Domestic Homicide Review

Executive Summary

Report into the death of Miss Y on 19th April 2011

The panel send their condolences

to the family of Miss Y

Report produced by Sally Jackson – Independent Chair & Author

Introduction

This Domestic Homicide Review was conducted following the tragic death of Miss Y in Southampton. Deepest condolences are sent to the family of Miss Y.

At 05.21 on Monday 19th April the Police gained entry to the flat where Miss Y resided with her partner, Mr Z. Tragically, Miss Y was found deceased on the lounge floor. She had been stabbed. Mr Z was arrested and charged with Miss Y's murder. His trial started on 23rd April 2012 and he was found guilty of murder on 16th May 2012, the judge sentenced him to life in prison.

A review of this case was commissioned by Southampton Safe City Partnership following a request to do so by Hampshire Constabulary made on 9th May 2011. The review was undertaken in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004 as a Domestic Homicide Review. This took place in order to examine the role of the agencies involved in the case with a view to learning lessons and, where needed, to alter practice in order to improve outcomes for victims and their families involved in future, similar cases.

This summary document outlines the circumstances of the case, the findings of the review and an overview of the recommendations made by the Domestic Homicide Review Panel. A more detailed chronology of events and action plan for recommendations can be found in the full overview report.

Process

The review of Miss Y's homicide began with a panel meeting on 17th June 2011, with meetings taking place on six occasions up until 23rd September 2011. Then, following the advice of the Home Office and a decision by Southampton Safe City Partnership there was a break in the review from September 2011 until criminal proceedings including the trial of Mr Z were complete. Two further panel meetings took place in May and June 2012.

In May 2011 email contact was made with Miss Y's sister who, for the purpose of this review is known as Miss X. Miss X acted as next of kin for Miss Y, and gave permission to the Chair for Miss Y's medical records to be accessed. An interview with Miss X was conducted in July 2011, with the details of this contributing to panel discussions, the content of the overview report and the actions to be taken as a result of this review. The panel wish to send their condolences to the family of Miss Y and thank them for their hugely valuable input to this process.

The terms of reference for the review were to:

- Review the involvement of each individual agency, statutory and non- statutory, with Miss Y and Mr Z between 1st April 2004 and 19th April 2011.
- Summarise the involvement of agencies prior to April 2004.

This timeframe was agreed for the review due to 2004 being the year which an initial trawl of records indicated the relationship between Miss Y and Mr Z had commenced. As the review progressed further information came to light to indicate that the relationship may have started earlier, this is acknowledged and reflected in the narrative chronology of events.

This review also included the Strategic Health Authority responsibility to undertake an independent mental health homicide review (under Health Service Guidance (94) 27).

The agencies responsible for providing details of their involvement, through chronologies of contact and individual management reviews were as follows:

1. The Society of St James – provides supported housing to people affected by mental health and substance misuse issues, both parties used these services
2. Options – provides counselling and support to people with substance misuse issues to support them to live free of substances
3. NHS Southampton – provide GP services in the city, practice 1 and practice 2 are referred to in this report.
4. Southampton University Hospitals Trust (SUHT) – provide the Emergency Department and inpatient Hospital services in the city
5. Southern Health NHS Foundation Trust – provide the secondary care mental health services in the city.
6. Sovereign Housing – a local housing association, owners of the flat where the homicide occurred
7. Hampshire Constabulary – provides the Police Service for Hampshire including Southampton.

In addition, Hampshire Fire and Rescue service gave information to the narrative chronology but given their limited involvement the panel agreed there was no need for an individual management review.

Where relevant each of the contributing agencies were required to:
- Provide a chronology of their involvement with Miss Y and Mr Z during the time period.
- Search all their records outside the identified time periods to ensure no relevant information was omitted.
- Provide an individual management review if necessary: identifying the facts of their involvement with Miss Y and/or Mr Z, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

In order to critically analyse the case, the terms of reference required specific analysis by the panel of the following:
- Communication and co-operation between different agencies involved with the couple
- Opportunity for agencies to identify and assess domestic abuse risk
- Agency responses to any identification of domestic abuse issues
- Organisations access to specialist domestic abuse agencies
- The training available to the agencies involved on domestic abuse issues
- Review the care and treatment, including risk assessment and risk management of the couple in relation to their primary and secondary mental health care.

And for the panel to:
- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
- Improve inter-agency working and better safeguarding of adults experiencing domestic abuse.
- Sensitively involve the family of Miss Y in the review, if it is appropriate to do so in the context of on-going criminal proceedings.
- Commission a suitably experienced and independent person to produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.

- Commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary.
- Establish a clear action plan for individual agency implementation as a consequence of any recommendations from individual management reviews.
- Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.
- Provide an executive summary.

