Domestic Homicide Review
Under Section 9 of the Domestic Violence Crime and Victims Act 2004 (as amended)

In respect of the death of a woman
CerDHR2014-15/01

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Presented to Ceredigion Community Safety Partnership on 27th July 2015

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1. Introduction

1.1. At 9:24 on Monday 3rd March 2014 a 999 telephone call was put through to the police in which a man, now known to be the perpetrator, stated that he had killed his 'friend', a female. The call was made from a land-line and from an address the victim and perpetrator shared. He explained that his 'friend' was on the floor in the kitchen and that he had killed her whilst hallucinating that there were people coming to murder them and rather than allow her to be raped and killed he killed her himself. He had intended to kill himself as well. On arrival, the police discovered the female 'friend' had died following a vicious attack. The post mortem concluded that death resulted from her throat having been cut (a severed left carotid artery), but there were also several other slash and stab wounds including at least eleven which were consistent with defensive injuries. The perpetrator had also suffered a number of non-fatal and self-inflicted stab wounds to the abdomen and throat. He was taken to hospital where he refused treatment but later, following time in police custody, was returned and treated for his wounds. From the outset the perpetrator claimed to be mentally unwell and, following police questioning and treatment for his wounds he was assessed and transferred to a mental health facility.

1.2. On 12th March 2014 the Chair of the Ceredigion Community Safety Partnership (CSP) was notified of the death of the victim. The case was referred to a specially convened Domestic Homicide Review Steering Group meeting comprising representatives from the CSP responsible authorities for a preliminary discussion of the circumstances of the death and to discuss the incident against the criteria set out in the *Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2013)* and the *Ceredigion Domestic Homicide Review Protocol (2014).* The CSP Domestic

Homicide Review Steering Group initially met on 24th April 2014 and again subsequently on the 6th May 2014 at which time the decision was made to undertake a Domestic Homicide Review (DHR). The Chairs were contacted on 3rd June 2014 and informed of the decision and requested to undertake the review accordingly. The Home Office was notified on 7th May 2014.

1.3. In the production of this report, agencies have collated sensitive and personal information under conditions of strict confidentiality. The relationship (both with each other and, in relation to the perpetrator, with other people), family, medical and other relevant histories of the victim and perpetrator have been traced back over almost 25 years. Throughout the discussions the DHR panel and all agencies involved have balanced the need to respect the privacy and dignity of the family and respect for the criminal justice process with the need for all agencies to learn lessons and so improve safety for the future.

2. Purpose, Scope and Terms of Reference

2.1. Every DHR is intended to enable professionals to understand fully what happened and what needs to change to reduce the risk of such tragedies happening in the future. A DHR is not intended to inquire into how a victim dies or who is responsible for the death. Nor are DHRs part of the disciplinary process if errors are uncovered it is for the individual agencies to discover whether any individual is to blame.

2.2. The purpose of a DHR is outlined in section 3.3 of the *Multi Agency Statutory Guidance* (and re-iterated in the *Ceredigion Domestic Homicide Review Protocol*). The purposes are to:

- establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;
- apply these lessons to service responses including changes to policies and procedures as appropriate;
- prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2.3. The DHR panel determined not to set a time-limit on the investigation. The couple had lived in more than two locations and from early enquiries it became clear that the perpetrator's mental health had been of note over an extended period. For these reasons, it was important to trace information held by a number of agencies in various areas and over a relatively long time.

2.4. The present case was one in which initial information collected by the police and reported by other agencies present at the steering group indicated that there was little if any contact between the couple and any agency. Despite this it was felt that lessons could be learnt. In this situation the most important issues to be addressed were identified in the Terms of Reference as:

- The effectiveness of communication between the different agencies and individuals involved.
- The extent to which information was shared appropriately:
    - Within individual agencies.

- Between agencies.
- Across geographical boundaries.

- The effectiveness of risk assessment and risk management within the agencies involved.
- The effectiveness of communication between statutory bodies and third sector bodies.
- Could more have been done to raise awareness of services available to victims of domestic violence and abuse?
- Other matters as considered appropriate by the panel.

