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NEW FOREST COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Susan

2014

Independent Chair and Author of Report: Althea Cribb

Associate Standing Together Against Domestic Violence

Date of Completion: August 2016

STANDING together
against domestic violence

1. Executive Summary

1.1 Outline of the Incident

1.1.1 On the day of the homicide, Susan's husband found her body. A Home Office pathologist carried out a post mortem: there were numerous stab wounds on Susan's body, a number of which could have been fatal.

1.1.2 Police identified an unrelated male, Michael, as responsible for the attack. No connection was established between Susan and Michael, but a connection was later established between Michael and Jack, the son of Susan's former partner Robert. This connection included key links and communication that implicated Jack in Susan's murder.

1.1.3 On 21 April 2015, Michael was convicted of Susan's murder and sentenced to life imprisonment. Jack was convicted of conspiracy to murder and sentenced to life imprisonment with a specified minimum term of thirty years.

1.2 Domestic Homicide Reviews

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

1.2.2 The New Forest Community Safety Partnership, in accordance with the Revised Statutory Guidance for Domestic Homicide Reviews (March 2013), commissioned this Domestic Homicide Review.

1.2.3 The purpose of these reviews is to:

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

(b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

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

1.2.4 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.3 Terms of Reference

1.3.1 This review aims to identify the learning from Susan's case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.3.2 Two time periods were reviewed for any learning that could be gained: 2006/07 and 2012 to the date of the homicide.

1.4 Independence

1.4.1 The Chair of the Review was Sally Jackson, Partnership Manager of Standing Together Against Domestic Violence. Sally has 20 years' experience of working in the Violence Against Women and Girls sector. She is part of a team of DHR Chairs at Standing Together who have so far completed over 40 DHRs.

1.4.2 The Report Writer was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has over nine years experience working in the domestic violence and abuse sector and has received DHR Chair's training from Standing Together.

1.4.3 Neither Sally nor Althea have any connection with the New Forest Community Safety Partnership or any of the agencies involved in this case.

1.4.4 Sally Jackson was the substantive Chair for the majority of the Review. Althea Cribb entered the Review in October 2015 to write the Overview Report. Althea Cribb subsequently took over the substantive Chairing of the Review from Sally Jackson in February 2016.

1.5 Parallel Reviews

1.5.1 There were no reviews conducted contemporaneously that impacted upon this review.

1.6 Methodology

1.6.1 Individual Management Reviews (IMRs) and chronologies were sought from all organisations that had contact with Susan and/or Jack, and/or Michael. IMRs were received from:

(a) Hampshire Constabulary

(b) Southern Health NHS Foundation Trust (Lymington Hospital)

(c) University Hospital Southampton NHS Foundation Trust (Southampton General Hospital)

(d) Hampshire Hospital NHS Foundation Trust (Royal Hampshire County Hospital, Winchester)

(e) National Probation Service / Hampshire and Isle of Wight Community Rehabilitation Company

(f) West Hampshire Clinical Commissioning Group (General Practices)

(g) Hampshire Children's Services

1.6.2 The Review Panel members and Chair were:

(a) Sally Jackson, Chair, Standing Together Against Domestic Violence

(b) Althea Cribb, Chair (Associate, Standing Together Against Domestic Violence)

(c) Annie Righton, New Forest District Council

(d) Amanda Wilson, New Forest District Council

(e) Richard Hadley, Hampshire Children's Services

(f) Jaki Metcalfe, West Hampshire Clinical Commissioning Group

(g) Jo Lappin, Adult Services

(h) Liessa Mallinson, Victim Support

(i) Donna Cullimore, Home Group IDVA

(j) Alison Alford, Hampshire and IOW Community Rehabilitation Company

(k) Sue Holmes, National Probation Service (Hampshire)

(l) Colin Mathews, Hampshire Constabulary

(m) Gina Cook, West Hampshire Clinical Commissioning Group

1.6.3 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.7 Contact with the Family

1.7.1 The Independent Chair spoke with one of Susan's sisters on a number of occasions. She stated that she was contributing to the review on behalf of another sister and those of Susan's children who wanted to contribute. The comments have been incorporated into the report. She and one of Susan's children reviewed and commented on more than one version of the final report.

