Domestic Homicide Review Overview Report

'Suzi'

Died: August 2016

Tony Blockley – Independent Chair
Paul Johnston – Independent author
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PREFACE

'Suzi' is not the real name of the victim of the domestic homicide that took place in Cardiff in August 2016; the pseudonym was chosen by the domestic homicide review panel who would like to take this opportunity to express its profound condolences and sympathy to her family, friends and her university colleagues.

Suzi's family, who are from China, have been invited to take part in this review, but they have not been in contact with the Public Services Board since the invitation was made, nor are there any continuing lines of communication between them and the university in Cardiff where Suzi studied. The invitation for them to participate is open-ended, and the panel would like to assure them that in undertaking this review, we are seeking to learn lessons from Suzi's tragic death.

The key purpose for undertaking a domestic homicide review is to enable lessons to be learnt from homicides where a person dies because of domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening again. Suzi's death met the criteria for conducting a domestic homicide review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004.

Domestic violence is defined as 'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality'. This can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse.

Controlling behaviour includes a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour includes an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Since December 2015, an offence is committed by a person if he or she repeatedly or continuously engages in behaviour towards another person that is controlling or coercive and at time of the behaviour, the two people are personally connected. The behaviour must have a serious effect on the victim and the perpetrator must know or ought to know that the behaviour will have a serious effect on the other person. ('Personally connected' means the two-parties are in an intimate personal relationship or they live together and are either members of the same family or they live together and have previously been in an intimate personal relationship with each other). Proof that the behaviour had a 'serious effect' can be established if on at least two occasions it can be shown to have caused fear that violence would be used against the victim or If it causes serious alarm or distress which has a substantial adverse effect on the victim's day-to-day activities. The phrase 'substantial adverse effect' may include, but is not limited to stopping or changing the way someone socialises, physical or mental health deterioration, a change in routine at home including those associated with meal-times or household chores, attendance record at school, putting in place measures at home to safeguard themselves or their children, changes to work patterns and employment status or routes to work.

In 2015 the Welsh Assembly passed the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV). The Act seeks an improved collective public sector response, stronger leadership and a more consistent focus on the way such issues are tackled in Wales and more importantly it seeks to stop the abuse happening in the first place. Amongst other things the Act requires the appointment of a national adviser, the delivery of a prescribed programme of training for Local Authority, Health Authority and Fire Authority staff, the production of national and regional strategies for tackling VAWDASV, work in schools to understand healthy relationships and Improved services to victims and survivors.

The term domestic abuse will be used throughout this review as it reflects the range of behaviour encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

1. INTRODUCTION

1.1 This is the report of a Domestic Homicide Review (DHR) following the death of Suzi in August 2016; she was murdered by her partner, Adult A. Suzi was born in China and attended school there until she was about 15. She and her brother then came to the United Kingdom to further their education. Suzi was a student at University at the time of her death.

1.2 Adult A was found guilty of Suzi's murder and he was sentenced to life imprisonment with a recommendation that he serves 18-years before he can be considered for parole. In sentencing him, the Judge said, *"You inflicted 41 injuries to her body as a result of dozens of impacts, which included the use of a rod-like weapon...You broke* [Suzi's] *right jaw, fractured two ribs and inflicted serious bruising which covered at least a third of her body".* She added, "[Suzi] *provided you with a home, clothing, she bought a car for you. You took what she gave...You lied and lied again in order to attempt to exculpate yourself from the overwhelming evidence which was that during the early hours of* [Date], *you relentlessly and remorselessly inflicted physical injury upon a defenceless young woman."*

1.3 The review provides an independent overview of the service provided to Suzi and to Adult A by agencies that had contact with them. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.4 The review has not sought simply to examine the conduct of professionals and agencies. To illuminate the past to make the future safer, the review has been professionally curious and has sought to find a trail of abuse and to identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. The aim was to consider how abusive behaviour by perpetrators can be prevented and to recommend solutions to help recognise abuse and either signpost victims to suitable support or to design safe interventions.

1.5 In an effort to view events through Suzi's eyes so as to understand the reality of her situation, the review sought, with some success, to involve those around her including her family, friends, neighbours and those in the community as well as professionals.

2. TIMESCALES

2.1 In line with agreed protocols, in August 2016, the police notified the Cardiff Public Services Board of the circumstances of Suzi's death. Agencies were asked to undertake a review of their records to identify any information they held about Suzi and about Adult A; they were also asked to secure their records.

2.2 In consultation with local partners, all of whom understand the dynamics of domestic abuse, the Chair of the Public Services Board notified the Home Office of the decision to commission a Domestic Homicide Review. The review commenced during August 2016, but in consultation with the police Senior Investigating Officer, it was then suspended until the completion of the criminal proceedings against Adult A. The review concluded during November 2018. The PSB acknowledges that the review has taken longer to complete than usual, but the delay is due to a combination of attempts to source additional information to add to the richness of the review, and to staff turnover within Community Safety at Cardiff Council. The dissemination of lessons learned from the review was not adversely affected by the delays.

3. CONFIDENTIALITY

3.1 The pseudonym 'Suzi' was chosen by the review panel with a view to protecting her true identity. She was in her early 20s when she died, and her ethnicity was 'Chinese'.

3.2 Until the report is published it is marked: *Official Sensitive Government Security Classifications 2018.*

3.3 The review panel all signed-up to the following principles of confidentiality during the review process:

- *Information discussed by any agency representative within the ambit of a panel meeting would be strictly confidential and treated as such during the meeting and in the subsequent handling of any data considered at it*
- *The information was not to be disclosed to third parties without the prior agreement of the partners of the meeting.*
- *Information shared should be directly or indirectly relevant to the review*
- *Clear distinctions should be made between fact and opinion*
- *All agencies were to ensure that the minutes of meetings were retained in a confidential and appropriately restricted manner. The minutes would aim to reflect that all individuals who are discussed during the meetings should be treated fairly, with respect and without improper discrimination. All work undertaken would be informed by a commitment to equal opportunities and effective practice issues in relation to age, disability, gender, gender identity, race, religion and sexuality.*

4. TERMS OF REFERENCE AND SCOPE OF THE REVIEW

4.1 After careful consideration, it was agreed to review each agency's involvement with Suzi and with Adult A between 1st April 2014 and August 2016, subject to any information emerging that prompted a review of any earlier incidents or events that were relevant.

The review has addressed:

- *Whether the incident in which Suzi died was an isolated incident or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse*

- *Whether there were any barriers experienced by Suzi's family/friends/colleagues in reporting any abuse in Cardiff or elsewhere, including whether they knew how to report domestic abuse should they have wanted to*

- *Whether Suzi had disclosed abuse while at University in Cardiff and what support/policies and procedures are available for students there and what information is provided to students on healthy relationships/domestic abuse generally*

- *Whether Suzi had experienced abuse in previous relationships in Cardiff or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died*

- *Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Suzi that were missed*

- *Whether Adult A had any previous history of abusive behaviour to an intimate partner, a relative or a co-habitee and whether this was known to any agencies*

- *Whether there were opportunities for agency intervention in relation to domestic abuse regarding Suzi and Adult A or to dependent children that were missed*

- *Whether any training or awareness raising requirements are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the region*

- *Whether there were any barriers to Suzi accessing advice and support around domestic abuse, whether cultural issues had an effect and if so, what can be done within the ethnic Chinese community to recognise domestic abuse and encourage the reporting of it*

- *The extent to which controlling behaviour and financial abuse was a feature of the relationship and whether agencies knew about it*

5. METHODOLOGY

5.1 As is standard practice, on notification of a potential domestic homicide, a multi-agency scoping exercise was undertaken to ascertain whether agencies had any record of involvement with Suzi or with Adult A in any context that could have relevance to the review. The following agencies responded positively and were asked to provide Individual Management Reviews (IMRs) and chronologies of their contact during the period under review. The authors were independent in that they had no previous involvement with Suzi

or with Adult A or any line-management responsibility for staff that had been involved with them.