3. Process

3.1. General

3.1.1. Notification of the DHR was sent to agencies (statutory and voluntary) who were asked to identify whether there was any involvement with the couple or with either of the individuals and, if so, to undertake a management review of any contact with the victim and the alleged perpetrator. The organisations were asked to look critically and openly at individual and organisational practice to ascertain whether changes could and should be made and, if so, how this should be achieved. Each agency was asked to ensure a senior member of staff who had no prior involvement with the case would complete the Individual Management Review (IMR). Each agency was referred to the *Ceredigion Domestic Homicide Review Protocol (2014)* for guidance notes on how to prepare an IMR and for information concerning each aspect of the DHR. Where agencies had no contact with the couple, they were asked to complete a nil return but also consider whether they might review their procedures to ensure that they reach all those who need their support.

3.1.2. A DHR panel was established whose task was to ensure all relevant information was obtained and conduct a robust analysis of IMRs and any other information from family, friends, neighbours or colleagues. The Panel had joint independent Chairs, two lecturers from the Department of Law and Criminology at Aberystwyth University appointed to conduct such work when required in Ceredigion. They, along with the Chair of the Community Safety Partnership, appointed the rest of the panel ensuring representation from a range of agencies relevant to this case. In addition to agency panel members, a former General Practitioner was appointed as a panel member to act as a consultant. This was important because it was clear that the treatment, review and sharing of information from one GP surgery to another about the mental health of the perpetrator was going to be an aspect of the work of the DHR.

3.1.3. At the first meeting of the DHR Panel the terms of reference provided by the Chairs of the DHR in consultation with the Chair of the CSP were reviewed and agreed.

3.1.4. In this case, there was very little involvement by agencies and professionals with either the victim or the perpetrator. Despite this, five IMRs were received. All the IMRs were produced quickly and were of a high standard. The authors either were DHR panel members or were briefed by members of the panel. Three IMRs recorded no contact with the victim or the perpetrator, but then considered whether more could be done to raise awareness within their own agency.

3.1.5. Upon receipt of the IMRs a composite chronology of events was produced. The IMRs and integrated chronology were discussed by the

DHR panel and clarification and more information were requested and received. The IMR authors discussed their reports with the panel and amended IMRs were submitted.

3.1.6. Contact between the DHR panel and the Dyfed Powys Police investigation team was conducted through the Senior Investigating Officer who was a member of the panel.

3.1.7. Contact with family members was made by the independent Chairs.

3.1.8. The DHR panel met on five occasions, four of which were to consider the IMRs, information reports and to progress this Overview Report.

3.2. **Timeliness of the Review**

3.2.1. The DHR panel agreed that any legal proceedings had to take precedence and were very careful not to compromise any criminal investigation. Criminal proceedings went ahead and were resolved in November 2014.

3.2.2. This review has exceeded the six month timeframe specified for a DHR. Although we maintained momentum in the review delays were experienced. Firstly, we delayed to await the resolution of the case. Secondly, although we sent out press releases early in the process requesting information from the public, these were not published until after the court case was resolved and this caused a further delay. Thirdly, tracing the historic heath records from the 1990s took a little time. Finally, we allowed time after the resolution of the case to discuss things with the families.

3.2.3. The Overview Report and Action Plan was presented to the CSP on 27th July 2015 when the DHR report and action plan was agreed.

4. Domestic Homicide Review Panel

4.1. Independent Review Chairs and Authors: Professor John Williams and Kate Williams. Both of the Chairs are currently lecturers in the Department of Law and Criminology at Aberystwyth University. Both have legal training and Professor Williams is a barrister. Professor John Williams has experience of Serious Case Reviews. Kate Williams has legal training, has lectured in both law and criminology and has both practical (through being a trustee for VSO working with victims of domestic abuse) and research experience of domestic abuse.

4.2. The members of the panel are senior managers from the key statutory agencies. Some of the panel members were also the authors of the IMRs. IMR authors had no direct contact or management involvement with the case.

Panel Membership:

- Detective Chief Inspector from Dyfed Powys Police
- Assistant Director, Assurance Safety and Improvement, Hywel Dda University Health Board
- Head of Policy Support, Ceredigion County Council
- Domestic Abuse Co-ordinator, Ceredigion Domestic Abuse Forum. (whose remit includes liaison with all the voluntary sector bodies involved in domestic abuse within the area).
- Retired General Practitioner (with experience of both mental health and general practice).
- Ceredigion Community Safety and Civil Contingencies Manager

4.3. Panel membership was kept to a core minimum to permit the case to progress quickly and because it was clear from the outset that there had not been much contact between the couple and any agencies.

