LONDON BOROUGH OF SOUTHWARK
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

BARBARA HUBERT AGED 33

MURDERED IN NOVEMBER 2018 IN SOUTHWARK

REVIEW PANEL CHAIR AND REPORT AUTHOR
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Domestic Violence Homicide Review Panel – LB Southwark CSP
'Barbara Hubert' murdered by 'Adam Smith' and both found dead in Southwark In November 2018

EXECUTIVE SUMMARY

Introduction

This summary outlines the process taken by the Community Safety Partnership Domestic Violence Homicide Review Panel established in March 2019 under s9 Domestic Violence, Crime and Victims Act 2004 by the London Borough of Southwark (LBS), independently chaired by Bill Griffiths CBE BEM QPM, to review the murder of 'Barbara Hubert' (not her real name) aged 33, caused by being pushed from her 8th floor flat in early November 2018 by her partner, Adam Smith (another pseudonym) also aged 33.

The process began with a meeting of all agencies that potentially had contact with those involved prior to the death of Barbara. Agencies participating in the review were:

Primary Care Services – GP Practices for Barbara and Adam (Individual Management Review (IMR) provided)
South London and Maudsley NHS Foundation Trust (SLAM) (provided IMR)
Guy's and St Thomas' NHS Foundation Trust (G&StTH) (provided chronology of contact)
Kings College Hospital NHS Foundation Trust (KCH) (provided chronology)
London Ambulance Service NHS Trust (LAS) (provided IMR)
Metropolitan Police Service (MPS) (provided letter with chronology)
LB Southwark Safeguarding Board
Specialist drug and alcohol addiction advice - Southwark Drugs and Alcohol Action Team
Specialist domestic abuse advice – Solace Women's Aid

A helpful source of background information was from family members and friends and colleagues of the couple. Both families were provided with Home Office information on the DHR process and attention drawn to the advocacy services. They were provided with draft copies of the overview report and their feedback included. Each contributor has been allocated a pseudonym:

Edward and Susane Hubert, Barbara's parents (also contributed to Terms of Reference)
Sarah, Adam's former partner (deceased)
Marie, Adam and Sarah's daughter (aged 13)
Rose, Sarah's mother and guardian to Marie
Rae, Sarah's sister and aunt of Marie
Helen, Adam's former partner (Cardiff) and mother of Child B (aged 6)
Jane, Adam's former partner (Leicester)
Kate, Adam's girlfriend and mother of Child C (aged 3 weeks)
Nora, friend and former work colleague of Barbara
Nazia, Barbara's flat-mate
Jim, friend and work colleague of Adam

One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with Barbara Hubert's 'voice' at the heart of the process. This was an unimagined and appalling tragedy for Barbara's family and, through the Chair, the Panel offered their heartfelt condolences upon the loss of Barbara. For the family of the perpetrator, news of Adam's actions must have been profoundly shocking, as well as inexplicable, and they have endured loss, for which deepest sympathy is also offered.

The process ended when the Southwark Community Safety Partnership Board approved a final version of the overview report at a meeting on 4 June 2020.

Domestic Violence Homicide Review Panel – LB Southwark CSP
'Barbara Hubert' murdered by 'Adam Smith' and both found dead in Southwark In November 2018

Background information (The Facts)

Barbara is from Slovakia and came to the UK in 2006. With financial support from her parents, she studied media communications and then gained employment in the hospitality sector where she met a friend, Nora, and they remained close. In 2016, Barbara's parents purchased a two-bedroomed 8th floor flat in Southwark for her to live in. She invited a flat-mate, Nazia to live there and share the running costs.

Adam was born in Barbados in 1985 and when aged about 10, emigrated with his mother to the UK. They settled in LB Southwark where he attended a local school. His mother soon met another man and they had a son together. Thereafter, Adam had a troubled relationship with his mother due to not feeling accepted by her. They were estranged in the months leading up to the fatal incident. Adam was a field engineer with an IT service company and his work took him around Europe.

