at community Multi Agency Risk Assessment Conference (MARAC) meetings. In 2012 the organisation was committed to supporting domestic abuse training and made this mandatory for all staff to complete domestic abuse awareness, with all clinical staff completing a half day domestic abuse level 2 training and Children's staff completing a full day level 3 domestic abuse and half day MARAC and DASH training.

Sticker system The Domestic Abuse Sticker system was started by the safeguarding team in the spring of 2011. The idea was that a sticker that looked like Bar code could be added to the Child's Personal Health Record (Red Book) the numbers under the bar were the telephone number of the National Domestic Abuse Helpline. It was designed as a discrete way of giving this information to all women as part of a universal service without any stigma or discrimination. It was initiated as part of domestic abuse awareness raising among Professionals, which included enhanced level three domestic abuse training to all Children's services. Clinical staff and a half day MARAC training to all Children's services case holders at a time when there had been another domestic homicide in the Mid Essex area. The training also included how to approach Domestic Abuse Routine Enquiry.

Annex C - Sussex Fair access to all policy

C:\Users\elizabeth\Documents\fair_access_health.pdf

Annex D

Thank you for submitting the Domestic Homicide Review (DHR) report for Maldon ('Susan') to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 July.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded that this is a sensitively written report which clearly articulates domestic abuse within the traveller community and probes the barriers to reporting. The research undertaken to inform the review is evident throughout the report and the Panel praised the invitation of an independent traveller liaison officer to become a panel member. The Panel also commended the engagement of both families in the review which has provided important insight into the relationship between the victim and perpetrator.

There were, however, some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- You may wish to consider whether the learning identified in relation to mental health risk assessments should be broadened in scope as it has national as well as local resonance, in particular assessment of the risk posed to the safety of others as well as oneself;

- The Panel was concerned at some of the language used in the report and identified a number of terms which they suggested could be more sensitively framed. For example:
  - 3.1.5 – replace "advertised" with "announced"
  - 3.1.7 – replace "other partner's" with "new partner's"
  - 5.1.4 – replace "dealing with" with "working with" or "supporting"
  - 2.1.14 – replace "motives" with "risk factors"

- It would be helpful if the report could clarify which police force the chair/author was working for and when she retired to reassure readers there are no conflicts of interest;

- Paragraphs 7-12 of the statutory guidance outlines in detail the purpose of domestic homicide reviews which, you will note, is wider than simply examining agency responses. You may, therefore, wish to review paragraph 1.8.1 in the light of this;

- Research from 1982 is quoted as a source for a statement in paragraph 4.1.5 and the Panel queried whether the findings are still relevant and have not been superseded with more recent studies or statistics;

- Please note "HMIC" in paragraph 2.1.4 should be "HMRC";

- There is no information in the report which sets out the timescales for conducting the review and explains any delays;

- The Panel queried the relevance of the statement in 4.1.6. If relevant, the Panel suggested there should be further context provided to justify its inclusion;

- Given the victim was pregnant when she was murdered, it would be helpful if the report could confirm whether a serious case review was considered;

- The Panel noted the executive summary is a chapter within the overview report and recommended that, for future reviews, it should be a standalone report that can be read in isolation, as outlined in the statutory guidance;

In terms of presentation, the Panel recommended a formal front page for the report which contains the name of the Community Safety Partnership, month and year of death, the author's name and the date the report was completed.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely
Charlotte Hickman
Chair of the Home Office DHR Quality Assurance Panel