1.7.2 The chair also spoke with another sister of Susan's on the telephone and discussed the review findings with her. Her comments have been incorporated into the report.

1.7.3 The Independent Chair interviewed Susan's husband and discussed the findings with him.

1.7.4 The Independent Chair attempted contact with Jack in the prison in which he is held. No response was received to the letters sent. Jack's father was spoken with by the Police Family Liaison Officer and he declined to contribute to the review.

1.7.5 Due to there being no relationship between Michael and Susan, no contact was attempted with Michael.

1.8 Chronology of Events (Susan and Jack)

1.8.1 Susan had contact with: Hampshire Constabulary; her two General Practices (she changed GP in November 2013); University Hospital Southampton NHS Foundation Trust (Southampton General Hospital); Southern Health NHS Foundation Trust (Lymington Hospital) and Hampshire Hospital NHS Foundation Trust (Royal Hampshire County Hospital, Winchester).

1.8.2 Jack's family had contact with Hampshire Constabulary and Hampshire Children's Services.

1.8.3 Jack was known to Hampshire Constabulary for a number of matters, most recently minor incidents for example Jack being witness to a public order assault in 2010. He had a juvenile caution for causing damage in 2002.

1.8.4 On two occasions in 2006 – October and November – Jack's mother called Hampshire Children's Services for advice and information. In the first instance, Jack's mother expressed concern that Jack's father and Susan (who lived together) did not want Jack living with them: Children's Services offered support in resolving the issue. On the second occasion, Jack's mother alleged that Susan had assaulted Jack. Jack's mother was advised to call the police if Jack were to be injured.

1.8.5 Susan was noted as having attended her GP twice with physical and mental health issues in December 2006, in which she mentioned "stress" or "a lot happening" at home.

1.8.6 On 29 April 2007 Robert (Jack's father and Susan's partner) called Hampshire Constabulary at 1.07am to Susan's home, reporting that his 'ex-girlfriend' (Susan) was beating him up. Officers attended and spoke to Robert and Susan. Susan was reported to be heavily in drink. Robert stated that the dispute was verbal only; he had not been assaulted, had no injuries and was making no complaint. As a result of the police attendance, the argument was resolved and Robert left. Susan made no complaint of being the victim of any offences. No further action was taken.

1.8.7 On 10 April 2012 Susan saw her GP reporting low mood stemming from her relationship with her "on/off partner". The GP recorded that Susan was seen with the partner in question who raised concerns over Susan's behaviour. The GP discussed couples counselling and individual counselling, and also prescribed an anti-depressant medication. At a further appointment a week and a half later, Susan was recorded as having made progress with counselling sessions and the medication.

1.8.8 Susan attended a GP on 60 occasions from 20 April 2012 to the day she was killed, for 25 different physical and mental health issues. She also attended University Hospital Southampton NHS Foundation Trust seven times for different physical health issues. Only the significant events are included here.

1.8.9 Susan attended her GPs on 11 occasions throughout this timeframe due to “low mood” or other mental health issues. She was variously prescribed anti-depressant medication and referred / signposted to counselling services.

1.8.10 Robert called Hampshire Constabulary on 20 April 2012 reporting an incident between him and Susan. On attendance, Robert admitted to hitting Susan on the jaw. Susan declined to provide a statement or complete the Domestic Abuse Stalking Harassment and Honour-Based Abuse (ACPO-CAADA DASH 2009) risk identification checklist. Susan agreed that the incident be dealt with through Robert receiving a conditional caution, as part of the CARA pilot. Robert accepted the conditions of the caution: not to reoffend for four months and to attend two workshops to address his offending behaviour. It was reported that Robert completed the conditions satisfactorily.