Key findings

1. Miss Y had a relationship with Mr Z from 2003 until her death in April 2011– this relationship was known to agencies. On a number of occasions especially earlier on in the relationship Miss Y said she wanted to end the relationship (August 04, March, April and June 06) but was always persuaded by Mr Z to reconcile. There were stable and positive times in the relationship, as agencies and her family recognised that Mr Z could be supportive of Miss Y and enabled her to cope with the effects of her schizophrenia (especially during 2007-8).
2. Mr Z was a drug user and alcohol dependent; he struggled to reduce his alcohol consumption during their relationship. Miss Y was felt by mental health services to be vulnerable to sexual exploitation due to the manifestation of her schizophrenia and alcohol use. This case highlights that sometimes individual incidents alone may not reach thresholds for intervention on their own but the combination of information from several agencies regarding Miss Y and Mr Z as a couple if shared would raise significant concern and trigger further action.
3. Miss Y had a long-standing and positive relationship with mental health services. Despite active symptoms of her illness (olfactory hallucinations, ideas of reference, paranoia and hearing voices) Miss Y made progress over time to live independently, having spent many years of her adult life in acute mental health hospital, rehab hospital or supported living. Miss Y and Mr Z had shared a flat together since 2007. Miss Y attended all her appointments and was well engaged with mental health services with consistent relationships with her Consultant Psychiatrist and Community Mental Health Nurse (Care Co-ordinator) with whom she had a good rapport.
4. She was last seen on 12th April 2011 by her care co-ordinator when her presentation was calm, less distressed and although complaining of paranoia was planning for her marriage in spring 2012. During all of her contact with Mental Health services Miss Y was felt to be generally vulnerable to exploitation due to her symptoms, excessive use of alcohol at times and her risk taking behaviours. However, more recently prior to her death she was no longer using alcohol to excess and the risks from this had reduced.
5. There was on-going contact/professional relationships for both Miss Y and Mr Z with a wide range of agencies – over critical periods, however none identified neither domestic abuse existing nor identified risks of domestic abuse. This is despite indicators of possible domestic abuse for example; Miss Y wanting to leave the relationship but saying that Mr Z would not accept this and feeling scared of Mr Z when he got angry, Mr Z threatening or attempting suicide causing her to re-establish the relationship, Mr Z trying to dissuade Miss Y from moving to Cheltenham in late 2005; and Mr Z trying to persuade Miss Y not to trust the rehabilitation centre staff in 2006, this could be seen as attempts to isolate Miss Y. The combination of these issues could have been identified as risky had information been shared in more detail by key services. This combined, would have indicated higher risk and ideally triggered action to address the domestic abuse issues present in the case.
6. There were missed opportunities for enquiry about domestic abuse for example, in 2005 and 2010 when Miss Y visited her GP several times with fears she had an STI

or pregnancy (none were found) and a 'traumatic' ear injury which was not investigated. Also at the time of a road traffic accident in 2011, Mr Z's bizarre behaviour was noted but no link was made as to the possible effects this could have on the safety of his partner Miss Y. This case contained the so called 'toxic trio' of substance misuse, mental health and domestic abuse although it was not recognised as such by professionals at the time.

7. Police and mental health teams action at the time of the road traffic accident in 2011 was according to policy, but did allow Mr Z to 'slip through the net'. No follow up action was taken regarding his mental health issues triggered by use of drugs. There was not a follow up process in place to deal with such an acute episode of psychosis, caused by drug reaction in a person who was likely to use that drug again.

Was Miss Y's death predictable and/or preventable?

The clear learning points from this review stem from the fact that Miss Y was never identified or assessed as experiencing domestic abuse, despite on several occasions, risk factors associated with domestic abuse being apparent.

This is clear in examples in the chronology and individual management reviews summarised in the full report particularly where Miss Y described being frightened of Mr Z, especially when he was drunk, and where health staff discussed concerns re Miss Y being vulnerable to exploitation (both sexual and financial).

As domestic abuse was not identified through agency practice at the time, it is difficult to establish how Miss Y's death could have been predicted or prevented by this means. If at some stage in the course of the relationship between Mr Z and Miss Y domestic abuse had been clearly identified and a referral made, or specialist support sought, Miss Y may have had the opportunity and support to safely extricate from the relationship, as separation may have been an outcome of that intervention. However it is still impossible to say whether or not that would have prevented the eventual and tragic outcome.

