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Safe City Partnership
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Domestic Homicide Review
Overview Report

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

Contents

Introduction

This Domestic Homicide Review was conducted following the tragic homicide of Miss Y on Monday 19th April 2011. This was the first domestic homicide review to be carried out in Southampton. It was carried out in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

The review of Miss Y's homicide began with a panel meeting on 17th June 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 the trial of Mr Z was complete. The trial started on 23rd April 2012 and Mr Z was found guilty of Murder on 16th May 2012. The panel reconvened again shortly after this

This report outlines the circumstances of the case and the findings of the review. This was undertaken to examine the role of the agencies involved with a view to learning lessons from the case and, where needed, to alter practice in order to improve outcomes for victims and their families involved in future, similar cases. It:

- Summarises the key facts of the case and the sequence of events.
- Summarises the key issues, key decisions and whether with hindsight different decisions or actions could have been taken
- Identifies examples of good practice and notes where systems need to improve
- Outlines the conclusions and lessons learned from the review
- Details both recommendations from individual agencies and from the Review Panel.

Miss Y's Family input

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. In addition Miss Y's Godmother, her husband and their daughter were able to supply written statements which have informed the process. The panel wish to send their condolences to the family of Miss Y and thank them for their hugely valuable input to this process.

Further detail of Miss Y's family involvement is given on page 34 of this report.

Process

On Monday 19th April 2011 the police discovered Miss Y had been murdered at her home address by Mr Z. On 9th May Hampshire Constabulary made a request that a Domestic Homicide Review take place, as it met the criteria of a review, set out below:

> *A review of the circumstances in which the death of a person **aged 16 or over** has, or appears to have, resulted from violence, abuse or neglect by-*
>
> *(a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship;*

The Southampton Safe City Partnership took responsibility for this review as prescribed by relevant legislation and guidance. They appointed Sally Jackson – at that time Manager of Hidden Violence and Abuse at Portsmouth City Council, as independent chair and author of this report. This reflected local and national guidance which suggests that Domestic Homicide Review Chairs are appointed using a 'reciprocal' arrangement with those in neighbouring Local Authorities and Community Safety Partnerships, to be delivered within their current paid position. Sally subsequently moved on from this post to become Partnership Manager at Standing Together Against Domestic Violence, but continued to chair the review and author the report through a separate arrangement with Southampton Safe City Partnership.

A panel was formed of the following members:

Sally Jackson – Independent Chair and Overview Report Author
Sarah Lawrence – Community Safety Co-ordinator, Southampton City Council
Linda Haitana – Community Safety Manager, Southampton City Council
Kevin Walton – Hampshire Constabulary
Michelle Barry – Chair of Southampton Sexual and Domestic Violence Forum, voluntary sector representative for violence against women and girls services
Lindsay Voss – NHS Southampton, Consultant/Designated Nurse Safeguarding Children and lead for domestic violence
Julie Kerry – Associate Director, Mental Health and Learning Disability, NHS South Central (Strategic Health Authority)
Jo Lappin – Head of Safeguarding, Mental Health, Learning Disability and substance misuse services, Southern Health NHS Foundation Trust
Steve Smith – Housing Services, Manager Southampton City Council
Sue Lee – Manager, Safeguarding Adults Team, Southampton City Council
Administrators from Community Safety Team at Southampton City Council including: Julie Le Marquand, Georgina Beaton and then Kerry Owens.

The panel met on the following dates

17th June 2011	Initial meeting
15th July 2011	Meeting with individual management reviews Authors
12th August 2011	Chronology review
9th September 2011	1st draft of individual management reviews
23rd September 2011	Presentation of final individual management reviews

Following a meeting of the Southampton Safe City Partnership and on the advice of the Home Office, it was decided to break until the trial was complete. The trial started on 23rd April 2012 and Mr Z was found guilty of Murder on 16th May 2012 the panel convened again on:

25th May 2012	Panel met to review report
21st June 2012	Panel met to agree final report
31st July 2012	1st draft of report presented to Southampton Safe City Partnership.

The final version of the report was then drafted and approved by Southampton Safe City Partnership and the DHR panel. This was sent to the Home Office in November 2012 for Quality Assurance and was deemed appropriate to publish. During this time further contact with Miss Y's family was attempted.

Terms of Reference

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:

The Society of St James
Options
NHS Southampton
Southampton University Hospitals Trust
Southern Health NHS Foundation Trust
Sovereign Housing
Hampshire Constabulary

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.

The following seven agencies were asked to search their files but found no contact with either Miss Y or Mr Z:

Hampshire Probation Trust
Raglan Housing
Southampton City Council Safer Communities Team (including the Independent Domestic Violence Advisor Service and Anti Social Behaviour Team)
Southampton City Council Housing Services
Southampton Rape Crisis
Southampton Women's Aid
Southampton Voluntary services
Stonham Housing – Refuge and Outreach provider
Solent Mind

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 of the following:

1. Communication and co-operation between different agencies involved with the couple
2. Opportunity for agencies to identify and assess domestic abuse risk
3. Agency responses to any identification of domestic abuse issues
4. Organisations access to specialist domestic abuse agencies
5. The training available to the agencies involved on domestic abuse issues
6. 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 to:

1. 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.

2. 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.

3. Improve inter-agency working and better safeguarding of adults experiencing domestic abuse.

4. 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.

5. 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.

6. 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.

7. Establish a clear action plan for individual agency implementation as a consequence of any recommendations from individual management reviews.

8. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

9. Provide an executive summary.

Miss Y Family Composition

Name	Gender	Relationship	Year of Birth	Location
Miss Y	Female	Partner	1976	Southampton
Mr Z	Male	Partner	1956	Southampton
	Male	Father Miss Y	Unknown	France
	Female	Step-Mother Miss Y	Unknown	Same as above
	Female	Godmother Miss Y	Unknown	Southampton
Miss X	Female	Sister Miss Y	Unknown	Cheltenham
	Male	Brother Miss Y	Unknown	Australia

Profile of Agencies involved in the review

The Society of St James – provides supported housing to people affected by mental health and substance misuse issues, both parties used these services

Options – provides counselling and support to people with substance misuse issues to support them to live free of substances

NHS Southampton – provide GP services in the city, practice 1 and practice 2 are referred to in this report, and these are the practices involved in this case.

Southampton University Hospitals Trust (SUHT) – provide the Emergency Department and inpatient Hospital services in the city

Southern Health NHS Foundation Trust – provide the secondary care mental health services in the city.

Sovereign Housing – a local housing association, owners of the flat where the homicide occurred

Hampshire Constabulary – provides the Police Service for Hampshire including Southampton

Terminology

This report details various parts of the Mental Health Act 1983 used when treating patients with mental health issues. To clarify here is a brief description of the acts used and their powers, as well as other relevant terms:

- Section 3 is the detention to a psychiatric inpatient unit for treatment of psychiatric illness and may be for a duration of up to 6 months, although this can be extended
- Section 17 leave - This allows a responsible clinician (the approved clinician who has overall responsibility for the patient's care) to grant a detained patient under their care permission to leave the premises of the hospital where they are liable to be detained.
- Section 25a was known as 'supervised discharge in the community'. This has now been superseded by the Community Treatment Order (Mental Health Act 1983, as amended 2007).
- Section 136 details removing a mentally ill person from a public place to a place of safety allows for the removal to a place of safety of any person found in a place to which the public have access who appears to a police officer to be suffering from mental disorder and to be in immediate need of care and control.
- PHQ9 - the approved mental health assessment tool for GP's
- CA12 - A form used locally by police to notify other services of a vulnerable adult at risk being involved in one of their call – outs.

Narrative Chronology

The victim (Miss Y) and the perpetrator (Mr Z) had been in an intimate partner relationship since 2003. This was an 'on and off' relationship and there were no children from their relationship or involved in the case. Miss Y was diagnosed with schizophrenia in 1997 and with depression in 2000. She had a history of alcohol misuse starting from her late teens and there are documented overdoses in 1999, 2002 and 2004. Mr Z was diagnosed with severe alcohol dependency and drug misuse issues. He was assessed by mental health services in 1996 and 2003 both instances followed the breakdown of a long term relationship. He was diagnosed with depression and mixed anxiety and depression respectively.

This section describes the chronology of events identified as of interest to this review. It includes information about events beyond the timeframe agreed where these are seen as relevant to the review.

2003/4

The first recorded time that identified Miss Y & Mr Z as a couple is in February 2003 when Mr Z was arrested by Hampshire Constabulary for damaging a garage door, it was noted at this time that Miss Y was listed at the same address.

Later that year on 23/08/03 Mr Z attended the Emergency Department of Southampton University Hospital Trust accompanied by Miss Y. Mr Z had a wrist laceration and was assessed with a primary condition of alcohol misuse and related depressive type symptoms, he left the department before wounds could be dressed.

On the 19/12/03 Miss Y spoke with her project worker at The Society of St James about Mr Z's drink problem and related that he got 'quite angry'. Miss Y intended not to give Mr Z her new address until he 'sorted himself out'. However on 29/12/03 it is noted that Mr Z stayed the night. On 02/01/04, Mr Z was barred from The Society of St James project due to a fight with another male resident whist he was drunk (denied by Mr Z).

Following an appointment that Miss Y had with Community Mental Health Services on 07/01/04, contact was made with Miss Y's project worker at The Society of St James to discuss concerns re Mr Z's influence on Miss Y, her finances and her drinking. On the 19/01/04 The Society of St James recorded several phone calls from Mr Z insisting on speaking to Miss Y. He was informed that she was lying down & not available and reminded him that he was banned. He stated 'do you think that makes a difference?' He was advised that they would call the police if he did attend, and were told by Mr Z 'I will see you in a bit.' However it does not appear he re-attended on that occasion.

On 28/01/04 at her appointment at the Department of Psychiatry Miss Y said she was considering moving in with Mr Z. However by 04/02/04 at an appointment at Community Mental Health Services Miss Y disclosed she wanted to end the relationship as she was 'frightened of his anger when he was drinking.' On 10/02/04 Miss Y finished her relationship with Mr Z.

On 12/02/04 Mr Z phoned again wanting to speak to Miss Y and then subsequently turned up at her address. He was told to wait outside by Miss Y's The Society of St James project worker, and Miss Y came down. Miss Y & Mr Z then left together. On16/02/04 Miss Y's project worker spoke to her about Mr Z visiting the home (because of his ban) and his behaviour and how it affected all of the residents. Miss Y was again reminded of the ban on 02/03/04 when Mr Z again visited The Society of St James project looking for Miss Y.

