

# **DOMESTIC HOMICIDE REPORT**

## **Executive Summary**

**Bromley**

**“Susan”**

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# Executive Summary

## 1. Summary

- 1.1 Susan (the victim)<sup>1</sup> and Alex (the perpetrator) were not known to any agencies as a couple prior to her death. She was 20 years old and he was 33 years old. Susan was clearly a vulnerable child and adult, and Alex was a known and dangerous perpetrator of domestic abuse. This review found that the agency involvement with them as individuals could possibly have led to different outcomes; however, there is no direct causal link between the death and the agencies who knew Alex and Susan.
- 1.2 The possibility of these different outcomes could only have been achieved if a greater understanding of the pathology of a victim of domestic abuse is understood and we, as a society and agencies, address the problem of serial domestic abuse by perpetrators.

## 2. Details of the incident

- 2.1 In November 2013, Susan was found unconscious at an address in Croydon, not her home address. She had obvious head, arms and facial injuries and was unresponsive. She was transferred to Croydon University Hospital where her life was pronounced extinct. Her partner, Alex, was subsequently arrested and charged with her murder. He has accepted responsibility for her death and a new trial date was fixed for 2015. He has now been found guilty of murder, and was sentenced to life imprisonment with a minimum term of 20 years.
- 2.2 It is believed that the cause of death was an injury which was consistent with an accelerated fall as well as an assault.

## 3. The review

- 3.1 These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Bromley Community Safety Partnership (CSP) as Susan had lived in Bromley for all her life. The initial meeting was held on 24<sup>th</sup> March 2014 to consider the circumstances leading up to her death.

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<sup>1</sup> Pseudonyms have been used throughout this document for reasons of confidentiality. The name for the victim was chosen by the family

- 3.2 Susan and Alex were not known at all, **as a couple**, to any agencies, voluntary or statutory. This review has discovered significant features in both their individual lives which are described below. These features resulted in much contact with many agencies, and it is their separate paths which has formed the most illuminating aspect of the review. The circumstances of their lives have provided an opportunity to gain an insight into the process whereby vulnerable individuals are victimised and perpetrators serially abuse different partners.
- 3.3 The panel believes that this case should have an impact beyond Bromley because of the nature of the circumstances. The reality of the risk posed by a perpetrator and the opportunities for violence by that individual towards a young woman who has had a difficult life are truths which do not belong to local boundaries.
- 3.4 To enable this learning process to take place, the information relating to previous victimisation by Alex has been mentioned in this review. The detail of this has not been included as the panel decided that this would put the confidentiality of other victims at risk. What was also agreed was that the previous history of Alex established that he was a serial perpetrator and a very violent and dangerous man; although, all the characteristics of his violence have not been outlined in the interests of those he abused.

#### **4. Terms of Reference**

- 4.1 The full terms of reference are included in Appendix 1 and were agreed by the panel that consisted of all the relevant partner agencies from Bromley that dealt with Susan or Alex (see appendix 2). The panel was independently chaired by Anthony Wills, a domestic violence partnership consultant and ex-Police officer. The central purpose of this review was to:
- a. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
  - b. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

## **5. Contact with family and friends**

- 5.1 A meeting (and further contact) was held with Susan's mother, two of her brothers and a partner to one of the brothers. At this initial meeting a very close friend of Susan was named and she also agreed to speak with the chair. The views emanating from these discussions are referred to within the report.
- 5.2 A further meeting was held with the family on the 16<sup>th</sup> February 2015 where this report and its contents were discussed at length. They were also given space subsequently to consider any changes they may wish to make or thoughts that would bear further consideration. To date they have made no such submissions.
- 5.3 Any opportunities to discuss this review with Alex will not be progressed until after the prosecution is complete. He has been informed by letter that this review is underway. (Following his conviction Alex has been contacted in prison but he has yet to agree to participate in this review. Should he do so an additional report will be attached to this review.)