5. Individual Management Reviews

5.1. IMRs were received from the following agencies who were involved with the victim and/or the perpetrator:

Agency	**Original IMR received**	**Amended IMR Received**
Hywel Dda Health Board (for hospital and GP information in Dyfed Powys and from Hereford)	29/07/14	08/12/14
Ceredigion County Council	17/07/14	30/10/14

5.2. Information Management Reviews were received from the following agencies who did not have contact with either the victim or the perpetrator:

Agency	**Original IMR received**	**Amended IMR Received**
Dyfed Powys Police	08/07/2014	28/11/2014
Ceredigion Domestic Abuse Forum	09/07/2014	05/12/2014
National Probation Service	10/07/2014	24/11/2014

5.3. Thirteen agencies advised that they had no contact with either the victim or the perpetrator:

- Fire & Rescue Service

- Education;
- Probation Services;
- Statutory Housing Services;
- The Wallich (Third Sector Housing support services);
- The Care Society (Third Sector Housing support services);
- Homestart (family support);
- Health services (school nurses, health visitors, midwifery);
- West Wales Women's Aid;
- Hafan Cymru (Domestic Abuse Support);
- Rape & Sexual Assault Support Centre;
- Seren (Historic Abuse Counselling Services);
- Victim Support.

5.4. Each IMR noted the contact they had with either the victim or the perpetrator and analysed how they were dealt with and whether anything more could have been done. Each report goes broader than just this case looking at issues concerning how they might improve awareness and information sharing (even where it may not have had an impact on the outcome of this particular case).

5.5. The panel scrutinised and quality assured each IMR. Specific issues were raised and considered in depth at panel meetings. There were a number of requests for more information which resulted in amendments and additions. There was a timely response to all the queries raised.

5.6. All the IMRs were of a high standard; for most of the authors it was the first time they had undertaken an IMR.

6. Family Relationship Background

6.1. During their relationship, there was minimal contact between victim and perpetrator and their respective families. Their immediate known relations are:

	Relation	**Comment**
Victim	Brother	Minimal contact during the ten-year period leading up to victim's death.
	Mother	Passed away 2013
Perpetrator	Adult daughter	Victim and perpetrator spent the 2013 Christmas period with his daughter.
	Adult son	No known recent contact.

7. Chronological Sequence of Events (including criminal proceedings)

Date(s)	**Event**	**Comment**
11/1948	Victim born	
09/1954	Perpetrator born	Court record refers to dob as 11/1954
10/2002	Perpetrator arrested by West Mercia Police for breach of the peace. Assessed under Mental Health Act 1983.	Perpetrator sectioned under s.2 Mental Health Act 1983.
11/2002	Perpetrator discharged from detention.	

11/2002	Letter from hospital psychiatrist to Perpetrator's General Practitioner.	The diagnosis then was of a 'probable hypomanic episode and it refers to earlier (1998) diagnosis of 'a well systematised set of delusions involving various paranormal experiences'. It states that the risk of suicide is low and risk to others is moderate partly because when he is 'unwell' he has the potential for physical violence. Furthermore, it notes his reluctance to engage with mental health services.
2002 -	Ongoing contact between perpetrator and General Practitioner on a range of issues, including mental health.	GP in Herefordshire undertakes a number of mental health reviews. He is eventually removed from the Severe Mental Illness Register by his Ross on Wye GP, by which time perpetrator and victim had moved to Wales. History of mental

		illness not noted in the summary at his new GP surgery.
2004	Victim and perpetrator become involved. They are living in Herefordshire.	The precise nature of the relationship at times unclear (he is referred to as her lodger on occasions). However, their relationship appeared to be more than landlord tenant.
2011	Victim and perpetrator move to Pembroke.	Perpetrator gains some casual employment
09/2011	Victim purchases house in Ceredigion.	Perpetrator described as 'lodger'.
06/2012	Couple referred to RELATE by GP following a consultation at which both victim and perpetrator attended.	
07/2012	Victim diagnosed with breast cancer.	Ongoing contact with NHS.
06/2013	Victim presents at hospital with fractured right wrist.	Victim claims she tripped and broke her wrist
06/2013	Perpetrator states to a member of the public that victim's wrist broken following an	Victim attended fracture clinic on two occasions. Discharged on 23/07/2013