On 10/03/04 Miss Y moved into The Society of St James all-female supported house. On 08/04/04 Southern Health received a phone call from Miss Y's father informing them that Miss Y was seeing Mr Z again and was also drinking.

On 25/05/04 Mr Z reported that he had been robbed whilst drunk in a park. He had suffered injuries but could not remember what had happened. He stated that he was going to Wiltshire to 'dry out'.

On 26/05/04 Miss Y telephoned her GP in practice 1 saying she believed Mr Z needed counselling, she was worried about him. She explained she had been in a similar position, because she has schizophrenia.

On 26/05/04 Mr Z attended practice 1 and reported drinking again, the Doctor noted impulsivity and control issues and previous admission to Department of Psychiatry 15 months ago. He was noted in low mood and tearful.

On 02/06/04 Mr Z had an appointment at Community Mental Health Services to discuss detox. 04/06/04 practice 1 note his 'anger and irritability'. A bed was not available at Department of Psychiatry so a referral to the Home Treatment Team was made to start a community detox. Mr Z refused any follow up, other than admission, and left before this was resolved.

On 03/08/04 Miss Y was spoken to again by The Society of St James staff about Mr Z attending the home as he was banned. Miss Y explained that she was trying to cut contact with Mr Z but that she couldn't get him to accept that she just wanted to be friends. When she attended her appointment at Community Mental Health Services that day she was described as low in mood, seeing Mr Z again and she disclosed that she had taken a small overdose.

The following day (04/08/04) Miss Y was given a verbal warning by The Society of St James staff for allowing Mr Z into the property as he was banned. Miss Y also had a new patient check at her new GP surgery practice 2.

On the 05/08/04 the project worker at The Society of St James called the Community Psychiatric Nurse to notify that Miss Y had been drinking and had taken an overdose. Miss Y had an outpatient's appointment that day and her medication was revised, limited compliance with medication was noted, by the nurse.

Throughout September 2004 Miss Y's non compliance with medication continued. By the end of the month (29/09/04) Southern Health Foundation Trust note that Miss Y is 'psychotic and becoming increasingly difficult to manage in the community'.

On 01/10/04 The Society of St James contacted the Community Psychiatric Nurse with their concerns for Miss Y's deteriorating condition and were advised that as she was not a threat to herself or anyone else and as she was refusing to go to hospital there was little anyone could do. On 06/10/04 Miss Y was assessed and taken on for intensive daily support by the Home Treatment Team.

Throughout October Miss Y continued to refuse medication, on the 15/10/04 she was advised that if she did not take her medication she would not be able to take her holiday with her father. With daily reminders this did improve and on 22/10/04 Miss Y spent a week on holiday with her Father.

On the 01/11/04 Miss Y's project worker from The Society of St James informed the Community Psychiatric Nurse that Miss Y was seeing Mr Z and drinking again. It was noted by the Home Treatment Team, on the 15/11/04 that they were having problems contacting Miss Y and that when they did see her she was drinking heavily. On 18/11/04 Miss Y was detained under section 3 of the Mental Health Act and taken to the Department of Psychiatry by ambulance; she was admitted.

On 05/12/04 Miss Y while still detained under section 3 of the Mental Health Act met Mr Z in the garden of the hospital who took her out for a drink. A missing persons report was made although the police note that she had told staff where she was going (and what for) and had been allowed to leave. Hospital staff told police that she was still hearing voices that were telling her to be sexually active and that she could become aggressive to the public if she drank. The next day police were informed that she had returned.

On the 10/12/04 Miss Y was visited in hospital by her project worker from The Society of St James. She noted that Mr Z had been making a nuisance of himself at the hospital and that they were trying to get him banned from the ward. Throughout the rest of the month Miss Y remained unwell and on the ward.

2005/6

In January 2005 Miss Y's condition was starting to improve and a move to Cheltenham to be nearer her sister was discussed. Her sister liaised with staff to inform them of mental health services available in that locality, and was happy to support Miss Y with this move.

In February Miss Y's health had deteriorated but the ward had discussions with a women only project in Cheltenham and made applications for Miss Y.

On 02/03/05 Mr Z visited, he was noted to be smelling of drink and he shared his concerns about Miss Y moving away. However Miss Y is noted to be happy about the move on the 04/03/05.

On 30/03/05 it was noted that Miss Y's mood had dipped and that Mr Z was visiting a lot. Preparations were made for Miss Y to move to an assisted rehabilitation unit. On 11/04/05 Miss Y moved to the rehabilitation unit.

On the 20/04/05 staff at the rehabilitation unit note that Miss Y was considered to be vulnerable to exploitation and reported actively protecting her from Mr Z and alcohol.

On 21/04/05 Mr Z self-referred himself to Options a drug and alcohol counselling service. He was given an initial assessment and put on the waiting list. He was subsequently offered an appointment on 28/04/05. Mr Z attended his appointment at Options on 28/04/05 and made a further appointment for 05/05/05.

Mr Z did not attend his appointment at Options, a letter was sent offering a further appointment on 12/05/05.

On 09/05/05 Miss Y's father attended a managers hearing to assess renewal of her s3 under the mental health act. This was renewed.

On 12/05/05 Mr Z did not attend his appointment at Options. Options wrote to him to ask if a further appointment was required and having heard nothing 1 month later, closed his file.

On 18/05/05 Miss Y had a routine cervical cancer screening at her GP surgery.

On 23/05/05 a visit to the Cheltenham project for Miss Y was organised for 02/06/05. This visit happened and the Cheltenham project decided that at this time Miss Y was too unwell to put on the waiting list. They agreed to reassess on 16/06/05. On 28/06/05 Miss Y was put on the waiting list for the Cheltenham project.

On 12/07/05 Mr Z was in contact again with Miss Y and they went on a cycle ride together.

On 15/08/05 overnight leave for Miss Y was increased with a view to discharge in October.

On 22/09/05 discussions were had as it appeared that Miss Y was relapsing again. She was due to go on holiday with her family in France. It was noted that she stopped taking her medication whilst on holiday.

19/07/05 Miss Y consulted her GP as she had concerns that she may be pregnant and also had a sore throat. She said she had not been sexually active recently. No further investigation was recorded.

On 22/11/05 a visit from Community Mental Health services was declined by Miss Y as she had arranged to go out with Mr Z for the day. By December Miss Y was having regular contact with Mr Z but a restriction of no alcohol was being adhered to.

On 13/12/05 police were called by Miss Y as the voices in her head had told her that Mr Z was going to attack a staff member of a local late night time economy venue, police liaised with Community Mental Health services and no further action was taken.

On 24/12/05 police were called to Mr Z's address by a project worker there (The Society of St James). Mr Z was drunk and an incident had occurred whereby he had been stabbed in the leg. At that stage it wasn't clear if this had been done to him or if it was self-harm, Mr Z was given notice to quit this address due to his aggressive and intimidating behaviour. Mr Z was taken to Southampton General Hospital but refused to engage with police during the investigation, and other residents were uncooperative. The police found Temazepam, empty alcohol cans and cannabis in his room. The hospital notes indicate that he was assaulted by 'a person he knows at his home.' He left the hospital with his mother (to spend Christmas with her) before final treatment was carried out to the wound.

Miss Y continued as an inpatient and was mentally unwell over the Christmas period, again stopping her medication.

On 11/01/06 an application for vulnerable adult assessment for Miss Y was discussed due to her potential for exploitation by others. This was further discussed on 17th January at the rehabilitation unit but the appropriateness was questioned due to there being no actual incidents to note.

At the end of January (31/01/06) Miss Y's gradual discharge back to her Society of St James property "still on section" was planned for March. The Society of St James project worker noted Miss Y's vulnerability regarding Mr Z, 'who drinks and is abusive when drunk'.

On 27/02/06 Miss Y is recorded as still be on the waiting list in Cheltenham but with no current vacancies.

On 14/03/06 Miss Y informed staff that she had finished her relationship with Mr Z.

On 22/03/06 Mr Z was detained under section 136 after having thrown himself into the river in Salisbury, he had made several comments about wanting to kill himself.

On 07/04/06 Mr Z stayed overnight with Miss Y she was advised by The Society of St James re her license being at risk. Miss Y said that she doesn't want to be in a relationship with him, but that he persuades her.

On 09/04/06 police were called to Miss Y's residence as she failed to return home. Staff were concerned for her welfare, due to her vulnerability. She returned while the police were there and informed them that she had been out drinking and lost track of time.

On 10/04/06 Mr Z was detained under section 136 by police whilst drunk in Salisbury. He was seen to be acting strangely around a telephone kiosk and not making any sense to officers. He was arrested for damage to the telephone kiosk and possession of 4 grams of cannabis. He was cautioned for both these offences.

On 11/04/06 Miss Y returned to the rehabilitation unit drunk after being out with Mr Z. Miss Y was advised that drinking was not good for her mental health and she disclosed that Mr Z had told her not to trust the lodge staff.

On 13/04/06 Miss Y told her project worker that she did not want a relationship with Mr Z but that she could not say no to him. She also consulted her GP as she was lactating (a side effect of her medication) and thought she may be pregnant (she was not).

During May 2006 Miss Y was discharged from the rehabilitation unit back to The Society of St James property, with Miss Y's father present at the discharge meeting. During this month Miss Y had started to experience hallucinations, believing that others in the Society of St James house were making her clothes smell bad. She also thought that someone had taken money out of her bank account. It was arranged for Miss Y to spend the weekend at the rehabilitation unit to monitor her mental state.

On 06/06/06 Miss Y stated that she had broken up with Mr Z. But they were back together by the 10th and on the 19th June she was spending her weekend leave with him. On 04/07/06 Miss Y had a bad weekend with Mr Z, she described him as drinking and being abusive and that she had now finished the relationship. On 10/07/06 Miss Y advised that her relationship with Mr Z was back on.

On the 12/07/06 police intelligence notes that Mr Z was trying to get hold of a gun, a firearms warning was flagged against his name and this intelligence was passed to Wiltshire Constabulary (as that is where Mr Z was residing). On the same day Miss Y's Project Worker discussed her having a contract with Mr Z that he had to be drink free for 6 months before she would think of moving in with him.

On 21/06/06 Miss Y visited her GP for a contraceptive check, no other enquiries were recorded.