## **6. Equalities**

- 6.1 The nine protected characteristics of the Equality Act 2010 have been considered by the panel. Both Susan and Alex are described as being of white European background. Susan did have learning difficulties but the panel do not believe this amounted to a disability as defined by the act. No other characteristic was regarded as relevant with the exception of possibly sex and age. It is accepted that women are more likely to suffer domestic abuse than men, and this review seeks to deliver recommendations with that reality in mind.
- 6.2 Susan was 20 years old at the time of her death and Alex was 33 years old. This age gap was considered by the panel, but it was the specific characteristics of Susan and Alex (vulnerability and dangerousness) that were significant rather than their respective ages.
- 6.3 Alex was recognised as having psychological issues from a very early age and interventions took place during his childhood. He was not diagnosed in his later life as having any mental health issues which would amount to a disability as defined by the act.

## **7. The Facts**

### **7.1 Introduction**

- 7.1.1 Susan's relationship with Alex lasted approximately nine months and they lived in a multi-occupation house in Bromley where they had met originally. There is no record of any contact with any agencies that identified any concerns about the relationship. There were no reports to the Police or other agencies about domestic abuse or related issues that involved this couple.
- 7.1.2 Susan had no children. Alex is now known to be the father to three children with two women.
- 7.1.3 For reasons outlined above, much of this review deals with Susan and Alex separately, and for the purpose of this executive summary, their history is again addressed separately and in much abbreviated form. Fuller information is contained within the body of the report. What is evident in this review is that a vulnerable individual and a very dangerous male did come into contact and, had different practice and policies been instituted, the outcome may have been different. It is vital to learn from these circumstances so that future action in such cases, which are not atypical, can be modified, where possible, to improve the response to domestic abuse.

### **7.2 The perpetrator - Alex**

- 7.2.1 Alex first began to come to the significant attention of agencies when he was 2 years old. Continuing contact through his childhood with the statutory sector was in a safeguarding, medical and mental health context. Psychological interventions when he was 16 years old demonstrate a troubled young person, becoming very challenging, who had experienced domestic abuse within the family. At this time he was becoming increasingly well known to the Police for his offending behaviour.
- 7.2.2 Alex has a history of involvement with the Police in London (at least four Boroughs) and the Home Counties. He has twelve criminal convictions and four cautions for twenty-one offences. He was first convicted of robbery in 1995 when he was 15 years old. Apart from the prosecution in relation to Susan and domestic related cases described below, Alex was convicted of other offences including assaults, criminal damage, burglary and possession of drugs. Prior to his contact with Susan, there are records of four previous partners (and their relatives) that Alex is alleged or proven to have assaulted.

- 7.2.3 From 1999 until the incident where Alex has admitted killing Susan in 2014, there is significant detail of high levels of violence towards women and sometimes their relatives. It is clear that over this lengthy period the compliance with agency processes (largely Police) was found to have occasionally failed and the supervision of cases was inconsistent
- 7.2.4 It is worth quoting the Police assessment of this contained in the IMR from the Metropolitan Police: *“It is clear that [Alex] is an individual that presented a significant risk to women throughout his previous relationships. There were DA [domestic abuse] incidents involving four previous partners within the Metropolitan Police Service (MPS), these included five incidents of violence and four Non Crime Book Domestic Incidents. There were similarities throughout all these cases. [Alex] indicated controlling and coercive behaviour throughout with a vicious temper. In all of the cases, the victims withdrew their allegations or were reluctant to give evidence at various stages of the investigations. This was despite significant reassurances from Police. Each victim was emphatic that if they were compelled to attend court they would say that they had lied. One victim got as far as court, but refused to be cross examined. It is clear that all of these victims were intimidated and vulnerable because of [Alex’s] behaviour.”*
- 7.2.5 Alex was known to Probation from 2009 after serving a prison sentence for a domestic assault. He undertook no courses in Prison although Healthy Relationships programmes were run in prisons at that time. He completed his licence with no further offending and appears to have been compliant and motivated to address his offending.
- 7.2.6 Alex was managed as a Level 1 MAPPA offender, which means he was managed by Probation alone. His offending behaviour in relation to domestic abuse was not clearly identified, and his risk level (medium) may have been a reflection of that.
- 7.2.7 Alex was recognised as being suitable for placement on an Integrated Domestic Abuse Programme (IDAP), but his licence period was too short to complete the course at this time and shorter interventions were not then available.