	argument between them that culminated in her attacking him. He states that he had to restrain her and in doing so, her wrist was broken. No Agency was made aware of this statement.	
09/14	Psychiatric Report	Perpetrator informed the psychiatrist that he had never previously been violent to any woman but that the victim's wrist was fractured when he was trying to restrain her from injuring a third party (the victim was intoxicated).
10/2013	Home in Ceredigion put on the market.	
11/2013	Victim fails to turn up for hospital appointment.	
02/03/2014	Last time victim seen alive by neighbours.	
03/03/2014	Paramedics find victim dead at home.	
03/03/2014	Perpetrator arrested on suspicion of murder of	

	victim.	
05/03/2014	Perpetrator assessed as being fit to be interviewed.	
07/03/2014	Perpetrator charged with victim's murder	Detained at Swansea Prison until 03/2014.
03/2014	Perpetrator transferred to Caswell Clinic for psychological assessment.	Perpetrator has undergone two psychiatric reports. Each report states that the perpetrator had been suffering from paranoid schizophrenia for the past 20 years and, at the time of the killing he had severe psychotic symptoms with complex delusional symptoms. The delusional ideas are longstanding and firmly entrenched.
08/14 and 09/14	Psychiatric reports	These detailed and very professional reports were prepared after the offense. GP records show a history of bipolar affective disorder.
10/2014	Perpetrator pleads guilty to and is convicted of	

	manslaughter by reason of diminished responsibility. The Perpetrator was sentenced to an indefinite hospital order under section 37 Mental Health Act, 1983.	

8. Family/Friends/Neighbours/Colleagues Involvement

8.1. As noted in 6.1, there was no contact between victim and perpetrator and their respective families, other than the visit by perpetrator's daughter over the 2013 Christmas period.

8.2. For a brief period in 2012, perpetrator had an acquaintance with a third person whilst living in Pembrokeshire. A statement was taken from this third person, but it did not have any bearing on the case. A number of neighbours and others provided statements as part of the police investigation into victim's death. These statements provided background information.

8.3. The perpetrator's son and daughter were contacted as part of the Panel proceedings. They were again contacted once the report was finalised by the Panel. Neither responded to the request to contact the Chairs.

8.4. The victim's brother was contacted and spoke at length on the telephone to one of the chairs when the panel was discussing the case. He provided some interesting background information to the relationship but nothing

that was relevant to the DHR. The brother was contacted again once the report was finalised by the Panel. He again responded, he discussed the report in detail and in person with the other Chair and stated that he was very supportive of the work that had been done. These conversations lasted for more than three hours in total.

9. Overview

9.1. The couple first appeared in the Dyfed Powys police area in February 2011. Both parties were British Caucasian, and neither was registered as disabled. Their general health status is described in 7 above. To begin with, they were in Pembrokeshire, but later settled in Ceredigion. The victim and perpetrator had a relationship over ten years, the exact nature of the relationship is unclear as in official records they both refer to the perpetrator as the victim's tenant. Neighbours and family report a more permanent and personal relationship. It is evident from the DHR that whatever the nature of the relationship it was turbulent, involving heated disagreements. However, there is no definite evidence that it was an abusive relationship or involved domestic violence. The only mention of relationship problems occurred in 2012 when the victim mentioned relationship difficulties to her doctor. The perpetrator was present. The doctor referred them to RELATE but, so far can be ascertained, they never made an appointment. There is no evidence that the problems were abusive in nature.

9.2. The perpetrator had been married and had two adult children. The victim had no children. The perpetrator had a history of mental illness, going back to at least 1997. However, at the time of the homicide he was not on the Severe Mental Illness Register, (his last assessment had been in 2011) and his GP in 2014 was not actively monitoring his mental health.

9.3. At their previous address, in Herefordshire, the only agencies involved were health, housing and police. The housing visits related to claiming financial support. In the case of the victim, the health visits were for physical health problems. In the case of the perpetrator the health links were often to do with mental health; he had been the subject of a s.2 Mental Health Act 1983 detention. His mental health needs had also brought him to the attention of the police. There is no suggestion in any of the mental health records that the perpetrator posed a risk to self or others.

