Domestic Homicide Review

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1. INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected deaths of Belle and Howard in C. (Belle and Howard are pseudonyms chosen and /or approved by family members of the deceased persons). It was commissioned by Monmouthshire County Council (MCC) acting for Monmouthshire Local Service Board in its role as the Community Safety Partnership for the county.

On the morning of Friday 19th June 2015 Gwent Police were contacted by a friend of Belle and Howard to say that he had called at their house, at the request of another mutual friend who had been trying to contact them with no success, and that he could see them lying on their living room floor. The police arrived within minutes and effected entry with the help of a neighbour. An ambulance had also been called and paramedics arrived at almost the same time as the police. Belle and Howard were both pronounced dead at the scene. Post mortems carried out the following week found that Howard had stabbed Belle and then himself. A double inquest held on 11th November 2015 later confirmed this.

1.2 PURPOSE OF THE DOMESTIC HOMICIDE REVIEW

Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be 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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

The purpose of a 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 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 policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 PROCESS OF THE REVIEW

The decision to commission a DHR was taken by the Local Service Board in January 2016. An appropriately independent, experienced and qualified Chair was approved by the Home Office and appointed in February 2016 and at the end of March 2016 she received additional Home Office approved specialist training for the role from the organisation Advocacy After Fatal Domestic Abuse (AAFDA). One of the other panel members also received this training, which was intended to add value and substance to the review process and to assist in the full capture of learning.

1.4 TIME PERIOD

The Home Office was informed of the intention to conduct a DHR in February 2016 and the first review panel was held on 15th April 2016. The panel was appointed after consultation between MCC, Gwent Police (GP), Aneurin Bevan University Health Board (ABUHB) and the panel chair. The process has been completed and the report submitted in October 2017. There was a significant delay in the DHR process being initiated and this is reflected upon in section 2.8 below. A further substantial delay was caused by an unavoidable crisis affecting the family of the chair and report author.

1.5 TERMS OF REFERENCE

The objective of this DHR was to review and evaluate the care and input of relevant agencies and the context and circumstances leading up to the incident. The second was to identify any contributory factors to the homicide and learn appropriate lessons across organisations. The DHR's specific terms of reference, as agreed by the panel were agreed at the first panel meeting as a draft and modified as necessary during the progress of the review.

Terms of Reference - Domestic Homicide Review

Purpose of the panel

- To establish the facts about events leading up to and following the deaths of Belle and Howard
- To examine the roles of organisations involved in the case, the extent to which Belle and Howard had involvement with those agencies, and the effectiveness and appropriateness of single agency and partnership responses to the case.
- To establish whether there are lessons to be learned from this case about the way in which local organisations and partnerships worked individually and together in carrying out their responsibilities to safeguard the wellbeing of those deceased.
- To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.
- To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Monmouthshire in order to improve our work to better safeguard victims of domestic abuse.

The scope of the panel review

- To produce a chronology of events and actions leading up to, and in relation to the deaths of Belle and Howard from the period from 1st April 2006 until 19th June 2015 * (with earlier information if needed and available) seeking information from:
    - Organisations who had contact with them
    - Local community organisations
    - Their family, friends and employers
- To review current roles, responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what might have happened to result in a different outcome.
- To review this against what actually did happen to draw out the strengths and weaknesses and other possible practice.
- To review national best practice in respect of protecting adults from domestic abuse
- To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse at local, regional and national levels.

*NB The Combined Chronology produced and available at Appendix One in fact dates from 2001 as all Howard's records from his move to the county have been included for background. The initial meeting of Belle and Howard is believed to have been at some time in 2006. The first entry for Belle in the chronology is from 2008.

The review will also specifically consider:

- Whether family, friends and employers are prepared to participate in the review.
- An assessment of the extent to which family and friends were aware of abusive or concerning behaviour from the perpetrator to the victim (or other persons)
- An assessment of the extent to which family and friends were aware of any abusive or concerning behaviour from the victim to the perpetrator (or other persons).
- A review of any barriers experienced by the family in reporting abuse or concerns, including whether they (or the victim) knew how to report domestic abuse had they wished to.
- A review of any previous concerning conduct or a history of abusive behaviour from the perpetrator and whether this was known to any agencies.
- Whether it would have been possible to conduct a Multi-Agency Risk Assessment Conference.
- An evaluation of any training or awareness raising requirements necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in Monmouthshire.
- Whether the perpetrator had any previous history of abusive behaviour towards the victim, or any previous or current partner and whether this was known to any agencies
- To review communication to the public and non-specialist services about available specialist services related to domestic abuse or violence.
- Whether the work undertaken by the services in this case is consistent with their professional standards, protocols, guidelines, policies and procedures.
- Any other information that becomes relevant during the conduct of the review

Panel Membership
The panel was made up of representatives of organisations that had some involvement in the victim's life and that of the perpetrator, organisations that have duties to care for adults at risk of domestic abuse, and organisations that have local knowledge and insight. Statutory partners that had no contact with the victim or perpetrator, e.g. Fire and Rescue Service, were not invited to attend.