On 29/09/06 the Society of St James project worker talked to Miss Y about her drinking (she had noted how shaky she was) Miss Y talked about how she felt that no one would want her because of her illness which is why she sticks with Mr Z.

A meeting was held on the 17th October 2006 by Southern Health to review Miss Y being placed under section 3 of the Mental Health Act. Miss Y disclosed that Mr Z had been verbally aggressive to her about three weeks ago when drunk. Risks and vulnerability were discussed but Miss Y did not recognise that she was at any risk.

On 28/11/06 Miss Y's medication was reviewed in light of the deterioration in her mental health.

On 12/12/06 Miss Y was offered her own flat owned by Sovereign Housing and on 14/12/06 reported that she was going to spend Christmas with her family in France.

2007/8

On 25/01/07 Miss Y signed the tenancy and moved into her own flat. On 26/01/07 Mr Z moved his belongings into the flat.

On 07/02/07 Miss Y consulted her GP at practice 2 feeling she may be pregnant, although she was not.

Throughout the rest of 2007 Miss Y remained fairly well and there were no reported incidents with Mr Z.

On 19/03/08 Miss Y consulted her GP as she believed there was a tampon still in place and requested an internal examination from her GP. No tampon was found and no other enquiries were recorded.

On 05/08/08 Miss Y attended her GP for routine cervical cancer screening.

On 21/07/08 Miss Y presented at her outpatient appointment with Southern Health as very psychotic; her medication was increased. On 05/08/08 Miss Y said she was finding it difficult to go out without Mr Z for support.

On 20/10/08 a Care Programme Approach meeting took place and it was felt that the last 18 months were seen to have been positive. As a result Miss Y was discharged from the section 25a.
On 08/11/08 Mr Z was noted to have enlarged lymph nodes warranting further investigation following an MRI scan.

On 08/12/08 Mr Z attended a CT scan of his chest, pelvis and abdomen. On 23/12/08 there was a multi-disciplinary meeting (with Mr Z & Miss Y in attendance) to discuss Mr Z's case. A plan was made to see Mr Z at the clinic and take a biopsy.

2009/10

On 17/01/09 there was a small arson reported to police outside of Miss Y's flat. This was due to Mr Z having problems with some local youths. Mr Z refused to co-operate with the police enquiry. A strategy meeting was mooted by Adult Mental Health services, but never took place. The records from Adult Mental Health services on the 19/01/09 also mention Mr Z was in possession of a machete and knuckleduster, but it appears this was not disclosed to the police. Miss Y & Mr Z were offered a move, but they declined.

Throughout the year Miss Y remained fairly well with some reoccurring symptoms of her mental health problems such as hearing voices.

On 02/08/09 Miss Y attended practice 2 complaining of genital soreness. She queried if any STI's present but nothing was found to be present. There is no record of any investigation as to why she may have had these symptoms, however hydrocortisone cream was prescribed by the GP.

On 25/09/09 Mr Z was arrested for breach of the peace. He was very drunk and had been arguing with his female neighbour. A bind over was requested by the arresting officer, but the custody officer felt that as Mr Z had not been in trouble since 2003, had various health problems, had described himself as Miss Y's carer and the fact that both parties had been drunk, he would not progress any action on this matter.

On 08/01/10 Mr Z attended a surgical outpatient appointment at the local hospital and was referred to a specialist. On 11/01/10, Mr Z was informed that he had anal skin cancer. At that time, doctors were unsure whether it was recurrent lymphoma or new skin cancer. On 25/01/10 Mr Z attended an oncology appointment and a course of chemotherapy and radiotherapy was planned. On 08/02/10 during an admission for chemotherapy and radiotherapy treatment nursing staff noted that Mr Z had not handed in his medication when admitted. Nursing staff believed he was taking Oramorph, without being documented.

On 03/03/10 Mr Z had an emergency admission following complications to radiotherapy. He was sent to Salisbury hospital and discharged on 29/03/10.

On 23/03/10 Miss Y attended her appointment at Community Mental Health services and presented as unwell and delusional.

On 18/04/10 Miss Y called the Fire Service to attend a small fire amongst the gas meters at her property. It was put out by another resident and no suspects identified. No further action was taken.

On 03/05/10 Mr Z had another emergency admission to SUHT due to his cancer, he was discharged home on 13/05/10. On 05/05/10 at a home visit from mental health services to Miss Y it was noted that Miss Y was now Mr Z's carer.

On 03/06/10 Miss Y visited the practice 2 'very insistent' that she had a blood test for syphilis, as 'things had been happening'. The blood test was clear. There is no record of further investigation.

On the 01/07/10 Miss Y again visited her GP requesting screening for Chlamydia, there is no record of further enquiry.

On 11/10/10 Miss Y attended her appointment at Community Mental Health services and was noted to be experiencing increasing symptoms of her mental health problems and requesting to stop medication.

On 24/10/10 at a routine GP appointment for medication (Depixol) Miss Y described 'having family problems', there is no record of this being investigated any further.

On the 25/10/10 at Miss Y's appointment at Community Mental Health services symptoms were noted as much improved. However on 15/12/10 Miss Y was seen at a Care Programme Approach meeting and it noted as displaying active psychosis.

On 23/12/10 Miss Y visited her GP complaining of a painful right ear. Although the doctor's notes indicate that it 'looked like trauma' there is no evidence of further investigation as to the cause. Throughout the year Miss Y attended her GP regularly (every 3 months) for her contraceptive injections.

2011

On 04/01/11 Miss Y attended her GP complaining of similar pains to her last visit (23/12/10) but in her left ear and on the 18/01/11 she visited again with pain in both ears and reduced hearing. She was noted to be using cotton buds to clean them.

On 20/01/11 police were called to a road traffic accident, whereby Mr Z had crashed into 3 vehicles before stopping. Miss Y was a passenger he then got of the vehicle, and was shouting that there were aliens and spaceships blowing up things. Mr Z was detained under s136 of the Mental Health Act due to his bizarre behaviour, and after providing a negative breath test for alcohol. He was taken to the local Hospital to be assessed for any head Injury. He was then taken to a place of safety for a mental health assessment. The place of safety was unable to accept him into their care due to his violent behaviour at that time. Mr Z was taken back to custody and was assessed by the mental health team there. He was then informally admitted to a mental health ward. Whilst in this ward Mr Z had stated that he had raped and murdered his wife following this police then carried out a welfare check but found Miss Y safe and well.

On 21/01/11 Mr Z was assessed on the ward and diagnosed with an acute psychosis secondary to cannabis (skunk) use, which had since resolved. He then left hospital voluntarily.

22/01/11 Mr Z attended practice 2, describing how he had declined input from the mental health team on 21 Jan when contacted, but had rung again on 22 Jan. He regretted this decision and was feeling low and tearful. He reported that recent events had been scary and he was very glad no one had been hurt. He disclosed making plans for the future including a holiday to Cornwall. He was concerned he may lose his driving licence. At this time he disclosed lifetime cannabis use and "supergrass" for the last 6 months. On assessment there was no evidence of thought disorder, no complaints re memory or concentration. His appetite was good and he denied odd experiences or perceptual disturbances and had a full recollection of events.

On 24/01/11 Miss Y visited her GP with an aching neck and back pain following the road traffic accident and complained she was still experiencing ear pain.

On 26/01/11 Miss Y visited the GP again complaining of pain in her coccyx (following the road traffic accident) and that it was painful to sit up in bed. This was followed by a visit on 07/02/11 accompanied by Mr Z. Miss Y was still experiencing lower back and arm pain following the road traffic accident, arm pain had not been mentioned before, Mr Z was adamant that she should have an MRI. Paracetamol and Ibuprofen was suggested for the pain and Miss Y indicated that it was relieved by both.

On the 11/02/11 Miss Y attended for her routine cervical screening, no further enquiries were recorded and no mention of the back or arm pain.

On 23/02/11 Mr Z was seen in practice 2 “demanding” antibiotics for infection he “knows he has” from the healed scar on his operation site. There was no sign of infection on examination and no raised temperature. However antibiotics were prescribed (co-amoxiclav 375mg three times a day.) and the GP noted “this man was verbally aggressive when I declined antibiotics” “I think this man needs further mental health assessment” however this was not followed up.

On 02/03/11 Mr Z attended practice 2 and was noted to be angry that he had not heard about his CT scan being expedited following last admission. This was chased up. On 25/03/11 Mr Z attended practice 2 again asking for Viagra reporting that the consultant had advised him to try for 3 months. He was counselled for this and advised he did not fit the NHS criteria, however a pack was prescribed “in view of his problems”.

On 12/04/11 Mr Z called the police to report that Miss Y had received a threatening phone call. Police attended and Mr Z reported that an Asian male had made threats to kill. Miss Y had not heard the specific threats and neither of them could offer a possible explanation. Both appeared on good terms and police had no concerns for their welfare.

13/04/11 was the last time that Miss Y visited her GP; this was for her routine Deprixol injection.

18th April 2011 - The night of the murder

On 18/04/11 at 20.49 Mr Z's neighbour, who was 8 months pregnant, called the police stating that Mr Z had intimidated her. He had threatened to go to the police and report her for stealing electricity to grow drugs (not substantiated) & she believed he was going to force his way into her flat.

At 21.24 the neighbour called the police again saying that Mr Z had called her mobile and informed her that she had until 21.30 to stop stealing electricity or he was going to harm her and her 5 year old son.

At 21.49 Mr Z called the police and said that he had called a neighbour re the threatening phone call the previous week and was reporting her for stealing electricity and growing drugs.
South Central Ambulance Service were on the scene at this time, and there was a delay in police attendance due to high demand on services. South Central Ambulance Service were reluctant to leave the pregnant neighbour and her child until the police had attended (unclear who had called them). The neighbour's partner also refused to attend as he had also received threats (from Mr Z).

At 23.02 Mr Z called again stating he had uncovered a drugs ring and had scared 6 black and 1 white males away. He said he would call the press if the police didn't get there.

At 23.10 police attended responding to the above previous call outs and concluded that Mr Z had significant mental health issues but felt that Miss Y was a calming influence on him. Mr Z was reminded that it was the police's job to investigate crime.

Police noted Mr Z's mental health issues at the scene.

At 00.31 Mr Z again called the police saying that he had 'busted a major drugs ring and wanted police protection'. When asked about his current location he started to become abusive and said that the call taker should already know that. He also said that he had spoken to Sky News about it and wanted to know what the police were going to do. Every time that the call taker asked a question, Mr Z was abusive and swearing. He was told to stop swearing and he said that he 'would see what the telly had to say about it' and hung up. His mental health issues were noted and he was also noted as a persistent caller to the control room. There was no deployment of police at this time.