- Cardiff Metropolitan University
- Cardiff and Vale University Health Board
- South Wales Police
- GP Surgery

5.2 IMR authors were also asked to arrive at a conclusion about the service provided by their own agency and to make recommendations, where appropriate. Agencies with knowledge of Suzi and/or Adult A before the dates set for the review, were asked to provide a summary of their involvement. In addition, they were asked to include information that came to light after Suzi's death that might identify learning for the future.

5.3 This overview report has been compiled from analysis of the multi-agency chronologies, the information supplied by agencies in their IMRs, from open source material, from an interview with one of Suzi's friends and from specialist support provided by BAWSO, Women's Aid and the Chaplaincy at Cardiff Metropolitan University. The findings of previous reviews and research into various aspects of domestic abuse have also been considered as well as other relevant references including the Home Office guidance for conducting domestic homicide reviews.

Comment: *BAWSO is an all-Wales voluntary organisation which provides specialist services to victims and black, Asian and minority ethnic people (BAME) people affected or at risk of Domestic Abuse and all forms of violence.*

5.4 The panel determined that matters concerning Suzi's family, the public and media would be managed by the review chair before, during and after the review.

5.5 The review panel took account of coroners and criminal proceedings (including disclosure issues) in terms of timing and attempting to contact Suzi's family and friends to ensure that relevant information could be shared without incurring significant delay in the review process or compromise to the judicial process.

6. INVOLVEMENT IN THE REVIEW

6.1 SUZI'S FAMILY

6.2 The police and the welfare advisors at Cardiff Metropolitan University worked together to support Suzi's family after they had travelled from China to Wales for Suzi's funeral. They supported them through the court proceedings as well as linking them to other agencies for further support through regional language and dialect experts and other local agents employed by the university. The support was always led by the needs and wishes of Suzi's family.

6.3 The university has confirmed there is no ongoing contact with Suzi's family now they have returned to China. They added that culturally, they would have expected the family to withdraw once the court proceedings had finished.

6.4 The review chair has written to Suzi's brother to tell him about the review and to ask whether he or any other members of his family would like to participate in it. There has been no response and telephone calls to the brother's mobile telephone have gone unanswered. The police believe he may have returned to be with his family in China. It is not known whether there are any other family members in the United Kingdom.

6.5 ## FRIENDS AND FELLOW STUDENTS

6.6 One of Suzi's closest friends participated in the review and many of her fellow students were canvassed as to whether Suzi had disclosed anything that could have had a bearing on the review. Unfortunately, none appear to have been aware of the situation she was in.

6.7 ## NEIGHBOURS AND THE WIDER COMMUNITY

6.8 Neighbours gave evidence during the criminal proceedings about occasions they had heard and seen Adult A being aggressive towards Suzi – and resumes of what they said have been included in this report. As mentioned above, BAWSO, Women's Aid and the Chaplaincy at Cardiff Metropolitan University all supported the review.

6.9 ## REQUEST TO INTERVIEW ADULT A IN PRISON

6.10 The review chair wrote to Adult A to explain that a domestic homicide review was taking place and to ask whether he would be prepared to participate in it. To date he has not signaled any intention to do so.

Comment: *Accounts provided by convicted perpetrators are often a useful source of information for domestic homicide reviews, but it should be stressed that no-one can be compelled to participate in the process. When an interview does take place, invariably it is not possible to challenge what is said, and there could be any number of reasons why explanations provided may be inconsistent with other known aspects of a case. Such contributions, while welcome, should always be treated with due scepticism and with an open mind.*

6.11 ## THE REVIEW PANEL MEMBERS

6.12 The review panel consisted of the following, all of whom were independent in that they had not previously been involved with Suzi or with Adult A or had line management responsibility for anyone who had:

Name	Organisation
Tony Blockley	Independent Chair
Paul Johnston	Overview report author
Stephanie Kendrick-Doyle	Housing and Communities, Cardiff Council
Alison Jones	Interim Community Safety Manager, Cardiff Council
Natalie Southgate	Improvement Project Manager, Gender Specific Services, Cardiff Council
Beth Aynsley	South Wales Police – Independent Protecting Vulnerable Person Manager
Alys Jones	Operational Manager – Safeguarding Social Services, Children Services, Cardiff Council

Linda Hughes-Jones	Head of Safeguarding, Cardiff and Vale University Health Board
Nikki Harvey	Welsh Ambulance Service NHS Trust – Named Professional Safeguarding
Angelina Rodriques	BAWSO
Rakhshanda Shahzad	BAWSO
Kenneth Wise	Lead Nurse – Cardiff and Vale University Health Board
Paul Fitzpatrick	Co-ordinating Chaplain – Cardiff Metropolitan University
Nicola Jones	Cardiff Council Domestic Abuse Co-Ordinator
Sharon Jones	South Wales University

6.13 The review panel met on the following dates:

24th August 2017	15th October 2018
26th October 2017	26th November 2018
26th January 2018	7th May 2019
28th June 2018	

6.14 ## REVIEW CHAIR AND AUTHOR OF THE OVERVIEW REPORT

6.15 The Cardiff Public Services Board requested tenders from suitable applicants to act as chair and overview report author for this review. Following a competitive process, Tony Blockley was commissioned to undertake the role of review chair and Paul Johnston was appointed overview report author.

6.16 Tony is a senior lecturer at Derby University and is also completing a PhD in domestic violence and abuse, with a focus on risk identification and analysis. He is chair of the multi-agency child sexual exploitation strategic group within Derbyshire, the vice-chair of a domestic violence and sexual abuse services charity and the victims-lead on the advisory board for 'No Offence' CiC. Previously, he was responsible for a police department that included all aspects of public protection. He devised and delivered training for specialist services that included safeguarding and multi-agency working.

6.17 Paul is a specialist independent consultant in the field of domestic homicide investigation and review, both in the United Kingdom and abroad. He has senior management experience in many aspects of public protection and has developed comprehensive policies and guidance around the investigation of forced marriage, so-called 'Honour-based violence', harassment/stalking and the interviewing of children and other vulnerable witnesses. He was head of police homicide review and then the criminal investigation department and later became Deputy Director of a project investigating over 3,000 deaths associated with 'The Troubles' in Northern Ireland. He has been Chair or report author in more than 60 domestic homicide reviews. He is a former regional coordinator for the training and deployment of police family liaison officers and is a special advisor to an organisation that provides domestic violence and sexual abuse services and a registered charity that offers free specialist counselling for adults who are 18 or over and who experienced childhood sexual abuse, incest or sexual violence.

6.18 Paul also belongs to an international investigation facility that provides expertise in investigations of the worst crimes known to humanity including sexual and gender-based violence in conflict zones and is a consultant and expert witness in cases at the European Court of Human Rights involving abduction, murder and domestic abuse femicide.

6.19 Neither Paul nor Tony are members of the Cardiff PSB and are not associated with any of the agencies involved in the review. They are both former police officers, Tony with Derbyshire Constabulary and Paul with the West Yorkshire Police.

7. PARALLEL PROCESSES

7.1 There was a police investigation into the circumstances of Suzi's death and subsequent court proceedings which resulted in the conviction of Adult A for her murder.

7.2 Due to the circumstances of Suzi's death and the recent contact she and Adult A had with South Wales Police, the force referred itself to the Independent Police Complaints Commission (now IOPC). The matter was referred back to force by the IPCC, instructing South Wales Police's Professional Standards Department to conduct a local investigation. The investigation determined there to be no misconduct case for the officers to answer.

7.3 Suzi's death was referred to the Coroner, who opened an inquest and then adjourned it because Adult A had been charged with her murder. The inquest has now been 'adjourned indefinitely' on the basis of the findings at the Crown Court.

8. EQUALITY AND DIVERSITY

8.1 Race, religion and belief were certainly issues pertinent to the relationship between Suzi and Adult A. There was evidence that Adult A specifically wanted a Chinese girlfriend, as evidenced by what he told the police during one of the interviews after he had been arrested for murdering Suzi. It is widely acknowledged that women are hugely disproportionally victims of domestic abuse and murdered by partner/ex-partners. This is also reflected in nationally published figures which reflects ethnicity disproportionality.[1]

8.2 In addition, it was mentioned earlier in this report that during the police investigation into Suzi's murder, they examined mobile telephone messages between her and Adult A. He said it was Suzi's fault that he had to shout at her and hit her repeatedly. Suzi usually apologised, accepted the blame and said she would try even harder to be 'British' and to listen more – and to 'Think and behave like one of you.'

