Domestic Homicide Review

EXECUTIVE SUMMARY

'Suzi'

Died: August 2016

Tony Blockley – Independent Chair
Paul Johnston – Independent author
Johnston and Blockley
November 2018

1 INTRODUCTION

1.1 This summary outlines the process undertaken by the Cardiff Public Services Board domestic homicide review panel in reviewing the events that led to the death of 'Suzi' in August 2016. Suzi was murdered by her partner, Adult A.

1.2 Suzi is not her real name; the pseudonym was chosen by the review panel with a view to protecting her true identity. She was in her early 20s when she died, and her ethnicity was 'Chinese'. To protect his identity, the perpetrator has been referred to as Adult A throughout this report. He self-described himself as being 'White British'.

1.3 Suzi was born in China and attended school there until she was about 15. She and her brother then came to the United Kingdom to further their education. Suzi was a student at Cardiff Metropolitan University at the time of her death. She was from a wealthy family and was expected to return to China to manage the family business once she had completed her studies. Her family provided her with a substantial financial allowance while she was in the UK. She and Adult A had met via a dating website in 2015 and had been in a relationship for about 15-months before he murdered her.

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

2 TIMESCALES

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

2.2 The review commenced during August 2016, but in consultation with the police Senior Investigating Officer, it was then suspended until the completion of the criminal proceedings against Adult A. The review concluded during November 2018. The PSB acknowledges that the review has taken longer to complete than usual, but the delay is due to a combination of attempts to source additional information to add to the richness of the review, and to staff turnover within Community Safety at Cardiff Council. The dissemination of lessons learned from the review was not adversely affected by the delays.

3 CONTRIBUTORS TO THE REVIEW

3.1 AGENCIES

3.2 The following four agencies confirmed contact with Suzi and with Adult A and they were asked to submit Individual Management Reviews or summary reports. The authors were independent in that they had no previous involvement with Suzi or with Adult A or any line-management responsibility for staff that had been involved with them.

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

3.3 SUZI'S FAMILY

3.4 Cardiff Metropolitan University confirmed there is no ongoing contact with Suzi's family. They returned to China after Suzi's funeral and as far as in known, none of the family have come back to the United Kingdom.

3.5 The review chair has written to Suzi's brother to tell him about the review and to ask whether he or any other members of his family would like to participate in it. There has been no response and telephone calls to his mobile telephone have gone unanswered.

3.6 FRIENDS AND FELLOW STUDENTS

3.7 One of Suzi's closest friends participated in the review and many of her fellow-students were canvassed as to whether Suzi had disclosed anything that would have had a bearing on the review. Unfortunately, none were able to offer any information.

3.8 NEIGHBOURS AND THE WIDER COMMUNITY

3.9 Neighbours gave evidence during the criminal proceedings about occasions when they heard and saw Adult A being aggressive towards Suzi. A resume of what they said can be found in the 'chronology of events' section below.

3.10 The Black Association of Women Step Out (BAWSO), an all-Wales voluntary organisation which provides specialist services to victims and black, Asian and minority ethnic people (BAME) affected by domestic abuse supported the review, as did Women's Aid and the Chaplaincy at Cardiff Metropolitan University.

3.11 ADULT A

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

3.13 THE REVIEW PANEL MEMBERS

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

Name	Organisation
Tony Blockley	Independent Chair
Paul Johnston	Overview report author
Stephanie Kendrick-Doyle	Cardiff Council Community Safety Manager
Beth Aynsley	South Wales Police Independent Protecting Vulnerable Person Manager
Natalie Southgate	Improvement Project Manager, Gender Specific Services, Cardiff Council
Nicola Jones	Domestic Abuse Co-ordinator, Cardiff Council
Alys Jones	Operational Manager – Safeguarding, Cardiff Council
Linda Hughes-Jones	Head of Safeguarding, Cardiff and Vale UHB
Nikki Harvey	Welsh Ambulance Service
Jade Atkinson/Amanda Seed	Cardiff Women's Aid
Paul Fitzpatrick	Cardiff Metropolitan University
Nicola Jones	Cardiff Council Domestic Abuse Co-Ordinator Cardiff Council

3.15 REVIEW CHAIR AND AUTHOR OF THE OVERVIEW REPORT

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

3.17 Paul Johnston was the report author. He has been involved in more than 60 domestic homicide reviews. Previously, he led 73 murder investigations, many of which were of a 'domestic' nature. He was head of police homicide review and then the criminal

investigation department and later became Deputy Director of a project investigating over 3,000 deaths associated with 'The Troubles' in Northern Ireland.

3.18 Paul belongs to an international facility that provides expertise in investigations of the worst crimes known to humanity, including sexual and gender-based violence in conflict zones. He is an expert witness in cases at the European Court of Human Rights involving abduction, murder and domestic abuse femicide and currently, he is one of four experts appointed by the United Nations Special Rapporteur on extrajudicial, summary or arbitrary executions to conduct a human rights investigation into the murder of a prominent journalist within in the Saudi Arabian consulate in Istanbul.