At 01.40 police received a further call from Mr Z stating that he had murdered the only person he had ever loved. He also asked where his parents were and refused to answer any questions. Mental health issues were noted and again no deployment was made.

At 02.04 Mr Z called the police and said that he had murdered Miss Y and that he wanted to speak to someone (about the murder) in a nearby car park. He then hung up. His mental health history was noted and the call was graded 2 for deployment as he'd already been seen that night. A police unit was at the address within 6 minutes of this call.

At 02.11 a neighbour also called the police to report that Mr Z was shouting that he'd killed someone, and that this had been going on since 1am. At this point the police had arrived and started to talk to Mr Z via the intercom.

At 02.16 the police control room tried to contact Miss Y on her mobile but without a result. They then called the landline and Mr Z answered ‘what?’ and put the phone down but did not hang up. The call taker heard him moving around and heard him say ‘the best thing to happen to me is dead on the floor’ they also heard a lot of swearing at someone on the intercom.

At 02.25 the local police Sergeant was informed and further police units are deployed. They were unable to gain entry to the property and it became a critical incident. Mr Z held a knife to his chest and threatened to set the flat on fire. Both Firearms and Public Order Units were then deployed as the situation had developed into a siege. Adult Mental Health services were unable to help, they could not comment on Mr Z’s mental state because they had not seen him for 2 months. Mr Z would not allow police into the property and Miss Y’s welfare could not be established.

At 05.21 entry was finally gained to the flat. Mr Z was arrested and tragically Miss Y was found deceased on the lounge floor. She had been stabbed.

Mr Z was seen in custody by a doctor and placed under constant supervision.

Individual Management Reviews

In this section the individual management reviews completed by the key organisations to this review are analysed.

Hampshire Constabulary

Hampshire Constabulary conducted their individual management review based on a search of relevant reports, files and interviews with the officers and controllers involved in this case.

Their review highlights that Mr Z had a varied criminal history including burglary, theft and various driving offences including drink driving. Miss Y had no criminal history. On every occasion, prior to the night of the homicide, when the police had been involved with Mr Z and/or Miss Y, policies and procedures were correctly adhered to. There were no domestic abuse incidents reported to the police prior to the murder.

Their review highlights that there was not clear communication between Hampshire and Wiltshire forces - the two forces involved in this case, because at that time there was not a Police National Database, this has since been rectified and this information would be shared today.

The report does question why the custody officer for the incident on 25/09/09, did not follow the attending officer's request for Mr Z to be bound over. He instead decided that, due to Mr Z's health, the fact that he had not been in trouble since 2003 and that as he was Miss Y's carer he should instead be released. The officer did not check up on Mr Z's account of his health or Miss Y's care needs. However, it is noted that as the other party refused to make a statement, it was unlikely to proceed to court anyway. This incident could be seen as an example of Mr Z's manipulative behaviour.

The individual management review notes that on 20/01/11, when the road traffic accident occurred the alcohol breath test was negative, but no drug test was completed. As there were clear mental health issues for Mr Z, and all parties involved in the collision were insured, it was decided by police that Mr Z would be dealt with by mental health services and no charges should be brought.

Hampshire Constabulary have since indicated that they will refresh the decision making process for arrests of suspects with mental health issues, recognising that decisions may not always be in the best interest of justice, but may sometimes be a better assurance of community safety and the public interest. This issue is addressed in Hampshire Constabulary recommendations which state that: force policies and procedures are amended to provide police officers with more guidance when dealing with suspects who have mental health issues.

The individual management review details the night of the murder 18/04/11. It highlights how the initial phone call from the neighbour at 20.49 and subsequently at 21.24 and from Mr Z at 21.49 were dealt with appropriately, once the police attended at 23.10, and there was no way the police could have predicted how the night would end.

When the officers first attended the scene at 23.10, they found both Miss Y & Mr Z to sober and calm, with Miss Y being noted as a calming influence on Mr Z. The officers felt the situation had been dealt with and that they would not be called again. On reflection a check on previous incidents (particularly the road traffic accident on 20/01/11) and the nature of Mr Z's concerns, could have highlighted another possible episode of paranoia/delusion.

Police officers attending in response to the calls on 18.4.11 made by the neighbour, noted that the neighbour had thought that it was Mr Z's mental health issues that had caused him to behave in the way he did that evening. This incident was recorded in police records as a separate incident to the subsequent telephone calls from Mr Z including the final call about the homicide.

There was a further call from Mr Z at 00.31 indicating that things had not calmed down at all and he was still concerned re the allegations of a drugs ring. Hampshire police were very busy at this time and the decision not to deploy officers was made.

Although this was understandable considering the specifics of the night, and the fact that police had attended earlier and left the scene calm, had this been considered in context with the mental health issues noted in Mr Z's history and of the paranoia Mr Z demonstrated at the road traffic accident and the fact that clearly he was no longer as calm as when the attending officers had left, with hindsight, perhaps communication with the Adults Services Out of Hours Crisis Intervention Team (re his mental health) would have been a better response. This incident provided the panel with an example of a case being judged just below the threshold of 'risk' of further action.

The further call from Mr Z at 01.40 informing the police that he has just killed "the only person he ever loved" clearly should have initiated a response. It should be noted however, that this would not have prevented Miss Y's death.

Following neighbours reports that Mr Z was shouting that he had killed Miss Y, the handling of the incident was as per procedure. The Hampshire Constabulary recommendations and actions include revising the control room procedures for dealing with calls from those with mental health issues, which should alter future responses to similar incidents.

The following morning a supervisor in the police Public Protection Unit routinely searched the police database to identify any incidents within the previous 24 hours that related to vulnerable adults, including to assess whether a notification of an adult at risk form (known locally as a CA12) had been submitted.

In this case the supervisor noted that the attending officer for the 2049 incident had not submitted a CA12 so the supervisor requested that he did so. It was noted on the logs for the later calls to the address that this request for a CA12 had been made. It may be that the supervisor was being extra cautious about finalising the paperwork for the 2049 incident because she was aware how events had concluded that night. It then appears that there was a delay in the original officer completing the form due to rest days and bank holiday time off as the weekend after the homicide was Easter weekend and the following weekend was May Day weekend. The attending officer completed the CA12 form on 5.5.11. This was submitted to the Public Protection Unit and belatedly forwarded to Adult Services. By the time it was submitted Mr Z had been arrested and charged with murder and was in custody.

When considering how events had panned out it served little purpose by the time it was submitted. Although this was outside of the time frame for this review, as it happened post the night of the homicide, it was felt this was of interest to the review.

NHS Southampton (GP's)

This individual management review was completed using primary care notes, which included correspondence from other providers and the computerised GP contemporaneous notes as well as interviews from the GP and administrator from practice 1 and the practice manager and GP from practice 2. Miss Y attended practice 2 and Mr Z attended both (1 then 2) plus practice 3 in Salisbury.

Miss Y was diagnosed with schizophrenia in 1997 and with depression in 2000. She had a history of alcohol misuse starting from her late teens and documented overdoses in 1999, 2002 and 2004.

Mr Z was diagnosed with severe alcohol dependency and drug misuse issues. He was assessed by mental health services in 1996 and 2003 both instances followed the breakdown of a long term relationship. He was diagnosed with depression and mixed anxiety and depression respectively. He took an overdose in 1996 and self-harmed (cut his wrist) in 2003.

The analysis in this individual management review clearly identifies both good practice and where practice could be improved. It relates this practice to national policy and guidance and highlights the specific areas of learning.

The review records that finances were a consistent issue with Mr Z, and how he was frustrated at not being able to work. He had discussed his impulsivity and control issues with his GP (26/05/04) as well as his irritability and anger (0406/04).

Both Miss Y and Mr Z were being treated for mental health issues; Miss Y with schizophrenia and Mr Z with anxiety and depression. Both individuals struggled with alcohol dependency and admitted to the use of illicit drugs; Miss Y amphetamines (speed), LSD and cannabis in her teenage years and Mr Z amphetamines and cocaine in the past and a lifelong cannabis use.

There were a number of possible indicators for potential abuse which were not considered or identified by GP's. It is clear from the review that practice 2 (that both Miss Y & Mr Z were registered at) had no clear policy or guidance for staff on how to respond to domestic violence and abuse.

Practice 1 did not have a Safeguarding Adults Policy but had some training in 2006-7. Although practice 2 did have a Safeguarding Adults Policy, the GP interviewed was unaware of it. Neither practice has provided its staff with specific domestic violence and abuse training. This perhaps explains why triggers or indicators of abuse were not identified or further explored.

In 2006/7 all GP surgeries in Southampton signed up to, and have been accredited with achieving, their Information Management and Technology Directed Enhanced Service which underpins a universal electronic paperless patient record. All data is coded including clinical conditions, medical procedures, social circumstances and administrative details.

There are read codes within this system specific to domestic violence as well as to indicate whether routine enquiries about domestic violence and abuse have been made. There is no evidence of these read codes being used by any of the practices during the review period, for these cases, which is not unusual locally.

The use of accurate read codes identifying the risks and vulnerabilities of Mr Z regarding depression, drug and alcohol use, and for Miss Y regarding her experiencing schizophrenia and her being diagnosed under a section 25a could have triggered an exploration of other risk factors within their relationship.

Miss Y's alcohol misuse and Mr Z's recent drug misuse were not assigned read codes by the GP's involved to indicate that they were current and on-going issues; had this been the case it may have prompted further investigation and an assessment of the risk posed by the relationship.

The review notes that both Miss Y and Mr Z had attended new patient checks, Miss Y in August 2004 and Mr Z in October 2007, both in practice 2. This should have included screening for alcohol misuse. There is no record of any assessments on this for Mr Z or Miss Y, this was a missed opportunity to assess current social circumstances and potential risk factors individually and in their relationship. Both individual's records had information regarding their alcohol misuse and past history of drug use. There is no evidence on reviewing the notes that the Primary Care Team enquired as to the use of recreational drugs for either Mr Z or Miss Y. This would have presented an opportunity for the practice involved to engage help from appropriate specialist services.

Miss Y attended several routine cervical screening appointments, appointments for contraception, queries about possible pregnancy and tests for sexually transmitted infections. At none of these appointments was she asked about her wider sexual health and relationships. This would have been an ideal opportunity to enquire about relationships. Perhaps especially, so as the Department of Psychiatry had noted Miss Y as vulnerable to sexual exploitation following her being sectioned in the early part of 2005.

