Pen-y-bont ar Ogwr
Mwy Diogel

Safer Bridgend
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Domestic Homicide Review
Overview Report
DHR 03

Report into the death of a 67 year old woman (Mary)

On 20th June 2015

Report produced by Malcolm Ross M.Sc
Independent Chair and Author

May 2017

Statement from the Daughter and Son of Mary

“Our mother was a very capable person. Everyone would go to her if they needed help. She was a strong person, a matriarch, the head of the family, of the business, of everything.

She was very sure of her opinions, there was no beating about the bush, you knew where you were with her, we always could and did go to her. She was generous with her time – with the wider family, as well as with her immediate offspring. She was charitable in that respect and also supported local charities.

We hope this report will do justice to our mother’s life and help us and future generations to understand why this tragedy happened”.

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List of Abbreviations

AAFDA	Advocacy After Fatal Domestic Abuse
ABMUHB	Abertawe Bro Morgannwg University Health Board
A&E	Accident and Emergency Department at Hospital
ARC	Assisting Recovery in the Community
BCBC	Bridgend County Borough Council
BCSP	Bridgend Community Safety Partnership
CART	Contact Assessment Review Team (Social Services)
CDAT	Community Drug and Alcohol Team
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disorder
CPS	Crown Prosecution Service
DHR	Domestic Homicide Review
GP	General Practitioner (Doctor)
HRPW	Harm Reduction Project Worker
IMR	Individual Management Review
ISP	Initial Sentence Plan (Probation)
MARAC	Multi Agency Risk Assessment Conference
NPTCBC	Neath and Port Talbot County Borough Council
OASys	Offender Assessment System (Probation)
Ogwr DASH	Ogwr Drug and Alcohol Self-Help Group
PPD1	Police Public Protection Referral Form
PPN	Public Protection Notification (PNN replaced PPD1 in 2014)
RSL	Registered Social Landlords
SARA	Spousal Assault Risk Assessment
SAS	Single Assessment Service
SIO	Senior Investigating Officer (Police)
SMART	Substance Misuse Assessment Referral Team

WAST	Welsh Ambulance Service Trust
WCADA	Welsh Centre for Action on Dependency and Addiction previously WGCADA changed October 2013
WIISMAT	Wales Integrated In-Depth Substance Misuse Assessment Tool

INTRODUCTION AND BACKGROUND

1.1 Introduction

1.1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 67 year old woman, (known in this report by the pseudonym of Mary) on 20th June 2015. Her son (known as P) was arrested and charged with her murder. P appeared before the Crown Court in February 2016, but the jury were unable to reach a verdict. There was a second trial in April 2016 when on 15th April P was convicted of murder and on 18th April 2016, he was sentenced to life imprisonment with a recommendation from the trial Judge that he is to serve 20 years.

1.2 Purpose of a Domestic Homicide Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011 and reviewed in December 2016[2]. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[3], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*
>
> - *psychological*
> - *physical*

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.

- *sexual*
- *financial*
- *emotional*

The new guidance also included controlling and coercive behaviour as being:

> "Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
>
> Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

1.2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

- Establish what lessons are to be learned from the 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 on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.
- To assist the victim's family in their meaningful healing process.
- Contribute to a better understanding of the nature of domestic violence and abuse : and
- Highlight good practice

1.3 Process of the Review

1.3.1 South Wales Police notified Bridgend Community Safety Partnership of the homicide on 25th August 2015. Crown Prosecution Service (CPS) had been advised of the death and concluded on 13th July 2015 that there were grounds to charge P. Bridgend Community Safety Partnership Review Steering Group, a sub-group of BCSP, reviewed the circumstances of this case against the criteria set out in Government Guidance and recommended to the Chair of BCSP that a Domestic Homicide Review should be undertaken. The Chair ratified the decision.

1.3.2 The Home Office was notified of the intention to conduct a DHR on 25th August 2015. An independent person was appointed to chair the DHR Panel and a second independent person appointed to write the Overview Report. At the first review panel terms of reference were drafted. On …… the Community Safety Partnership Board approved the final version of the Overview Report and its recommendations.

1.3.3 Home Office Guidance[4] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

1.4 Independent Chair and Author

1.4.1 Home Office Guidance[5] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on evidence the review panel decides is relevant, " and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

1.4.2 Bridgend County Borough Council (BCBC) decided that in this case to appoint both an independent chair and an independent author.

1.4.3 The Independent Author and Chair, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing over 90 Serious Case Reviews and chairing that process and, more recently, performing both functions in relation to Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies or the Local Authority. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.4.4 Mr Ross is a consultant to Winston Limited, and works with Mr Martyn Jones who is also a DHR author and has worked alongside Mr Ross in this review.

[4] Home Office Guidance 2016 pages 16 and 35
[5] Home Office Guidance 2016 page 12

1.5 Domestic Homicide Review (DHR) Panel

1.5.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mr Ross chaired the panel. Other members of the panel and their professional responsibilities were:

Name	Designation	Agency
Malcolm Ross	Principal Independent Chair & Author for this review	
Martyn Jones	Independent Chair & Author from Winston Partnership	
John Davies	Community Safety Team Leader	BCBC
Bethan Lindsay-Gaylard	Domestic Abuse Co-ordinator	BCBC
Zoe Wallace	Head Primary Care (Bridgend & Neath Port Talbot)	ABMU
Paula Wade	Victim Support	
Lynn Davison	Deputy Head of Safeguarding Adults	ABMU
Vaughan Jenkins	Group Manager Operations Department Bridgend & Vale of Glamorgan UA's	Fire and Rescue
Sue Hurley	Independent Protecting Vulnerable Person Manager	South Wales Police
Rosie Frewin	Regional Development Manager - Western Bay Calan DVS	Calan DVS
Elizabeth Walton-James	Group Manager – Safeguarding & Quality Assurance	BCBC
Debbie Osowicz	Deputy LDU Head National Probation Service	National Probation Service
Rhian Jones	Team Manager South Wales 2	Probation
Naomi Drew	Inspector – Community Safety Partnership	South Wales Police
Russell Warwick	Adult Protection Officer	BCBC
Becky Hancock	Deputy Chief Executive	WCADA
Karen Evans	Business Support Officer	BCBC

1.5.2 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

1.5.3 The Panel was supported by the DHR Business Support Officer, as described in table above. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.6 Parallel Proceedings

1.6.1 The Panel were aware that the following parallel proceedings were being undertaken:

- BCSP advised HM Coroner on 7th January 2016, that a DHR was being undertaken.
- The review was commenced in advance of criminal proceedings having been concluded and therefore proceeded with awareness of the issues of disclosure that may arise.

1.7 Time Period

1.7.1 It was decided that the review should focus on the period from 1st January 2011 (the start of the year when Mary's husband. known as Michael, died), up until the time of death of Mary on 20th June 2015, unless it became apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended.

1.7.2 The review also considered any relevant information relating to agencies contact with Mary and P outside the time frame as it impacts on the assessment in relation to this case.

1.7.3 The review also considered P's involvement in the family run business around 2006.

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1.8 Scoping the Review

1.8.1 The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the BCSP to identify agencies that had involvement with Mary and P prior to the homicide. Where there was no involvement or insignificant involvement, agencies were advised accordingly.

1.9 Individual Management Reports

1.9.1 An Individual Management Reports (IMR) and comprehensive chronology was received from the following organisations:

- Abertawe Bro Morgannwg University Health Board (ABMUHB)

- Bridgend County Borough Council Adult Services Well Being Directorate
- MARAC[6]
- Mental Health
- National Probation Service
- South Wales Police
- Welsh Centre for Action on Dependency and Addiction (WCADA)

1.9.2 In addition reports were received from:

- Fire and Rescue Service
- NPT Children's Services
- WAST

1.9.3 Guidance[7] was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

1.9.4 Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the Overview Author and the Panel.

1.9.5 The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

1.10 The area

1.10.1 The town where this Family resided at the time of the homicide is situated in the M4 corridor of South Wales. It is a small town with just over 10,000 residents, the majority being aged between 25 years to 64 years. There are very few residents aged between 16 and 24 years (only 9%)

1.10.2 The main employment of the residents is classed as professional occupations followed by those within the skilled trades and administrative and secretarial worlds. Unemployment is low, around 5%. The majority of people are in full time employment (30%) or retired (20%). 40% of residents have no formal

[6] MARAC – Multi-Agency Risk Assessment Conference – comprising of representatives from statutory and voluntary agencies where discussions regarding risk assessments for victims of domestic abuse take place and a safety plan for the victim is agreed.

[7] Home Office Guidance 2016 Page 20

qualifications while those with GCSEs, A level or degrees constitute around 55% of the population.

1.10.3 The majority of the households (38%) consist of one family with no dependent children, followed by 34% of household which are single occupancy.

1.11 Summary

1.11.1 Mary was a widowed lady whose husband, Michael died in 2011. They had four children, two sets of twins. The oldest twins are P and his brother, known as Kurt. The second set of twins, was a male, known as Josh, and female, known as Jessica. Josh died aged 33 years from an overdose of prescribed drugs in 2015. All of the remaining children are now adults with their own families.

1.11.2 Kurt told the review that initially Michael ran a successful furniture and upholstery business and following his death Mary and her two boys, P and Josh continued to run the business. Kurt helped now and again.

1.11.3 In the months before the death of Mary, P had been drinking heavily. He had sought help from his GP and other medical sources as well as mental health in an attempt to curtail his drinking habits. He made it clear to professionals that he did not want to stop drinking altogether.

1.11.4 On the afternoon of 19th June 2015, Kurt was helping P move property from a van on the driveway of their mother's house into the garage. P had been sleeping rough in the workshop of the family business and only days before, his mother had asked him to move into and share her house so he would have a proper home.

1.11.5 At about 4.00pm P told Kurt that he had had enough of work and went into the house to sleep. He woke at about 5.00pm and went to a local public house for a drink. Kurt finished off the property moving and joined P at about 6.00pm by which time P had had quite an amount to drink. Kurt left his mother in her house 'alive and well'.

1.11.6 During the afternoon of the following day, 20th June 2015, Jessica became increasingly concerned about her mother's safety as she could not contact her. She sent her husband (known as Jack) to her mother's house, and through the front window of the house, Jack saw something under a blanket on the lounge floor. He banged the front door and P arrived from inside the house and attacked Jack. P was armed with a Stanley type knife. He threatened to kill Jack but P was overpowered and Jack managed to contact the police. He found the body of Mary under the blanket on the floor.