Conclusions and key learning

The key learning from this review highlights the need for training and education among services, particularly focussed on the identification of possible indicators of domestic abuse. This particularly needs to highlight that domestic abuse is not just physical violence, assessment of risk and ensuring a safe and appropriate response. (See recommendation 1)

At the time that Miss Y was involved with key services such as primary and mental health services and supported housing, training about domestic abuse was not a key requirement for staff. It was generally covered in the wider safeguarding adults agenda, often within a section of the training that identified that domestic abuse could be a safeguarding issue, but without much detail on indicators and risk factors and response. (See recommendation 1)

As long ago as 2000, national research evidenced the prevalence of domestic abuse among service users of mental health services. Janet Bowstead in her report 'Mental health and domestic violence' showed that 50-60% of female mental health service users have experienced domestic abuse and 20% will be currently experiencing it. Also Phillips, Kelley and Steiner et al in 'Sociolgeopolitical issues' (DoH Secure futures for women) showed that 70% of in-patients in psychiatric care have histories of physical and/or sexual abuse.

It is clear that a holistic approach to providing education and training to all staff in contact points in health and social housing services, and other possible safe contact points for survivors will provide opportunities for women in a similar circumstance to Miss Y to be recognised as displaying signs or indicators of abuse. This would then trigger appropriate

questions, risk assessment and where appropriate, referral to specialist support. (See recommendations 1 and 2)

Miss Y did inform her Society of St James housing support worker and other health staff that she was 'frightened of Mr Z' especially when he had been drinking. Sadly there appeared at times to be an acceptance that this is common in 'so called' chaotic relationships. (See recommendation 1)

Miss Y attended her GP for routine cervical screening and contraception appointments, and at times she also reported to the GP that she felt she may be pregnant or have contracted a sexually transmitted infection; however there is no record of any further enquiry at these times into her relationship or how she may have contracted any infection. These appointments provide an ideal opportunity to ask female patients (when they are usually attending on their own) further questions about their relationship and any problems they may have. This could have led to identification of domestic abuse issues and subsequent referral to specialist support. (See recommendation 3)

Mr Z was known to have alcohol issues and to become aggressive when drunk, Miss Y was seen as vulnerable, especially to sexual exploitation, and most of the main agencies involved were aware that they were a couple. The risks for each individual were not linked as risks to each other which again prevented identification of the combined risk posed to Miss Y through domestic abuse. In developing care plans for clients it is recommended that key relationships are part of the information included in assessing risks and identifying possible safety plans and mitigating factors. (See recommendation 5)

It is important that people with additional vulnerabilities or factors that may lead to more chaotic lifestyles for example mental health or substance misuse issues, are assessed in the same way as any other individual displaying indicators of domestic abuse. Therefore the interactions that they have with other services such as police, housing, health and those in the voluntary and community sector will be assessed according to the risks posed as well as their need and wishes rather than by assumptions by these services based on their mental health or substance misusing issues. (See recommendation 5)

Following the road traffic accident in January 2011, Mr Z was diagnosed as having a psychotic reaction to the strong cannabis (skunk) he had smoked. Bearing in mind it was known that Mr Z was a regular cannabis user, it could have been predicted that a further psychotic episode could occur if he continued smoking. However, there are only certain clinically recognised conditions that fall within the definitions of the Mental Health Act and dependence on drugs or alcohol is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorders in the Act.

The challenge for mental health services therefore is that they have no legal gateway to intervene and limited powers in relation to substance misuse. Any active treatment relies on the engagement and motivation of the individual concerned. It is a difficulty for substance misuse services that clients have to want to willingly engage for the treatment and or support to be provided and effective. When the use of substances can have such a dangerous effect on others (Miss Y was in the car with him and 3 other cars were hit) improved partnership working and the exchange of information about critical incidents such as this could improve services responses. It appears that Hampshire Constabulary felt it was a mental health issue and so did not pursue criminal proceedings, Mental Health Services (provided by Southern Health) assessed this case as being drug related and Mr Z discharged himself from their care. Mr Z chose not to engage with substance misuse services – in short he, on this occasion, fell through the net. (See recommendation 5)

On the night of the murder, bearing in mind it was a busy night; police were deployed and dealt appropriately with an earlier call out at the scene. It is argued that had they been more aware of Mr Z's previous psychotic episode following skunk use, they would have had more information on which to base their actions. The next phone call from Mr Z was only one hour later and clearly he was not calm as he still referred to the 'drug ring'. Considering his past actions, although the subsequent events could not have been predicted, it was predictable that Mr Z may act strangely and even aggressively, and therefore require further intervention. Mr Z had made a series of calls to the control room and was also abusive to the call taker. For these reasons no further action was taken at that time. Clearly when Mr Z called and said that he had killed the only person he had ever loved, a unit should have been deployed, although that would not at that time saved Miss Y's life. Hampshire Constabulary has reviewed both their control room procedures and their procedures for dealing with alleged offenders with mental health issues in the light of this.

Recommendations from the Panel

The following recommendations are those agreed by the panel, as these relate to cross-cutting issues affecting more than one agency. Detail of the implementation of these is given in the action plan contained in the full report.