There was good communication between Psychiatric Outpatients and the GP surgery that indicated the relationship between Miss Y & Mr Z - both individuals were at the same

practice from May 2007. Both were documented as having issues with alcohol and in 2004, it was Miss Y that contacted the GP to ask for help for Mr Z with his alcohol problems.

In October 2006 Miss Y described to her GP an incident whereby Mr Z had been drinking and was verbally aggressive causing Miss Y to sleep downstairs because she was scared. There is no record of this being further explored or recognised as an indicator of risk.

On a further occasion, Mr Z had indicated to his GP that there had been a split in their relationship due to his drinking. Again this was not explored further and there is no documentation of the assessment of risk that this may have posed to Miss Y. Mr Z's previous episodes of depression had followed the ending of long term relationships.

Miss Y had commenced weekly injections of anti-psychotic drugs prior to her admission to the Department of Psychiatry and in Jan 07 it was suggested that this responsibility was handed to the GP. This did not happen until Jan 08. The department were aware of issues with Miss Y's compliance with her taking her medication and the resulting deterioration in her mental health, and had asked to be notified if this was missed. Miss Y failed to attend on a number of occasions (7) for a variety of reasons; some of these were followed up by the GP but not all. However, there is no record of any contact being made with Community Mental Health Services teams at any point. Non-attendance can be seen as a result of a number of social and personal circumstances and an opportunity to identify risk factors may have been missed.

Although practice 2 completed the regular review of medication & basic health checks (blood pressure, blood test regarding lithium etc) it does not appear that these were used to review Miss Y's case holistically – Miss Y had on-going issues with medication compliance, alcohol, diet and inactivity but this was not recorded as a target for her care. These appointments were an opportunity to discuss and plan for all health and social factors that may have had a bearing on her condition.

Mr Z had reported feeling depressed on many occasions, the approved mental well being health assessment tool: PHQ-9 was completed but not recorded. This should have been followed up but there is no record of this.

At an interview for this review, the GP reported no concerns for Mr Z's mental health he did recall a conversation where Mr Z gave the GP a letter that he described as 'good news' it was in fact from DVLA revoking his license after the road traffic accident. The GP reflected that this showed lack of insight.

Mr Z was recorded in the GP records as being impulsive, controlling and with anger issues, although these do not appear to have been considered as risk factors in his relationship with Miss Y. In his records from 1996 he was assessed by the psychiatric team with depression following the breakdown of a long term relationship. At that time he had described himself as "suspicious possessive and jealous". He disclosed thoughts of "if I can't have her then no one can".

Mr Z was noted to be aggressive in practice 2's surgery on two occasions in 2011 – on 23/2/11 and 2/3/11. These incidents do not appear to have been explored or considered

as risk factors which was, again, an opportunity missed to identify and assess risk posed by Mr Z may have been missed.

Patients are required to have medication reviewed at least annually. Miss Y was known to have issues with compliance however she was prescribed a short term sedative, Zopiclone (usually prescribed for 1-2 weeks) for over a year by practice 2. The review also highlights confusion over Mr Z's prescriptions for strong analgesia. He was known to have had drug misuse issues and had a read code for this in his notes.

He was challenged regarding his overuse on one occasion in October 2009 when he requested Dihydrocodeine the day after he had been issued with Tramadol and Temazepam. Mr Z reported that the initial prescription had been issued to his girlfriend and that he was not taking those medications as he preferred Dihydrocodeine.

There is no record what happened to the original prescription. Mr Z was also challenged over his usage of Tramadol and Oramorph. When he explained that he had increased his Tramadol because of the pain prior to being prescribed Oramorph (January 2010), he continued to be issued with large quantities of Oramorph (2 litres at a time) for breakthrough pain with the intention that this should be transposed to a regular dose of slow release morphine sulphate. Mr Z was prescribed 10800mls of Oramorph in the period 11 January 2010 till 02 March 2011. He also received slow release morphine sulphate. Had further enquiry had been made about his current drug use, this may have prompted much closer monitoring of his prescribed medication.

Miss Y attended the GP in 2010 with what is described as a trauma like injury to her ear, although she denied knocking or pulling it. It is not recorded if any further enquiry was made. The GP said he knew the couple well and did not suspect abuse. The practice manager describes Miss Y as quiet and 'mouse like' good rapport with staff.

The individual management review correctly identifies the key learning in this case for both practice 1 and 2, as well as the good practice at times from both. Primary care practitioners were not at that stage routinely asking about alcohol or recreational drug use, neither did they routinely or opportunistically enquire about domestic abuse. There was no evidence of knowledge of risk factors for domestic abuse or the availability of local specialist services.

Current and planned activities in this area will seek to improved responses and NHS Southampton has made recommendations for action as part of the domestic homicide review process to address these key issues.

Southampton University Hospital Trust (SUHT)

This IMR was completed using the Emergency Department notes and case notes of both Miss Y and Mr Z. No interviews were carried out as no one person had been continually involved in either person's care, as is the nature of the Emergency Departments work.

Miss Y's family gave permission for Miss Y notes to be accessed so that any pertinent learning could be revealed. Mr Z was informed of the process via his solicitor in liaison with the Chair of this review.

Miss Y attended the department in March 07 for a blood test to check lithium levels but left before the test could be carried out. Miss Y was due to have an eye lesion excised in 2002 but did not attend for the appointment. Her GP was contacted and a re-referral suggested. However it wasn't until 2011 that Miss Y requested treatment for the lesion again. Miss Y attended the ophthalmology clinic on 12/04/11 but sadly the appointment for excision was not made prior to her tragic death.

Mr Z had multiple contacts with the hospital trust regarding the diagnosis and treatment of his bowel cancer and issues relating to alcohol and/or drug use with resulting injuries and mental health concerns.

Mr Z was diagnosed with cancer in 2009 and was an inpatient twice, once for chemotherapy and once following emergency surgery. During his stay for chemotherapy it was noted that he had not handed in his prescription medication and there were concerns that he was self-medicating in addition to prescribed.

The review highlights that it was not unusual that Mr Z would attend the Emergency Department for an intervention but leave before treatment could be offered. Outside the period of the review (in 2003) but of interest, Mr Z had two attendances at the Emergency Department firstly whist intoxicated with a lacerated wrist and subsequently with an attempted overdose which followed the break-up of a long term relationship.

On both occasions he left the department before treatment could be completed. On the first occasion it was felt that his injury was linked to depression and alcohol intake. On the second occasion a referral was made to the out of hours crisis team, but he had absconded before this could be followed up. He was noted to be verbally and physically aggressive at that time.

In December 2005, Mr Z attended the department with a laceration to his thigh, said to be caused by someone known to him. There was not an enquiry as to whether this was domestically related. Subsequent enquiry by the police was not able to confirm who was responsible or if in fact it was self-inflicted.

In January 2011, Mr Z attended the Emergency Department following the road traffic accident, although there were no physical injuries, his pupils were noted to be unequal and he was described as talking fast and repetitively, he was subsequently detained under the mental health act. He also attended the department by ambulance having self presented to Bitterne Police Station threatening to self-harm after using cannabis in late January 2011. The appropriate referrals to the Crisis Resolution Home Treatment Team were made, but again Mr Z left the department before these could be completed.

There were no obvious opportunities for staff to enquire about domestic abuse to Miss Y, it could possibly have been asked of Mr Z following his thigh laceration.

The Trust has training in place regarding mental health, substance misuse and staff are encouraged to ask about domestic abuse. There are guidelines in place for managing domestic abuse cases, however there is not a specific policy or guidance about carrying out routine or opportunistic enquiry. In this case even if enquiry had been made it would not have affected the outcome. The department's ability to provide holistic care was clearly hampered by Mr Z leaving the department before treatment could be completed.

Southern Health NHS Trust

The information for this review was gathered from the Trust's electronic records management system (RIO) which went live in February 2010. It included secondary record systems (paper based) for both Miss Y and Mr Z. Information was also gathered from the Epex database (used prior to RIO) and the Paris Adult Social Care database and from interviews with staff involved in the case.

Good communication is noted between Southern Health NHS Trust, the Society of St James and GP's at practice 2. This enabled both to have up to date information on the care plan and treatment of Miss Y's paranoid schizophrenia.

The review highlights that the staff involved in the case clearly had a positive and caring relationship with Miss Y.

There was also good communication with Miss Y's family, her father and sister particularly who were involved in her care. There was clearly a positive, trusted and caring relationship for Miss Y with her family.

The review indicates limited liaison with the Police following Mr Z being targeted by local youths in Jan 2009 (17/01/09). The review records that staff had sound knowledge of safeguarding procedures and policy but there was no recorded evidence found by the author of procedures being initiated, although they had been discussed. Verbal evidence of accounts shows it was considered and then discounted as the perceived threat (from local youths) had been removed.

In interviews carried out for the review, staff indicate being aware of early signs of domestic abuse, although not physical in nature in terms of the type of abuse presented. This was documented in early 2004 when staff noted that Mr Z was a contributing factor to Miss Y's drinking. At the times when Miss Y was able to end her relationship with Mr Z her drinking reduced.

There were also documented reports (Feb 2004) of Mr Z shouting at Miss Y and losing his temper and Miss Y had disclosed that she was scared of Mr Z's temper when he had been drinking. These were all discussed in multi-disciplinary team meetings and in sessions with the care coordinator but no formal safeguarding procedures were initiated or local domestic abuse services contacted for advice or referral.

Domestic abuse was also queried during Miss Y's stay at the rehabilitation unit, in reference to her suspicions about financial exploitation and when Mr Z had told Miss Y 'not to trust the staff'. As there was no documentation of actual exploitation it was decided that it did not meet the criteria for a safeguarding referral.

Being aware of the issues raised when Mr Z had been drinking, it was agreed that Miss Y could only stay with Mr Z whilst on section 17 leave if no alcohol was consumed. This was checked by staff.

The road traffic accident in January 2011 was deemed to be caused by Mr Z being in a drug induced psychosis having smoked strong cannabis (skunk). As the road traffic accident was not related to a wish to harm Miss Y or himself and neither had been drinking at the time, domestic abuse was not considered a factor.

However while in custody following this incident, Mr Z had reported that he had raped and killed his wife. This information was shared with police and a welfare check showed Miss Y to be alive and well.