1.11.7 P returned to the lounge of the house and when the police arrived he was drinking whiskey from a bottle. P was arrested for the murder of his mother.

1.11.8 Other emergency services were despatched to the address and Mary was pronounced dead at the scene. The opinion was that she had been dead for some time. A Home Office Pathologist attended and at a later post mortem examination, ascertained that Mary had died as a result of a series of stab wounds.

1.11.9 A trial took place at the Crown Court during February 2016, but the jury were unable to return a verdict. There was a second trial in April 2016 when on 15th April P was convicted of murder and on 18th April 2016, he was sentenced to life imprisonment with a recommendation from the trial Judge that he is to serve 20 years.

2. Terms of Reference for the Review

2.1 The aim of the DHR is to:

- 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;

- Identify clearly what the 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;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate;
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working,
- Contribute to a better understanding of the nature of domestic violence and abuse : and
- Highlight good practice

Process

2.2 An Independent Chair/Author has been commissioned to manage the process and compile the report. Membership of the Domestic Homicide Review Panel will include representatives from relevant agencies.

Individual Needs

2.3 Home Office Guidance[8] requires consideration of individual needs and specifically:

> 'Address the ten protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

2.4 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

[8] Home Office Guidance 2016 page 36

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

2.5 The review gave due consideration to all of the Protected Characteristics under the Act.

2.6 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

2.7 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act. However evidence of P's previous history of aggressive behaviour towards his former female partners was an important consideration when gathering evidence for the review.

Family Involvement

2.8 Home Office Guidance[9] requires that:

> "Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

2.9 The 2016 Guidance[10] illustrates the benefits of involving family members, friend and other support networks as:

> a) assisting the victim's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide;
>
> b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased, helping the process to focus on the victims and perpetrator's perspectives rather than just agency views.
>
> c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.
>
> d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of the victim and/or

[9] Home Office Guidance 2016 page 18
[10] Home Office Guidance 2016 Pages 17 - 18

perpetrator in order to see the homicide through the eyes of the victim and/or perpetrator. This approach can help the panel understand the decisions and choices the victim and/or perpetrator made.

e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

2.10 In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from South Wales Police at an early stage. Contact with the children of Mary was initially made by letter, telephone and home visits, explaining the review process and inviting them to contribute to the review should they wish to do so.

2.11 On 7th January 2016, the Author visited Mary's daughter, Jessica, at her home. She indicated that she wished to partake in the review process. Later that day the Author met the son of Mary, Kurt. He was also the twin of P. He had a considerable amount of information to disclose to the Author.

2.12 The Author has kept the family informed of the process throughout. The Author has met with Jessica and Kurt together with a representative of AAFDA on several occasions and they have made valuable contributions to the overview report. Arrangements were made for them to meet the panel members as per 2016 guidance[11].

2.13 Comments made by the family members have been included and referred to in this report. Please see section 'Views of the Family'.

2.14 A letter inviting P to contribute to this review was sent to him and his solicitor whilst P was in HM Prison on remand. He has not acknowledged the letter or

[11] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office – December 2016 para 53 (b) page 17

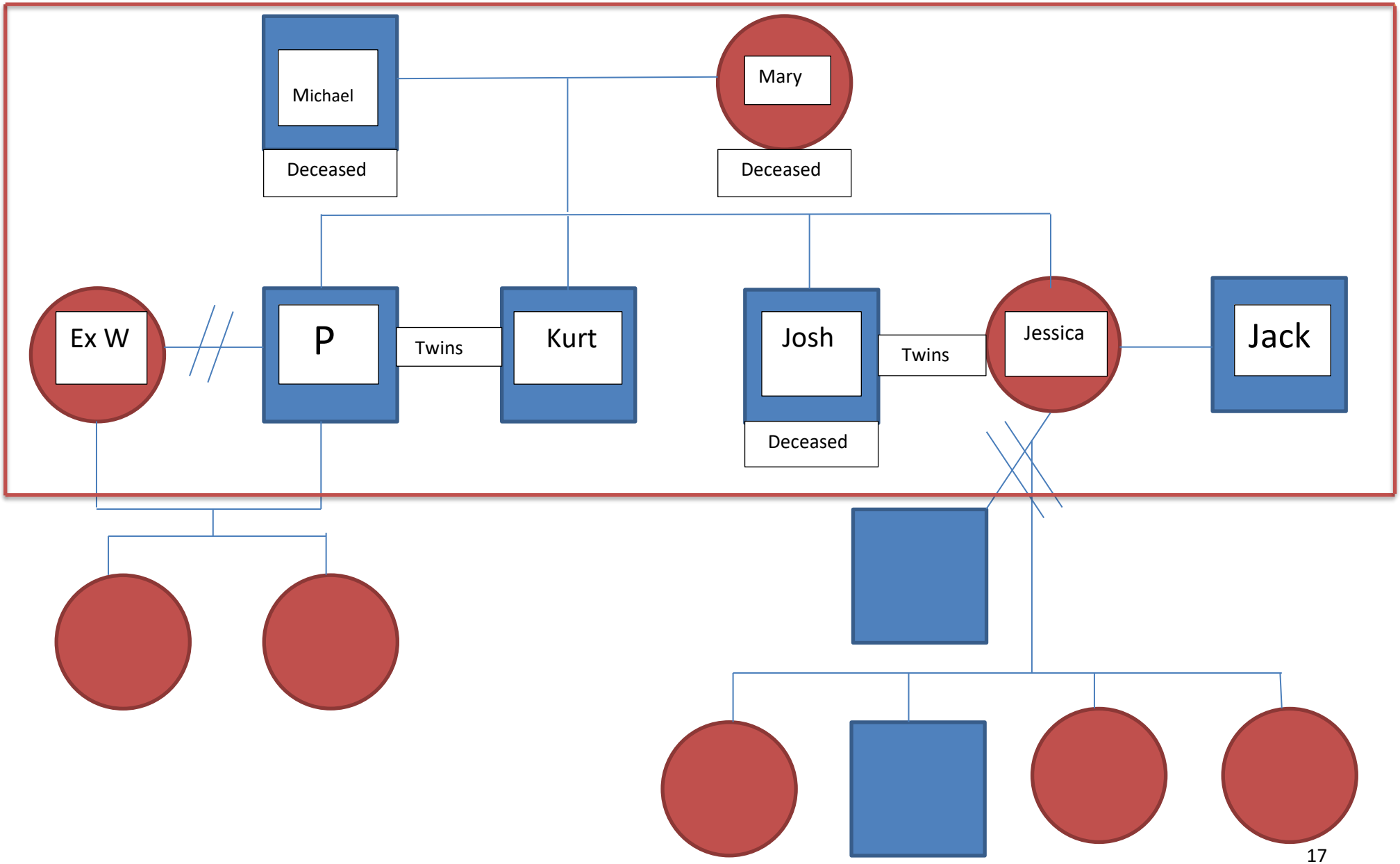
indicated that he wishes to be seen as part of the review. He has not replied to a request for the review to have access to his medical records.

2.15 Family members have been supplied with a redacted copy of the Overview report and the Executive Summary of this report.

Subjects of the Review

2.16 The following genogram identifies the family members in this case, as represented by the following key which has been agreed by family members.

Known as	Description of relationship to Victim
Mary	Victim
P	Perpetrator Son of Mary – Twin of Kurt - brother to twins Josh and Jessica
Kurt	Son of Mary – Twin of P - brother to twins Josh and Jessica
Josh	Deceased – Son of Mary – Twin of Jessica – brother to twins P & Kurt
Jessica	Daughter of Mary – Twin of Josh– Sister to Twins Kurt and P.
Michael	Deceased – Husband of Mary
Jack	Husband of Jessica – Son in Law of Mary
Ex W	Ex-wife of P


Michael
Deceased
Mary
Deceased
Ex W
P
Twins
Kurt
Josh
Deceased
Twins
Jessica
Jack

Female **Male** **Separated/Divorced**

3. Summary of Key Events.

3.1 GP records indicate that Mary had suffered from Chronic Obstructive Pulmonary Disease (COPD) for some time, but her condition was reviewed annually and was controlled.

3.2 On 30th July 2011, the Emergency Call handler at South Wales Police received a call which was traced to Mary's home address. The caller was a male person who stated that he was being attacked. When asked if an ambulance was required, he stated that he was the attacker and shouting and swearing could be heard in the background.

3.3 Police Officers attended and found Mary and her son Josh (now deceased) were present and had been engaged in a heated argument. Both were spoken to separately, they declined to tell the police what it was about, but mention was made about Mary's husband Michael having died which had caused Josh to suffer from depression, for which he had been prescribed medication.

3.4 Josh explained that he was feeling worse due to a failed internet relationship, his father's death and the fact that he was not taking his medication. One of his older brothers, Kurt came to Mary's house and collected Josh. Prior to leaving the police advised Josh to seek medical advice regarding his mental health issues.

3.5 The police officers who attended created a record on the police NICHE system with warning markers of 'suicidal' and 'mental health'. They also marked Mary's home address with a critical marker on the Common and Control Police System and a PPD1[12] form was submitted.

3.6 Two days later on 1st August 2011, Kurt called the police expressing his concern about Josh living with Mary and having mental health problems. Josh had apparently been behaving aggressively towards Mary. Kurt stated that during the incident on 30th July 2011, to which the police had attended, Josh had picked up a knife but had not made any threat to harm his Mother or himself but neither he nor Mary had mentioned that to the police when they had been in attendance

3.7 Kurt was asking for advice, and arrangements were made for him to see a particular police officer, but Kurt did not keep the appointment. Another PPD1 form was submitted. As Mary had not disclosed when officers had attended her home on 30th July, the incident was finalised.

3.8 During the evening of 27th October 2012, ExW contacted the police saying that she and P, her then husband, together with their two children had returned home to their house in a nearby Borough. P had become aggressive and argumentative.

[12] PPD1 – A South Wales Police Public Protection Form that includes a risk assessment measurement.

3.9 There had been mention about a separation. She complained that P had consumed intoxicating liquor and had been drinking all day.