1.6 PANEL MEMBERS

Name	Title	Organisation
Christine Edmondson	Independent Chair - report author	Independent
Rebecca Haycock	Regional Adviser for violence against women, domestic abuse and sexual violence (VAWDASV)	Gwent
Will McLean	Head of Governance, Improvement and Engagement	MCC
Jane Rodgers	Head of Children's Services	MCC
Linda Brown	Lead for Safeguarding (till 19.8.16)	ABUHB
Annette Morris	Lead for Safeguarding (from 19.8.16)	ABUHB
Bronwen John	Head of Partnerships and Networks	ABUHB
CI Joanne Bull	Chief Inspector, Operations	Gwent Police
Debbie Atkins	Team Manager	National Probation Service
Helen Swain	Chief Executive Officer	Cyfannol Women's Aid

1.7 CONFIDENTIALITY

This Domestic Homicide Review was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the report, its recommendations and its appendices have been accepted by the DHR Panel, reviewed by Belle's family members and approved by the Home Office. The report and appendices have been anonymised.

1.8 METHODOLOGY

Following the first panel meeting it was agreed that the Chair would conduct a series of meetings with family members of both parties, friends, colleagues and appropriate professional contacts. She was accompanied on most of these meetings by another panel member, Rebecca Haycock (RH) (the Gwent Regional Adviser for Domestic Abuse). Following the meetings and extended phone calls with some individuals, notes were produced by the chair, agreed with RH and used in compiling the review report. A large number of documents were also used in the review and these are listed below at 1.11.

1.9 PERSONS PARTICIPATING IN THIS REVIEW

Through meeting(s) and / or telephone calls(s):
(NB where & is used, both persons were present at the main meeting)

- Mrs M D (Belle's mother) - meeting, emails and telephone calls
- & Mr B D (Belle's step-father)
- Mr D B (Belle's father) - meeting, emails and telephone calls
- & Mrs K B, (Belle's step mother)
- Mrs J S, (Belle's aunt) - meeting, emails and telephone calls
- & Mr K S (Belle's uncle)
- Mrs M C (Belle's aunt) - emails and telephone calls
- Ms G H (Howard's daughter, Belle's step daughter) - meeting, emails, text messages and telephone calls
- Ms D H (Howard's sister) - meeting, emails and telephone calls
- & Ms S (Howard's niece)
- Ms A M (Howard's second wife)
- Mrs A M – Belle's friend and employer - meeting, emails and telephone calls
- & Ms H M - Belle's friend and colleague
- Mr MB – Belle's partner
- Dr R R – GP – Vauxhall surgery – telephone calls
- Ms C W - Belle's solicitor – telephone calls
- Mr P B – (B & Son Ltd, Funeral Directors) - telephone calls
- DC C O – Gwent Police Family Liaison Officer- meeting, emails and telephone calls.
- DCI N B – Gwent Policer Senior Investigating Officer -meeting, emails and telephone calls.

1.10 INVOLVEMENT OF FAMILY MEMBERS AND FRIENDS

The families of Belle and Howard have contributed to and been kept advised of the work of the DHR panel throughout the process. This contact, as above, was via letters, emails, phone calls and meetings, usually at the family members' homes. The chair and another panel member also met and or spoke with friends, colleagues and professionals who had contact with and knowledge of Belle and Howard. The assistance provided to the panel through the above contacts has proved invaluable.

1.11 DOCUMENTS USED IN THIS REVIEW REPORT

- Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office (from 1 August 2013)
- Chronology - ABUHB - Aneurin Bevan University Health Board
- Chronology – Gwent Police
- Chronology – National Probation Service
- Chronology – MCC Social Services department
- Chronology – combined – prepared by Nicky Neil, MCC
- Extract from notes – Emergency Department – Royal United Hospitals, Bath

- Individual Management Review - Aneurin Bevan University Health Board
- Individual Management Review – Gwent Police
- Individual Management Review - National Probation Service
- A box of documents received from Gwent Police (see Appendix One)

1.12 INDEPENDENCE OF THE CHAIR AND REPORT AUTHOR

Chris Edmondson, the chair and report author of this review is a freelance portfolio worker with a wide knowledge of local public service provision. Much of her work is as an independent person – she was for four years the independent chair of Monmouthshire Local Service Board, she was for eight years an independent member and chair of the Care Council for Wales Registration and Conduct Committees and also an independent lay member of the General Teaching Council for Wales and Education Workforce Council Professional Conduct Committees, and is currently an independent lay member of the Gwent Police Misconduct Panels. She has worked independently in a variety of roles for fourteen years after a career in senior management in the public and voluntary sectors.