### 7.3 The victim – Susan

- 7.3.1 Apart from minor childhood ailments, Susan did not come to the notice of the NHS for anything of significance until 1997 when she was 4 years old. Susan continued to have many interactions with health services but the causes of her presentations were never explored.
- 7.3.2 From 1999, Susan was recognised as having learning difficulties and in need of psychological support – which was never accessed.
- 7.3.3 From 1996, when she was two years old, Susan was known to Children's Services; although interventions were minimal.
- 7.3.4 In January 2007, when Susan was 13 years old, Children's Services in Bromley allocated a social worker to Susan following a core assessment. Her school reported serious concerns about her behaviour. When examined, it became clear that a number of issues were affecting Susan at this time:
- a. Susan's father was chronically ill and was subsequently to die whilst Susan was in her teens.
  - b. Susan's mother had left the home and she was a key figure in Susan's life.
  - c. Susan's brothers (she had four older brothers) were attracting attention locally for poor behaviour.
  - d. Susan was struggling to manage herself and had to care, to an extent, for her father.
- 7.3.5 Susan was regarded as a Child In Need and was not a Looked After Child, but there is little evidence that Susan ever developed a trusting engagement with her allocated social worker and the case was closed in December 2008.
- 7.3.6 Much information for this review came from Susan's school and it is clear that:
- a. Susan had moderate learning difficulties. All Susan's four older brothers experienced problems at school.
  - b. Home life was very challenging with very significant male role models and limited female input, which worsened dramatically when Susan's mother left under very distressing circumstances.
  - c. Susan's mother was in contact by phone, and was a supportive factor.
  - d. The family were resistant to outside support and rejected any offer of support from a social worker. They clearly loved Susan, but may not have managed her needs effectively.

- e. School was a refuge for Susan. The support given there was extraordinarily powerful and helpful.
  - f. The mother's capacity to help Susan was questionable.
- 7.3.7 Whilst Susan was at school, it is clear that her behaviour was challenging and multi-agency meetings were held to address her behaviours and seek solutions. The actual outcome of such meetings was limited and no escalation of support (beyond that provided by the school) or assessment was achieved.
- 7.3.8 The Police have records of a significant number of interactions with Susan which concerned street drinking and other issues
- 7.3.9 In 2010 in Bromley, Susan reported that her boyfriend at the time (not Alex) had threatened her and strangled her, but she wanted no further action and was referred to Victim Support.
- 7.3.10 Victim Support received five referrals from the Police relating to Susan, including this domestic assault (the only one which is a domestic assault allegation). In all cases Susan either declined support or could not be contacted.
- 7.3.11 Other records for Susan show that she was demonstrating a potentially problematic lifestyle. It is a characteristic of Susan that she did not engage with agencies that could have supported her. There was some contact with Children's Services about Susan after this period, but the mother was regarded as suitably able to support Susan's needs.
- 7.3.12 In terms of her contact with Health, from 2009 her GP records show that she had trouble sleeping, abdominal pains (2011) and possible panic attacks (also 2011). A referral to Children and Adolescent Mental Health Services (CAMHS) resulted in them suggesting she attend Bromley Y<sup>2</sup> although Susan did not attend.
- 7.3.13 These problems continued into 2012 when there are records describing her having blackouts, being stressed and upset. Medication was considered inadvisable because of "unexplained blackouts". Again, Susan was advised to attend Bromley Y but she chose not to follow this up.

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<sup>2</sup> Bromley Y is a long established local agency offering free therapeutic support to young people between the ages of 0 -18 years.