1.8.11 The next day (21 April 2012), Susan attended the Emergency Department of Royal Hampshire County Hospital, Winchester (Hampshire Hospital NHS Foundation Trust). The reason for her visit was recorded as ‘assault’. The triage record stated that Susan had been assaulted by her ex-boyfriend: he had punched her to the face and the back of her head. Susan was given pain relief. A notification was made to Susan’s GP that stated that Susan had been seen “with reported facial assault to back of head and jaw”. There was no information on how the assault had occurred or who had assaulted Susan.

1.8.12 Susan attended her GP on 25 April 2012 with regard to the assault and injury to her jaw. She stated she needed to have more time off work as she couldn’t work with a bruise on her face. She attended again on 4 May 2012 reporting ear pain and some impaired hearing as a result of the assault, for which she was treated. Susan saw her GP a further 13 times with regard to this pain in 2012. She saw a consultant in June 2012 (Southampton General Hospital) in relation to this, and attended Lymington Hospital (Southern Health NHS Foundation Trust) in February 2013 for an assessment of right-sided hearing loss. The consultant’s opinion was that Susan had sustained some inner ear damage as a result of the assault.

1.8.13 On 1 June 2012 the GP recorded “came with partner very angry as has been given the wrong [medication]”. The GP also noted accusations from Susan’s partner about her behaviour. The GP noted that Susan “agrees to discuss all probs with [another GP at] next [appointment].” It was not clear from the record whether it was Susan or her partner who was “angry”.

1.8.14 On 16 July 2012 Jack’s mother called Hampshire Constabulary seeking advice about Jack, who was aged 20 at the time and living with her. She reported that over the previous 12-18 months since being back in contact with his father, Jack had started “throwing his weight around” at home and trying to intimidate his mother. She was considering asking him to leave and wanted advice

about this. The officer advised that if she asked Jack to leave and she feared a breach of the peace might occur, to call the police. No further action was taken.

1.8.15 Susan contacted Hampshire Constabulary on 5 November 2012 alleging that Robert had sent her abusive text messages, following her ending of the relationship (after, she reported, he had become controlling and jealous). Susan made clear that she did not want the police to contact Robert, or take any steps to investigate the matter. She wanted to change her mobile number and required a police crime reference number to do this. No further action was taken. A risk assessment was completed with Susan and she was assessed as standard risk. The risk level was reviewed and raised to medium, and Susan was contacted for support to be offered, which she declined.

1.8.16 On 4 August 2013 Susan attended the Emergency Department of Southampton Hospital (University Hospital Southampton NHS Foundation Trust) having taken an overdose of paracetamol. She stated it was her birthday, and she was fed up with her family at home and this was not a planned event. Susan was observed overnight, and stated she had no suicidal thoughts and was deemed to be low risk. Susan was referred to the mental health service while in the hospital, but discharged herself before the assessment was completed, after agreeing with the consultant that she would seek follow up and support from her GP. The same day the GP surgery received the notification from the hospital that Susan had been admitted for the overdose.

1.8.17 Susan saw a GP on 21 August 2013 regarding this overdose. She reported feeling better since her housing situation was due to improve and she would be moving shortly. Susan's last attendance at her GP (for a physical health related issue) was 1 September 2014.

1.8.18 Susan's family described her as "bubbly, hard working and outgoing", a woman who loved life. Her husband reported that Susan had not sought help from other agencies during difficult times in her life or during difficult relationships. She had spoken frequently with her GP, and he felt that, had the GP offered more support around her home life or relationships, Susan would have appreciated this and would have considered taking extra help.

1.9 Chronology of Events (Michael)

1.9.1 Hampshire Constabulary reported that Michael had 36 convictions for 74 offences dating from the 1990s to 2014. These were mostly drug offences, theft, fraud and minor assaults.