8.3 There has been nothing during the review to suggest that Suzi, Adult A or their families were treated less favourably on any protected characteristics as defined by the Equality Act 2010 or that any protected characteristics had a detrimental impact on contact and response to the reported domestic abuse incidents.

[1] Domestic abuse - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

8.4 Suzi's first language was Chinese. She also spoke fluent English, French and Spanish. The review panel is not aware of anything to suggest that her gender precluded her from asking for or receiving services.

8.5 No agency held information that indicated Suzi or Adult A lacked capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever required for either of them.

9. DISSEMINATION

9.1 Whilst key issues identified by the review will be shared appropriately, the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Panel. The IMRs will not be published. The DHR report will be made public and the recommendations will be acted upon by the agencies concerned. The content of the report and executive summary is anonymised in order to protect the identity of the victim, perpetrator, family members, staff and others, and to comply with the Data Protection Act 2018 and General Data Protection Regulation (GDPR). The report will be produced in a form suitable for publication after any Home Office approved redaction has taken place.

Comment: *Specifically, the report will be shared as follows:*

- *Suzi's family will be written to in advance of publication telling them of the date and place it is to take place*
- *South Wales Police and Crime Commissioner*
- *Adult A's Offender Managers from HM Prison and Probation Service*
- *Cardiff Public Services Board*
- *South Wales Police*
- *Clinical Commissioning Group*
- *Cardiff Adult Safeguarding Board*
- *Welsh Government*

10. BACKGROUND INFORMATION

10.1 COERCIVE AND CONTROLLING BEHAVIOUR

10.2 Controlling and coercive behaviour is at the heart of domestic abuse. It is a deliberate and calculated pattern of sustained behaviour intended to create fear. The law on coercive control, which was introduced at the end of 2015, enables charges to be brought in domestic abuse cases where there is evidence of repeated controlling or coercive behaviour.

10.3 Coercive control is an abuse of power pattern of behaviour which is more than merely unpleasant; it is strongly linked to the most serious harm and homicide. It is central to domestic abuse, whether or not there is physical violence. It can operate 24-hours-a-day, so that victims may live in fear and anxiety for years. Often, it is invisible to other agencies and those outside of the dynamics of the relationship.

10.4 The cumulative effects on a victim of coercive control can be debilitating[2] and thoughts by a victim that somehow, they are responsible for the abuse is not uncommon. There are patterns to coercive and controlling behaviour, many of which have become evident to the review panel during this DHR, in the way Adult A treated Suzi throughout most of their relationship. As this report progresses, many of those behavioural patterns will be highlighted and commented upon.

10.5 SUZI

10.6 As mentioned previously, Suzi was born in China and attended school there until she was about 15. She and her brother then came to the United Kingdom to further their education. She spoke English, French and Spanish and studied for a BA before accepting a place on a master's course. Suzi regularly achieved 80% in her assignments and always engaged in class discussions, but her work deteriorated throughout her Master's year to the point that she was told she would have to re-sit the year. The decline in Suzi's academic achievement appeared to coincide with the time she was in a relationship with Adult A.

Comment: *One of the most common forms of controlling behaviour involves making it hard for a partner to continue or start studying, or from going to work. Supressing the potential of a partner is about the abuser feeling their power and control is under threat and a fear that the victim is going to achieve something in their own right and will then have the confidence to move forward.*

10.7 Suzi was from a wealthy family and was expected to return to China to manage the family business once she had completed her studies. Her family provided her with a substantial financial allowance while she was in the UK. She and Adult A had met via a dating website in 2015 and had been in a relationship for about 15-months when he murdered her.

10.8 On the day that Suzi died, Adult A telephoned the police to say his girlfriend was having difficulty breathing and that he had assaulted her the previous evening. He told the operator he had been "*Really, really horrible*" to her and that he had tried to resuscitate her. Suzi was taken to hospital by ambulance, but she could not be saved. She had sustained 41 injuries, including a broken jaw; more than one-third of her body was bruised.

10.9 When Adult A was arrested, he told the police that he and Suzi had argued because she had cheated on him and that he pushed her onto the sofa and had punched her in the ribs. During a police interview, he said "[I]...*just lost it. I punched her pretty, pretty, hard."*

Comment: *The police did not unearth any evidence during the murder investigation to suggest that Suzi had been seeing anyone other than Adult A.*

10.10 OPEN SOURCE MATERIAL

10.11 During the subsequent murder trial, witnesses described Suzi as being a happy, outgoing, and loyal person who made friends easily and was *"Full of life".* Her brother said she was an energetic person who was gifted at languages. He told the jury that during her relationship

[2] https://www.loveisrespect.org/healthy-relationships/power-and-control/

with Adult A, his sister had lost weight and that he had noticed she was wearing heavy make-up and that she had dark patches around her eyes.

10.12 A neighbour gave evidence to the effect that while he was resident in a neighbouring flat, he had heard a man's voice calling a woman *"You filthy whore".* He also heard the man saying, *"One day I'm going to kill you".* This neighbour's partner, who also lived in the flat, stated that she would hear the male raising his voice at the woman around 6-7am and it would end up with him shouting at her and with her screaming. At the same time, it often sounded as if objects were being thrown around the flat.

10.13 Another witness told the court that in the weeks before Suzi's death she had overheard two arguments, during which a man had repeated: *"Why do you keep doing this?"* She also heard a female crying and whining throughout the night that Suzi died.

Comment: *On one occasion, around four-months before Suzi's murder, one of the witnesses reported his and his partners concerns to the police. The witness had been loath to do so beforehand, through fear of what Adult A may do if he were to discover they had contacted the police. Adult A had been verbally aggressive towards them previously, for no apparent reason.*

10.14 Suzi's brother said his sister had told him on three occasions that she wanted to break-up with Adult A because he was *"Not a reliable guy",* and one of Suzi's friends gave evidence to the fact that Suzi had stayed with her one night and in the morning when she woke up, she discovered that she had missed 30 phone-calls from Adult A. The friend had noticed that Suzi had black eyes and when she asked her about it, she said there were *"Cultural differences"* within the relationship.

Comment: *It is widely acknowledged that women are most at risk of serious harm and death when they decide to leave an abusive partner, or they actually do leave, or they form a relationship with someone else. The main reason given by men who kill their partners is not that they were provoked, but it was because they felt they had lost power and control over her. There are many forms the behaviour can take including resorting to stalking campaigns either physically or through social media, or through repeated telephone calls and text messages. Sometimes the stalking behaviour can look to others like acts of true remorse for previous abusive behaviour, but all too often the intention is to regain control by 'getting back together', often based on the promise that the abuser will change their behaviour. When that fails, the feelings of losing power and control can very quickly manifest themselves into a desire to create a climate of fear in the eyes of the victim with threats to kill the victim, the victim's family and a new partner not being uncommon.*

During the police investigation into Suzi's murder, they examined mobile telephone messages between her and Adult A. Much of the conversation involved Adult A demeaning Suzi by calling her 'Worthless', 'Stupid', 'Disrespectful' and 'Embarrassing'. He said it was Suzi's fault that he had to shout at her and hit her repeatedly. Suzi usually apologised, accepted the blame and she said she would try even harder to be 'British' and to 'listen more' – and to 'think and behave like one of you'.

10.15 Another friend, who has been interviewed by the report author, said that Suzi had been against drug use, but that she had started smoking cannabis with Adult A. She recalled Suzi speaking of Adult A's anger problems and how he could be *"A bit controlling".* The friend added that Suzi and Adult A were not equals; Suzi paid for everything including the rent, their food and their clothing.