In 2003, Adam met Sarah who gave birth to Marie when aged 15 in 2005. He was living in Southwark at the time but moved in with Sarah's family in LB Bexley. After a year, he separated from them but maintained an interest and relationship with Marie. He then lived with Helen in Cardiff and they had a son, Child B in 2012. He then met and lived with Jane in Leicester for about two years before returning to Helen. In November 2015, Sarah died suddenly and unexpectedly due to a blood clot. Subsequently, Adam moved back to London to give more of his time and support to Marie who was under the guardianship of her maternal grandmother (MGM), Rose.

Adam had a history of depression from 2007 and this sometimes manifest in suicide ideation. In 2010/12 he disclosed substance misuse (cannabis and crack cocaine) and associated auditory hallucinations. He was given medication for depression and referred to the Community Mental Health Team (CMHT).

In June 2018, Barbara met Adam through a dating website and they were together for five months. Barbara told Nora that when Adam first walked in her flat he said: "I'm not going anywhere". Friends were surprised that Adam had moved in within 4 days of his first visit. Barbara told her parents and friends that Adam was not an outgoing type and did not enjoy being in the company of others. At social gatherings, he hardly spoke at all and this avoidance was noted by Barbara's parents as well when they visited for a short holiday in September.

Friends became aware from Barbara that Adam "masturbates a lot" and she was embarrassed by that. Nora's understanding of the reason that Barbara's flat-mate Nazia left in September was connected with this apparent compulsion. The disclosure to Barbara's friends is relevant to this review because the compulsion later manifest in the child sexual abuse (CSA) of Marie that, in turn, became a critical issue on the day of the fatal incident.

For the duration of their relationship, Barbara suffered from neck/shoulder and back pain that was so acute on occasions that she called an ambulance. The clinical notes have been examined for evidence of this condition being caused by domestic abuse and it was established that Barbara self-disclosed in September 2018 that the problem had persisted for five months, therefore, from before she met Adam.

In the early hours of a morning in early September, Barbara called NHS 111 to report that Adam had been talking about suicide for a day and been refusing to eat which had been going on for a

long time as if he was starving himself. Within the hour, Barbara had followed the NHS111 recommendation to take Adam to Kings College Hospital (KCH). The risk assessment identified Adam's substance misuse and feelings of hopelessness as risk factors. He suggested his children and his relationship with Barbara as protective factors. The impression gained was that he had: "mild depression and possible misuse of cannabis".

He was discharged back to his GP and seen by the Practice Psychiatric Nurse in company with Barbara. He disclosed a low mood and: "feeling like the neighbours are talking about him". A referral was made to Talking Therapies and they were booked as a couple for further work with the nurse.

Adam missed the Talking Therapies consultation but with Barbara attended an appointment with the GP Registrar who was sufficiently concerned that he referred Adam to specialist mental health services for a psychiatric opinion, specifically marking his referral as urgent, on the basis of possible psychotic symptoms (hallucinations and paranoid delusions) and history of a previous suicide attempt (in 2010). Adam was provided with a MED3 certificate for workplace absence. The South London and Maudsley (SLaM) CMHT liaison team reviewed the GP referral of Adam and concluded that secondary service input was not needed. He was advised instead to consider reducing his cannabis use as a first step toward treatment and he could access support via Change Grow Live (CGL) an adult treatment centre for substance misuse.

At the end of September, Barbara went with a friend on a week's holiday to Mexico. Text messaging reveals Barbara's continuing concern that Adam was not eating; and also his minimalist style of communication. When Barbara was away, Adam took Marie on a surprise day-trip to Cardiff to see Helen. Marie has described a period when her father was driving while: "scratching himself under his trouser for some time". She felt uncomfortable and made a comment at which he desisted.

In early October, possibly while Barbara was still on holiday, Adam's work colleague and friend, Jim, answered the door to Adam who aggressively grabbed him by the shoulders and said: "You're part of that gang aren't you?" He went on to refer to the "[company they both worked for] gang" saying they had planted listening devices in the walls of his flat, adding that they had purchased the flat above so they could spy on him. Jim tried to reason and calm him but Adam walked out.

In mid-October, Adam returned to his GP for another MED3, also treatment for neck pain for which he was referred for physiotherapy. The doctor noted he was struggling with depression but he denied thoughts of self-harm or suicide. This was his last GP visit.