- 7.3.14 Finally in June 2013, Susan had discussions with her GP about wishing to conceive (the records state she was living with her partner and the assumption is that this is Alex).
- 7.3.15 The last occasion Susan came to the notice of agencies was when they assisted with the eviction of Susan and her family in 2013, when Susan was an adult, from the address that had been their home throughout their father's illness. Susan and her mother then rented rooms in the address where Susan met Alex. There is no evidence of any follow-up by any agency after the eviction took place.

## **8. Contact/Relationship with family/friends**

- 8.1 The family were very helpful in the review process and were able to provide much useful information which has been used within this report. The meeting is described at greater length within the main body of the review.
- 8.2 Their impression of Alex was that he was quite charming and generous. There was a slight concern about the age gap, but Alex did not appear to act as a much older person than Susan and these fears dissipated over time. Alex apparently "boasted" about being in prison but the family did not think generally he was "that clever". Alex gave Susan many gifts and appeared to treat her well. It was only very shortly (a few days) before Susan's death that she mentioned to any of the family that she may need to gradually move some of her property out of Alex's address so that it was not obvious. There was no sign or discussion about abuse of any form, and before any action was taken Susan was killed.
- 8.3 Susan did struggle at school; although, the Glebe School was praised for its efforts with her. She was hugely attached to her father and did "everything" for him. As the only girl in the family, Susan was a little "spoilt" and enjoyed being treated (which made Alex's generosity attractive). There was a complete acceptance of the fact that it was a very "male" household.
- 8.4 The eviction had a considerable effect on the family. They felt they were "dumped on the street and had nowhere to go". They were given no support and Susan and her mother found rooms where Susan met Alex.
- 8.5 Their relations with the Police were difficult and it was felt this partly stemmed from their experience with one officer. It became clear that their dislike of agencies in the statutory sector was exacerbated by their experience with the Police. They agreed

that they were resistant to any agency involving themselves in their family's life. This is particularly relevant when asked about their attitude to any intervention by Children's Services. Their deeply held belief is that the context of the family would mean that, if given the opportunity, Susan would be taken into care or "taken away" by Children's Services.

- 8.6 A friend of Susan also supported the review. She had known Susan for over nine years and she was "like a sister" to Susan and talked about things that affected them as girls. She felt that Susan began to engage in risky behaviour at the time of her father's death. She was extremely close to her father and struggled to deal with his passing.
- 8.7 Just before Susan's death, it was evident to her friend that she was unhappy in her relationship with Alex and she is sure he hit Susan at least once.
- 8.8 Susan was scared of Alex, and this was the biggest factor in her not speaking about the relationship or going to the Police.
- 8.9 Both family and Susan's friends made suggestions about how to improve a situation such as Susan's and these thoughts are incorporated into the report.

## **9. Analysis**

- 9.1 Relationship between Susan and Alex
  - 9.1.1 The relationship between Susan and the man who killed her had lasted for approximately nine months. There was no contact by them as a couple with any agencies. In 2013, Susan did discuss with her GP a wish to conceive and it can be assumed that the potential father was Alex. This was the only apparent opportunity to explore the relationship but that opportunity was not realised.
  - 9.1.2 This may have been a very limited chance to discover the circumstances of Susan's position and any threats to her.
- 9.2 Alex's dangerousness and the response.
  - 9.2.1 There is no doubt that Alex was serially violent towards his partners. The level of continuing threat was such that on many occasions they declined to support an investigation or prosecution and many were extremely fearful of him.