9.4. Since their arrival in Dyfed Powys police area, the only agencies involved with the victim and the perpetrator were from health (GP and the hospital) and housing (the council's housing services). Otherwise both victim and perpetrator visited health care professionals for reasons not associated with any abuse. In 2012, during a routine visit to the hospital to investigate possible cancer the medical notes refer to discolouration on the victim related to the cancer site. In 2013, the victim was seen at hospital with a fractured wrist. However, nothing in the notes or the questions asked by health care professionals suggest that the discolouration or injuries were linked to domestic abuse.

10. Detailed analysis

10.1. General Practitioner

10.1.1. The perpetrator, during his time as a patient of the Herefordshire practice, was placed on the Severe Mental Illness Register following his discharge from the section 2 Mental Health Act 1983 detention. The perpetrator had no contact with Mental Health Services between 2003 and the time of the offense although he was on the Mental Illness

Register and it was noted that he had a history of bipolar affective disorder (manic-depressive psychosis). The IMR from Hywel Dda notes that the Herefordshire Practice removed the perpetrator from the Severe Mental Illness Register on the 6th February 2012 because of failures to attend review meetings. The most likely reason for his failure to attend was that the perpetrator and victim had left the area in early 2011 and moved to Pembrokeshire. It is unclear who took the decision to remove him from the Register – was it done by a doctor, practice nurse or administrator? This is not recorded in the patient's notes. In light of the assessment in 2002 of moderate risk to others if the perpetrator was unwell (presumably if he suffered a delusional episode), it is of concern that there is no reason recorded for the removal from the register. It is unclear whether there is a distinction between removal from the Register for clinical reasons following an assessment, and removal for failure to attend. The Panel felt that this was a weakness in the system. A failure to attend removal must be emphasised clearly in the records along with any ongoing concerns that the doctor may have. Given the potential significance of the decision to remove, a doctor should approve the decision. This will reduce the risk of any severe mental illnesses, and the need for ongoing reviews, being missed.

10.1.2. The perpetrator registered at the Ceredigion Surgery on the 8th August 2012 after moving from Pembrokeshire to Ceredigion. His medical records were received on the 12th August 2012. They were summarised by the Practice Note Summariser on the 19th September 2012. This follows the standard practice regarding the transfer of patients. However, the summary failed to note that the perpetrator had previously been on the Severe Mental Illness Register and was removed

only six months prior to registration with the Ceredigion Surgery. Had this been properly summarised it would have been picked up on the computerised system and the Surgery and Doctors alerted to the perpetrator's diagnosis. References to the historical mental illness were part of the file transferred to the new surgery in 2012. However, the old GP surgery's records only contained information on the perpetrator's depression and brief information concerning the reasons for his inclusion on the Register. It is unclear why the mental health information in these records was not picked up and noted in the new surgery's summary of the patient's notes. It seems likely that the reason for the omission is that he had been removed from the Register some six months earlier.

The basis upon which the decision to remove the perpetrator from the Severe Mental Illness Register will most likely affect the content of any summary made at a new surgery. Procedures must ensure that any ongoing concerns a doctor may have when a patient is removed from the Register for failure to attend are recorded and flagged up for inclusion in any subsequent record summary.

10.1.3. Although it would not have led to a different outcome in this case, the panel recommends that GP and Health Boards should review their procedures for:

a. removal of patients from the Severe Mental Illness Register;
b. the recording of the reason for doing so including any ongoing concerns;
c. ensuring the timely transfer of medical records to a new surgery and of their summary by the new surgery; and

d. the procedures for summarising patients records to ensure that areas of potential concern, particularly in relation to mental health, are clearly identifiable.

10.2. Health Board and Hospital Services

10.2.1. The victim presented to hospital on the 12th June 2013 with a fractured wrist. It appears that the perpetrator accompanied her. The victim attended fracture clinic two days later; the fracture clinic record notes that the victim advised that the injury had been sustained during a fall. Available X-Rays were reviewed during the DHR process and the injuries were noted as not being inconsistent with this version of events. Nothing in the notes indicates that this version of events was ever challenged or questioned. It is noted in one of the later psychiatric evaluations for the purposes of criminal proceedings that the perpetrator admitted fracturing her wrist whilst trying to restrain her from injuring a third party. However, this information was not conveyed to the hospital; both perpetrator and victim claimed it was a result of a fall. The Panel felt that the circumstances warranted at least some questioning of their version of events. This would include questioning the victim alone. Whereas practitioners are not required to make definitive assessments of such situations, hospitals must have procedures for ensuring that possible concerns are properly identified recorded and shared, on a confidential basis, with appropriate practitioners or agencies including primary care. Front line staff must be trained to identify possible domestic abuse and how they can ensure that any concerns are fed into the procedure.