3.10 ExW put her children to bed and upon doing so, P requested her to go down stairs and she refused to do so. P had gone to the children's bedroom with two knives saying, 'We are going to be in the news in the morning'. This caused two daughters to become terrified; they pleaded with their father not to hurt them. P put the knives down and he said 'Can we get over this?' and then he shouted to his children not to say anything about the incident. When ExW went to retrieve the knives P pushed her away onto the bed. He picked up the knives again and left the bedroom. A subsequent conversation took place between them downstairs during which time P did not have a knife in his possession. Following that discussion, ExW went to the children's bedroom and waited until P fell asleep.

3.11 Once P had fallen asleep, she and the children ran from the house to her parent's house and called the police. Officers attended, took a statement from her and went to P's address and he was arrested. He was interviewed and admitted the argument with his wife in front of the children but denied having knives. He was charged with an offence of affray and eventually he appeared before Swansea Crown Court where, on 30th January 2013, he was sentenced to 36 weeks imprisonment suspended for 2 years and he was ordered to carry out 150 hours unpaid work. A Restraining Order was also issued for the protection of ExW and her children, which would last for 5 years.

3.12 The police action during this series of events indicated that a PPD1 form submitted initially indicated a High Risk assessment. Information was shared with Social Services, Probation, Health, Independent Domestic Violence Advisor (IDVA) and the South Wales Police Domestic Abuse Unit. The whole issue was referred to MARAC. During his period on bail, P was not allowed to approach ExW or the children.

3.13 On 29th October 2012, a Strategy Discussion took place following the referral made about ExW and her children. It was agreed that Social Services would conduct an Assessment on the family, who were, by this time, staying at ExW's parents' house.

3.14 On 30th October 2012, a Critical Warning Marker was created on South Wales Police Command and Control Systems in relation to ExW's parent's address, which ensured that any call to that address would be treated as urgent. Positive action would have been expected and in that event officers would attend without due delay and deal with any situation that had taken place in an assertive manner, making arrests if necessary. In addition arrangements were made for an alarm system to be fitted to her parents' address.

3.15 On 31st October 2012, Social Services indicated that ExW was seeking a divorce from P and arrangements were being made to sell the family home. ExW initially declined the offer from the police for a 'Police Watch' on the

address but later consented to a process of 'walk and drive passes' on a regular basis by officers. This continued for 6 weeks and all visits to the premises and area were logged and documented.

3.16 On 5th November 2012, ExW contacted the police reporting that P had removed £4000 from their joint bank account and had been paid into Mary's account. ExW was also concerned that P had written to the children's school and she thought he may visit the school and collect the children. ExW was advised that no criminal offences had apparently been committed but a PPD1 form was submitted and shared with partner agencies on 9th November 2012. This matter was also reported to Children's Social Care.

3.17 On 16th November 2012, a MARAC in a neighbouring borough was held where ExW was discussed. Actions were raised and agreed. The actions raised for the police had been addressed. Another MARAC was held due to ExW and the children moving nearby with ExW's parents.

3.18 During November 2012, Probation had dealings with P due to his court appearances. There was sharing of information between the Court Administration and MARAC.

3.19 On 25th November 2012, a 999 call was received that was traced to Mary's address. A man's voice could be heard shouting and swearing in the background. Another call was made a few moments later where Mary stated that she was having problems with Josh who was suffering with his nerves. Officers attended and found Josh drinking a can of lager. He was agitated and he explained that he had been prescribed medication for clinical depression and Anorexia. He added that he was not taking his medication and that he had recently travelled to Switzerland where he intended to take his own life. He explained this was because of the failed internet relationship. He said that he intended to go back to Switzerland within the next month and he intended to commit suicide.

3.20 Officers attempted to persuade Josh to seek medical advice from hospital on a voluntary basis. He then ran from his mother's house into the road where he continued to make threats to kill himself. Officers detained Josh under Section 136 of the Mental Health Act 1983. He was taken to hospital for an assessment, but due to his level of intoxication, an assessment was not possible. He was then taken to the Police Station as a place of safety overnight. The following morning he was returned to hospital where he was left in the care of the hospital. The Police submitted a PPD1 which was shared with agencies and also submitted a F300Mental Health Detention Record.

3.21 At 9.00pm on 4th January 2013, the police 999 call handler received a call that was abandoned. The Call Handler returned the call and Mary answered. She said that Josh had made the call and then abandoned it. Josh then took over the phone conversation but refused to give his details or the reason for the initial call. Officers were despatched to the address and found both Mary and Josh intoxicated. There had been a verbal argument between them regarding

Josh's intention of going to Switzerland to end his life. Mary wanted Josh to leave the house. Jessica did not want Josh in her house when he was intoxicated because of her children being present so Mary stayed at Jessica's house.

3.22 Police officers that attended were aware of the Warning Signals on the police information system and they attended within 22 minutes. A PPD1 form was submitted. The risk was assessed as 'no indication of serious harm'. Information was shared with other agencies through the PPD1 process. Enquiries were made by PPU and revealed that Josh had been arrested under Section 136 Mental Health Act, treated at hospital and released, therefore no referrals to other agencies were made. Mary was offered advice and support from the Police Domestic Abuse Unit.

3.23 On 11th January 2013, Josh was offered an appointment with the Community Mental Health Team at a Day Services centre following a referral by his GP.

3.24 On 29th January 2013, a Community Mental Health Nurse (CMHN) wrote to P's GP stating that she thought that a further appointment for a medical assessment at Outpatients Department would be beneficial regarding his mood swings, suicidal ideations, use of alcohol and his poor coping mechanism. P would receive information about this in the near future.

3.25 On 6th February 2013, P did not attend his appointment. Another appointment was made for him at the Day Services centre on 27th February.

3.26 Also on 6th February 2013, ExW called the police concerned about P. She had received a text message from him stating he was contemplating taking his own life. She stated that he had previously attempted suicide by taking tablets. She had been to his address and found empty tablet packets.

3.27 Police officers contacted P by telephone. He was evasive about where he was and his speech seemed slurred. Officers recorded him as a Missing Person and commenced enquiries to trace him. He was found at the Probation Offices in Swansea where he had gone for a pre-arranged meeting with his Probation Officer.

3.28 Officers attended at the Probation Offices and spoke to P who said that he was feeling depressed but not suicidal. He stated that he had been taking his tablets. He was taken to his mother's house by the police officers albeit there were concerns by his sister about his mental state. A further PPD 1 form was submitted which was copied to the neighbouring authority for information.

3.29 At this point, both P and Josh were under the CMHT and appointments for both of them were being made.

3.30 An appointment was made for P with a CMHN on 19th February 2013. As a result of this appointment a letter was sent to an Associate Specialist CMHN at a local hospital requesting a further assessment of P. This appears to have

resulted in P engaging with the CMHN and that he was compliant and accepting help. The CMHN had noted that P had a history of depression and social stressors. He had attempted suicide in 2001 after marital problems. He had researched methods of ending his life. He had stated that he thought he was suffering from seasonal affective disorder. The CMHN requested a further assessment.

3.31 An assessment took place with Josh on 27th February 2013. He was seen with Mary. It was ascertained that he felt he was suffering from severe depression due to a history of alcohol abuse and non-compliance with his medication. He had a history of self-harm and overdosing. There was no record of disclosure of domestic abuse.

3.32 On 7th March 2013, the CMHT wrote to Josh's GP regarding the assessment. It was noted that Josh was suffering from low self-esteem and isolates himself, often staying at home for the majority of time. He was to be referred to an occupational therapist to encourage him back into the community.

3.33 During March and April 2013, Probation records show that P's case was supervised. In March his alcohol misuse, relationships and lifestyle were discussed. There was no referral made to Children's Social Care, which the Probation IMR author suggests would have been good practice. It is noted that he was attending at an agency in Bridgend. The meeting in April 2013 recognised that was drinking heavily and suggested a referral to an intervention agency, albeit the agency is not identified. The Probation IMR Author indicated that there should have been a referral to Children's Services.

3.34 On 19th April 2013, Josh was discharged from the CMHT with a note saying 'No response from patient.'

3.35 On 9th May 2013, the Community Drugs and Alcohol Team (CDAT) sent P a letter offering him an appointment with the SMART team at WGCADA's[13] agency

3.36 On 13th May 2013, Probation completed an Initial Sentence Pal (ISP) in respect of P and assessed his risk of causing serious harm to be medium. The IMR Author comments that it would have been expected that this risk assessment to have been completed within 15 working days from the date of sentence and would have required information from both Social Services and the Domestic Abuse Unit of South Wales Police. It goes on to indicate that a Spousal Assault Risk Assessment (SARA)[14] was not completed as practice would have expected.

[13] West Glamorgan Council on Alcohol and Drug Abuse changed to WCADA in October 2013

[14] The SARA manual defines spousal assaults as any actual, attempted or threatened physical harm perpetrated by a man or woman against someone with whom he or she has, or had had an intimate, sexual relationship. This definition is inclusive: it is not limited to acts that result in physical injury or death; it is not limited to relationships where partners are or have been legally married; and it is not limited by the gender of the victim or the perpetrator. The Spousal Assault Risk Assessment (Guide) P. Randall Kropp and Andrea Gibas 1999.

3.37 Over the next two weeks two more letters were sent to P with appointments for him to attend the SMART[15] Team as he had not attended the appointments previously offered.

3.38 On 5th June 2013, P engaged with agencies and he met with a representative from CDAT. That day he was subject to an assessment by staff from Bridgend Assessment Team, which is an integrated team that provides a single assessment. It is a screening service and uses a common screening assessment process. The assessment was conducted by an experienced Monitor and Assessment Officer from ABMUHB[16].

3.39 The assessment related to substance and alcohol misuse and it identified that P was dependent upon the primary substance; Alcohol, (up to 15 units of vodka per day). The secondary substance of benzodiazepines was also identified. During the assessment P was compliant to the process and expressed a desire to reduce his consumption of alcohol but not to be abstinent from it. He was then referred to WGCADA, (known as WCADA as from October 2013)

3.40 The Wellbeing Directorate IMR author indicates that parts of the assessment tool in place at the time were not completed with particular reference to the section that deals with Domestic Abuse. This matter is further discussed later in this report.

3.41 On 12th June 2013, the Probation data system showed evidence that P had admitted that his drinking had continued and that he had contact with his children. The IMR Author indicates that it would have been good practice to liaise with Children's Social Care and the Domestic Abuse Unit of South Wales Police.