2. BELLE'S STORY

2.1 Summary of the facts of the case Belle's Story

Belle was almost 36 when she was murdered by her husband on 18th June 2015, less than a week before her birthday. Her husband Howard had just had his 52nd birthday. After attacking Belle with a kitchen knife, causing fatal wounds, Howard stabbed himself several times and also died. The couple had been living in the house they rented in C where they had moved three months earlier from another house in C. Belle's clothing and other possessions were found to be packed into bags and suitcases in the kitchen of their house on 19th June, the day their bodies were discovered.

2.2 Background – events leading up to 18th June 2015 (2006 – 2012)

Belle and Howard were married on 1st June 2012. They had been in an "on and off" *(source – interview with M & BD, J & KS)* relationship since meeting sometime in 2006, when they both rented separate properties in a small square in C. Howard was a regular in a local pub/restaurant where Belle was catering manager, so they may have become friendly through either or both of these circumstances.

The relationship was a difficult one; the first recorded contact with the police was on 13th May 2008, when a member of the public called the police because of a violent argument Belle and Howard were having. Both refused to tell the police the reason for the argument and Belle was taken to her mother's home for the night. The incident was treated by the police in line with policy and procedures current at the time for a standard domestic violence incident and was the first of several reported to the police by others over the next few years. Family and friends recall many such incidents, but Belle rarely called for assistance from emergency services; Howard never did. Family members recall that Howard had broken one of Belle's ribs during these early years of their relationship. *(Source – interview with Mrs MC & Mrs MD)* On 24th January 2009, Belle attended the Accident and Emergency service in Bath with "left sided rib pain" *(source – Royal United Hospitals Bath records),* but no other information relating to this, other than anecdotal, has been found.

On 16th February, 2009, Belle's mother, M, called the police to report that Howard had sent a text message to say that he was going to commit suicide. M reported to the police that Howard had apparently previously slit his wrists and throat. Officers went to Howard's home, but he claimed that the text message had been misinterpreted by Belle and as there was no indication of any intent to self-harm, officers left him with advice and no referral was made. Howard reported to the police officers that attended that he had meant he was going away for a few days as he needed time by himself. However, Belle's mother said that Belle had shown her the text concerned and that it was a very explicit threat of suicide, which she recalled included the phrase "end it all". *(source – interview with Mrs MD)*. Howard's family members described many actual and threatened suicide attempts by Howard over a number of years. *(Source – Interviews with Ms DH, Ms GH and Ms S)*. Howard failed to attend a mental health appointment with the Community Mental Health Team (CMHT) the following month. The police were again called by a member of the public, probably a neighbour, at just after midnight on 29th April 2009, with a report of "arguing, shouting, screaming at each other, lots of banging noise, a recurring problem" *(source*

– *Gwent Police chronology).* When the police arrived, both Belle and Howard described it as a minor verbal argument only, neither disclosed any offences and both refused to complete a Domestic Violence Recording Form (DV1) though one was submitted. It is not recorded whether Belle was spoken to alone on this occasion. Later that year, on 4th July, Belle attended the Accident and Emergency Department at the Royal Gwent Hospital in Newport, saying that she had been "out drinking with friends, tripped over and banged head" *(source – ABUHB chronology)*. Belle had clearly been drinking and the hospital had no reason not to accept her explanation as plausible, so no enquiries were made or advice given. However, as part of the DHR process, two accounts were given by different family members that might account for this injury – one was when Howard had pushed Belle down some stone steps near their house, *(source – interview with Mrs MD)* and one which recalled Belle being pushed into a wall by Howard after an evening's drinking. After this push, Howard turned to the family member and said "see what she makes me do?" *(source – interview with GH).*

The next contact with police was at 3.21 am on 14th November 2010. A 999 call from a neighbour stated that Belle was "screaming for her life and a male is beating her up" *(source – Gwent Police chronology).* The attending officer noted that Belle had said that "her partner had held her down with his arms and shouted at her, pulled her hair and tried to strangle her." *(source – Gwent Police chronology).* This seems to be one of the occasions when Belle was able and / or prepared to tell officers what had actually happened during the incident. Officers reported that Belle was offered help from an Independent Domestic Violence Advisor or from Women's Aid, but Belle said that she did not require this and that she and Howard "would need to make a decision about their future together" *(source – Gwent Police chronology)* – Howard "was trying to deal with things from his past. She was trying to support him with those issues." *(source – Gwent Police chronology).* Howard was initially arrested for actual bodily harm, but it was noted that in fact his injuries were worse than Belle's and the charge was withdrawn. Officers did know at this point that Howard had a conviction for assaulting his ex-wife, although they were not aware of the full details. Following the incident, a letter was sent to Belle with details of support services.