- 9.2.2 It is also true that he was prosecuted successfully a number of times and served time in prison for his crimes against women. On occasions these prosecutions were impressive for the diligence with which they were pursued.
  - 9.2.3 Some of the interventions by Police are marked by process failures or a lack of supervision, albeit that some were in the relatively distant past
  - 9.2.4 Any terms of imprisonment seem to have had no impact on his offending behaviour.
  - 9.2.5 Opportunities in prison to conduct some form of intervention were not realised. On licence with Probation, Alex behaved appropriately and he was not considered sufficiently dangerous to be graded at a level of risk which would have resulted in a multi-agency response.
  - 9.2.6 The history of Alex continuously begs the question as to what should or could have been done differently to safeguard existing and future victims of domestic abuse particularly in relation to the perpetrators of such crimes.
- 9.3 Susan and the context of her life
- 9.3.1 It was identified early that Susan had learning difficulties and other problems which carried on throughout her life. Much emphasis was placed on the competency of Susan's mother, but the review found that this confidence in the mother's abilities to care for Susan was misplaced, often through the simple fact of geography.
  - 9.3.2 Susan's home life had gradually worsened as she approached and entered her teenage years. Her father's increasingly debilitating, and finally terminal illness was a huge part of her existence and she often had to care for him rather than him being able to support her. Her parents separated in 2006 in very difficult circumstances, and Susan was left living with her father and brothers at a time in her adolescence when female support would have been extremely important.
  - 9.3.3 Susan was a child in need but engagement was "inconsistent" and it is clear she was unenthusiastic about the involvement of Children's Services. This is not unusual and her home circumstances and the attitudes of her family will have exacerbated this.
  - 9.3.4 This issue resulted in much debate at the panel meetings. What is clear is that there is no direct causal link between Susan's contact with Children's

Services and Susan's death. It may be considered; however, that her vulnerability, social skills and risky behaviour could all have been ameliorated with ongoing professional help.

9.3.5 It is potentially possible that increased support may have allowed her to adopt a safer lifestyle and a more productive existence, which could have altered the outcome of her life.

#### 9.4 Susan and contact with Health agencies.

9.4.1 Susan had very considerable amounts of contact with General Practitioners and other medical professionals. None of these seem to have resulted in an exploration of the circumstances of her life which could have elicited more information on which agencies could have provided a broader form of support.

#### 9.5 Susan and specialist support

9.5.1 Susan was referred to Victim Support on a number of occasions without achieving any form of interaction. Victim Support's policies now direct that action is taken with repeat referrals of this kind, and this would lead to increased attempts at intervention.

9.5.2 The possible support of specialist services from other Boroughs for different victims cannot be fully progressed for confidentiality reasons. However, there must be a possibility of doubt about referral mechanisms and actions following these referrals, if made, because of the subsequent response of the victims.

#### 9.6 Over-arching issues

9.6.1 There are a number of general issues which have become evident during this review:

- a. The communication between and within agencies has not been as effective as might be expected.
- b. Local partnership working requires improvement.
- c. Policy adherence and supervision is clearly an issue for the MPS.
- d. The issue of domestic abuse within someone's life is rarely considered within their presenting context. It appears to have never been considered in Susan's case.

#### 9.7 Good practice

- 9.7.1 The support provided by the teaching assistant at Glebe School was of a highly impressive nature.
- 9.7.2 The efforts of the Metropolitan Police to secure Alex's return from Spain and the subsequent prosecution demonstrate a commitment and determination which is worthy of praise.

## **10. Conclusions and Recommendations**

### 10.1 Preventability

10.1.1 The very limited contact by Susan with any agency when in the relationship with Alex, or any broader awareness of that relationship, makes it impossible to describe this death as preventable. What this review has shown is that different approaches to the following issues can potentially make a difference and increase the likelihood of preventing domestic homicides and abuse:

- a. The vulnerability of children and young people
- b. The repeated offending (albeit occasionally unproven) of a very dangerous individual
- c. Increased and knowledgeably delivered professional inquisitiveness
- d. Adherence to policies and practice aligned with good supervision
- e. A well organised partnership process overseeing the individual and combined responses of agencies involved with victims and perpetrators.

10.1.2 Examples of areas where an effective partnership could have made a difference are:

- a. during the eviction of the family
- b. dealing with violent men
- c. supporting vulnerable children and young people
- d. multi-agency training
- e. a specialist domestic violence court
- f. a joined-up approach within Health agencies.