Comment: *Witness Statements obtained by the police during their murder investigation suggested that Adult A had Suzi's bank card and knew her PIN. Suzi's financial profile indicated that soon after her relationship with Adult A began, there was a decrease in her use of higher-end retail outlets and specialist Chinese shops and*

restaurants and an increase in spending at fast food outlets and in particular at Adult A's place of work (a public house). Suzi did not drive, but less than a month after she met Adult A, a car was bought using her credit card. She then paid for car insurance, fuel and for car-parking.

10.16 OTHER SOURCES OF INFORMATION

10.17 In an attempt to understand what services may have looked like to Suzi, the panel sought expert advice and guidance around the effects of some of the potential cultural issues that Suzi may have faced during her time in the United Kingdom, especially after she met Adult A. The panel is grateful for the time and effort given to the review by BAWSO, Women's Aid and the Chaplaincy at Cardiff Metropolitan University in this regard, all of which has been of immense value.

10.18 The likelihood was that Suzi experienced multiple layers of vulnerability while she was in the United Kingdom and her awareness of just how vulnerable she was may have been limited.

10.19 There is a significant academic leap between the experience of being an under-graduate student and a post-graduate student. A significant change and expectation is that post-graduate study encourages independence and autonomy thereby limiting the contact between university staff and the student. Suzi may well have felt lonely and isolated as a result of this, which could in turn explain why she sought friendship via an internet dating website.

10.20 There will have been high expectations placed upon Suzi by her family to succeed academically. This in itself would have created a significant amount of stress for her. It is recognised by the University that this may make 'asking for help' even harder for post-graduate students.

10.21 The panel recognise that often a person travelling overseas can take many years to 'acclimatise' to the change in culture and expectation. Relationships formed early on with local residents can quickly become a 'point of reference' and sometimes trust is given freely by the visitor and then exploited by the local person.

10.22 Issues of honour and shame for someone in Suzi's position cannot be underestimated. Although domestic abuse is becoming more recognised in China as an issue that requires specialist support and positive action, the panel recognises that the understanding of these issues and therefore support provided to victims is likely to be very different to the support and community response in the United Kingdom. These issues may have been a further significant factor as to why Suzi did not reach out to the University for help.

10.23 The panel felt that it was likely that Suzi was unaware of specialist support available to her outside of the University.

Comment: *A recommendation in respect of the provision of awareness raising about domestic abuse and the services that are available to victims (for overseas students in particular) will be made from this review.*

10.24 Suzi may not have been aware of the potential dangers of online dating websites or the perpetrator behaviours that exist in searching for Asian women. There is evidence to suggest that Adult A specifically wanted a Chinese girlfriend. During the police interview after he had been arrested for Suzi's murder, he said, *"You don't understand, this girl is perfect. She was what I've wanted and she's Chinese. I've wanted a Chinese girlfriend…''* Moreover, the panel recognise that for many, International students are viewed as affluent and consequently that they have a significant amount of disposable income.

Comment: *This could be an indication that Adult A harboured a hyper-sexualisation and fetishisation of Asian women. A known form of racial discrimination, it is based on a perception that a small-bodied Asian woman is likely to be softly-spoken, gentle, submissive and non-confrontational. An underlying element of it is that the man is able to own and to possess the Asian woman and that he has the power easily to hurt her.*

10.25 Furthermore, it is possible that romantic relationships may well have been frowned upon by Suzi's family and despite studying overseas, there may have been 'eyes' and 'ears' around Suzi that could report back to them. The panel speculate that this may have contributed to Suzi using dating websites.

10.26 The review panel recognise that these are not necessarily just 'Chinese' issues. There are specific cultural defining behaviours and responses from areas of India, Pakistan, The Near and Middle East, Africa and South East Asia. Specific zonal (area or community) responses, which may be faith, family, society and sub-culturally defined, further complicate the issues. Consequently, when thinking about matters such as awareness-raising and the sharing of information about domestic abuse, the panel resisted the temptation to focus solely on a specific ethnic identity, so as not to exclude others who may be at risk.

11. NARRATIVE CHRONOLOGY OF RELEVANT AGENCY INVOLVEMENT

11.1 The next section of this report will detail what agencies knew about Suzi and about Adult A before the events of August 2016. Where appropriate, an analysis of the involvement of the agency will also be included.

11.2 ### 2012

Suzi commenced her studies at Cardiff Metropolitan University in 2012 and was still there at the time of her death. She presented as a well-adjusted and happy student.

11.3 ### CARDIFF METROPOLITAN UNIVERSITY

11.4 International cohorts at Cardiff Metropolitan University can make up as much as 20% of the student population. The university understands the specific needs of international students with cultural and faith needs which may not be met by mainstream student support. This is particularly important because of the potential for social isolation and cultural alienation within a large metropolitan city, which can leave students vulnerable and subject to exploitation. Cultural aspects are also individualised as well as driven by social and national identities, which may then further drive responses to abuse which are not always recognised, with personal honour or feelings of intense shame, being a particular example.

This process can then lead to further isolation and the avoidance of social, agency or police engagement.

11.5 In order to address this, the university employs a specialist team of extremely well qualified international welfare advisors who have specific responsibility for the safety and welfare of its international students. They are directly linked to the Chaplaincy team who are theologically qualified and CBT/Chartered Psychologists.

11.6 Suzi spent three-years as a fully supported and internationally accredited student on an undergraduate programme. Her contact with course tutors, academic staff and the international welfare team/office was high.

11.7 International students are frequently reserved, private, struggle culturally and tend to relate intensely to close relationships, friendships and family connections. Suzi showed no concerns during this time and was fully engaged within the support and engagement structure.

11.8 Suzi's transfer to a master's programme marked a change in her status. Master's students are 'academic associates' with quasi-staff status, conduct more research alone and have less direct contact with staff. Suzi was working with a new group, many of whom she would not have known. The requirements at this level are much higher and it is entirely normal for students to be working/researching away from university and for email submission to be much more common.

11.9 Suzi had routine staff and welfare contact and at no stage did she reach out or disclose to any staff, students or support teams within the university. All welfare teams are trained to recognise domestic abuse, which forms a critical part of its risk-assessment process.

Comment: *Suzi's university friends were interviewed by the university's support teams and by the police and none said they knew anything about Suzi being abused. International students are often very private and introverted and although this can be extended to intimate individual relationships, it rarely extends to the group dynamic, particularly where someone is at risk.*

11.10 2014

In April 2014, the police received an emergency call reporting that Adult A had been to the home of his ex-partner's (not Suzi) friend and was banging on the front door. The caller added that he was becoming violent, which she stated was because her friend had ended her relationship with Adult A.

11.11 It was ascertained that neither party had made any threats and that no offences had been committed. Adult A had been compliant and calm when spoken to by the police, but he was given 'suitable advice' and was taken home.

11.12 The officers reported that the incident was a 'verbal altercation only' and that there had not been any incidents between the pair during the previous three-months.

Comment: *South Wales Police Policy at this time did not require the submission of a PPD1 under such circumstances. Policy changed in June 2015 and a PPN (formerly PPD1) is now required for all domestic abuse*

incidents that fall within the Home Office definition and this includes verbal arguments irrespective of whether there have been previous reports of domestic abuse.

11.13 ## 2015

In June 2015, Suzi saw the practice nurse at her GP Practice to ask for a sexual-health check because she was in a new relationship.

11.14 Suzi saw the GP six-days later due to a minor issue not connected to this review.

Comment: *There is no record that Suzi raised any concerns about her partner or that there was any specific enquiry about her partner or about domestic abuse during either of these contacts.*

11.15 ## ANALYSIS OF SUZI'S ENGAGEMENT WITH HER GENERAL PRACTITIONER

11.16 National Institute for Health and Care Excellence (NICE) guidance states that staff in certain areas including sexual health practitioners should ask relevant questions as a matter of routine to help people disclose abuse, even where there is no indication of it taking place. There is nothing to indicate that happened on either occasion Suzi attended the practice.