10.2.2. The need for training in identifying, recording and sharing concerns should be a key priority within Health Boards and Hospitals. Joint

training with primary care providers is essential to promote a greater understanding of how to share concerns.

10.3. **Local Authority**

10.3.1. The victim and perpetrator had limited contact with the local authority; it was confined to Council Tax Benefit and Housing Benefit matters. Although policies were in place in respect of potential fraud and its investigation, there were no formal procedures or guidance relating to sharing information concerning wellbeing (including safety) of claimants either within the Authority or with other agencies. It was only more experienced staff who recognised that there was a responsibility on staff to report concerns relating to domestic abuse.

10.3.2. Domestic abuse procedures should be introduced that reinforce the duty of all front line staff across all departments in local authorities to record and share information within and outside of the authority relating to concerns about the suspicion or disclosure of Domestic Violence.

10.3.3. Local Authority Domestic Abuse policies should be widely disseminated to all staff and management as a matter of urgency.

10.4. **Police**

10.4.1. The Police were not involved in the relationship between the victim and the perpetrator as any concerns were not reported to them. Appropriate checks were made with other police forces to see whether there was any history of domestic abuse before the victim and perpetrator moved to the Dyfed Powys police area. The responses did not identify any history of domestic abuse.

10.4.2. It is essential that the Police in conjunction with other relevant Agencies continue with the design, development and implementation of the Multi Agency Safeguarding Hub (MASH) to identify possible cases of domestic abuse through the sharing of information. Once online, all relevant agencies should report concerns to the Police for inclusion on the MASH. There must be compatibility between information systems used by agencies in the Domestic Abuse Forum (or similar) and the central information hub to ensure that concerns are effectively and efficiently recorded. To be effective, it is essential that information concerning possible domestic abuse is fed back from the MASH to the appropriate persons within each of the agencies.

10.5. Third Sector

10.5.1. There is no evidence that either the victim or perpetrator had contact with a third sector organisation working in domestic abuse, although on the 13th June 2012 the couple were jointly advised by their GP to approach RELATE, a relationship counselling service. There is no evidence that they approached RELATE.

10.5.2. The police and other agencies need to keep in mind that the third sector can play a pivotal role in developing information sharing protocols. For example, one of the main domestic abuse organisations operating in the area already uses an information system, Modus, presently used by some police forces.

10.6. Domestic Abuse Forums

10.6.1. The local Domestic Abuse Forum, as with Forums elsewhere, is responsible for reducing incidents of domestic abuse, increasing

reporting, identifying preventative measures and awareness raising amongst agencies and the general population.

10.6.2. All the agencies involved in the local Forum need to review current measures to identify additional opportunities to increase awareness of domestic abuse including greater use of the media.

10.6.3. Similarly, all agencies involved in the local Forum should review current practices relating to identifying, recording and sharing concerns.

10.6.4. Good practice would suggest that both local and other forums explore means of fostering closer collaboration between all member agencies as it is only through trust between agencies that real information sharing is likely to arise.

10.7. **Procedural Matters**

10.7.1. The Panel was concerned that minutes of their meetings were regarded as being automatically subject to discovery in any subsequent criminal hearing. It was felt that this could inhibit open discussion and the ability to explore all options, and could delay the review of the case by the Panel. The Panel accepts that ultimately, a court could require discovery, however this should not be automatic and competing interests should be balanced before requests are made to disclose minutes.

10.7.2. During the review, the Panel sought the assistance of the local media to identify community members who might have contributed to its deliberations. It is regrettable that such assistance was not forthcoming until after the conclusion of the criminal proceedings. The media

should be encouraged to assist DHRs in identifying potential background knowledge.

11. Recommendations

11.1. Many of the recommendations have been acknowledged by agencies as part of the IMR process and there is already evidence to demonstrate that these matters have or are in the process of being actively addressed. They are, nevertheless, included as lessons learnt during the DHR.