The decision about their future must have been taken, as Belle and Howard had broken up, in late 2010 or early 2011, for some months. There is a log of another 999 call from a neighbour on 26th February 2011, where "a male trying to get in via a window and a female trying to shut the window" *(source – Gwent Police chronology)* was reported. Howard had left before the officers arrived and Belle declined to make a complaint. This incident is likely to have taken place during the period of separation, as Belle's mother recalls a phone call from a neighbour regarding such an incident during a weekend when Belle's mother and stepfather were away from home, and when Belle had moved in with them temporarily. Belle's mother told the neighbour that she should have no worries about contacting the police, as everyone was aware of the situation, and that a visit from the police could be helpful in the circumstances. This is confirmed in an entry in Belle's mother's contemporary diary and demonstrates that Belle was never without alternative accommodation and /or refuge with family members. This emergency call was handled by Gloucestershire Police; the address is not contained within the Gwent Police records available to the report author.

Belle's friends and family members recall that during this period of separation, Howard "haunted" Belle, trying to persuade her to go back to him, but later in 2011 Belle became engaged to someone else. Howard had persisted in contacting her and fought with her new partner on at least one occasion, which was recorded on 10th April 2011 by Gwent Police. This was not graded

as a domestic violence incident or referred to the Domestic Abuse Conference Call (DACC), as Belle had intervened in a fight between her fiancé and Howard and got slightly injured in doing so; under revised policy and protocol now current this incident would be treated as a domestic violence matter *(source – Gwent Police chronology)*.

2.3 The Wedding

Belle eventually decided to resume her relationship with Howard and they became a couple again in early 2012. Belle and her previous fiancé had already arranged their wedding; the same venue and date were then used for Belle's wedding, but Howard, rather than her previous fiancé, was to be the bridegroom.

Belle's family and friends were not happy about her marriage to Howard. One of her maternal aunts recalled saying "Is it congratulations or commiserations?" *(source – interview with K & JS)* to Belle's mother on the day of the wedding, and at the party following the wedding friends noticed that Howard danced just one dance with Belle and spent the rest of the evening getting drunk at the bar, pushing her away when she wanted to speak or dance with him *(source – interview with AM & H).* Although Belle had, on several occasions both before and after the wedding, gone to stay with her mother, and had suggestions from friends of sharing accommodation were she to leave, she stayed with Howard despite episodes which left her shaken and frightened. Friends and family say that although she may have been frightened at the time of his attacks and their fights, she was not generally frightened of him and frequently said that she could "handle him" *(source – interview with M & BD, D & KB)*. One friend also recalled that Belle had told her that she knew, on the day of the wedding, that she was making a mistake in marrying Howard *(source – interview with AM & H).* It is possible, even likely that, although she did feel physically capable of holding her own in a fight, Belle was still frightened of Howard and concealing this from family and friends. She was certainly subject to controlling behaviour from him, being frightened to smoke in his presence and not engaging in social activities where Howard was not present. *(source – interview with AM & H).*

2.4 2012 – 2015

After a few months of marriage, Belle visited her GP on 31st October 2012 "feeling depressed. Looking after new husband who has arthritis and working hard". Belle requested medication for depression but did not want counselling. By the time of her review with the GP on 5th December 2012 she was "feeling much better" with "more time to herself following her redundancy" *(source – ABUHB chronology)*. Friends say that she lost her job as catering manager at "the B" due to Howard's behaviour, and it was after this, through Howard's friendship with one of the staff at the Hotel, that Belle started to work at the Hotel, building up from being an occasional catering assistant to a full time and much valued staff member, described by one of her employers as "a grafter" who could "turn her hand to anything" *(source – interview with AM & H)*. Friends and colleagues report, however, that Howard was a problem at her new place of work too – he would visit the Hotel frequently, staring at her as she worked and getting very jealous if she spoke to male customers and phoning her up far too often if he wasn't sitting at the bar *(source – interview with AM & H).*

On 31st March 2013 Belle herself called 999, reporting that "she has had a verbal argument with Howard tonight and wants him out of the house." *(source – Gwent Police chronology)* Belle later

left the house, spending the night with her mother and refusing to complete the Domestic Abuse, Stalking and Harassment (DASH) form, although a skeleton DASH was later submitted. Later in the same year, on 13th May, Belle and Howard had a violent argument in the car park following an incident at Belle's workplace, the Hotel. Howard hit Belle and was later convicted of common assault. Bail conditions were imposed on him between his arrest and conviction and he was not able to have any contact with Belle for two weeks. Howard spent this time staying with his sister D and with his brother S *(Source – interview with DH).* A police marker flag was placed on the couple's current address, (though this did not move when they did). *It is not clear from the records whether the fact that Howard had a conviction for assault on his second wife was discussed at the ensuing DACC call.
*N.B. In the current NICHE police system, markers are now placed on individuals as well as on addresses – this was not the case in 2013, but it means that police officers are now able to track past histories much more efficiently and accurately.