1.9.2 Probation were involved with Michael when he was on licence from December 2012 to March 2013, following a period in prison. He had been convicted of burglary (non-dwelling), theft and failure to attend court on three occasions. Michael did not breach his licence although he engaged only to a minimal level.

1.9.3 Michael was sentenced to an Unpaid Work Order in July 2013, in which he was to complete 120 hours of unpaid work for possession of a class B drug (cannabis). Michael's attendance was sporadic which led to him being suspended from Unpaid Work and subsequently to breach action on 30 January 2014, for which he received a 16-week custodial sentence, suspended for six months, and a six-month curfew. This sentence ended probation's involvement with Michael.

1.10 Issues Raised by the Review

1.10.1 Nothing presented within this review suggested that the homicide of Susan could have been predicted or prevented.

1.10.2 The review has nevertheless established learning in relation to Susan's need for support around her mental and physical health needs, and the domestic abuse she experienced.

1.10.3 Susan had extensive contact with her GP surgeries, including many contacts that could have involved further enquiry by the GP about Susan's home life and relationships, which could have led to referrals for further specialist support in the community. For example, following her attempted suicide, and the domestic assault.

1.10.4 On two occasions Susan attended with her "partner" and the GP inappropriately discussed their relationship with them together, instead of seeing Susan alone. On the first occasion, the GP recommended couples counselling, which can be very unsafe in relationships where one partner is abusive. On the second occasion, the GP should have known that Susan was a victim of domestic abuse, as she had been recorded as having been assaulted by her partner. Recommendations have been made by the Clinical Commissioning Group to address this.

1.10.5 The GPs should have flagged Susan as a frequent attender, and considered all of her issues together, rather than treating each attendance and issue as new or discrete. A recommendation is therefore made.

1.10.6 Two of the hospitals also had opportunities to follow up with Susan after her attempted suicide (University Hospital Southampton NHS Foundation Trust) and the domestic assault (Hampshire Hospital NHS Foundation Trust). Assuming that follow up would take place by the GP fails to recognise the hospitals' own responsibilities to respond proactively and positively to patients' mental health issues and disclosures of domestic abuse/violence.

1.10.7 A recommendation is made for all three involved hospitals to either develop a domestic abuse policy – alongside training – or to ensure that any existing policies / procedures and training are effective.

1.10.8 Through panel discussions, additional learning was identified for Children's Social Care, for which recommendations have been made.

1.11 Recommendations

The recommendations below should be acted on, in addition to the actions identified in individual IMRs. Initial reports on progress should be made to the New Forest Community Safety Partnership within six months of the Review being approved by the Partnership.

1.11.1 Recommendation 1

The General Practices referred to in this Review, with the support of the CCG and NHS England where appropriate, to ensure that frequent attenders are identified and flagged, and develop of a set of options to be considered when a frequent attender is identified. Options could include the patient seeing the same GP whenever possible, and regular reviews of all the patient's presenting issues.

1.11.2 Recommendation 2

Southern Health NHS Foundation Trust to develop and implement an effective domestic abuse policy, that covers all hospital departments, is supported by training and ensures staff are aware of the need to check victims' safety when disclosures are made, regardless of their relationship to the perpetrator. University Hospital Southampton NHS Foundation Trust and Hampshire Hospital NHS Foundation Trust to report to the Community Safety Partnership on the effectiveness of their domestic abuse policies, procedures and training.

1.11.3 Recommendation 3

Children's Social Care to ensure that their website pages provide information about support services for those dealing with the aftermath of allegations of abuse.

1.11.4 Recommendation 4

The Local Safeguarding Children's Board to set out and implement actions to ensure that all agencies in contact with victims/survivors of abuse offer them support regardless of whether they are exhibiting obvious signs of distress; this includes multi-agency action plans made when a case does not meet the Children's Social Care threshold and is therefore closed.