3.42 On 9th July 2013, P's case was allocated to Harm Reduction Project Worker (HRPW) from WGCADA. He however did not keep his first appointment on 16th July 2013.

3.43 On 23rd July 2013, P attended at a WGCADA meeting with the HRPW and stated his intention was to reduce his weekly amount of alcohol he consumed to 95 units per week. He explained the reason for his dependency of alcohol was to do with his home life. He did however indicate that since he has been involved with SAS (Single Assessment Service) his alcohol level has reduced. Kurt's view is that he is of the opinion these were ''false words by his brother'.

3.44 P did not attend his arranged appointments with WGCADA on 6th August 2013. At the next meeting on 19th August 2013, P stated that he had reduced his alcohol intake to 70 units per week and he was having alcohol free days. He was pleased with his progress and it was agreed that his next appointment would be in 3 weeks' time. He attended WGCADA on the 9th September 2013,

[15] SMART – Substance Misuse Assessment Referral Team

[16] ABMUHB Abertawe Bro Morgannwg University Health Board

a day earlier than arranged. During this appointment he informed the HRPW that he was making good progress with reducing his alcohol use and that his next goal was to reduce to 50 units per week. P requested that his appointments were due monthly. This was agreed and he was informed that if he felt the need to talk prior to his next appointment, not to hesitate to call in or telephone the agency. P contacted the HRPW on the 7th October 2013, to say he was unable to attend his appointment that day as he was at work.

3.45 On 4th November 2013, P attended his appointment with WCADA (now changed from WGCADA). He had reduced his intake to 55 units per week and he had stopped drinking vodka, he was drinking lager instead. He said he was having three days per week 'alcohol free'. On the 3rd December 2013, P contacted the HRPW to say he was unable to attend his appointment that day as he was busy with work. It was agreed that a further appointment would be made after Christmas

3.46 On Christmas Eve, ExW called the police concerned about P. He was at his home alone and drunk. The Christmas tree was lying on the floor and he was upset. She was concerned about his history of overdosing and his previous suicidal ideations. He had asked her to call his mother which was out of character. Officers attended and found him to be intoxicated. He was upset that he was on his own. The officers offered to take him to his mother's house, which he accepted. A PPD1 form was submitted and noted by the Vulnerable Adults Unit and also referred to the Neighbourhood Policing Team. No further police action was believed necessary.

3.47 By February 2014, P told WCADA that he was doing well, his drinking was now under control and his business was improving. He was of the view that he no longer required the services of WCADA and his case was closed. He was told that in the event of him requiring support he could return at any time.

3.48 However, on 25th February 2014, the owner of a hairdressing salon contacted South Wales Police saying that a man, who he knew to be P, was in a hairdressing chair in an unresponsive condition. Officers attended and found P extremely drunk, having been drinking all day and apparently under the influence of an unknown drug. An ambulance was called and he was taken to hospital. No further police action was taken.

3.49 On arrival at the hospital P was seen by a triage nurse but then walked out of the hospital without treatment.

3.50 On 30th April 2014, P reported to the police that he had been assaulted. He had in fact been ejected from a public house due to his behaviour and no assault had taken place. Police records were updated and no further action was taken.

3.51 By June 2014, P reported to his Probation Officer that he was now moving on from his marriage breakdown and concentrating on his business that was doing well. A risk assessment was completed that indicated a medium risk which was deemed appropriate. He was having regular contact with his children under the

conditions of the restraining order that was still in force. Access was in the presence of another family member.

3.52 In August 2014, an appointment was made for Josh to attend a psychological therapy session. If he did not engage it would be assumed that he did not want to participate.

3.53 On 10th October 2014, P was arrested for being drunk and disorderly and attacking door staff in a public house in Bridgend. He was found to be in possession of a Class B controlled drug. He admitted buying the drugs from two unknown men the previous week and he wanted to experiment with drugs. He admitted he thought he may be an alcoholic. He was charged with both offences and appeared before Bridgend Magistrates Court on 27th October 2014. The drunk and disorderly charges were withdrawn and he was committed to the Crown Court for sentencing for the drug offence and also for breach of his suspended sentence. He appeared before Cardiff Crown Court on 21st November 2014 and was fined a total of £840.00 or 2 months imprisonment in default.

3.54 On 17th November 2014, P telephoned the WGCADA office requesting assistance and support to address his alcohol use. Due to the length of time since his last appointment and in accordance with the Single Assessment Service (SAS) procedure, he was referred to the CDAT's Bridgend Assessment Service. He was offered an appointment on 22nd December 2014, which he did not keep.

3.55 On 15th December 2014, P called the police and reported that he had been approached in the bus station by a man (whose name he knew) who accused him of sending 'bad emails'. The man had then head butted him. He stated that he was not injured and did not require medical treatment. Arrangements were made to see him later that day to make a report of the assault.

3.56 At lunch time that day, the man named by P, called the police to say that he had been approached in the bus station and had offered P his condolences regarding the break-up of his marriage. P had grabbed the man by the throat. He was reporting this in event that P had also reported the incident. Follow up enquiries by the police resulted in both men being seen and neither of them wished to make a formal complaint so the matter was closed.

3.57 At 11.00am on 2nd January 2015, ambulance service were called to Mary's house where Josh was unconscious. Despite the ambulance paramedics performing CPR Josh went into cardiac arrest and died at the scene. Mary gave the account that Josh had been fine during the previous evening. She had checked on him during the night and found him to be sleeping. At about 10.00am she heard a loud noise from his bedroom and found him lying on the edge of his bed. A post mortem examination revealed that Josh had died from 'Citalopram Toxicity', an overdose of his prescribed drug. There were no suspicious circumstances surrounding his death and it was treated as a sudden death by HM Coroner.

3.58 On 8th January 2015, Mary spoke to her GP by telephone. She reported that her son Josh, had recently died and apart from being naturally upset, the GP recorded that she was calm and collected on the phone. She explained that she had her family around her supporting her.

3.59 On 19th March 2015, Jack contacted the police concerned for P's safety; he had been separated from his wife for three years, his younger brother had died recently and he was drinking heavily. There had been a disagreement between P and his mother. This increased Jack's concerns about P, who he thought, may be suicidal. In addition P's ex-wife had received a text from him saying goodbye to her and the children. She also called the emergency services

3.60 Officers attended at P's address and saw an unloaded BB[17] gun in the hallway together with a rope hanging from the bannister. They could also see empty blister packs of pills and alcohol containers. P was located inside the premises lying on the settee with loud music playing. They roused him by shaking him and he informed the officers that he had not been coping well with everything he had going on. He admitted he had consumed a lot of alcohol and had taken six tablets of Ibuprofen and Paracetamol. An ambulance took him to hospital for a medical assessment. The police officers submitted a PPN[18] form which was shared with NPTCBC Gateway.

3.61 At hospital P was assessed by an Emergency Department Consultant and also seen by a psychiatric liaison team. It was noted that he had tried to commit suicide that afternoon and that he had a history of low moods and problems with alcohol and had a recent bereavement. After ensuring he was medically fit he was discharged. He was also discharged from mental health care with information about community addictions support services and a discharge letter was sent to the GP that included a history of the problem and signposting to community addictions services. He was given contact numbers for drug and alcohol teams and CRUSE[19].

3.62 There is little information about any of the family members between March and the date of the fatal incident on 20th June 2015. It appears that P's health deteriorated following his brother Josh's death and according to Kurt, P became more aggressive. P said he had several issues going on in his life at that time as described previously. The day after this comment Mary told Kurt that she didn't want P in her house.

3.63 It appears that on 19th June 2015, P and Kurt were unloading property from the factory into the garage at Mary's house. After a while, P went inside the house

[17] BB guns are a type of air gun designed to fire spherical metal projectiles similar to shot pellets of approximately the same size. Modern BB guns usually have a barrel with a bore caliber of 4.5 mm (0.177 in) and are available in many varieties. These guns usually use steel BB shots, plated either with zinc or copper to resist corrosion, and measure 4.3 to 4.4 mm (0.171 to 0.173 in) in diameter and 0.33 to 0.35 g (5.1 to 5.4 gr) in weight. Some manufacturers still make lead balls around 0.48 to 0.50 g (7.4 to 7.7 gr) in weight and slightly larger in diameter, which are generally intended for use in rifled barrels. The term "BB gun" is often incorrectly used to describe a pellet gun, which fires non-spherical projectiles. Although in many cases a steel BB can be fired in a pellet gun,[2] pellets usually cannot be fired in a gun specifically designed for BBs. Similarly, the term is also often used incorrectly to address airsoft guns, which shoot plastic balls that are larger but much less dense.

[18] The PPD1 referral form was changed to PPN in 2014

[19] CRUSE –a national charity providing free bereavement counselling

to rest but soon came back outside and stated that he was going for a drink at the local public house. Kurt continued with the unloading and when he had finished he joined P at the public house. They drank for a while and Kurt left his brother there.

3.64 During the afternoon of the following day, 20th June 2015, Jessica became concerned that she could not contact her mother by telephone. She asked her husband Jack to attend Mary's house and on arrival the door was answered by P armed with a Stanley knife with a snapped off blade. A struggle ensued between Jack and P. Jack managed to overpower P in the lounge of the house. Whilst pinning P down, Jack noticed the body of Mary under a blanket on the floor. He managed to summon the assistance of the emergency services.

3.65 Mary was found to have what was described as 'unsustainable injuries'. She had died at the scene and had been dead for some time. P was arrested. A Forensic Post Mortem was conducted and recorded that Mary died of multiple stab wounds.

3.66 P appeared before the Crown Court in February 2016, but the jury were unable to reach a verdict. There was a second trial in April and on 15th April 2016 and P was convicted of murder. On 18th April 2016, he was sentenced to life imprisonment with a recommendation from the trial Judge that he is to serve 20 years.

4. Analysis and recommendations

4.1 In completing this review report the author and Mr Jones have seen numerous people who were connected in some way with either Mary or P and they are able to give background information about the family life and the individuals concerned. Two of the people seen are siblings of P. Their comments are included within the report at various stages and it is made clear to the reader when their comments are referred to.