After receiving his sentence of a 12-month community order, which commenced on 29th May 2013, Howard returned home to Belle. As part of his order he began a "respectful relationships" course on the 9th August 2013 which he went on to complete *(source – NPS chronology)*. However, on 6th March 2014, before the community order had elapsed, a 999 call was made from the couple's house, during which Belle was heard to shout "why did you hit me?" before the phone was hung up. The attending officer reported that this was a verbal argument and that Belle had refused to complete the DASH form and was staying at her mother's house for the night. This incident was discussed at the Domestic Abuse Conference Call (DACC) the following day and upgraded from standard to medium, after probation disclosed that Howard was currently serving a community order for an assault on Belle. The note from the DACC states that Howard's offender manager would be informed about the incident. The incident was discussed with Howard by his offender manager and the notes of the conversation show that Howard did not mention the incident until asked about it, that it had been an argument over moving house and that he "felt he should have dealt with it better and was disappointed with himself." *(source – NPS chronology)*

There is also a note in the National Probation Service (NPS) chronology which states that on 26th March 2014 a home visit was made "in line with change of address and continued to explore DACC information" *(source – NPS chronology)* - when Howard said he was "feeling a bit more settled now and feels the police call was vindictive from neighbours but also disappointed voices were raised from disagreement." *(source – NPS chronology).* Howard's assertion that the call was made by neighbours is in conflict with the evidence that the call was made from the couple's house, but we cannot be sure exactly what information was shared with the offender manager following the DACC call.

The NPS chronology records three home visits; the offender manager did not see Belle at home at all during these visits. Belle's mother recalled being told by Belle that Howard had told Belle that she was not permitted to be at their home when the offender manager was visiting him. *(source – interview with MD).* There seems to be a discrepancy between the details of domestic violence incidents according to NPS and those recorded by Gwent Police. Gwent Police record four previous incidents, not including the Hotel incident and Belle's intervention in the fight between Howard and her fiancé, whereas the NPS records state: "Police checks received back indicating one verbal dispute prior to the index offence in relation to DV and the index offence information." *(source – NPS chronology)* The index offence is Howard's attack on his second wife. There is a second note: "checks back from DAU regarding DV call outs for H. There is one for index

offence and one previous as disclosed by H for a verbal argument in March 2013." *(source – NPS chronology)* It is not apparent why there is such a discrepancy. (Please see section 3.3 below – "Communication between agencies".)

Howard completed his community order on 28th May 2014. During the year the order had run, he had cancelled two appointments with the Community Mental Health Team (CMHT), requested a re-referral and advised by his GP that he must attend, been referred to a rheumatologist and to Primary Mental health support Services, failed to attend for a blood test, failed to attend another two CMHT appointments, received a mental health assessment by the First Access service and then failed to attend two further mental health appointments. Despite missing his appointments, he was attending the GP surgery during this time with "depressive episodes" *(source – ABUHB chronology)* and being told that he must attend appointments in order to get help and improve his situation. There is evidence that Howard did discuss his health with his allocated probation worker and mentioned one missed appointment, but he did not disclose the full extent of this non-attendance.

Belle had no children and was not pregnant at the time of her death, although her family believe that she would have liked to have children. Howard had had a vasectomy and Belle was aware of this. Howard had five natural children, three from his first marriage and two from his second marriage, and had adopted the son of his second wife. Belle had a close relationship with Howard's daughter from his second marriage, G, who was 19 at the time of the deaths. G describes Belle as "more like a friend than a stepmother." *(Source – interview with GH).* G would often stay with Belle and Howard, although Howard had recently told G she could not stay frequently as she was not contributing to the household expenses. Belle's mother recalls that Belle told her that Howard was worried that G might want to move in with them, and that this would endanger his housing benefits, which he claimed throughout his relationship with Belle. Family members and friends say that life was happier for Belle when G was staying in the house. G had made a tentative arrangement to stay with Belle and Howard on the night of the 18th June, the date of the incident, but this did not happen. G's mother believes that this would have put her daughter's life in danger. *(Source – interview with AM)* As seen above, Belle and Howard's relationship was difficult from an early stage; Howard is described by family members as "a Jekyll and Hyde character" with a "split personality" – *(Source – interview M & BD and several others)* charming and great company when sober but violent and abusive after drinking. Howard suffered from psoriatic arthritis and depression, was receiving disability benefits and didn't work; during their relationship, it was Belle who paid the rent and household expenses. Howard would frequently borrow money from his family members; the bond on the house they rented had been paid by Belle's mother and father. Belle is described by family members, friends and colleagues as "very caring" and "compassionate" *(Source – interview D & KB and several others)* – she is reported to have felt very sorry for Howard and to have attributed his drinking, temper and violent outbursts down to pain from his condition and to his unhappy childhood. Family members of both Belle and Howard, as well as friends, all say that they believe Howard exaggerated the symptoms of his illness in order to continue receiving disability benefits, but all those interviewed stressed that Belle was consistently caring and sympathetic towards him.