### 10.2 Conclusions

10.2.1 Susan had a most difficult childhood and adolescence. The context of her family circumstances, her own learning difficulties and an inability of the agencies involved in her care to change those circumstances led to her being a vulnerable individual. Eventually Susan came into contact with a man, known to be extremely violent, who then killed her.

- 10.2.2 Vulnerable individuals, particularly women, are more likely to suffer abuse and such abuse can become increasingly violent and ends in death too often.
- 10.2.3 Alex's childhood, adolescence and adulthood were full of warning signs about his potential dangerousness. He was mainly dealt with by single agencies and the added value of a joined up approach was not realised. The opportunity, albeit limited, to provide Alex with a programme to address his abuse whilst in prison was also not realised.
- 10.2.4 The lessons learnt from this case could lead to developments in Bromley particularly within the partnership arena, children's services and within Health organisations, which would allow for continuing improvement in this difficult and complex area.
- 10.2.5 Partnership, training, policies and processes are all capable of improvement to reduce the risk to vulnerable women and deal with serially violent perpetrators.
- 10.2.6 It is also to be hoped that this case would stimulate change in other localities where the opportunity to examine their processes in such detail has not been realised.
- 10.2.7 This death should provide an opportunity for agencies to be motivated to perform their roles differently and with a greater understanding of how vulnerable women can be supported to avoid the chances of victimisation.
- 10.2.8 Finally, the death of Susan was the responsibility of one person and that is Alex. His history makes it crystal clear that more must be done with male adolescents and men, particularly those who are clearly dangerous, and that the delivery of this work must be regarded as a priority.

### 10.3 Recommendations

- 10.3.1 The recommendations fall into three main categories; those that are to be completed by single agencies, those largely falling within Bromley and those beyond Bromley. The full details are contained within the body of the report and within the action plan (Appendix 3) which will be the responsibility of the Community Safety Partnership, supported by the domestic abuse partnership, and the Children and Adult Safeguarding Boards. The MPS internal recommendations are shown at appendix 4.
- 10.3.2 The Bromley recommendations focus on:

- a. Developing the local domestic abuse partnership
- b. Training for staff around domestic abuse including plans to allow monitoring
- c. Implementing the IRIS<sup>3</sup> programme and the NICE guidance in Bromley
- d. Raising awareness of domestic abuse in child and youth settings and the wider community
- e. Reviewing 'The Child's Journey In Bromley ' to seek further developments
- f. Conducting a multi-agency SCIE review<sup>4</sup> using this case as an example
- g. Mapping the prevalence of domestic abuse in the Borough, and the provision of services to feed into an updated strategy and commissioning plan.
- h. Implementing a "champion" system for domestic abuse throughout the partnership.

10.3.3 Recommendations beyond Bromley focus on:

- a. Minimum national standards of reporting in all health settings
- b. A Specialist Domestic Violence Court in Bromley (which also serves other Boroughs)
- c. Closer work between the Police and Probation to strengthen the management of domestic abuse cases (and lists of previous convictions always noting where violence includes a domestic abuse context)
- d. MPS reviewing their use of the 'Recency-Frequency-Gravity-Risk' model to ensure that it addresses the harm, opportunity and threat posed by high impact offenders of Domestic Abuse
- e. That the MPS (with ACPO) consider the viability of a National Flagging System for serial perpetrators and repeat victims of Domestic Abuse
- f. That Her Majesty's Prison Service reviews the delivery of suitable programmes for all violent abusers
- g. That the identification (flagging) of domestic abuse perpetrators be introduced in all criminal justice agencies
- h. That the CSP in a neighbouring Borough<sup>5</sup> consider the learning opportunities possible from the evidence of Alex's possible needs when a child within that Borough.

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<sup>3</sup> [www.irisdomesticviolence.org.uk](http://www.irisdomesticviolence.org.uk)

<sup>4</sup> <http://www.scie.org.uk/children/learningtogether/what-to-expect/commissioners-of-reviews.asp>

<sup>5</sup> This Borough is known to the Bromley CSP and will be provided with a copy of this review.