Comment: *The Cardiff and Vale University Health Board (UHB) is in the process of ensuring that a standardised sexual health pro-forma, which will include routine enquiry questions, is used in the Department of Sexual Health, Community Clinics and GP practices. Staff are being made more aware of the UHB 'Ask and Act' referral pathway and UHB is also in the process of securing the services of an IDVA from RISE in Cardiff to work directly with clients attending the department of sexual health.*

(Recent changes in legislation (the Social Services and Well-Being (Wales) Act 2014 Part 7 and the introduction of 'Ask and Act' under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015), will require changes in the training and awareness needs for professionals).

11.17 ## APRIL 2016

In April 2016, the police received a report of *'*Ongoing domestic abuse' in the flat that Suzi and Adult A shared. The caller stated that he had heard things being thrown around and that the same thing happened every morning. The caller identified Adult A by name; he did not know the name of the female but added he could hear her crying. He also said he had heard Adult A saying, *"How many beatings do you have to have?"*

11.18 The police spoke with Adult A who said there had been 'noise issues' with people in neighbouring flats. He added that they had been banging on the floor of their flat while he had been involved in a *'verbal argument'* with Suzi.

11.19 There were no visible signs of a disturbance at the premises. Adult A and Suzi were spoken to separately. When the Officers first arrived, Suzi had been in the shower. When she was spoken to, she was dressed only in a towel and the officer said she could not see any obvious signs of bruising or injuries. Suzi confirmed there had been a *'verbal argument'* between them and she said that Adult A had never been violent towards her.

Comment: *Speaking to both parties separately is effective practice. No information was forthcoming from Suzi that caused the officers to be concerned. There were no signs of a disturbance within the property, Suzi displayed no obvious signs of distress and no physical injuries were apparent.*

It has been a feature of many domestic homicide reviews that the victim of domestic abuse made a conscious decision not to tell the police (and other agencies), about the violence or other abuse they were suffering. The reasons are varied and are known to include a lack of confidence, (the impact of coercive relationships erodes the self-confidence of those being subjected to abuse), emotional attachment with the abusive partner, a fear of reprisals and a real fear of being made homeless.

11.20 Adult A told an officer that he and Suzi's relationship had been going through a *"Rocky patch"* and that they had been arguing a lot recently. During the conversation, he said that he suffered from attention deficit hyperactivity disorder (ADHD). No criminal offences were apparent, and Adult A was invited to leave the premises to prevent any further breach of the peace.

Comment: *Physically removing someone from a situation that has the potential to escalate into a breach of the peace is common police practice where there is a lack of evidence of a criminal offence having been committed and therefore no power of arrest exists. It can only ever be a temporary measure because there is no lawful means available to officers to prevent an individual from returning to the address.*

11.21 A DASH risk-indicator checklist was completed with Suzi which indicated the risk to be standard. The checklist noted one 'positive response.' In answer to the question 'Is the abuse happening more often?' the response was recorded as *"Yes".*

Comment: *DASH risk-assessment questions are based on extensive research of domestic abuse. The aim is to make an accurate and fast assessment of the danger a person is facing, so the right help may be provided as quickly as possible.*

'Standard-risk' means the current evidence does not indicate likelihood of causing serious harm.

Being assessed as at 'Medium-risk' means indicators of risk of serious harm have been identified with a perpetrator having the potential to cause serious harm but who is unlikely to do so unless there is a change in circumstances.

A risk-assessment of 'High' is determined when there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Serious harm is defined as a risk that is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

11.22 A Public Protection Notice (PPN) was completed without any telephone contact number being recorded for Suzi. The Officer who spoke to Suzi stated that when she asked Suzi for a contact number, she had told her that she did not have a mobile phone. The Officer said she looked around Suzi's bedroom to see if she could see one, but she couldn't.

Comment: *The PPN did not include the fact that the person who called the police had heard Adult A say, "How many beatings do you have to have?" However, this information was readily available on the Niche system to the risk-assessor within the Eastern Domestic Abuse Unit, whose role is to research the intelligence systems and conduct a full risk-assessment irrespective of how much information is recorded on the PPN. The Officers spoke to the caller by telephone after attending the incident. They said that they clarified the report with him, and no additional information was forthcoming during the conversation that elevated the risk-assessment.*

This review has identified a discrepancy between the neighbours' recollection of the incident, which was recorded some four-months after the event, and that recorded by the police at the time. Such a discrepancy could indicate an individual failing; however, this was considered as part of South Wales Police's internal

Professional Standards Department Investigation which found that there was no case to answer for the attending officers.

It is clear that Suzi did have a mobile telephone; one of her friends talked about Suzi receiving numerous text messages from Adult A and during the investigation into Suzi's murder, and the police examined mobile telephone messages between the two of them. The review panel considers it highly likely that Suzi told the police that she did not have one at the behest of Adult A, and it serves as another indication of her isolation and Adult A's control over her.

11.23 A Domestic Abuse Unit 'Risk-assessment' review subsequently upgraded the risk-assessment to 'Medium-Risk' because of the incident mentioned above between Adult A and his previous partner, the concern being that should his relationship with Suzi end, he may not readily accept it. A referral was not made to MARAC because the risk was not judged to have been high.

Comment: *A MARAC is a meeting where information is shared on the highest-risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. The primary focus of the MARAC is to safeguard the victim and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.*

An IDVA is an Independent Domestic Violence Advocate who works with both men and women who are 'high-risk' victims of domestic abuse. The IDVA's are specially trained to provide unbiased advice and information and to work in partnership with other agencies to increase safety for individuals experiencing domestic abuse. Their aim is to reduce the risks of further incidents by carrying out risk-assessments and safety planning. They provide signposting and access to other services, such as health, substance misuse and mental health. The IDVA's also represent the views of the victim at MARAC's.

11.24 The PPN was shared with Cardiff Woman's Aid (CWA).

11.25 ## JULY 2016

During a morning in early July 2016, the police received a report to the effect that a young woman had been running from some flats wearing only a dressing gown and flip-flops. A few minutes later, a man, who appeared to be looking for her, came out of the flats; he got into a car and drove-off. A short time later, he returned with the young woman. The caller was concerned because the man was behaving aggressively towards the young woman.

11.26 The police attended and found that the two people were Suzi and Adult A. They were spoken to separately. Adult A said he had recently been diagnosed with testicular cancer, which had caused stress between him and Suzi and that they had had a loud altercation. Suzi was told about the call to the police and she said there had been a verbal argument between them that morning and that she had left the flat.

Comment: *Adult A's medical records have not been accessed during this review, so it is not known whether he had been diagnosed with testicular cancer. The Cardiff and Vale University Health Board is unclear of their obligations around the disclosure of medical information of a perpetrator and a recommendation from this review is that clarity be sought from the Home Office about the issue.*

11.27 The officer reported that Suzi was wearing a bathrobe and that she did not have any visible injuries. He noted, *"There were no concerns, no offences, everything was in order and both parties were left calm, talking with one another inside the address."*

11.28 The DASH risk-indicator checklist was completed with all the answers being negative and was assessed as standard-risk. No telephone number was recorded for Suzi, but a telephone number was recorded for Adult A. The risk was subsequently revised by a risk-assessor within the Domestic Abuse Unit, again elevating the risk level to 'Medium-Risk' because Suzi was identified as a 'Repeat medium-risk victim' of domestic abuse. The PPN was shared with Cardiff Women's Aid as before, which is deemed as a referral to the support service.

Comment: *The computerised record management system maintained by South Wales Police is NICHE - Officers and Staff use it to record crimes and incidents and the progress of investigations into them. The actions taken by individual Officers is recorded on the NICHE Occurrence Enquiry Log (NICHE OEL)*

11.29 ## ANALYSIS OF THE INVOLVEMENT OF SOUTH WALES POLICE

11.30 Safeguarding information is currently shared between the police and the university on a case by case basis, considering issues of consent and of perceived risk. Advice and guidance is sought by the Police Student Liaison Officer for Cardiff from the South Wales Police Information Management Department where required. An information sharing protocol between the South Wales Police, the Data Protection Officers from the Universities in the South Wales area and their welfare and security departments is currently under construction aimed at formalising procedures, considering data protection legislation, legality, necessity and proportionality. The review panel considered the merits of the police including in their data gathering processes whether a potential victim of domestic abuse is a student and if so, where they are studying. Given the number of international students known to be in the city at any one time, the panel acknowledged the value in identifying potential victims at an early stage, so that the range of support provided by the universities could be utilised to best effect.