1. All services involved in this review should ensure relevant staff are fully trained in identifying, assessing and responding to domestic abuse.

2. Southampton Safe City Partnership should ensure that the Pippa (Prevention, Intervention and Public Protection Alliance) project is implemented. This will provide a clear point of contact for workers seeking advice and information about domestic abuse cases and will provide a place to make referrals of domestic abuse cases that require specialist support.

3. NHS Southampton should ensure that the IRIS (Identification and Referral to Improve Safety) project is implemented and sustained in the City to work closely with GP practices to improve identification and referral of domestic abuse cases. The project should involve both Practice 1 and 2 as involved in this case within its first set of practices involved in the project.

4. Key services including Health and the Local Authority should require specific standards in training for providers so that all professionals and practitioners are able to ensure domestic abuse identification, assessment and appropriate referral.

5. The Vulnerable Victims group should consider how agencies can respond more effectively to the cumulative impact of standard and medium risk cases for adults with compounding issues such as mental health and substance misuse as well as domestic abuse. To include consideration of developing a triage system similar to Multi Agency Safeguarding Hubs used in other parts of the UK, or the triage used for children and young people cases in Southampton.

Recommendations from Individual Management Reviews

The following recommendations are those detailed within each contributing organisations individual management review. These relate to specific service issues and are included in the action plan for the review.

Hampshire Constabulary

6. Force policies and procedures are amended to provide police officers with more guidance when dealing with suspects who have mental health issues.

7. Force control room standard operating procedures are amended to provide clear risk based guidance on how to respond to calls from people with mental health issues.

NHS Southampton (GP)

8. Increase GP and practice staff awareness and identification of domestic violence, the potential effects on relationships / families and the service provision available for support and intervention. Develop close working relationships with domestic violence services (e.g. IDVA – Independent Domestic Violence Advisors) and health services.

9. Increase awareness of GP role and responsibility in Safeguarding Adults with the development and implementation of individual practice Safeguarding Adult Policy. This policy should include recognising and managing Domestic Violence.

10. New patient registration forms to have a detailed section requesting information on the consumption of alcohol, over the counter medications, alternative medication and illicit drugs to facilitate lifestyle assessment and opportunistic signposting to appropriate drug and alcohol services.

11. A greater correlation between the data available in the form of easily identifiable read codes and the information contained in individual patient records. Increase performance management of Primary Care services to ensure practices are complying with this mandatory process in line with guidance using uniform read codes.

Southampton University Hospital Trust

12. Validate the 2011 update of management of domestic abuse guidelines.

13. Ensure training re: management of domestic abuse is always included on the orientation for Emergency Department nurses and doctors.

14. Include training re: management of domestic abuse on forthcoming Vulnerable Adult Champions Programme.

15. Ensure that the record of referral from Emergency Department re: mental health problems is included on the patient's electronic mental health records by the mental health team receiving the referral, regardless of whether the patient is seen in Emergency Department, the Mental Health team refuse to see or patient self discharges/absconds.

16. Disseminate learning from this review at key Trust groups.

17. Ensure clinical and non clinical staff have easy access to information and resources on all vulnerable adults issues.

18. Facilitate access to specialist services for victims of domestic abuse when they attended the acute hospital site.

Southern Health Foundation Trust

19. Provide awareness for all staff groups of the recently developed domestic abuse policy including the availability of domestic abuse training throughout the trust.

    a. Additional actions in SHFT individual management review but not in action plan:

b. Joint working to be implemented across care teams when both partners are under SHFT care teams.
c. Consider further guidance to be given in the Data Protection Caldecott and confidentiality policy as to when/if you can access a person's healthcare record if their partner is subject to safeguarding or there are potential risk indicators in relation to the relationship.
d. Include a professional development pathway for Domestic Abuse training.

The Society of St James

20. Each service within the Society to ensure that at least one member of staff attends specialist domestic violence training each year, if this is appropriate to the role of the service. This is in order to keep teams up to date with the issues, and to maintain awareness of the issues over the longer term. This needs to be in line with the role of the service, so may not be considered relevant within the Registered Care Home, for example.

Sovereign Kingfisher

21. Refresher domestic violence training for all Customer Service Advisors and Housing Officers.

22. Improved access to relevant policy and procedures.

23. Review effectiveness of induction process for new starters.

24. Have a specific module within the Sovereign training framework covering domestic abuse.

25. To access Hampshire domestic abuse training programme.

Options

26. Supervisors to attend DASH (Risk Assessment) and MARAC (Multi Agency Risk Assessment Conferences) training course.

27. To ascertain how long client files should be kept before destruction.

28. Refresher training for team on file management and codes of practice.