11.2. General practitioners and Health Boards should review their procedures and ensure that:

a. the decision to remove patients from the Severe Mental Illness Register or from recall should be made by the medical practitioner responsible for the patient. The clinician must record the reason for doing so including identifying any ongoing concerns;
b. medical records are transferred to a new surgery in a timely manner; and
c. the procedures for summarising patients' records should be in line with current best practice to ensure that areas of potential concern, particularly in relation to mental health, are clearly identifiable.

11.3. Hospitals, General Practitioners and primary care contractors must have procedures, for ensuring that possible concerns are properly identified, recorded and shared, on a confidential basis, with appropriate practitioners or agencies including primary care. These procedures must be reviewed periodically. Front line staff must be trained to identify signs of domestic abuse and ensure that any concerns they have are fed into the procedure without delay. Staff uptake of training should be monitored.

The Domestic Abuse Forum should have an overview of the procedure and the monitoring of uptake.

11.4. The training of all staff to a level appropriate to their need, in identifying, recording and sharing concerns should be a key priority within Health Boards and Hospitals. Joint training with General Practitioners and primary care contractors will promote a greater understanding on how to share concerns. The training programme should be reviewed regularly and an overview of both the training programme review and the monitoring of uptake.

11.5. For local authorities:

a. procedures should be introduced that reinforce the duty of all frontline staff across all departments in local authorities to record and share information within and outside of the authority relating to concerns about the suspicion or disclosure of domestic violence;

b. Local Authority Domestic Abuse policies should be widely disseminated to all staff and management as a matter of urgency.

11.6. The Police, in collaboration with other agencies on the Domestic Abuse Forum, must continue to develop and implement a Multi-Agency Safeguarding Hub (MASH) to ensure the sharing of all information on possible cases of domestic abuse.

11.7. The third sector should play a pivotal role in developing information sharing protocols.

11.8. All the agencies involved in Domestic Abuse Forums (or equivalent) need to review current measures to identify additional opportunities to

increase awareness of domestic abuse including greater use of the media. Similarly, all agencies involved in the forum must have procedures relating to identifying, recording and sharing concerns and for the provision of training. This must include considering what are the indicators of abuse and identifying coercive conduct by the perpetrator. In designing these, lessons may be learnt from child protection and adult safeguarding procedures. These procedures should be considered by the forum and revised when appropriate. The training programme should be regularly reviewed and participation monitored. Monitoring reports should be considered by the forum.

11.9. In order to encourage open discussions at DHR meetings, minutes should not normally be discoverable. This will facilitate open discussion in the DHR meetings. Only in the case of a public interest to disclose being established should they be made available.

11.10. Consideration should be given to developing a template for a public information notice to be inserted in local newspapers. The media should be encouraged to be more involved in assisting DHRs particularly in identifying any background knowledge of the case from members of the public.

11.11. While not arising directly from this review but mindful of the implementation of the *Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015*, all Agencies should encourage the speedy adoption of a Domestic Abuse designated lead in line with the VAWDASV Act. Thought should be given to expanding this to all GP Surgeries by having Domestic Abuse Lead Partners along the same lines as existing Child Protection Leads.

12. Conclusion

12.1. Whilst the relationship between the victim and perpetrator was turbulent and they argued a lot, throughout both this review and the criminal investigation there has been no clear evidence that the relationship between the victim and perpetrator was abusive. Whilst in the past the perpetrator had suffered mental health problems these seemed to have stabilised and in 2011 his then GP removed him from the Severe Mental Illness Register. The mental health problems were not noted by his present GP and were therefore not being monitored. It seems likely that they had begun to manifest themselves again though it is not clear whether this occurred before or after the death.

12.2. Therefore whilst there was a history of mental health issues there seems to have been no indication that these had re-emerged.

12.3. Sadly, the death of the victim in this case could not have been predicted. However, there is a possibility that the risk of such incidents in the future could be reduced if the reasons for removing a patient from the Severe Mental Illness Register are clearly recorded, along with any ongoing concerns. Where medical records are transferred between surgeries, it should be done in a timely fashion. Procedures for summarising such records at the recipient surgery should ensure that areas of potential concern, particularly in relation to mental health, are identified.