11.31 The force already has in place a performance framework which scrutinises its response to domestic abuse at all levels of the organisation. This is summarised as follows:

- Domestic abuse features as a priority area within internal performance processes
- Force policy and guidance has been refreshed and publicised internally
- Selection and promotion processes include assessing knowledge and understanding of protecting the public and the Police and Crime Commissioners priorities.
- The force has attained White Ribbon Status and recruited 24-White Ribbon Champions to support/ raise awareness around domestic abuse
- The force has introduced victim satisfaction surveys to inform continued improvement.

11.32 As mentioned previously, speaking to both parties involved in an incident is recognised effective practice. In respect of the two incidents involving Suzi and Adult A, nothing was said by Suzi to cause the officers any concern for her safety. Taking Adult A to a different

location to lessen the likelihood of a breach of the peace developing was also effective practice; it is a recognised method of allowing parties involved in domestic arguments the opportunity to have time and space apart, during which they may reflect on the incident that has resulted in the police attending.

11.33 Following the report in early July, there is no record of the reporting person being spoken to or additional enquiries being undertaken. Under such circumstances, contact with the reporting person would be expected practice. This issue is considered to be an individual failing and has been addressed by South Wales Police with the officers concerned. Officers investigating domestic abuse incidents can undertake additional enquiries with neighbours and this forms part of South Wales Police's ten-point plan for investigating domestic abuse incidents. However, the course of action taken by officers is dependent on the circumstances and discussions with those directly involved. On this occasion, officers were satisfied that such action was not required given the results of enquiries undertaken with Suzi and Adult A and the presenting circumstances; both parties were spoken to separately and stated they had had a verbal argument, there were no signs of a disturbance within the property, no disclosures of abuse and no visible injuries to Suzi.

11.34 In both incidents, the officers followed correct procedure in completing and submitting a PPN and they were then appropriately re-assessed using professional judgement.

11.35 ## SUZI'S ADMISSION TO HOSPITAL IN JULY 2016

11.36 Suzi was admitted to Cardiff University hospital the day after the police had responded to the report of her being seen running wearing only a dressing gown and flip-flops. She had presented there with a large swelling on the left side of her face and with difficulty opening her mouth.

11.37 Initially, Suzi said she had a history of tooth discomfort and that an abscess had 'popped' just before the swelling started to develop. During an assessment, Suzi said she had fallen about a week previously and had suffered a slight swelling, which then reduced, so she didn't think much of it. She added that the acute swelling started two-days previously. When Suzi was told she needed surgery, she appeared surprised and upset.

Comment: *An examination revealed that Suzi had a fractured jaw which appeared to have been displaced.*

11.38 It is not clear from the accident and emergency documentation how long Suzi was in their care, but she was referred directly to the Maxillo-Facial team and so would not have been seen by an emergency unit clinician. It appears that a member of the emergency unit nursing team must have undertaken some observations though; the history from the dental hospital indicated a 'fall on level', whereas the history given to the Maxillo-Facial staff was 'fall on stairs'.

11.39 The following day, Suzi went for surgery. The surgeon planned to fix the angle of the mandible and drain the abscess but found that the fracture had healed and that there was no mobility to Suzi's jaw.

Comment: *The surgeon was of the opinion that Suzi's injury had been sustained at least three-to-four-weeks before the surgery.*

The pre-operative checklist noted 'Bruises to both knees and legs' and that 'the boyfriend will collect'.

11.40 A note was made by the Maxillo-Facial doctor about a discussion with Suzi's Brother. The note is short and very difficult to read but appears to indicate that Suzi's brother was concerned as to how his sister had come by her injuries. It also appears to indicate that Suzi again said that she had fallen and that she had been under the influence of alcohol at the time.

11.41 Hospital in-patient notes state that Suzi had gone outside with her boyfriend.

Comment: *This is the only record of Suzi's boyfriend having been there, and if that was the case, there would have been ample time and opportunity when he wasn't there for staff to have asked her about her injuries and what had caused them.*

11.42 ## SUMMARY OF THE MEDICAL TREATMENT SUZI RECEIVED

11.43 For the purpose of this review, a head and neck surgery consultant prepared a report on the basis of the original medical notes he had been given.

The report reads:

'[Suzi] *was seen at the University Hospital of Wales, Accident + Emergency Department, on* [date]. *The history given was that she had been in pain in the left over the 2-3 days. She describes having fallen over 1-2 weeks ago on the stairs; she had pain but had left it. There were no problems with eating.*

She attended the University Dental Hospital on and examination at that time revealed a left sided cheek swelling, which was firm; hot to palpation and the radiograph taken showed a left angle fracture. She was therefore admitted and on [date], *she was taken to theatre for a planned open reduction and internal fixation after drainage.*

In light of the large facial swelling and the nature of the fracture, [specialist registrar], *who was taking the case to theatre, asked me to come and assist. This I did. The findings were that an incision was made in the submandibular area and sharp dissection was performed to approach the area of the mandible. It was felt at that stage that this had healed, there was no mobility of the fragments and the abscess was drained. The lower left wisdom tooth was removed, following copious irrigation with saline of the area, a size 18 drain was inserted and the area was closed with 3.0 vicryl and 4.0 ethilon. She made a good postoperative recovery and was eventually discharged home on* [date].

[Suzi] *was a 24 year old lady who presented to the Accident and Emergency Department at the University Dental Hospital on* [date] *with a grossly swollen left cheek. Radiographic evidence showed there to be a fracture but once she was taken to theatre, examination revealed this to be healed and there was no mobility of the fragments, therefore it must have healed at least 3-4 weeks before the event. There was no other fracture and it was at the left angle.*

From reading the notes there were no other injuries noted and she described this as having happened after falling down the stairs. For that to occur one would have expected other facial injuries although if the fracture had now healed, these would have resolved but it is also compatible with a direct blow to that side, either a punch or a kick'.

11.44 ANALYSIS OF THE INVOLVEMENT OF CARDIFF UNIVERSITY HOSPITAL OF WALES

11.45 When Suzi was admitted to the emergency department, the prompt on the rear of the admissions card *'Has domestic Violence been excluded'* was not completed, despite the presence of bruising to both of Suzi's knees and legs being noted by the ambulance crew and the emergency unit staff.

11.46 NICE guidance is that staff should be able to recognise the indicators of domestic abuse and should ask relevant questions to enable people to disclose it. The history of how Suzi came by her injuries should have raised concerns. Suzi was seen in several settings and there were many opportunities to safely make enquiries about domestic abuse. There is no record of any such enquiries being undertaken, even though Suzi's brother had raised his concerns with a doctor from the Maxillo-Facial team about how his sister had received her injuries.

11.47 The exact nature of the brother's concerns was not documented. The doctor made a short note that is difficult to read. However, it appears that Suzi was given an opportunity to disclose how she came by her injuries and the inference from the notes is that the doctor considered it may have been a result of domestic violence. The documentation of this episode is not only difficult to read, but it lacks factual information about what was said by Suzi, by her brother and by the doctor.

11.48 AUGUST 2016

On the day that Suzi died, Adult A telephoned the police to say his girlfriend was having difficulty breathing and that he had assaulted her the previous evening. He told the operator he had been *"Really, really horrible"* to her and that he had tried to resuscitate her. The ambulance crew that attended the emergency call documented that Suzi's airway was clear, but that she was not breathing and that she didn't have a pulse. They also recorded that standard resuscitation procedures were given, that Suzi was 24 and that her partner had called saying she had collapsed and was unable to breath after drinking four-pints of water. The documentation also stated that the partner had given CPR, that he had admitted to beating Suzi the night before and that Suzi had bruises to her face and limbs.