4.2 Mary had lots of tragedy throughout her life. Her father died of a heart attack when she was quite young following which her mother committed suicide not long afterwards. She had two brothers and one sister. Her sister is still alive. One of her brothers, a twin, committed suicide and the other brother died of a drink related illness. Her husband Michael died in 2011, of pancreatitis, alcohol dependency and diabetes. Her husband apparently left considerable debts linked to the family business and the house that were estimated to amount to around £65,000. She was left to pay the debts off. She was unaware that the house had been re-mortgaged by her husband. It is the view of Kurt, that P was instrumental and influential in these debts being incurred by Michael.

4.3 Mary suffered from anaemia and brittle bones. She had to have injections every month. She is described by a close friend as being 5 stone in weight, 5 ft. tall and very thin and frail. Mary had problems with P after he left his partner and he used to upset his mother with his behaviour towards her.

4.4 She was distraught when she found Josh dead on his bed in her house.

4.5 Mary lived in the same house since 1970, where she had the two sets of twins. Her husband had started the business in the garage of the house. Initially it was quite successful, but he wanted to expand and rented business units which cost money. Once her husband died Mary was left to run the business and the children helped now and again. The business declined and Mary feared that her house would also go with the business and she would become homeless. The business was dissolved on 16th May 2012 and after starting again under a new name, it was finally voluntarily liquidated on 15th January 2015.

4.6 Mary thought a lot of P and when he and his wife separated she was concerned for him. P started drinking heavily, thought initially as a result of the pressure from his failed marriage. Mary's health deteriorated. P started sleeping at the factory unit around about May 2015 and Mary found out and allowed him to move in with her. That was only 11 days before Mary's death

4.7 It is apparent that after the death of Josh, P's life style was affected. He attempted to commit suicide which was seen as a call for help. He was already dependent on alcohol. His brother Kurt stated that after this incident Mary did not want him in the house with her. Kurt described P as having anger management problems but he had never been referred for any support. He described how P was unable to do work because of his drinking problem. Kurt had to chase the people who owed P money through the business. Kurt described how a few days before the death of Mary, P was taking diazepam which he had from a friend. He also had high blood pressure and this together with alcohol affected his cognitive functions. Kurt could tell that his brother was not well as his brother suddenly shaved his head which was most unusual. It indicated to Kurt that something was not right with his brother. Kurt is not aware of any referral for P regarding his alcohol misuse, (the information above indicates that this view is misinformed).

P's drug and alcohol support.

4.8 The WCADA IMR indicated that P was offered numerous opportunities to receive support. The first referral was in June 2013 from a CDAT Assessor. P was put on a waiting list and written to in July 2013 with an appointment for 16th July, which he did not attend. A second appointment was offered for 23rd July to which he attended. He did not attend the next appointment on 6th August but attended on 19th August. He attended WGCADA on 9th September but cancelled his appointment on 7th October stating he was unable to attend due to work commitments. P attended his next appointment on 4th November, however cancelled his appointment on 3rd December, again stating that he was unable to attend due to work. His final appointment with WGCADA was on 1st February 2014. It appears that in general terms he attended every other appointment. It is of interest that, from the point of assessment (on 5th June 2013) to the end of his engagement, P sought help to reduce his alcohol consumption rather than to stop it all together.

4.9 However on 19th February 2013, he did engage with the CMHN and at that time he appeared compliant and accepting help and support regarding his dependency on alcohol.

4.10 On 21st February 2013, the CMHT wrote to an Associate Specialist at Maesteg Hospital asking for P to be seen as the CMHT were clearly concerned about his mental state.

4.11 P was seen again by CMHT on 20th March 2013 and referred back to his GP. He was also given the contact details of CRUSE and WCADA and CDAT.

4.12 It is noted in the Wellbeing Directorate IMR that the CDAT assessment tool had not been completed fully in particular areas and questions relating to Domestic Abuse had not been completed. This issue was identified in an earlier Domestic Homicide Review for Bridgend (DHR02) where a recommendation was made to rectify that issue:

> *Recommendation No 3 (DHR02)*
> *DASG (Bridgend Domestic Abuse Steering Group) to ensure all agencies to conduct a review of their training programmes regarding information sharing and the completion of risk assessments to ensure that there is common knowledge across all agencies of the implications and meanings of the various risk assessment tools and models used by agencies. DASG to also ensure and ISP (WASPI) is produced and agreed. This is also an opportunity to embrace joint risk assessment training.*

It is hoped that a new assessment tool based on All Wales Template from Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT) guidance will be introduced across all agencies in the near future and will thereby instil consistency across all agencies. The Wellbeing Directorate IMR makes recommendations for the implementation of the WIISMAT risk assessment tool within that agency. There is a need for the WIISMAT risk assessment tool to be incorporated wider.

> **Recommendation No 1**
>
> **Western Bay Substance Misuse Area Planning Board and treatment providers to ensure that domestic abuse questions are being asked and recorded as part of the assessment and care planning/review process.**
>
> **Recommendation No 2**
>
> **Bridgend Community Safety Partnership Executive Group to take responsibility for coordinating the promotion of awareness raising around domestic abuse in all its forms within the community for victims and perpetrators and how to identify and report concerns of domestic abuse, signposting victims and perpetrators for support and guidance.**

4.13 It appears that P was considered for and offered support for his alcohol problems. Some of the support offered he accepted. Other offers he declined but it is difficult to see how support agencies such as WCADA and CDAT could

have done anything more for him. It was clear that he intended to continue drinking albeit, he said, in smaller amounts. His referral to WCADA was not mandatory and therefore there was no process of WCADA informing any agency of his reluctance to engage.

4.14 The summary in the Mental Health IMR states that P received routine liaison psychiatry input following his presentation to Accident and Emergency with suicidal thoughts and behaviour. The IMR indicates that the views of his family and the police dealing with him at that time were not recorded. The IMR goes on to say:

> 'There are limitations on what mental health services can undertake on behalf of adult service users who have capacity to consent or withhold consent to share information with family members particularly when there is no evidence or dangerousness that might lead to liaison with police and other criminal justice agencies to consider risk management planning'.

4.15 This quote has particular significance when then history of domestic abuse and his 'dangerousness' with P's previous wife is considered. The IMR further comments that an objective assessment of risk of repeat attempt suicide was not recorded as P claimed he would not do it again. This is irrespective of his history and circumstances; alcohol misuse, debt problems, poor appetite, matrimonial problems involving domestic abuse and a recent bereavement which may have indicated a risk of further suicidal behaviour. The IMR contains a recommendation to the effect that all mental health professionals assessing people admitted to A&E services should document an analysis of the suicidal behaviour including the history and an estimate of the likelihood of a repeat attempt and not to rely on the person's self-reporting.

Probation Intervention with P

4.16 The National Probation Service had two statutory involvements with P. The first was in respect of a Community Order that he received from Magistrate's Courts in October 2012. The second was in respect of a 24 month Suspended Sentence Supervision Order he received with requirements to do 150 hours unpaid work. During the time of the Order, it is noted in the National Probation IMR, that working with P was difficult and he was resistant. He missed some unpaid work appointments reportedly through illness, but the feelings of the Offender Manager was his absences were due to the effects of alcohol. The IMR indicates that there were missed opportunities to enforce these issues more robustly. There were further issues identified in that the Spousal Assault Risk Assessment (SARA) had not been completed and the OASys assessment had not been completed on time. It must be remembered that all of this time P was subject to a restraining order.

4.17 As the Order progressed and contact with P continued, it became known that he was having contact with his children. By this time contact with WCADA had lapsed and the Offender Manager made a referral for further intervention. It could have been expected that this would have triggered an update to the

OASys system and Children's Social Care being informed. This did not happen and the update to the OASys system was later than it should have been.

4.18 In June 2013, P was drinking heavily and continuing to see his children and again there is no evidence of contact with Children's Social Care. It is noted that intervention and challenge by the Offender Manager was difficult due to P's resistance.

4.19 The Offender Manager became aware that P had begun to work with his mother. His reporting was increased to monthly but again the OASys system was not updated as expected.

4.20 P's Offender Manager was changed for the fourth time for reasons of re-structuring teams and the re-organisation of the Probation Service. The fourth Offender Manager found P to be unwilling to discuss his relationships or any alcohol issues but he would regularly discuss the business and how that was progressing.

4.21 The National Probation Service IMR states that Offender Managers ought to take a more investigative approach to offender assessments and seek to verify information that offenders provide. It states that the quality of information contained within the records of P could have been improved and identifies that there is need for further work with Offender Managers to develop a more holistic view of offenders, taking into account all of the information know and considering the views of all professionals involved. It is clear that P was not under the supervision of the Probation Service at the time of the death of Mary.

4.22 The National Probation Service IMR makes a total of six pertinent recommendations aimed at correcting the issues identified within examination of the information for this review. Once the Action Plan has been completed there is confidence that the issues raised will be adequately addressed.

Police Involvement with Mary and P.

4.23 At the end of July 2011, Kurt took Josh to stay at his house for a while and give Mary some respite from Josh. Kurt discovered that during the argument with his mother that led to this action, Josh had picked up a knife. Kurt was concerned and contacted the police for advice. Albeit there was no recorded threat to harm Mary, the Police arranged for Kurt to speak to an officer. Kurt did not keep the appointment at the specific request of Mary, and the matter was closed and filed. The police had attended the incident from which this subsequent advice was being sought by way of an immediate response and this was deemed to be a verbal argument. There was no information disclosed concerning a knife but officers submitted a PPD1 form.

4.24 It is the view of the Police IMR author that Kurt ought to have been seen and given advice albeit it must be noted the appointed officer recorded that appropriate arrangements were put into place and it was unfortunate that Kurt neither kept to his appointment or re-arranged an alternative appointment. However safeguarding measures were put into place in respect of Mary and the property because Josh was removed from the premises.

4.25 All of the contacts between the police and the members of this family relate to Mary having problems with two of her sons, mainly when they had consumed alcohol. On examining those contacts, the Police IMR Author is of the opinion that the Police contacts with the family was in line with policies and procedures in force at that time.

4.26 On the vast majority of occasions officers attended, the necessary forms and files were completed informing other agencies of the incidents in accordance with current policies. The MARAC process would naturally inform Mental Health agencies.