Howard had a history of violence in his past relationships, particularly with his second wife A. They had separated because of his controlling behaviour and frequent violence but after their separation he stalked her, driving past her house frequently and entering while she was absent as well as present. A said that on one occasion she woke up in the middle of the night to find

Howard sitting on the end of her bed. The most serious occasion was in 2000 when Howard entered A's house, despite the locks having been changed, and attacked A with a meat cleaver, in front of their two children and A's son from a previous marriage. He was disturbed by their neighbours shouting that the police had been called and also banging on the door. Howard then left the house, cutting his wrists outside the house before getting into his car and driving off, ending in a crash into a conservatory from where he was taken to hospital and arrested. He was later convicted of common assault – a source of great distress to his second wife A who believed that he was to plead guilty to attempted murder and that she did not need to appear in court because of his guilty plea. *(Source – interviews with AM & DH)*

Friends and family members have re-iterated that Belle did not normally appear frightened of Howard and that she always said that she "could handle him". There were however, reports of several occasions following attacks when Belle was certainly afraid of Howard; reports of Belle hiding from him in a graveyard late at night, another occasion when Belle arrived at a friend's flat in a distraught state, after Howard had locked her into the house and pressed a pair of scissors to her throat. She would not allow the friend to contact the police and returned to Howard the following day, but on this occasion, she had appeared to be very frightened.

Belle's friends and colleagues and her step-daughter G have confirmed that Belle knew about the attack on his second wife; and A, Howard's second wife, was so concerned when she heard in early June 2015 that Belle was planning to leave Howard, that she sent a Facebook message to Belle to warn her to be careful. G had also told Belle about her father's violence to her mother, A. Belle did not disclose this to her own family members or to her doctor, although she had disclosed to her GP that Howard had been violent "in the past, but not now", *(source – ABUHB chronology)* and did disclose and discuss the message from A with friends and colleagues at The Hotel. *(Source – interview with AM & H)*

Belle had been discussing the possibility of her leaving Howard with family members and friends for a long time, but had always stayed with him, returning after nights spent with her mother and with friends, following incidents and fights. However, sometime in late April or early May 2015, Belle entered a relationship with another man, a regular at the hotel where she worked. The relationship quickly became serious and Belle wanted to move in to his house, which she may have been planning to do. It is also possible that she was considering a move into her mother and stepfather's home; this had always been a safe place for her and she knew that they wanted her to leave Howard. Mrs JS was told by MB, Belle's new partner, that he had suggested that Belle move back to her parents' home for 6 months as it would allow a "cooling off" period for Howard and would also ensure that their own, new relationship was stable. (*source – telephone conversation with Mrs JS and with Mr MB).* Mr MB was also concerned as he was renovating his house and considered it was not yet fit to live in, though he reported that Belle was not concerned about this. In late May Howard became suspicious of the relationship but Belle assured him that it was not intimate and that they were just friends. Howard sent extremely abusive and threatening text messages to both Belle and her new partner. *(Source – Gwent Police evidence files)* Belle's close family members and friends, as well as Howard's daughter, were aware of this new relationship and very pleased about it, as they thought her new partner might be the support Belle needed to finally leave Howard. G believed her father was desperate for Belle to stay with him because he was dependent on her not just financially but also for his care "she would fetch his tablets, his drinks, food, anything". G said that Belle felt very sorry for Howard and was worried about the effect that her leaving might have on him. G also considered that her father's behaviour

was controlling to an extreme level. G confirmed that she had told Belle about the dangers of leaving; she was not surprised at her father's suicide but was quite sure that his attack on Belle was impulsive rather than planned. (*source – interview with G).*