The review notes that Southern Health did not have a specific domestic abuse policy at the time of this case and that responses were covered within their Safeguarding Adult's Policy. A domestic abuse policy was ratified in April 2011, and published in June 2011 but at the time of this review none of the staff interviewed were aware of the policy.

Domestic abuse is covered as part of the safeguarding adults and children training modules within Southern Health, but at the time of writing there was no specific domestic abuse training available. The Trust has been commissioning a 2.5 day Sexual Violence against Women and Children course for 3 years for staff in forensic and mental health services.

The review highlights that staff had good knowledge of local specialist support agencies for domestic abuse but none were contacted either for advice or for referral in this case. Southern Health NHS Trust provided coordinated care for Miss Y's mental health issues and did notice and record indicators of domestic abuse, however these always appeared to be just below the threshold for further action which may have been a safeguarding referral or refer to a specialist agency. It appears the lack of reported incidence of physical abuse affected decisions to name Miss Y's experience as domestic abuse.

A review of Southern Health's policy and staff guidance on domestic abuse is planned as indicated in the recommendations for this review.

Society of St James

The Society of St James is a homelessness charity which among other services provides supported housing for people with mental health issues. They provided a brief individual management review, which may be in part due to a lack of resources to deliver reviews, or experience in being involved in such serious case reviews within third sector organisations such as the Society. However it is a point to note that the Panel were disappointed in the lack of depth and insight into domestic abuse demonstrated in their individual management review.

Miss Y was referred to The Society of St James in 2003 and was supported by a worker with a particular interest in working with women who had experienced abuse. They supported Miss Y with her mental health issues and her, at that time, on off relationship with Mr Z. Staff had recognised that Miss Y's relationship with Mr Z was not in her best interest, but did not see it as 'any more problematic that other relationships we see between service users'.

The review states that they saw no evidence of physical domestic violence or abuse. It appears that staff did not have knowledge and training sufficient to recognise power and control issues as domestic abuse or that it includes behaviour far wider than just physical harm. In early 2004 Miss Y had told staff that she was frightened of Mr Z (04/02/04) but this was not recognised as a possible indicator of abuse. On several occasions Mr Z tried to visit Miss Y at The Society of St James premises even though he was banned and Miss Y had ended the relationship. Staff allowed Mr Z access to Miss Y (albeit outside of the accommodation) and warned Miss Y of the consequences for her license if he continued to visit. This was a missed opportunity for staff to be able to support Miss Y's decision to end the relationship and take responsibility for his visits away from her and instead to rest it clearly with Mr Z.

Mr Z was also a resident with Society of St James within their move- on service; at the time of referral he was homeless and struggling with his alcohol use. Mr Z was evicted from his accommodation following a number of alcohol related incidents of aggressive behaviour. Mr Z was known to be in a relationship with Miss Y as they were frequent visitors of each other. However Mr Z's aggressive behaviour was not recorded as a risk factor for Miss Y.

It is important to credit of The Society of St James in that it has now instigated a rigorous training plan delivered by local specialist trainers, to be attended by key staff to improve their identification and response to domestic abuse.

Sovereign Housing

Information for this individual management review was taken from the Sovereign Kingfisher Housing Management System. This includes records of all requests for repairs, interviews with staff members and information from the anti-social behaviour (ASB) management system.

The property rented by Miss Y at the time of her tragic death was built in 2006, a three story block comprising of one and two bedroom apartments. Nominations for properties within the block were made through Southampton City Council.

Miss Y started her sole tenancy in late January 2007, as new accommodation, all residents moved in at around the same time in hopes of building a community.

Miss Y moved to here from her supported housing at the Society of St James, her care coordinator was still involved and giving support at the time of the move. A referral to Mind for specialist support was also made by Miss Y's Care Co-ordinator at one point, but it was advised that adequate support was in place. All support agencies recognised that Miss Y was ready for independent living with the continuation of support.

In April 2010 Miss Y informed Sovereign Kingfisher that Mr Z had moved into the property. The review demonstrates significant anti social behaviour in the block where Miss Y and Mr Z were tenants. Some of this related to the relationship between Miss Y, Mr Z and a particular set of neighbours. The review notes that these issues were usually as the result of heavy drinking. However most of the anti social behaviour in the block related to the tenants of another flat not known to be connected in any way to Miss Y or Mr Z.

Sovereign Kingfisher has policies and procedures in place about domestic abuse ensuring cases are prioritised. There were no reported instances of domestic abuse between Miss Y & Mr Z to Sovereign, or any triggers identified by staff. Miss Y and Mr Z were always willing to contact the service and responded to any queries from their landlord.

Sovereign Kingfisher found no indicators of domestic abuse in their contact with the case or reported by Miss Y, Mr Z or their neighbours, and as such their policies were not utilised. The individual management review does question whether the high number of anti social behaviour issues in the block in general may have diluted the staff's ability to recognise and deal with any issues that Miss Y was experiencing. However due to the frequency of contact and the positive relationship between Miss Y and their staff this would not appear to be the case.

Sovereign have as a result of this review instigated refresher training for staff and reviewed their induction process. This includes ensuring all staff are familiar with policies and procedures.

Options

Options is an alcohol counselling and support agency. The service has worked in partnership with Hampshire Probation Trust in delivery of their perpetrators programme through support work with partners of perpetrators on the programme. The service has also provided training on alcohol identification and brief advice to specialist domestic abuse workers in Southampton.

Information for this IMR was gained from their database, Mr Z's file and interviews with the counsellor involved and that counsellor's supervisor.

Options had no contact with Miss Y but did have contact with Mr Z during April and May 2005. Mr Z had referred himself to the service describing his alcohol intake and his frustration that although he had long periods of abstinence he 'always' returned to drinking. He was described in good health, although slightly depressed. He talked of Miss Y and at that time she was an inpatient in the Department of Psychiatry. He is recorded to have said that he 'got very stressed because he had no say in her treatment'. Options recognised with hindsight that this could be an indicator of power and control issues.

The review details the notes from Mr Z's first session describe two previous significant relationships. The first where he married at age 20 and had four children, this ended in divorce due to his wife being unfaithful. In regard to his second relationship he describes his partner as career minded. He wanted children and this relationship broke down after 10 years. Mr Z related his heavy drinking as starting following this break up. He talked of recently starting a relationship with Miss Y.

Mr Z was offered further appointments which he failed to attend. This was followed up and further appointments offered but again he failed to attend. As this is a service reliant on the client self engaging, there was no more that could be offered and the case was closed.

Options noted that changes had taken place in the service since 2005 which involve more rigorous risk assessment at a triage point, that is supported and verified by a supervisor. All staff are aware of safeguarding responsibilities and staff and volunteers all sign up to the Options confidentiality policy codes of practice, policies and procedures. Supervisors are due to attend domestic abuse risk identification and Multi Agency Risk Assessment Conference training.

Miss Y's Family

As Miss Y's father lives in France, her sister Miss X acted as next of kin and liaison for the family. Miss X lives in Cheltenham so contact was made by the chair by letter and by phone as this was most convenient for her. It's clear that Miss Y's family were actively involved both in her life and her care. Miss Y spent holidays with her father in France and at one stage was hoping to move to supported accommodation in Cheltenham to be nearer to her sister.

Miss X was not aware of domestic abuse being an issue within the relationship although she could recall an instance several years ago when Miss Y reported that Mr Z had slapped her and pushed her into a book case. The relationship was certainly chaotic at times but also the family recognised that there were periods of time when the relationship was supportive and positive for both Miss Y and Mr Z.

The family were concerned particularly regarding the action following the road traffic accident in January 2011 and Mr Z's subsequent admittance under the Mental Health Act, as no follow up from mental health services was evident.

They also shared concerns about the police action on the night of Miss Y's death and the non-deployment of a police response following Mr Z calling to say he had killed her. The Panel has ensured both of these aspects have been raised as part of the review.

The review was delayed while the case concluded through the criminal justice system. This was a lengthy break and this break did make it more difficult to sustain contact with the family once it resumed. As this was immediately after the trial, and co-incidentally almost exactly a year after Miss Y's death this was clearly an emotional time for the family. Contact through the Family Liaison Officer was pursued, and fortunately contact was resumed with the family via Miss Y's Godmother.

Miss Y's Godmother, her husband and their daughter were able to supply written statements which hugely informed the process. This was after they had had the opportunity to read the report and there were still some elements that they felt needed more investigation. Through conversation with Miss Y's Godmother and a further panel meeting the following facts were established.

Following the arson attack on 17.01.2009 it appears that Mr Z had told Miss Y and her family that the Police wished to move them via a witness protection programme. This was subsequently found by the panel to be untrue and an idea fabricated by Mr Z. Mr Z had not offered any assistance to the investigation and may have been in fear of reprisals. He had been offered advice and support from the Police who also arranged with his housing provider (Kingfisher) to repair the door and locks, and provided him with an alarm. However he was never told he had to move house or was to be assisted by any witness protection programme. The tenancy of the house was of course Miss Y's, which Mr Z had moved into.

Following the Road Traffic Incident in January 2011, when Mr Z was subsequently treated by Mental health services, the family queried that he was discharged with what appeared to be little or no follow up and support. Mental Health services have since recognised the gap between mental health and substance misuse services and have now set up a

protocol for joint working - 'Working with Mental Health Problems, Substance Misuse & Alcohol Misuse Joint Working Pathways – Southampton Area' plus a 'Screening Tool Guide'.

SHFT helpfully provided details of their contact and subsequent follow up of Mr Z as follows: Mr Z was offered ongoing care which he declined. He did retract that and was then visited at home 3 days following his discharge (when Miss Y was also present) both appeared well and no concerns were raised. He attended a 7day follow up appointment with the Community Mental Health team and was kept on their systems, he was due to be discharged one month later but was in fact discharged two months later – the day before Miss Y's murder. His GP was informed of the discharge, with a summary explaining the reason for his admission (acute psychosis due to cannabis use) and the discharge plan. Although Mr Z had engaged with mental health services and tried to stop smoking cannabis he had not engaged with substance misuse services; the new joint protocol between mental health and substance misuse should help ensure clients with dual issues are better catered for, especially those that may be a risk to themselves and others.

Following the road traffic incident the family were particularly concerned that Mr Z was immediately supplied with a new motablility car. This is especially pertinent as it is now known that Mr Z earnt money/drugs by driving his dealer around to make deliveries. So the car gave him the ability to obtain more cannabis and possibly risk another psychotic episode. However on investigation it became clear that the only way Mr Z could have had access to a car so swiftly would be by his request under the insurance cover. So rather than be automatically provided with a car he must have specifically requested it, another example of his manipulative behaviour. However as his license was subsequently withdrawn on health grounds, there appears to be a lack of communication between the insurer, motability and the DVLA; Mr Z was not the owner of the car.