4.27 However, there are two occasions when police responded to incidents involving P in circumstances that gave rise to concerns about his mental health, where the police returned P to his mother's address, apparently without concerns for the safety of Mary and the risk that P posed towards her. The first incident was on 6th February 2013 when the police had been called by P's ExW stating that P had contemplated suicide by taking tablets and she had found empty tablet packets. P was found at the Probation Service Offices, depressed but not suicidal. None the less he was delivered home to Mary.

4.28 The second occasion was on Christmas Eve 2013, when he was found by ExW intoxicated at the family home, the Christmas tree on the floor and he was upset. The police were called and offered to take him to his mother's address which P accepted. Although a PPD form was submitted it is not clear of the risk to Mary was considered.

4.29 Both of these incidents were some two years prior to the death of Mary and there had never been any concerns presented with regard to P's behaviour towards his mother. At that time he was more of a risk to himself and both of these reported incidents were concerns for his personal safety. The initial one was a missing person report and he was located with Probation who shared no concerns. When the officers took him to his mother's home they did so because that appeared to be the most suitable place at the time. He was clearly in a condition where he needed some support and his mother's address was seen as the most suitable place and there were no objections from anyone. It can be seen that there has never been any reported incidents of concerns of domestic violence specifically between P and his mother.

5. **Family Views**

5.1 As stated above, in accordance with the Home Office Guidance, members of Mary's family were written to at an early stage of the process, explaining the purpose of the Review and offering them the opportunity to contribute to the review should they wish to do so.

5.2 Mary's daughter Jessica, and her son, Kurt asked to be seen and they were both visited. Details of what they told the Overview Author and Mr Jones are recorded within this report. So too are the comments made by P's former wife and also a life time friend of Mary

5.3 The sister of Mary and her daughter, Mary's niece, have also been seen and have contributed towards the known facts on this review. All of the comments made by these people are also incorporated within this report.

5.4 As stated above, P and his solicitor were written to at the beginning of this review process, inviting P to participate in this process. He did not reply to the letter. Efforts were then made to obtain from P his signed permission to access his medical records which have not been successful. His brother Kurt offered to liaise with P to get his written permission but he was unable to do so.

5.6 More efforts were made following his conviction to seek permission for P's medical records to be examined for the purposes of the review, but he was moved to a different prison. It appears that P requested the prison authorities not to disclose to anyone, including his family, where he is currently located within the prison system and the prison authorities are of the opinion to do so would breach the Data Protection legislation. Notwithstanding any duty H.M. Prison service may have to cooperate with the Domestic Homicide Review process, the location of P within the prison system is unknown to the review author. P is clearly not willing to assist in the disclosure of his medical records nor is he willing to participate with the review. The National Probation Service is also unable to help in these circumstances.

5.7 This Overview Report is therefore submitted without the benefit of the views of P and without any details of his medical or mental history that may have assisted in formulating conclusions. Health colleagues have the details of his medical and mental history available and ready to formulate into the required IMR and chronology but cannot take the matter any further without consent.

5.8 The Author has maintained periodic contact with Jessica, Kurt and also Ex.W during this review by either letter or telephone contact and with the valuable assistance of a representative of AAFDA. Arrangements will be made to see them again before publication.

5.9 Towards the end of the preparation of this report for submission to the Safer Bridgend Partnership Board, the family were again approached regarding engaging with the review process. By this time Kurt and Jessica were being supported by AAFDA (Advocacy After Fatal Domestic Abuse) and arrangements were made to see Kurt on two occasions to examine the overview report in detail with the AAFDA representative, the Author and Mr Jones from Winston Ltd. It was at these meetings that the family decided that the members of the family were to be referred to as indicated in the matrix on page 11 of this report.

6. 2016 Home Office Guidance[20]

6.1 As stated earlier in this report, the Perpetrator in this case declined to be seen by the report author and declined permission for details of his medical records

[20] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office December 2016

to be made available to the review process. It is thought that those records may hold significant information that would have been very valuable to this review.

6.2 The revised Home Office Guidance on Domestic Homicide Reviews was published on 8th December 2016. Section 10 of the guidance –Data Protection – deals with the release of medical information and requires the Department of Health to:

> *"encourage clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and, where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:*
>
> > *a) The review team should be informed about the existence of information relevant to an inquiry in all cases; and*
> >
> > *b) The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.*
>
> *The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest.*
>
> *The Department of Health recognises that DHRs have a strong parallel with child Serious Case Reviews. Guidance advises doctors that they should participate fully in these reviews when the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent. The Department of Health believes it is reasonable that this should be the principle that doctors should follow in cooperating with DHR's." (Paragraphs 99 and 100 refer)*

6.3 This new section of the guidance appears to be the avenue by which medical information regarding perpetrators such as P in this case, could be made available to the review process even when the perpetrator declines to give permission. The Panel are of the opinion that this needs further explanation by the Home Office as some panel members consider that to do so without permission is still breaching the data Protection and even Human Rights of the Perpetrator.

6.4 It is considered that before any proactive action is taken regarding this part of the new guidance a more detailed explanation is required as well as a sample template letter that could be used nationally so that every DHR approaches this sensitive issue from an identical position.

Recommendation No. 3

The Chair of Bridgend Community Safety Partnership requests the Home Office for further clarification of paragraphs 99 and 100 of the new Home Office Guidance for the Conduct of Domestic Homicide Reviews December 2016, especially regarding the term '*The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest'* and for the Home Office in conjunction with Medical Regulatory Bodies, the Department of Health and Welsh Government, to produce a sample template letter that could be used Nationally informing the perpetrators that their medical information is to be disclosed as well as advising health agencies of this process irrespective that permission has not been obtained from the perpetrator.

7. Conclusions

7.1 Mary was not a well person. She suffered from long term illnesses and together with the deaths of relatives she was often seen in a stressed condition. She worried about the financial future of herself and the family business, having been left in considerable debt by her late husband. She feared that she would lose her home due to the debts and would become homeless. When Josh attempted to commit suicide there was a missed opportunity to conduct a risk assessment on Mary's safety.

7.2 Mary also suffered emotional abuse from two of her sons, P and Josh. They too had troubled existences. Both turned to their mother for support at times when she was the one who needed support.

7.3 It is clear that she could not count on her sons, Josh and P, to take the business forward. Both it appears, had alcohol misuse problems which were both sporadic and long term and prevented them concentrating on the business.

7.4 P had significant inputs from the health and mental health services but his alcohol misuse was not significantly reduced despite the interventions he received. P's risk to all women in his life should have been assessed.

7.5 When Josh died, P took it badly and his situation continued to spiral downwards. His mental health deteriorated but there does not appear to be much consideration as to how Mary was coping with him. He moved in with her because she felt sorry he had been made homeless but there is no evidence of him supporting his mother. There is opinion from contributors to the review from outside the family that Mary has been taken advantage of financially by Josh and P.

7.8 On the afternoon of the murder of Mary, Kurt and P were at Mary's house unloading a van. P went to the local public house and started drinking. He was joined by Kurt sometime later, but Kurt left P in the public house after a period of time. During the following hours P and Mary argued and he subsequently attacked her in her own home.

7.9 At Crown Court in April 2016, P was convicted of murder.

7.10 In evidence P claimed he lost his temper and hit out at his mother killing her. It is clear that the attack on Mary was sudden and violent.

7.11 Whilst P's mental stability varied from time to time, there was no direct evidence to show that he had been violent to such a degree to cause injury to his mother previously. There are reports suggesting that she could not cope with him but physical violence was not something that was evident and she made no complaint of physical injury at the hands of P. What has become apparent during the course of this review is that Mary experienced coercive control and influence for many years from P in particular and unfortunately that had not been reported to any agency.

List of Recommendations

Recommendation No 1 **Page 23**

Western Bay Substance Misuse Area Planning Board and treatment providers to ensure that domestic abuse questions are being asked and recorded as part of the assessment and care planning/review process.

Recommendation No 2 **Page 23**

Bridgend Community Safety Partnership Executive Group to take responsibility for coordinating the promotion of awareness raising around domestic abuse in all its forms within the community for victims and perpetrators and how to identify and report concerns of domestic abuse. Signposting victims and perpetrators for support and guidance.

Recommendation No. 3 **Page 28**

The Chair of Bridgend Community Safety Partnership requests the Home Office for further clarification of paragraphs 99 and 100 of the new Home Office Guidance for the Conduct of Domestic Homicide Reviews December 2016, especially regarding the term '*The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest'* and for the Home Office in conjunction with Medical Regulatory Bodies, the Department of Health and Welsh

Government, to produce a sample template letter that could be used Nationally informing the perpetrators that their medical information is to be disclosed as well as advising health agencies of this process irrespective that permission has not been obtained from the perpetrator.

Bibliography

Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 www.homeoffice.gov.uk/publications/crime/DHR-guidance

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - Revised August 2013 Home Office

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - December 2016 Home Office

The Spousal Assault Risk Assessment (Guide)
Randall Kropp and Andrea Gibas 1999.

Bridgend Community Safety Partnership

This document is also available in Welsh

DOMESTIC HOMICIDE REVIEW - DHR 03

ACTION PLAN

Agency	Recommendation / Action (SMART)	Lead Officer	Target Date For Completion	Desired Outcome	Monitoring Arrangements	How Will Success Be Measured?	Comments / Update on Progress
Western Bay Substance Misuse Area Planning Board Overview Rec No1	Western Bay Substance Misuse Area Planning Board and treatment providers to ensure that domestic abuse questions are being asked and recorded as part of the assessment and care planning/review process.	Western Bay Substance Misuse Area Planning Board	November 2017	All suitable patients are asked about domestic abuse as part of the assessment and care planning / review process.	Western Bay Substance Misuse Area Planning Board	Completed assessments to show evidence of domestic abuse questions being asked of suitable patients.	Updates to be provided by Western Bay Substance Misuse Area Planning Board. June 2018
Bridgend Community Safety Partnership Executive Group Overview Rec No2	Bridgend Community Safety Partnership Executive Group to take responsibility for coordinating the promotion of awareness raising around domestic abuse in all its forms within the community for victims and perpetrators and how to identify and report concerns of domestic abuse. Signposting victims and perpetrators for support and guidance.	Community Safety Executive Board Chair	Ongoing - via a collaborative information dissemination/communication strategy	Individuals and communities are aware of how to seek help and support for domestic abuse for themselves, family members, friends, etc.	Community Safety Executive Group	Number of events held with partners (measuring activity).	Updates to be provided to the Community Safety Executive Group.
Chair of Bridgend Community Safety Partnership Overview Rec No 3	The Chair of Bridgend Community Safety Partnership requests the Home Office for further clarification of paragraphs 99 and 100 of the new Home Office Guidance for the Conduct of Domestic Homicide Reviews December 2016, especially regarding the term *'The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest'* and for the Home Office in conjunction with Medical Regulatory Bodies, the Department of Health and Welsh Government, to produce a sample template letter that could be used Nationally informing the perpetrators that their medical information is to be disclosed as well as advising health agencies of this process irrespective that permission has not been obtained from the perpetrator.	Community Safety Executive Board Chair	Ongoing awaiting response from Home Office	Clarification of guidance from the Home Office.	Community Safety Executive Group	Guidance to be clarified.	Awaiting response from Home Office.
ABMU Mental Health	Suicide risk assessments conducted in A&E should include a formulation and estimate of future risk of suicide with a suitable risk management plan considered	Service Manager	September 2016	Healthcare records show evidence of formulation and estimation of future suicide risk	Audit of healthcare records	100% of healthcare records sampled show compliance with the standard.	