12. ADDRESSING THE TERMS OF REFERENCE

12.1

- *Whether the incident in which Suzi died was a single incident or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse*

12.2 There is no doubt that the incident which brought about Suzi's death was not an isolated one. South Wales Police were called to two-incidents involving Suzi and Adult A. The police officers who attended each incident spoke to Suzi and Adult A separately. Each time, both said they had been arguing and that physical violence had not taken place, which was supported by the observations of the police officers who saw no evidence of physical assault.

12.3 Suzi was admitted to hospital less than two-months before she died, with injuries that were consistent with her having either been punched or kicked to her jaw; she also had bruising to her knees and legs.

12.4
- *Whether there were any barriers experienced by Suzi's family/friends/colleagues in reporting any abuse in Cardiff or elsewhere, including whether they knew how to report domestic abuse should they have wanted to*

12.5 There were many potential and varied barriers to Suzi reporting the abuse. First and foremost, she must have been petrified that Adult A would inflict more violence upon her in retaliation for reporting him, assuming that she knew how and to whom to report abuse.

12.6 Suzi was a very bright and intelligent young woman, but she was thousands of miles away from home and was living in a country that was culturally very different to her own; despite the care and support given to international students by her university, she must still have felt isolated and at times frightened. She may have thought she had no legal right to go to the authorities in the UK or she may not have known what support mechanisms there are here or how to access them[3]. Adult A will certainly have stripped Suzi of her self-respect and her confidence during the 15-months they were together, yet she may still have felt a powerful emotional attachment to him.

12.7 Issues of honour and shame within the culture Suzi grew-up in cannot be underestimated and will certainly have influenced the way she thought about the situation she found herself in. It is also possible that romantic relationships may well have been frowned upon by her family who had heavily financed her being in the UK to study and who could have had sources of information here that would 'report-back' about what she was doing.

12.8 What is certain is that Suzi will not have wanted to embarrass her family, nor would she have wanted to worry them. She had quickly run out of money after meeting Adult A and certainly her standard of living and the quality of her accommodation had plummeted; she may have even thought she would end up homeless if she reported the abuse she was suffering.

12.9 The review panel has speculated that Suzi may have used a dating website to keep her activities hidden from her family because of her desire not to embarrass them. If she did, it will have served to contribute even more to her already substantial vulnerability and isolation.

12.10
- *Whether Suzi had disclosed abuse while at University in Cardiff and what support/policies and procedures are available for students there and what*

information is provided to students on healthy relationships/domestic abuse generally

12.11 Suzi had routine staff and welfare contact before she became a post-graduate student, but it appears that at no stage did she reach out or disclose to any staff, her fellow students or support teams within the university. All welfare teams are trained to recognise domestic violence and abuse, which forms a critical part of their risk-assessment process; none were

3 Between the Lines: Service Responses to Black and Minority Ethnic (BME) Women and Girls Experiencing Sexual Violence | Rape Crisis England & Wales

12.12 The Metropolitan University of Cardiff employs a specialist team of extremely well qualified international welfare advisors who have specific responsibility for the safety and welfare of its international students.

12.13 Safeguarding information is currently shared between the police and the university on a case by case basis, considering issues of consent and perceived risk. Advice and guidance is sought by the Student Liaison Officer at the university from the South Wales Police Information Management Department where required.

12.14 The review panel queried whether the police routinely ask potential victims of abuse if they are university students (and if so, whether a positive response would influence any risk-assessment, particularly in terms of isolation). Directly as a result of this review, South Wales Police is developing an Information Sharing Protocol with the universities in its area to strengthen and enhance the sharing of safeguarding information.

12.15 Police training is being amended to reflect the importance of enquiring about and recording on PPNs the fact that victims and/or perpetrators of domestic abuse are university students and where they study and risk-assessment processes are being updated to include the sharing of PPNs with Police Student Liaison Officers when either the victim or perpetrator discloses that they are university students.

12.16
- *Whether Suzi had experienced abuse in previous relationships in Cardiff or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died*

12.17 There has been nothing during the review to indicate that Suzi had been the victim of domestic abuse by anyone other than Adult A.

12.18
- *Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Suzi that were missed*

12.19 There were several opportunities that were missed for health professionals to 'routinely enquire' or exercise 'professional curiosity' about any domestic abuse experienced by Suzi. The 'Ask and Act' process was in place within the hospital at the time, which is designed specifically to encourage and enable staff to undertake routine enquiry, but even though the explanations Suzi gave to account for her broken jaw (and bruising to her knees and legs) were inconsistent with the medical evidence and her brother apparently queried with

medical staff how she came by her injuries, there is no indication in the records that domestic abuse was ever properly considered.

12.20 Guidance about domestic violence and abuse published by NICE in 2014 recommends that staff working in several areas including sexual health ask service users whether they have experienced domestic abuse or violence. This should be a routine part of good clinical practice even if there are no indicators of domestic abuse. Suzi was seen by her GP practice in June 2015 for a sexual health consultation. A routine enquiry should have been made at that time.

12.21 On the two occasions the police attended incidents involving Suzi and Adult A, they spoke to Suzi out of earshot of Adult A, but she did not disclose that any abuse had taken place, despite being asked about it by the officers.

12.22 The Public Protection Notice submitted by the attending officer did not include the disclosure made by the reporting person during the 999 call that he had heard Adult A say, *"How many beatings do you have to have?"* The officers have stated that they were aware of the text of the original call. A DASH risk-assessment was completed with Suzi's help and she was asked about violence in the relationship and she said there was none.

Comment: *It is recognised that in this situation, disclosure of the statement to Suzi and Adult A could have alerted them to the identity of the reporting person or potentially exacerbated the situation.*

12.23 ➢ *Whether Adult A had any previous history of abusive behaviour to an intimate partner, a relative or a co-habitee and whether this was known to any agencies*

12.24 The only occasion services knew of Adult A being involved in previous abusive behaviour to an intimate partner was when the police attended a report that he and his partner (not Suzi) had been involved in a verbal altercation. The incident did not meet the definition of a 'Domestic Abuse Incident' at that time. This information was available on the Niche system and was used by the risk-assessor considering incidents between Suzi and Adult A to inform and elevate the risk-assessment from standard to medium-risk.

12.25 ➢ *Whether there were opportunities for agency intervention in relation to domestic abuse regarding Suzi and Adult A or to dependent children that were missed*

12.26 No children were involved in the relationship between Suzi and Adult A.

12.27 How Suzi came by her injuries should have been explored by the hospital. Suzi was seen in several settings there and numerous opportunities presented themselves to safely make enquiries about her injuries and about domestic abuse. Suzi's brother raised his concerns about the nature of her injuries with a doctor from the Maxillo – Facial team, but what happened thereafter is not clear. Exactly what Suzi and her brother said was not documented; the doctor made a note that is largely illegible, but it does appear that Suzi was given an opportunity to disclose how she came by her injuries and the inference from the notes is that the doctor considered it may have been a result of domestic abuse. Nothing was done about the disclosure.

12.28 In the event of routine enquiries being made, Suzi may well have made disclosures given that Adult A was not there for much of the time. Following this an 'Ask and Act' referral would have been sent to the Health IDVA which would have generated a MARAC referral given the obvious level of risk to Suzi. Without doubt, the same process would have happened had the doctor told the Health IDVA about the concerns raised by Suzi's brother in respect of the nature of her injuries and about Suzi's response when asked about them. It should also have sparked a police investigation which would in all likelihood have resulted in the arrest of Adult A.

12.29 Even had Suzi not consented to the sharing of information, a referral to adult services within the Local Authority and to the police would still have been made given the extent of her injuries, because of the overriding principle of the need to preserve life and to prevent a crime in the public interest.

12.30
- *Whether any training or awareness raising requirements are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the region*

12.31 The panel agreed during the review that awareness raising about vulnerability and about domestic abuse and associated services should be targeted towards international students in particular. In addition, the current levels of training in domestic abuse procedure and publicity in relation to services available within the region should continue.