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

4 TERMS OF REFERENCE AND SCOPE OF THE REVIEW

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

4.2 The review addressed:

- *Whether the incident in which Suzi died was an isolated incident or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence*
- *Whether there were any barriers experienced by Suzi's family/friends/colleagues in reporting any abuse in Cardiff or elsewhere, including whether they knew how to report domestic abuse should they have wanted to*
- *Whether Suzi had disclosed abuse while at University in Cardiff and what support/policies and procedures are available for students there and what information is provided to students on healthy relationships/domestic abuse generally*
- *Whether Suzi had experienced abuse in previous relationships in Cardiff or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died*
- *Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Suzi that were missed*
- *Whether Adult A had any previous history of abusive behaviour to an intimate partner, a relative or a co-habitee and whether this was known to any agencies*

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

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

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

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

5 BRIEF CHRONOLOGY OF EVENTS

5.1 In April 2016, the police received a report from a neighbour of Suzi and Adult A that he had heard things being thrown around and that the same thing happened every morning. The caller said he could hear Suzi crying and that Adult A had been saying, *"How many beatings do you have to have?"*

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

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

5.4 Adult A told the police that he and Suzi's relationship had been going through a *"Rocky patch"* and that they had been arguing a lot recently. Adult A was invited to leave the premises to prevent any further breach of the peace.

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

5.6 A Public Protection Notice (PPN) was shared with Cardiff Woman's Aid and the Domestic Abuse Unit who assessed the incident as not being suitable for a MARAC referral because the risk was not adjudged to have been high.

5.7 During a morning in early July 2016, the police received a report to the effect that a young woman had been running from some flats wearing only a dressing gown and flip-flops. A few minutes later, a man, who appeared to be looking for her, came out of the flats; he got

into a car and drove-off. A short time later, he returned with the young woman. The caller was concerned because the man was behaving aggressively towards the young woman.

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

Comment: *Adult A's medical records were not accessed during the review, so it is not known whether he had been diagnosed with testicular cancer.*

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

5.10 Suzi was assessed as being of standard-risk of abuse at the time, but it was subsequently revised to medium-Risk because of the previous incident. The PPN was shared with Cardiff Women's Aid as before.

5.11 The following month, Adult A telephoned the police to say his girlfriend was having difficulty breathing and that he had assaulted her the previous evening. He told the operator he had been *"Really, really horrible"* to her and that he had tried to resuscitate her. Suzi was taken to hospital by ambulance, but she could not be saved. She had sustained multiple injuries.

5.12 A neighbour gave evidence at the subsequent murder trial to the effect that he had heard a man calling *"You filthy whore".* He also heard the man saying, *"One day I'm going to kill you".* The neighbour's partner said she often heard the man shouting around 6-7am and it would end up with the woman screaming. It often sounded as if objects were being thrown around the flat.

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

5.14 Suzi had been admitted to hospital in July 2016 for surgery to a fracture of her jaw. She had a large swelling to her face and had difficulty opening her mouth.

5.15 Suzi said she had fallen about a week previously and had suffered a slight swelling, which then reduced, so she didn't think much of it. She added that the acute swelling had started two-days previously.

5.16 The following day, Suzi went for surgery. The surgeon found that the fracture had healed and that there was no mobility to Suzi's jaw. The surgeon was of the opinion that Suzi's injury had been sustained at least three-to-four-weeks before the surgery.

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

6 KEY ISSUES ARISING FROM THE REVIEW

6.1 There was evidence during the police investigation that Adult A specifically sought a girlfriend of 'Far Eastern' appearance. The review panel believe that Adult A possibly harboured a hyper-sexualisation and fetishisation of Asian women, which is a known form of racial discrimination. It is based on a perception that a small-bodied Asian woman is likely to be softly-spoken, gentle, submissive and non-confrontational. An underlying element of it is that the man is able to own and to possess the Asian woman and that he has the power easily to hurt her.

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

6.3 The review panel was also of the opinion that Suzi likely experienced multiple layers of vulnerability while she was in the United Kingdom and her awareness of just how vulnerable she was may have been limited. Post-graduate study brings with it limited contact between university staff and the student and consequently Suzi may well have felt lonely and isolated, which the panel felt could explain why she sought friendship via an internet dating website.

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

7 CONCLUSIONS

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

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

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

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

7.5 There were several opportunities that were missed for health professionals to 'routinely enquire' or exercise 'professional curiosity' about any domestic abuse experienced by Suzi. The 'Ask and Act' process was in place within the hospital at the time, which is designed specifically to encourage and enable staff to undertake routine enquiry, but even though the explanations Suzi gave to account for her broken jaw (and bruising to her knees and legs) were inconsistent with the medical evidence and her brother apparently queried with medical staff how she came by her injuries, there is no indication in the records that domestic abuse was ever properly considered.

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

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

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

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

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

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

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

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

8 LESSONS TO BE LEARNED

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

8.2 An associated lesson learned for agencies is that they are less likely to become aware of an international students' plight than they would a student from the UK. Therefore, there is a need to make international students aware of how their vulnerabilities can be exploited by

those that seek to take advantage of them and what they should do about it if they think they may be in that position.

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

9 RECOMMENDATIONS FROM THE REVIEW

GENERIC

- Awareness raising about domestic abuse, how and to whom to report it and the associated services that are available to victims (for overseas students in particular) should be commissioned

- Efforts should be made to engage with the Chinese communities in Cardiff specifically around domestic abuse and the services that are available to victims

- That agencies should explore whether contingency plans can be put in place to mitigate the impact of a victim not being contactable by telephone.

CARDIFF METROPOLITAN UNIVERSITY OF WALES

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

SOUTH WALES POLICE

- South Wales Police to work towards finalisation of the Information Sharing Protocol currently in development to strengthen and enhance the sharing of safeguarding information between the service and the universities in its area

- Training to be amended to reflect the importance of enquiring about and recording on PPNs where victims and/or perpetrators of domestic abuse are university students and where they study

- Risk-assessment processes to be updated to include the sharing of PPNs with Police Student Liaison Officers where either the victim or perpetrator disclose that they are university students

Staff to be reminded of:

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

- The need to challenge victims and perpetrators with the information provided by the reporting person where appropriate

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

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

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

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

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

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

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

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