Bridgend Community Safety Partnership

Agency	Recommendation / Action (SMART)	Lead Officer	Target Date For Completion	Desired Outcome	Monitoring Arrangements	How Will Success Be Measured?	Comments / Update on Progress
Probation	For the Offender Manager to ensure the timely completion of OASys (Offender Assessment System) assessments during the course of an Offender's Order, particularly considering significant events.	Deputy Local Delivery Unit Head will ensure Team Manager's complete actions	31.05.2016	For the Offender Manager to ensure that all cases have an up to date OASys assessment that is reviewed and updated in line with Professional Judgement and performance measures.	Audit of OASys assessments completed for a 3 month period. Monitoring of OASys assessments completed in Supervision. Recording of actions through Supervision process. Guidance to be issued to all Offender Managers about professional judgement and definitions of significant events.	Offender Managers are able to identify during supervision, team meetings, cluster meetings, and through their completed assessments an understanding and practice of reviewing OASys assessments.	Action completed by Team Manager to Offender Managers.
Probation	To improve the quality of each OASys assessment completed	Deputy LDU Head Local Delivery Unit ensure Team Manager's complete actions	31.05.2016	For the Offender Manager to ensure that each OASys assessment completed is of sufficient quality, containing all relevant information required.	Offender Manager's Team Manager to actively monitor this via Supervision, Countersignature processes and OASys Quality Assurance. A. Follow up with actions from any assessments from the central Quality Assurance Process.	Evidence of accurate and detailed recording which links to risk management and the intervention plan.	Action completed by Team Manager to Offender Manager – Recording is improved but will be monitored during supervision as part of National Probation Service quality agenda.
Probation	To reinforce the need to complete the Spousal Assault Risk Assessment where appropriate.	Deputy Local Delivery Unit Head will ensure Team Manager's complete actions	31.05.2016	Offender Manager to understand the need to complete Spousal Assault Risk Assessment assessments in all appropriate cases.	Supervision with Offender Manager. Audit of appropriate DA cases for a period of 3 months.	Evidence of SARA being completed on relevant cases.	Action completed by Team Manager to Offender Managers. Offender Managers understands the significance of these assessments.
Probation	To improve the frequency and quality of recording on DELIUS (name of Case Recording System used by Probation.)	Deputy Local Delivery Unit Head will ensure Team Manager's complete actions	31.05.2016	For the Offender Manager to ensure that each contact with an offender, professional or any significant information is clearly and promptly recorded on DELIUS. Where intervention work with an offender (including 1:1 supervision work) has, or has not been successful, then Delius recordings need to clearly evidence this.	Team Managers to monitor through Supervision. Audit of Delius records for 3 month period Guidance to be issued to all Offender Manager's about quality of Delius recordings.	Evidence of accurate and detailed recording which links to the OASys assessment and risk management plan and the intervention plan.	Action completed by Team Manager to Offender Manager. Will continue to be monitored as part of the NPS quality agenda

Bridgend Community Safety Partnership

Agency	Recommendation / Action (SMART)	Lead Officer	Target Date For Completion	Desired Outcome	Monitoring Arrangements	How Will Success Be Measured?	Comments / Update on Progress
Probation	To develop a more holistic approach to Offender Management on a multi-agency basis.	Deputy Local Delivery Unit Head will ensure Team Manager's complete actions	31.05.2016	Evidence in Delius recording and OASys assessments that information from key statutory and non-statutory partners/agencies has been considered in day to day management of the offender, and the formulation of the risk management and intervention plan.	Audit of Delius records for a 3 month period. Audit of OASys assessments for a 3 month period Re-visit peer learning through Dysgu Cymru events on safeguarding, domestic abuse, and public protection themes. Team Meetings to include a standard agenda item on multi-agency working and safeguarding.	Offender Manage s will evidence dynamic conversations with partner agencies in relation to offender management and risk assessment.	Action completed by Team Manager to Offender Managers
Probation	To ensure Team Managers have effective over case management, Delius recording and OASys assessments.	Deputy Local Delivery Unit Head	31.05.2016	Appropriate management over sight in all cases.	Monitor supervision notes over a 4 month period. Audit Team Meeting minutes.	Evidence of discussions with Offender Managers to be recorded by Team Managers on Delius.	Completed evidence of supervision supplied to Dep Local Delivery Unit Head.

Appendix 1

Home Office

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Business Support Officer - IFSS & Early Help
Education and Family Support
Bridgend County Borough Council

31 May 2018

Dear Ms Evans,

Thank you for submitting the Domestic Homicide Review (DHR) report for Bridgend to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21 March 2018. I apologise for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel noted this was a complex case and commended the engagement with the family and the perpetrator's ex-wife. However, the Panel concluded that overall there is insufficient analysis of key issues in this case and this has resulted in a report that lacks sufficient depth and rigour. For example, the Panel noted the report concludes that the victim suffered emotional abuse and coercive control but this is not examined in any detail in the main body of the report. In addition, barriers to the victim accepting or seeking help have not been explored. There is also little comment on whether existing policies and procedures were complied with or analysis on any domestic abuse training and awareness of the practitioners involved particularly in relation to adult abuse.

The Panel noted that there was no response from the perpetrator in relation to the request to access his medical records. As a result the review lacks insight into whether the perpetrator expressed any thoughts of harm towards his mother to his GP or an understanding of their relationship from his perspective. Given the British Medical Association supports GP cooperation in domestic homicide reviews, the Panel felt this could have been pursued further with the GP practice and relevant information sought from the GP.

There were also some other aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The assessment by mental health services is not adequately explored. For example, there is no examination of their assessment of the perpetrator's risk to others. In addition, there is no mention of a carers assessment being considered when both brothers were referred to mental health services and this is not raised as an issue in the review;

- There is no specific assessment and learning identified on the potential risks of the police taking the perpetrator to his mother's house as described in paragraph 3.28;

- The review could have explored homelessness and any links to domestic abuse;

- The Panel felt there was considerable focus on "Josh" in the report and suggested reviewing the narrative to satisfy yourselves that it was evenly balanced between the different parties whilst ensuring that the victim remained at the heart of the report;

- The Panel noted there is a disconnect between the recommendations in the overview report and executive summary, which only list three recommendations, and the action plan, which contains 10. The Panel was clear that all recommendations should be included in both reports;

- It would be helpful to mention the ethnicity and age of the perpetrator within the narrative on equality and diversity;

- In order to enhance anonymity, you may wish to remove the precise date of death, the date of conviction of the perpetrator, the specific area where the victim lived, and the genders of the perpetrator's children. Please also note that the name of the AAFDA advocate is included in the report and it is not clear if they are content with this disclosure;

- It should be made clear in the report that the names used for family members are pseudonyms;

- There are inconsistencies between the overview report and executive summary. For example, the conclusions in both reports do not match;

- Please review both reports for typing errors.

The Panel would be grateful if you could provide a revised version of the report with the changes suggested by 31July 2018. Please clearly indicate where changes have been made in the revised report, and make it clear in the subject line of your email when resubmitting that the documents contained are revised versions for reconsideration. Please let me know if this will prove difficult.

Yours sincerely

Hannah Buckley
Acting Chair of the Home Office DHR Quality Assurance Panel

Appendix 2 This document is also available in Welsh

Malcolm A. Ross M.Sc., MICPEM

Ms. Hannah Buckley
Acting Chair of Home Office DHR Quality Assurance Panel
Public Protection Unit
2, Marsham Street
London
SW1P 4DF

Ref. DHR03 Bridgend CSP

Your ref.

Date. 31st January 2019

Dear Ms. Buckley

Ref. Bridgend Domestic Homicide Review 003

I refer to the above DHR that was completed and submitted to the Home Office in 2017, read on 21st March 2018 and returned from the QA panel on 31st May 2018.

In your response you make comment about a number of issues, some of which have been actioned resulting in minor amendments to either the Overview Report or Executive Summary, both of which accompany this letter.

There are however, areas of your response that, if I may, I would like to comment upon.

The second paragraph mentions that the report does not examine in detail the emotional abuse and coercive control the victim suffered in the main body of the report. It is stressed throughout the report that the Victim made no complaints to any agency about the abuse she experienced but information about her life, firstly with her husband before he died, and then later with the two of the three sons in her family, were obtained from friends and family members. When one looks at the information as a whole, it is clear that she was coerced and controlled. Instances such as her son selling her car and spending the money, her husband accruing a massive debt on his business unbeknown to the Victim which she had to manage after his death and evidence of the way alcohol abuse by her two sons affected her life resulting in the death of one and the other becoming a Perpetrator all point towards a woman who had little control over her life. She tried to run the family business after her husband's death but appeared to have limited support from her family. It was left to the Victim to do the best she could with a failing business.

Your response goes on to say that barriers to the Victim accepting or seeking help have not been explored. It is not known why the Victim did not report any of these issues mentioned above, so identifying barriers is difficult without making assumptions or speculating. The Victim was a Victim from when she was with her husband over many years to the date of her death. Barriers to accepting and seeking help were a relatively new concept and research will tell us that there are many barriers that exist and sometimes include cultural or traditional reasons for not

disclosing. There was no evidence of violence towards her until the fatal attack. Now domestic abuse and the causes and prevention of such abuse has moved on with significant research we can see in the Bridgend area of South Wales numerous initiatives aimed towards encouraging victims to come forward. In Bridgend Council buildings there is a suite named after another domestic homicide victim where victims and potential victims are seen and signposted to agencies for help. Such initiative and facilities were not available at the time of this Victim's troubled life.