The family were also concerned at the lack of information sharing at the GP practice where both Miss Y and Mr Z were patients. The family felt Mr Z's behaviour was not clearly assessed as a possible risk to Miss Y. The Caldecott information sharing guidelines were revised in March 2013 and now it is clear to staff how they can safely share information when risks are discovered. Data Protection - Southern Health NHS Foundation Trust Policies have been reviewed and it is made clear that in certain circumstances the subject's right to confidentiality may be overridden and that the Trust will support staff who do so. (**Data Protection, Caldicott & Confidentiality Policy, version 2 March 2013,** section 5.7: Disclosing information against the Subject's wishes. This position is also supported in the **Electronic Patient Record Policy, version 1 February 2013,** section 5.1: Data Protection and Confidentiality of Client information.). The implementation of the IRIS project (DV Education and Advocacy within GP Practices) has also helped GPs to be able to identify those risks and circumstances

Finally the family were confused as to why the report indicated that Mr Z was 'not deemed to be mentally ill at the time of the crime' to clarify although his defence was that he was mentally ill, the psychotic state that he was in at the time of the murder was not due to an enduring mental illness but a side effect of his cannabis use. He had been warned that this could happen again following the road traffic incident and yet chose to take the drug. This makes him responsible for his actions whilst under the influence of the drug. Although he was experiencing a mental health episode at the time, he was not diagnosed with an enduring mental illness.

This information has been fed back to the family via Miss Y's Godmother and they have indicated that they have found the DHR process helpful in enabling them to get some answers to the questions that arose following Miss Y's death. They have taken some consolation in the fact that the process has initiated changes that would improve the provision of support and care for someone who was in a similar position to Miss in the future.

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 either 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 (as Miss Y told her project worker at The Society of St James in 2004 and 2006). Mr Z threatened or attempted suicide when Miss Y did finish with him in 2006 causing her to re-establish the relationship. Mr Z tried to dissuade Miss Y from moving to Cheltenham in late 2005; and Mr Z tried to persuade Miss Y not to trust the rehabilitation centre staff in 2006 which could have been 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 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 Miss Y visited her GP several times with fears she had an STI or pregnancy (none were found) and the 'traumatic' ear injury which was not investigated. At the time of the 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 drugs. There was not a process in place to deal with an acute episode of psychosis caused by a drug reaction in a person likely to take 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, clear risk factors associated with domestic abuse being apparent.

This is clear in examples in the chronology and individual management reviews 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 the agencies 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 to, or specialist support sought Miss Y may have had opportunity and support to safely extricate herself 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 particularly highlighting that it 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 evidences 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

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 between DV team, 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 guideline

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 staffs 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 attend 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.

    Additional actions in SHFT individual management review:
    Joint working to be implemented across care teams when both partners are under SHFT care teams.

    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.

    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.

Comments on process

As this was one of the first domestic homicide reviews to be delivered under the current legislation in the UK, and the first for Southampton, both the chair and panel members found this experience a learning curve. It was fortunate that colleagues in Hampshire had the previous year (in preparation for the legislation) spent time producing a local procedure and practice document including templates of many of the necessary documents in line with the Home Office Guidance which meant the review could commence and key learning be discovered early in the process. Local colleagues experienced in delivering similar serious case review's for adults and children contributed to the panel and contributed their experience and knowledge to the process which was of huge benefit.

Some of the agencies asked to participate in the review were not immediately aware of their statutory responsibilities and explanation of the process did need to be emphasised on occasion, partly due to this being a relatively new legislative requirement.

The process requires significant resources in order to deliver the individual management reviews and chronologies of events and this was an issue particularly for the smaller organisations involved.

The completion of the review would not have been possible without the support of officers within the Community Safety Team at Southampton City Council – in particular Sarah Lawrence who co-ordinated this review from its inception. The need for a central contact point for panel and individual management review authors is essential to make reviews such as this one as efficient and effective as possible.

On the advice given by the Home Office the domestic homicide review was paused until the trial was completed. This occurred at the point at which individual management reviews along with their action plans were completed. As the police were part of the Panel and clearly any evidence that may have been considered pertinent to the investigation would have been given to the disclosure officer, it was perhaps in hindsight unnecessary to suspend the process. In this case there was no question of who killed Miss Y just as to the mind-set of Mr Z at the time. The Court found Mr Z guilty of the offence of murder, he was not deemed to be mentally ill at the time of the crime.

Clearer guidance around this issue from the Home Office would be useful. The break in the review process did not stop individual agencies from instigating their own internal action plans and updating the Community Safety Team who monitored progress, however the recommendations from this Overview Report had not been drafted or approved by the panel and so no multi agency action was progressed during this time.

Prior to the start of this review, it was agreed in a county group that the responsibility for chairing and authoring domestic homicide reviews would be shared across the area. The area consists of two unitary authorities (Portsmouth and Southampton) and the Isle of Wight and Hampshire Counties. In order to maintain independence, where a homicide occurred in one area of the county another authority, where there were no links to the case, would provide a chair and author. This reciprocal arrangement was attempted as a way of reducing the costs of the domestic homicide review. Consequently as this homicide was in Southampton, Portsmouth provided the role of chair and author initially. In the current climate the ability for the Hampshire and Isle of Wight DHR management group to

continue this no cost arrangement is likely to be compromised, as the number of people available across the counties with the necessary knowledge and experience and capacity to hold the position of chair and author reduce.

A point of particular interest is that the domestic abuse specialists who sat on the panel were able to immediately identify risk factors and signs of domestic abuse in the case as information came to light through individual management review's that had not been identified by other professionals, often seeing where opportunities for intervention was missed. This demonstrates how essential it is for such expertise to be part of all domestic homicide reviews in future.

Domestic Homicide Review for the case of Miss Y

Action Plan

Recommendation	Scope	Action to take	Lead Agency	Update / Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
1.All services involved in this review should ensure that relevant staff are fully trained in identifying, assessing and responding to domestic abuse.	Local	• Ensure multi agency and single agency training is regularly available • Monitor and evaluate the number of staff attending specialist local domestic abuse training courses • Feed this into 'Vulnerable Victims Group' (VVG) to take action where there are gaps in attendance.	Southampton City Council (SCC) Community Safety Team.	• All single agency actions (shown below) to deliver training have been completed.	Completed.	Action completed Outcome: Improved safety of victims by increase in use of risk based response.
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.	Local	• Launch point of contact (Poc) July 2012 • Ensure communication of new phone number and information to key services • Monitor and evaluate success of Poc • Develop multi agency and single agency training opportunities (see recommendation 1) • Ensure adequate resources for responding to cases (particularly at medium risk level).	SCC Community Safety Team	• Poc up and running and receiving calls in July 2012 • All key services aware of where to get advice, support and to make a referral for specialist help July 2012	Completed.	Completed. Outcome: Co-ordinated response to medium & standard risk cases and prevention of escalation of risk to high. Non police referrals to MARAC increase to ensure safety of victims not

Recommendation	Scope	Action to take	Lead Agency	Update / Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
						reporting to police even at this high risk level.
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 as priority to receive training.	Local	• Implement IRIS Southampton with provider of Advocate Educator (AE) and Clinical Lead • Recruit at GP practices – include Practice 1 and 2 from this review • Deliver to remaining practices in Southampton • Monitor and evaluate success of this project • Feed back progress to appropriate strategic board • Identify ongoing funding for IRIS Southampton.	NHS Southampton	• IRIS is up and running. This programme embeds specialised Domestic Violence and Abuse training and education, clinical enquiry prompts and enhanced referral pathway to specialist domestic violence services into practices. • 15 practices in Southampton are signed up for IRIS so far.	August 2013	Action ongoing Outcome: Increase opportunities for victims and survivors to access specialist advice and support at an early opportunity.
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	Local	• Draft and agree a section to be included in contracts with providers of mental health, drugs and alcohol services to ensure specific DA training is delivered to staff in local context • Include a requirement that once training received CAADA DASH[1] risk	VVG of Southampton Safe City Partnership	• VVG to progress this action linked to Commissioning work. • Southampton NHS CCG has made this requirement of providers.	April 2013	Action ongoing Outcome: Better training for key staff to improve safety of victims by increase in risk based response.

[1] CAADA = Coordinated Action Against Domestic Abuse a national organisation that developed the DASH = Domestic Abuse, Stalking & Harassment risk indicator checklist.

Recommendation	Scope	Action to take	Lead Agency	Update / Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
identification, assessment and appropriate referral		assessment is used as a tool by workers.				
5. The Vulnerable Victims Group (VVG) should consider how agencies can respond more effectively to the cumulative impact of standard and medium risk cases with compounding issues such as mental health and substance misuse. To include consideration of developing a triage system similar to Multi Agency Safeguarding Hubs (MASH) used in other parts of the UK, or the triage system used for children and young people cases locally.	Local	• Research good practice in other areas using MASH • Make business case for options including MASH in context of existing hubs, triage systems and point of contact in Southampton, ensuring links to similar projects and work such as 'toxic trio' (drugs & alcohol, domestic abuse and mental health). • VVG to discuss feasibility and relevance and agree way forward.	VVG of Southampton Safe City Partnership	• Other areas practice investigated • Link to developments within Safeguarding Adults and local triage arrangements.	Completed – this action forms part of wider developments.	Action ongoing Outcome: More co-ordination of responses to those deemed at medium or standard risk (across issues) and therefore improved multi agency responses.
6. Police force policies and procedures (Fop's) are amended to provide police officers with more guidance when dealing with suspects who have mental health issues.	Local	• Update and amend Fop's relating to Mental Health. • Communicate change to all operational staff. • Incorporate changes into any Mental Health training materials. • To complete an audit of all Mental Health detentions and custody disposals, 12 months after completion of Action 3.	Hampshire Constabulary	• Guidance regarding dealing with suspects suffering mental illness has been produced and about to be published (update as at 01/02/13)	March 2013	Outcome: All frontline staff will fully understand that most suspects who suffer with a mental illness must be taken through the recognised criminal justice route.
7. Police force control room standard operating procedures (SOP's) are	Local	• Update and amend SOP's relating to MH calls. • Communicate changes to call takers,	Hampshire Constabulary	• Amended SOP "signed off" by Head of Force Control Room FCR March 2012.	Completed June 2012.	Completed. Outcome: All call taking staff will fully