Belle's closest friends describe Belle as extremely happy during the last few weeks of her life – she had her hair professionally styled, rather than doing it herself as was her custom, and she started socialising with her own friends and colleagues, particularly those from work at the Hotel, which she had not done without Howard for several years. During this period, Howard made at least one suicide attempt and spoke about suicide to his family, friends and to Belle, who friends say was extremely concerned about the possibility that he might take his own life. On 8th June Howard visited his doctor with depression and reported "marital problems" and "no formed thoughts of self-harm more a wish of not wanting to be here". He also said that he was "keen to get better for the sake of the marriage." *(source – ABUHB chronology)*. His GP again referred him to the community mental health team and he had an appointment booked for 7th July 2015. Howard had been, in the past, a serial non-attender of appointments for mental health and other health issues, with 15 missed or cancelled MH appointments and 5 other missed appointments since 2001. Howard did speak to Belle, to his sister and to other friends and family about his intention to get help with his depression and to cut down his drinking in the weeks before his death. He told his sister that "he felt that the marriage could be repaired and he was drinking less and having counselling" *(source – interview with DH & S)* which may have referred to his mental health appointment and of his intention to attend this time. However, in the week before he died, he sent a text message to his daughter G, in which he threatened to commit suicide, although he later apologised to her during what was to be their last meeting. *(Source – interview with GH).* One of his text messages, from 16th June 2015, to Belle includes the following "go all solicitors u like…. you're wasting your time, I vow to u …. that you will be widowed before then." *(source – Gwent Police evidence files)*

2.5 18th June 2015

In addition to her concerns about his mental and physical health, Belle was worried about Howard's ability to pay the rent at the house they shared if she left him; his only income was his disability benefit payments and his housing benefit payments. The bond on the house had been paid by Belle's mother and father and Belle wanted to ensure that both her parents received the bond back at the end of the lease. Belle was also worried about Howard's ability to care for himself as well as about his suicide attempts. However, she decided to start divorce proceedings and, accompanied by her mother, went to consult a solicitor, CW, of a local firm of solicitors in C on the morning of 18th June. Belle's mother urged Belle to conceal her visit to the solicitor from Howard, but Belle did tell him some days before, which is evident from text messages between the two. *(Source – Gwent Police Evidence files).* The solicitor advised Belle to leave before Howard received the letter notifying him of the proceedings, and although there are different accounts of the exact advice given during the visit, the notes of the visit show that CW advised that the bond could be split, that Belle needed to notify the estate agent of her new address and that she did not have to stay at the property with him. CW recorded that she was worried as she would need to write to Howard to inform him that Belle wanted a divorce. Her note reads: "Client (B) stating that she had already told him she wanted a divorce so was not too concerned." *(Source – interviews with CW).*

Following the appointment with the solicitor, Belle returned home, and then went to work at the Hotel as planned. Later that day, her mother and step father went to do some gardening at Belle and Howard's home. Howard was very anxious to know what had been discussed with the solicitor, but M declined to give him any information. Despite some highly acrimonious text messages between Belle and Howard, later that day she sent him a text to say that she had got some cider for him and arranged to meet him, after she finished work, at a local Budgens store at 6.15 after getting a lift home from the Hotel with a colleague. Their meeting was filmed on Budgens CCTV of the car park outside the store and appears quite normal. They were also seen entering the store together on the CCTV recording. *(Source – Gwent Police evidence files).*

Later that evening the couple were heard, by one of their neighbours, having a violent argument. Even though they had only lived in this house since March, loud arguments were a regular occurrence and the neighbour had considered complaining to their landlords about them. The last time this neighbour can be sure of hearing Belle and Howard arguing on 18th June is around 10 pm that evening, although her teenaged son said that he had been woken by arguing next door during the night. Another neighbour also heard Belle and Howard arguing, but said that everything was quiet by the time she went to sleep at 1.00 a.m. Analysis of Belle's and Howard's mobile phones shows the last sent or read call on Belle's phone appears to be from Howard at 18.07 on 18th June, telling her that he would be "by Budgens". There is a dialled call from Howard's phone to Belle's at 20.31 on 18th June. This call was missed, and it may be that it was a call made to locate the handset, but this cannot be proved. Belle's phone was found in Howard's pocket, so she may have been unable to use her phone by 20.53, the time of an unread text message from MB, Belle's new partner. *(Source – Gwent Police evidence files).*

2.6 19th June 2015

Belle had arranged to be in work quite early on the morning of Friday 19th June. Howard had made an arrangement for this morning to drive a friend, H, to pick up some glass for a job the friend was doing. When neither turned up and phone calls to the pair were not answered, their friends and colleagues became concerned. A series of phone calls to ascertain their whereabouts followed and this alerted M, Belle's mother, who was visiting her doctor at the time. A mutual friend, J, who lived nearby, was contacted and went, with Howard's friend, to visit the couple's house to find out whether they were at home. All the doors were locked, and the keys were later found in Howard's pocket. On looking through the living room windows J and H could see both Belle and Howard lying on the floor and also saw what they thought was quite a lot of blood. They found a nearby neighbour who phoned for an ambulance and the police and both arrived very shortly at 11.56. The paramedics entered in order to check for signs of life and found that Belle and Howard were both dead. Friends and family including Belle's mother and stepfather arrived at the scene very shortly after the police and ambulance as they had all been worried about Belle and Howard who had not been heard from since the previous evening. Although a family liaison officer was appointed the following day, a liaison officer at this point, perhaps a police officer or other professional, might have proved very useful; Belle's mother learnt that her daughter was dead from her daughter's employer and friend AM. *(Source – interviews with MD and AM)* Belle's father and stepmother were told by Belle's sister in law by telephone, and also attended at the scene. *Source Interview with D & KB).*