The issue of whether agencies were conversant with policies and procedures is mentioned in your letter. There is nothing to suggest in any of the Individual Management Reviews that their authors had any concerns about policies and procedures not being adhered to, indeed the police actually comment to the effect that policies and procedures were taken into account (para 4.25 Overview Report). All agency personnel are suitably trained in the delivery of services in line with respective policies and procedures. It must be appreciated that in this case that the focus and primary concern of agencies was dealing with the Perpetrator's mental health issues and preventing him taking his own life.

There is mention about the disclosure of medical information in your response, which is dealt with in paragraph 98 – 100 in the December 2016 guidance quoted in my report. When the draft guidance was published for consultation in September 2016, I replied to the Home Office asking for clarification of the term, 'their confidentiality should be set aside in the greater public interest' (see para 99). It was clear to me at that time that this was a subjective test and different health professionals would consider this in differing ways. I suggested that the term should be made clearer and be more of a mandate with regard to disclosure if the perpetrator does not consent to medical records being disclosed. I did not have a reply.

Since then, I have, on numerous occasions spoken to Christian Papaleontiou and Frank Mullane from AAFDA on this subject stating that GPs and other Health representatives will and are, choosing not to disclose medical information without consent from the Perpetrator. There have been various pieces of advice about the legality of disclosing in these circumstances over the last 2 years but none has been a firm direction. The problem is that many GPs and Health professionals are cautious about breaching Data Protection legislation and now GDPR, which I will mention later in this reply. You mention the British Medical Association supporting GPs cooperating in this review process, but I do not see anything from that Association stipulating their support if action is taken against a GP by a disgruntled Perpetrator objecting to his medical records being disclosed without his permission.

It is for these reasons that the DHR panel at Bridgend included in the report Recommendation No 3, asking the Chair of Bridgend Community Safety Partnership to request further clarification of paragraphs 99 and 100. In response the CSP received a letter from Mr. Papaleontiou dated 2nd November 2017, stating:

> 'In the absence of a court order or police warrant, voluntary disclosure of an individual's health records can be requested under section 29 of the DPA. However, while health professionals have the power to disclose records, there is no obligation to do so. In such cases health professionals may only disclose information where the individual has given consent or there is an overriding public interest.'

The letter goes on to say: 'I am grateful to you for your suggestion which we will consider as part of our ongoing review of the statutory guidance.'

It is heartening to know that this issue will be considered in the ongoing review but in the meantime we are left in the position that if the medical professionals do not wish to disclose medical information without consent there is little DHR panels can do about it. This is explained in detail in the report and it would be interesting to know

how the QA panel thinks the DHR panel could have 'pursued further with the GP practice and relevant information sought from the GP'. If the information had been forthcoming it would have been included in the report.

Page 2 of your reply mentions the assessment by mental health service not being adequately explored. I would refer you back to the previous paragraphs.

Also mentioned is a carer's assessment not being considered. This highlights a common problem experienced in numerous DHRs that is the difference between a 'carer' and a mother caring for a sibling or relative. It is unlikely that the victim thought herself as a carer rather a mother with parental responsibilities. She was not in receipt of a carer's allowance and no mention of that was made throughout the review process by any agency representative. Had she had the allowance she would have been subject of a carer's assessment, but she was not. It is however appreciated that since the Victim's death, new legislation is now in place that would have helped the Victim in her circumstances.

The letter questions whether the police considered the risk when they returned the Perpetrator to his mother's address in February 2013. This concerned a call to police from the Perpetrator's ex-wife after she had received a text from him saying he was contemplating suicide. He was traced to a Probation Office and returned home to his mother. At no time did his ex-wife express any concerns about a risk he posed to others even when she knew that he was to be taken to his mother's house. On arrival at his mother's house, no concerns were expressed by his mother about her safety or any risk that the Perpetrator posed to anyone else. His sister showed concerns about his own mental health but there were no concerns expressed about his risk to anyone else. Police Officers submitted a PPD1 form and a MISPER form. The ambulance service that was called to the Probation Office did not have concerns about any risk and finally the Probation Officer did not have any concerns. This is alluded to in the Overview Report.

A similar situation arose on Christmas Eve (para 3.46) when he was returned to his mother's house and again no risks were identified. On both occasions the police took positive action to safeguard his well-being.

Mention is made of the Perpetrator being made homeless and whether any links between homelessness and domestic abuse were explored. The Overview Report clearly indicates that the Perpetrator's mother took him into her house as he was sleeping in the business premises after the break-up of his marriage. His mother acted because she didn't want him to be homeless. Paragraph 7.5 states: 'He moved in with her because she felt sorry he had been made homeless'. There is no suggestion that he was 'on the streets'. He was without proper accommodation for a very short time as opposed to the usual thoughts of people being homeless. Therefore there was no connection between his temporary situation and domestic abuse because there wasn't a connection.

Reference is made to the balance between the Perpetrator and his brother and the request is to reconsider that balance. Paragraph 9 of Home Office Guidance 2016 states:

> 'The narrative of each review should articulate the life through the eyes of the victim'.

Information and accounts of how the Victim lived her life is important and helps the review to be 'victim focused'. It is essential that in order to illustrate the life of the Victim elements of conflict she endured, crisis she experienced and the stress and strain of her everyday life is demonstrated and in accordance with the guidance information regarding this has been obtained from friends and family members. Having re-read the report I and the DHR panel are satisfied that the information

contained therein does exactly that. It gives an overview of the Victims life and without information about both sons mentioned the picture would not be complete.

It has been my practice when completing DHRs (well over 35) since 2011, to list the Overview recommendations and the IMR recommendations in the Overview report. In the Executive summary I would only list the overview recommendation and state that there are X number of IMR recommendation details of which are contained in the Overview report. Indeed the 2016 guidance page 40 Executive Summary Template guidance states:

> 'Recommendations from the Review – add recommendations as required.'

However, if both sets of recommendations are now required in both the Overview and the Executive Summary so be it. Please see amended versions of both reports together with this letter.

Your letter asks for the ethnicity and age of the Perpetrator within the narrative on equality and diversity. The DHR panel and I agree that both of those facts are irrelevant and purposely not included for two reasons. Firstly this case is nothing to do with cases that involve 'honour killing' or incidents where cultural issues may be concerned and age and ethnicity may be important to understand the context of the case.

Secondly both of those facts can be considered to be sensitive information and including them may lead to the identity of the individuals concerned. This is turn may be a breach of GDPR should the review reports be published.

This was a matter that I brought up with your colleague Charlotte Hickman at an AAFDA conference in Warwick on 4th June 2018. I sought advice from Charlotte that, given GDPR legislation has now been introduced, should DHR authors be obtaining consent from family members for the report to be published at all on the basis that, although anonymised and redacted, anyone can find the identity of those involved due to evidence from the trial, publicity and a myriad of other methods. My concern is that GDPR would be breached. Charlotte was unable to answer but said she would take the matter away for consideration.

Until firm guidance and advise is published by the Home Office such information, unless relevant, will not be included in my reports.

You touch on a similar matter in the next comment regarding the date of death, date of conviction and the area where the victim lived. The date of death is relevant to ensure and demonstrate that the CSP has complied with 2016 guidance i.e.

> 'The decision whether or not to proceed with a review should be taken by the chair of the CSP **within one month** of a homicide coming to their notice'.

The date of conviction may be considered necessary as an indication when family members and friends can be, or were, seen by the DHR author as many DHRs wait until after trial and appeal periods to make arrangements to do so.

There is little that can be done about indicating the area where those concerned lived as there is clear indication by the title of the CSP involved on the reports, in this case Bridgend. Genders of the children are an accepted point but in this case all of the children were adults.

The name of the AAFDA advocate has been removed from the Executive Summary– thank you.

The letter asks that it is made clear that the names used for family members are pseudonyms. Para 5.9 of the original Overview Report and the first sentence of the original Executive Summary makes that quite clear.

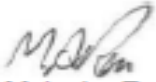
Your letter suggests that there are inconsistencies between the conclusion in the Overview Report and that of the Executive summary. On examination one is a variation of the other but contained all the relevant information and comments. For the sake of regularity both now read exactly the same.

Both of the reports have been re-examined for typing errors.

As is the usual practice to attach the Home Office response to the Overview Report when publishing and for the information of the family, for the sake of regularity, I will be appending a copy of this reply to you to the report.

If I can help further in any way please do not hesitate to contact me.

Yours sincerely,



Malcolm Ross. Independent DHR Chair/Author

Appendix 3 This document is also available in Welsh

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Business Support Officer - IFSS & Early Help
Education and Family Support
Bridgend County Borough Council

15 May 2019

Dear Ms Evans,

Thank you for re-submitting a revised Domestic Homicide Review report for Bridgend to the Home Office Quality Assurance Panel. The report was considered at the panel meeting on 24 April 2019.

The Panel was grateful to you for carefully considering the issues they raised as outlined in the letter of 31 May 2018. The Panel was especially grateful for the letter from the chair, Mr Malcolm Ross, dated 31 January 2019 which helpfully set out where amendments have been made. The Panel also noted the important additional information Mr Ross kindly provided in relation to some of the other observations they made.

The Panel was, however, disappointed as they were unable to identify a material improvement in the revised version of the report compared to the previous submission. However, to avoid further distress to the family who are keen for the process to be concluded and taking into account the considerable passage of time since the homicide, the Panel decided that the revised report could be published.

The Panel was keen to reiterate, however, that they stand by their original comments and observations and have therefore requested that their letter of 31 May 2018 together with this letter should be published alongside the report for transparency.

We would be grateful if you could provide us with the URL to the report and letters when they are available online by emailing us at: DHREnquiries@homeoffice.gov.uk.

On behalf of the Panel, I would like to take this opportunity to thank you, the chair and other colleagues for the considerable work that you have put into this particular review.

Yours sincerely

Charlotte Hickman
Joint Chair of the Home Office DHR Quality Assurance Panel