Also in October, Barbara lost her job due to the time off she was taking for her shoulder/back pain. She made it known she was not sorry to leave and, within the following two weeks attended three job interviews, one of which she learned on the day of the fatal incident had been successful.

At around the same time the second incident of CSA by Adam of Marie occurred, again when he was driving her somewhere. On this occasion, she strongly objected and he said he would seek help. From that point Marie refused to speak to her father but would not disclose the reason to Rose or Rae. When Rose asked Adam why Marie had stopped talking to him he said there had been a few obstacles in the relationship and he: "Feels like shit". He did not elaborate further.

Within a week, Adam called his friend Jim saying: "Look after your kids; make sure they do alright in life". Also Barbara randomly called on Nora over the weekend and disclosed that she had been lent some money by a mutual friend and that she "hated being broke". Nora's view is that Barbara was in debt because of Adam; he paid nothing toward household bills and she paid for his expenses. In early November, Barbara's parents transferred £600 to her bank account because she had not received her final salary to the full amount

The day of the fatal incident

Adam messaged Marie to say he would be calling to see her later. Barbara drove him there but Marie had left to visit friends. Adam was clearly agitated and Rae took him to a coffee shop. There he confessed that he had masturbated in front of Marie and that she had told him to stop which he did. He expected to be sent to prison and was inconsolable at the horror of what he had done to his daughter.

Rae has some experience of social work and, in discussion with Barbara, called NHS111 for advice. The assessment was that a known mental health problem (from the September call record) had worsened; the individual was having suicidal thoughts. The advice was to attend nearby Queen Elizabeth Hospital (QEH) Emergency Department (ED) for assessment within an hour. Barbara and Adam did attend but left without being seen by a clinician, apparently they reasoned because Adam was already known to KCH, their local hospital.

Having reflected, Rae contacted NHS111 again and asked to speak to a manager. The advice given was that Barbara should call NHS111 again and Rae relayed this by messaging Barbara. This call is important to the review but there is no record at the London Ambulance Service (LAS) contact centre that provides the NHS111 service to North East and South East London. It appears that Rae's call may have been answered by another contact centre and the record of it has not been traced despite extensive enquiries. The significance of this gap in the picture is that when Barbara called NHS111 again, there was a link made to the earlier first call from Rae, but not to the second when she spoke to a supervisor.

Barbara made her call to NHS111 about two hours after Rae had made the first call. The system alerted the call handler to the link to Rae's first call but did not pick up on her intervening call to the supervisor that has not been found. It was noted that Adam's depression had worsened and the Southwark address was provided. The 'instruction' provided again was to attend an emergency treatment centre within one hour. They set out for KCH ED and it is apparent from Barbara's messages to Rae that Adam had physically resisted Barbara on the car journey and they had returned home. When Rae suggested in her messages that Barbara could call the police or ambulance, Barbara declined saying she did not want to call the police on him. The time was about 8pm and Barbara confirmed that Adam had retired to his room but that her door was open so that she could hear him.

The neighbours below had retired to bed and at about 11:30pm heard the unmistakable sound of a female screaming and a loud thud as her body hit the ground. Within two minutes another thud was heard. Police and paramedics were called a few minutes later and arrived to find Barbara and Adam fatally injured on the ground. The flat was secured from the inside. The Coroner has ruled that Adam murdered Barbara and then died by suicide.

A handwritten note prominently displayed in the flat was clearly addressed to Marie and was an admission of Adam's inappropriate behaviour toward her together with a request for forgiveness and an apology. It also suggested future intention to seek help. It is felt that this was probably written in advance of the visit to her home with Barbara earlier that day when Marie had left before their arrival.

Conclusions from the review

On the day of the fatal incident, Adam was experiencing a mental health crisis over his prior inappropriate behaviour to his 13-year old daughter. Barbara was helping to resolve his inner conflict by taking him to meet Marie at her grandmother's home in order for him to apologise and seek forgiveness for what he had done. That meeting did not happen and advice from a call to NHS111 was for Adam to attend a nearby A&E hospital, which he did but did not stay to be examined. A second call was not linked (and cannot be traced) and a third call, that was linked to the first, resulted in a journey to KCH that Adam aborted by struggling with Barbara and they returned home. Within four hours he had murdered Barbara and killed himself.