Recommendation	Scope	Action to take	Lead Agency	Update / Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
amended to provide clear risk based guidance on how to respond to calls from people with mental health issues.		control room staff and managers. • Incorporate changes into any Mental Health control room training materials.		• Changes have been communicated to all FCR staff. • Changes have been incorporated into FCR training materials.		understand the pros and cons and risks that MH calls have when a police deployment decision needs to be made. .
8. Increase GP and practice staff awareness and identification domestic violence, the potential effects on relationships / families and the service provision available fro support and intervention. Develop close working relationships between DV team, IDVA's (Independent Domestic Violence Advisors) and health services.	Local	• Domestic Violence training to be an integral part of the GP Safeguard leads training programme. • Ensure GP engagement in IRIS project. • SCC lead and Designated Safeguard professionals to monitor IRIS project engagement and number of referrals to IDVA's.	NHS Southampton	• Audit of practices completed April 2012 • Primary Care engagement in IRIS project. • October 2012: NHS Southampton has approved funding for the IRIS project. This programme embeds specialised Domestic Violence and Abuse training and education, clinical enquiry prompts and enhanced referral pathway to specialist domestic violence services into practices. • Two Advocate educators have been appointed and are linked to general practices. The advocate educators and the local clinical lead have developed a training program for practices • 9 practices in Southampton are signed up for IRIS so far.	Completed February 2013.	Completed Outcome: Increased awareness and identification domestic violence. Increased interagency collaborative working. Frontline practitioners aware and able to identify potentially vulnerable adults and ensure be able to signpost and / or access appropriate services
9. Increase awareness of	Local	• Support GP's to have Safeguarding	NHS	• October 2012: Agreed	Completed February	Completed All practices have

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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.		Adults policy in place to include domestic violence issues. • Deliver training regarding domestic violence and safeguarding adults	Southampton	Safeguarding Adults policy template made available to all GP surgeries • Every practice sent a domestic violence / VAWG toolkit as well as Safeguarding Adults policy.	2013.	access to safeguarding adults policy and to IRIS training
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.	Local	• New patient registration forms to have an additional section requesting information on over the counter medications, alternative medication and illicit drugs.	NHS Southampton	• Audit of practices completed April 2012 • October 2012: A uniform new patient registration form has been proposed to include questions pertaining to illicit drug and alcohol use. NHS Southampton are currently working with the Local Medical Council (LMC) to ensure endorsement and a standard recording format in line with information governance rules and regulations.	Completed February 2013.	Completed This is advised as good practice but cannot be made compulsory under current NHS arrangements. Outcome: Primary Care clinicians increased awareness of illicit drug use to ensure safe and appropriate prescribing and facilitate holistic assessment social circumstances.
11. A greater correlation between the data available in the form of easily	Local	• Self audit by GP's on use of read codes including domestic abuse • Further work to be done by NHS	NHS Southampton	• Audit completed • 50% of GP's indicate they are using these correctly	Completed February 2013.	Outcome: Improved identification of victims of domestic

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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 Safeguarding team to ensure 100% compliance.		• Performance monitoring of primary care practices will be the responsibility of CCGs, Local Area Teams and Care Quality Commission will be the regulators. Until robust systems are established, NHS Southampton Safeguarding team continues to audit and monitor local practice.		abuse therefore preventing escalation of risk and improving safety. Local practice continues to be monitored by safeguarding team. Unable to change national performance monitoring arrangements for primary care.
12. Validate the 2011 update of the Management of Domestic Abuse guideline.	Local	• The domestic abuse management guideline to be updated.	Southampton University Hospitals Trust	• Guideline has been re-written and discussed at Vulnerable Adults committee. Awaiting final governance committee ratification.	Completed.	Outcome: All staff in the trust will have access to the domestic abuse management guideline.
13. Ensure training re: management of domestic abuse (DA) is always included on the orientation for Emergency Department (ED) nurses and doctors.	Local	• All staff treating patients with potential DA injuries will be aware of the potential for DA and be clear about the process to follow if they are concerned.	Southampton University Hospitals Trust	• The training is now included in all induction sessions.	Completed December 2011	Completed.
14. Include training re: management of domestic abuse on forthcoming	Local	• Key staff in all relevant clinical areas will be trained in DA.	Southampton University Hospitals	• 12 VA champions will be trained in 2012	The programme commenced December 2011	Outcome: Vulnerable adults champions will be

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Vulnerable Adult Champions Programme			Trust			trained in DA
15. Ensure that record of referral from ED 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 ED, MH team refuse to see or patient self discharges / absconds.	Local	• Patient's records of assessments and interventions in the ED by MH referral staff will be recorded and accessible to all agencies that need them.	Southampton University Hospitals Trust	• MD written communication and hand over will be effective.	Completed End December 2011	Completed.
16. Disseminate the learning from this review at key trust groups (e.g. NMG, Governance Committee).	Local	• Continually raise awareness of potential for DA with relevant staff.	Southampton University Hospitals Trust	• Agenda item at key trust groups in October and Nov 2011. • Members of relevant committees will disseminate learning and actions across the divisions.	Completed. End December 2011	Outcome: Dissemination of the learning and actions form the DHI will have taken place.
17. Ensure clinical and non clinical staff have easy access to information and resources on all VA issues.	Local	• Complete staffnet web resource for staff (Vulnerable Adult Pages) including information and signposting about domestic violence and launch this trust wide.	Southampton University Hospitals Trust	• Set up of pages completed and now being populated with information.	Completed.	Outcome: Up to date web based resources for staff
18. Facilitate access to specialist services for victims of DA when they attend the acute hospital		• Continue review of potential accommodation at General Hospital or Princess Anne (maternity ward) to host members of a domestic	Southampton University Hospitals Trust	• Pilot with Pippa services of 6 months to take place February 2013.	Completed - 6 month pilot from February 2013.	Updated Jan 2013 Outcome: Early access to specialist support, raising

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site.		violence team on site.				awareness with members of the public, patients, relatives and staff
19. Southern Health Foundation Trust (SHFT) to provide awareness for all staff groups of the recently developed Domestic Abuse Policy including the availability of domestic abuse training throughout SHFT.	Local	• Communication Department to ensure all staff in SHFT are aware of the development of the domestic abuse policy and training associated with it.	Southern Health Foundation trust	• Development of the domestic abuse policy and training associated with it.	Completed November 2011	Completed. Outcome: Staff are aware of the risks of domestic abuse and have a good knowledge base on domestic abuse indicators
20. Each service within the Society ensures that at least one member of staff of relevant services attends specialist domestic violence training each year.	Local	• Ensure each team reviews its training needs with regard to Domestic abuse awareness. Teams to send at least one member of staff each year on domestic abuse awareness training.	Society of St James	• Domestic Violence training over 70 staff working in front line services delivered in May 2012. The training comprises 4 half-day Basic Awareness courses and 1 full day Intensive training course. The training is being provided to the Society by Pippa.	Completed May 2012. Ongoing training annually.	Updated Jan 2013 Outcome: To ensure staff have in depth knowledge of issues within each team that is likely to be dealing with domestic abuse
21. Improved access to policy and procedures.	Local	• 100% front line staff to be familiar with and have access to policies and procedures. Will be part of the refresher training.	Sovereign Kingfisher	• ASB and DV policies and procedures were updated and made available to all staff on the intranet in August 2011.	Completed August 2011	Completed. Outcome: Policy and procedures accessible on intranet
22. Review effectiveness of induction process for new starters.	Local	• To ensure 100% of new starters receive ASB training within 6 weeks of joining Sovereign Kingfisher as part of their induction process.	Sovereign Kingfisher	• Housing Officers and Customer Service staff have an induction into ASB including DV policies,	Completed March 2012	Completed. Outcome: 100% front line officers to have received ASB training as part of

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				procedures and dedicated IT system in first 6 weeks. This is carried out by either the ASB officer or (for CSA's) the line manager. This is included in the staff 1:1 meetings.		the induction process
23. Refresher training for all Customer Service Advisors (CSA) and Housing Officers (HO).	Local	• 100% of CSAs and HOs to undertake refresher training in dealing with ASB (Anti Social Behaviour).	Sovereign Kingfisher	• HO's and CSA's have completed training on ASB policy, procedures, risk assessments and use of dedicated ASB system by December 2011.	Completed December 2011	Completed. Outcome: 100% front line staff to have received refresher training on recognising and dealing with ASB
24. Have a specific module within the Sovereign training framework covering domestic abuse.	Local	• Develop a specialist module on domestic abuse.	Sovereign Kingfisher	• 75% of housing officers and 50% of CSA's have attended external DV awareness training and MARAC training as at March 2012. Sovereign have now developed a two stage training course for DV and this is running on a rolling programme and remaining officers will be booked on these courses	Completed July 2012	Completed. Outcome: Relevant staff to complete the module as part of the accredited training framework
25. To access Hampshire wide DA training programme.	Local	• To participate in the DA training delivered through Hampshire DA forum.	Sovereign Kingfisher	• 50% of HO's have attended MARAC courses in last 3 years. Sovereign will continue to access local courses as they become available.	Completed. Ongoing training	Completed Outcome: To complete training in risk assessment (DASH) and MARAC, remedies and awareness
26. Supervisors to attend		• Supervisors to book place on course	Options Drug	• Training attended November	Completed.	Completed

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DASH & MARAC training courses.		on one of following dates 19th Sept, 10th Nov 2011 or 15th March 2012.	& Alcohol Service	2011	November 2011	Outcome: To refresh learning and ensure up to date & disseminate learning to the team
27. To ascertain how long client file should be kept before confidential destruction.		• Ask DHR Review panel. • Verbal request made. • Also ask commissioners at contract review meeting October & suggest included in contracts.	Options Drug & Alcohol Service	• Verbal request made to DHR panel – need to follow up • Diarised to ask at contract review meeting in October • Asked 5 yrs ok	Completed. November 2011	Completed Outcome: To ensure records are kept for required length of time
28. Refresher training for Team on file management & codes of practice.		• Include in team training and development day.	Options Drug & Alcohol Service	• On training session outline • Training completed.	Completed October 2011	Completed Outcome: Ensure all team members are completing files appropriately and adhering to codes of practice. NB This is also, and continues to be routinely monitored through supervision and file monitoring. Have introduced (October 2012)Critical incident log and early alert system