12.32 It was noted that recent changes in legislation (the Social Services and Well-Being (Wales) Act 2014 Part 7 and the introduction of 'Ask and Act' under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015), would require changes in the training and awareness needs for professionals. Since 2017, it has been mandatory for all health care staff to undertake training regarding violence against women, domestic abuse and sexual violence and to undertake refresher training every three-years.

12.33
- *Whether there were any barriers to Suzi accessing advice and support around domestic abuse, whether cultural issues had an effect and if so, what can be done within the ethnic Chinese community to recognise domestic abuse and encourage the reporting of it*

12.34 There were many barriers to Suzi accessing advice and support around domestic abuse, which have already been articulated above. Recommendations around awareness raising of domestic abuse and accompanying services for International students will come out of this review, but the panel is alive to the fact that many of the barriers are not just pertinent to students from China.

12.35
- *The extent to which controlling behaviour and financial abuse was a feature of the relationship and whether agencies knew about it*

12.36 Controlling behaviour by Adult A was very much a feature of the relationship. As this report progressed, some examples of his coercive and controlling behaviour were highlighted,

such as his interference with Suzi's studies, the way he demeaned and insulted her, the manner in which he took over Suzi's financial affairs and in effect 'lived-off her'.

12.37 Suzi came from a wealthy Chinese family; she was financially secure with regular and large sums of money being provided to her by her family. Within a very short space of time after meeting Adult A, there was a rapid decline in her financial circumstances, her appearance and her academic achievement.

12.38 Witness Statements obtained by the police during the murder investigation suggested that Adult A had Suzi's bank card and knew her PIN. The police studied Suzi's financial profile which showed that soon after her relationship with Adult A began, there was a decrease in her use of higher-end retail outlets and specialist Chinese shops and restaurants and an increase in spending at fast food outlets and in particular at Adult A's place of work (a public house).

12.39 It is known that Suzi did not drive, yet less than a month after she met Adult A, a car was bought on her credit card. Payments were then made in respect of car insurance, fuel and for car parking.

12.40 The author of this report interviewed one of Suzi's friends who told him that Adult A was controlling of Suzi and that she paid for everything including the rent, their food and their clothing.

12.41 Agencies knew nothing about Adult A's controlling behaviour and financial abuse of Suzi, or very much at all about their relationship.

13. AGENCY KEY LESSONS LEARNED

13.1 The key lesson learned by all the agencies involved in this review is just how vulnerable international students can be and how easy it is for the likes of Adult A to take advantage of it. Isolation from family and friends and cultural differences are at the heart of the issue, but they are two just two of the many difficulties international students face that collectively can make them more vulnerable to abuse than anyone else.

13.2 An associated lesson learned for agencies is that they are less likely to become aware of an international student's plight than they would a student from the UK. Therefore, there is a need to make international students aware of how their vulnerabilities can be exploited by those that seek to take advantage of them and what they should do about it if they think they may be in that position.

13.3 Education for international students about domestic abuse and what services are available to victims in the UK is also something that agencies highlighted as requiring attention, as was the need to strengthen and refresh the training for medical staff about asking routine questions and exercising professional curiosity around domestic abuse.

14. CONCLUSIONS

14.1 Analysis of the text messages between Suzi and Adult A, information from Suzi's friends and an examination of Suzi's financial profile all demonstrate what total control and dominance Adult A had over her. Suzi had to do as she was told, and she suffered for it physically and emotionally if she showed any sign of resistance.

14.2 Very quickly, Adult A took advantage of Suzi's financial status, he isolated her from her friends and fellow students, he degraded her by calling her derogatory names like whore, worthless, stupid, disrespectful and embarrassing and he indoctrinated her into believing she was to blame for breakdowns in their relationship and that it was she that made him beat her.

14.3 The challenge for agencies is that coercive and controlling behaviour of this nature usually takes place behind closed doors and rarely leaves any signs of it having happened or any witnesses to it. The chances of it being discovered are even more remote when the victim is already vulnerable for other reasons, as Suzi was, mainly because of her different culture and her isolation from her family in China.

14.4 This report has highlighted some of the many barriers to a victim reporting the abuse in such circumstances, so agencies must be equipped to take advantage of any intervention opportunities that are presented, such as for example when a victim is admitted to hospital with injuries. Strengthening and refreshing the training around routine enquiry in health settings is therefore essential, but the review panel concluded there is also a need to focus on the vulnerability of international students in particular, by way of awareness raising specifically around domestic abuse and associated services that are available to students in the UK. Communication channels between the police and the universities in South Wales are well established and effective, but further work is ongoing to explore whether potential victims of domestic abuse can be identified as students earlier, and if so how that information can be relayed to the welfare team/advisors at their respective universities/colleges in compliance with data protection principles.

14.5 South Wales Police were called to two-incidents involving Suzi and Adult A. The police officers who attended each incident spoke to Suzi and Adult A separately. Each time, both said they had been arguing and that physical violence had not taken place, which was supported by the observations of the police officers who saw no evidence of physical assault. It is clear now that certainly one of the people who made a report to the police had been loath to do so beforehand, through fear of what Adult A may do if he discovered who had made the report. This review has identified a discrepancy between the neighbours' recollection of the incident, which was recorded some four-months after the event, and that recorded by the police at the time. Such a discrepancy could indicate an individual failing; however, this was considered as part of South Wales Police's internal Professional Standards Department Investigation which found that there was no case to answer for the attending officers.

14.6 An individual failing on the part of police officers (not speaking to a person who had made a report about Suzi and Adult A was identified and has been addressed by South Wales Police with those concerned.

14.7 The Public Services Board would like once again to offer its sincere condolences to Suzi's family.

15. RECOMMENDATIONS

15.1 GENERIC

- Awareness raising about domestic abuse, how and to whom to report it and the associated services that are available to victims (for overseas students in particular) should be commissioned
- Efforts should be made to engage with the Chinese communities in Cardiff specifically around domestic abuse and the services that are available to victims
- That agencies should explore whether contingency plans can be put in place to mitigate the impact of a victim not being contactable by telephone.

15.2 CARDIFF METROPOLITAN UNIVERSITY OF WALES

- To seek to develop with the police an updated Information sharing protocol to include a means of identifying whether a victim of domestic abuse is a student

15.3 SOUTH WALES POLICE

- South Wales Police to work towards finalisation of the Information Sharing Protocol currently in development to strengthen and enhance the sharing of safeguarding information between the force and the universities in its area.
- Training to be amended to reflect the importance of enquiring about and recording on PPNs where victims and/or perpetrators of domestic abuse are university students and where they study.
- Risk-assessment processes to be updated to include the sharing of PPNs with Police Student Liaison Officers where either the victim or perpetrator disclose that they are university students.

Staff to be reminded of:

- The importance of speaking to the reporting person to clarify information and recording accurately any differences between the original report and subsequent details provided by them. If there is no additional information provided, this must also be recorded.
- The need to challenge victims and perpetrators with the information provided by the reporting person where appropriate.

- The requirement to record all relevant information on the PPN, including phone numbers and any additional contextual information.

15.4 CARDIFF AND VALE UNIVERSITY HEALTH BOARD GP PRACTICES. UNIVERSITY HOSPITAL OF WALES, DENTAL AND EMERGENCY DEPARTMENT AREAS.

- That health professionals seek clarity from the Home Office about what information can be disclosed about a perpetrator and in what circumstances

- That health professionals seek that their obligations around the disclosure of medical information is encapsulated in statute rather than merely in the Home Office guidance and Department of Health recommendations

- General Practitioner (GP) practices in Cardiff and Vale University Health Board to consider using a standardised proforma compatible with the Department of Sexual Health guidance when consulting with patients within the GP surgery on sexual health matters. NICE guidelines indicate that specific questions asked help people to disclose their past or current experiences of violence or abuse

- Cardiff and Vale University Health Board ensure that domestic abuse training for staff is compatible with the National Training Framework set out by Welsh Government

- Cardiff and Vale GP practices demonstrate that they are compatible with domestic abuse training for staff in line with the Welsh Government National Training Framework

- Cardiff and Vale UHB to remind staff of their individual accountability to patient documentation relating to legibility and robust documentation including appropriate presentation and compatibility of history