Adam had a long history of depression and suicide ideation linked to substance misuse that, from September 2018, had become more pronounced. He was assessed by a psychiatrist to have a 'dual diagnosis': "mild depression and possible misuse of cannabis" and placed unfit for work. However, he was not deemed to need secondary service input from SLaM. This would be reconsidered if symptoms persisted following six months abstinence from cannabis.

Prior to the fatal incident, there was no report of physical abuse by Adam. Taking the wider definition of domestic abuse, there was some evidence of his coercive control of Barbara: psychological – his mental health and well-being dominated their relationship while he showed no concern for her; sexual – his compulsive masturbation habit was a form of abuse; financial – he lived off Barbara's resources and contributed nothing from his; emotional – she made all the effort while he gave none and he was known for his moodiness, reclusiveness and minimal communication.

In addition to Adam's unresolved remorse for the abuse of his daughter, the Panel have identified seven other factors from the narrative above that added to pressure on his relationship with Barbara whereby she shifted from being a protective factor to an obstacle that threatened his position of control and his achievement of the goal of suicide. Many people hold the view that poor mental health makes people more likely to abuse their partner. The domestic abuse advocacy advice to the Panel is unequivocal: that a mental health condition does not increase the *likelihood* of domestic abuse, but the *severity* of it.

Edward feels strongly that the critical situation on the day of the fatal incident was handled badly, particularly in the final call made to NHS111 by Barbara. He made his concerns known in writing to the Coroner and these were written into the Terms of Reference for the review. He has had the opportunity to read a near-final draft of the overview and reasons: "in a critical situation, one should not wait for the situation to deteriorate into an unmanageable state. The information provided by Barbara in that call was alarming and should have prompted the dispatch of an ambulance to the scene".

The LAS conducted a 'Serious Incident' investigation as part of their IMR. The Panel have seen the findings and listened carefully to recordings of the NHS111 calls. They have considered the

powers available to paramedics and police under the Mental Health Act. The Panel agree with the finding of the LAS investigation that in the second call there was insufficient probing of cues and the potential severity of the patient's presenting symptoms were not fully explored. Despite this misgiving, the advice to attend A&E within one hour was appropriate given the information available to the call handler. Moreover, it cannot be known whether with further probing a higher outcome, such as an ambulance attendance, may have been more appropriate or a better outcome may have been achieved by passing the caller to a clinician.

Finally, it is acknowledged that much of this review has been focused on Adam and his story. This imbalance is caused partly by the disproportionate amount of information available to the review through his greater interaction with agencies, but it also reflects Barbara's kind and caring personality. It is obvious that she cared deeply for Adam and may not have recognised his behaviour as abusive. Barbara had lived in London for 12 years and had an excellent command of English. She had close English friends and was open with them and her parents about her relationship with Adam. If she had recognised the elements of his abuse, it is not known if she felt constrained, or there were barriers in reporting it or otherwise seeking help

Recommendations from the review

Six recommendations for internal improvements were made by IMR authors and these have been assembled in appendix 3 to the overview report and progress monitored by the Panel. Six wider recommendations were made for multi-agency improvement that the Panel debated and identified three strategic learning points arising from their review. A recommendation has followed from each:

Learning Point 1: Greater awareness is required by front-line professionals of the likelihood for the presence of mental health issues to increase the severity of domestic abuse

Recommendation 1

To identify and deliver an awareness programme for all front-line professionals that highlights the connection between mental health issues and domestic abuse

Learning Point 2: The system for managing psychotic patients who also have a substance misuse problem should provide better guidance to primary care

Recommendation 2

To review the system for managing psychotic patients who also have a substance misuse problem in order to provide and promote better guidance to primary care

Learning Point 3: The NHS111 system should be able to link earlier calls about the same patient when received by another contact centre

Recommendation 3

NHS England to review the NHS111 system to ensure that repeat calls about the same patient received in different contact centres are automatically linked

An Action Plan has been devised to implement these recommendations by November 2020.