A letter, which appears to be a suicide note written by Howard, was found in the house, and Belle's clothing and other belongings were found packed into bags in the kitchen. The furniture at one end of the living room was disordered, consistent with a violent struggle.

2.7 Events following 19th June

Post-mortems carried out on Belle's and Howard's bodies confirmed that the cause of death of both Belle and Howard was stab wounds to the chest, including the heart. Belle's wounds had been inflicted during an assault and Howard's wounds were self-inflicted. Expert medical evidence found beyond doubt that Howard had stabbed Belle, causing fatal injuries and then cut his own neck and stabbed himself fatally. *(Source – Gwent Police evidence files).*

A Family Liaison Officer (FLO) was appointed by Gwent Police as the family liaison officer for Belle's family and, unusually, also offered support to Howard's family. Both families were very happy with the support provided by the FLO, although this was necessarily limited in the case of Howard's family. Mr MB, who was understandably grief stricken, was not offered support and would have appreciated this, although he did not seek help at the time. Howard's sister, D arranged a very quiet, low key funeral for Howard and would have appreciated some form of support with this. She commented "I had more support when I had my house burgled than with going through this ordeal". *(Source: interview with Ms DH).* Belle's funeral was held on 16th July.

A double inquest was held in Newport Coroner's Court on 11th November. Family members of both Belle and Howard found the inquest very difficult and unsatisfactory; they felt that it was rushed and that they did not get answers to the questions they would like to have seen answered. Unfortunately, the Coroner used the wrong name for both Belle and Howard on more than one occasion, despite being corrected from the floor of the court by family members, and this was particularly upsetting. The Coroner's verdict was that Belle had been unlawfully killed and Howard had committed suicide.

This DHR commenced with the first panel meeting on 15th April 2016; this meant that Belle's family members were not aware of or able to access the support which they might have received from an independent advocacy service, which could have been of great assistance to them in the weeks following Belle's death and particularly around and during the inquest. They were unanimous in their praise for the support and kindness shown to them by their family liaison officer, but independent advocacy following the tragedy and throughout the inquest might have spared them some of the distress caused by the inquest and surrounding events. It would also have meant that their recall and memories would have been fresher when speaking with the panel chair.

3. ANALYSIS OF INDIVIDUAL MANAGEMENT REVIEWS

The analysis below is taken from the Individual Management Review produced by ABUHB. Comments from the report author are in plain text; *extracts from the Individual Management Reviews (IMRs) are shown in italics.*

3.1 Aneurin Bevan University Health Board

The ABUHB analysis dealt with Belle and Howard separately.

Belle

On 24/01/2009 Belle attended the emergency department at the Royal United Hospital, Bath, with left side rib pain, saying that she had "Had a fight last night? Cannot recollect how due to amount of alcohol ingested".

This incident is clearly outside the remit of ABUHB and is included here for clarity as it appears in the Combined Chronology of Agency Involvement (at Appendix One) and is also included in ABUHB's own chronology and IMR. The incident may be connected with a suspected broken rib mentioned by Belle's aunt, Mrs MC. The history given by Belle was that she had been drinking the previous evening and had got into a fight – she did not say with whom, and there is no way of knowing why she attended Bath rather than a nearer hospital.

On 04/07/2009 Belle attended A&E in the Royal Gwent Hospital with a head injury – the history she gave was that she had been "out with friends drinking, tripped over and banged head."

This may reflect the incidents mentioned by MB and GH during interviews, when Howard is alleged to have pushed Belle into a wall and/or down some steps near her house, though this is speculative and dates are not specified in interviews.

Belle attended her GP's surgery during 2012, 2014 and 2015 with episodes of depression.
Belle had very little involvement with health professionals apart from primary care services. She had a history of depression but presented to primary care services when she felt she needed help. The GPs engaged well with Belle. The practice offered appropriate medication, advice and regular appointments for review.

Belle had suffered from depression earlier in her life, particularly following the breaking of an earlier engagement just three weeks before the planned wedding. *(Source - Interview with M & BD)*

On 31/10/2012 Belle attended her GP feeling depressed and reported "looking after her new husband and working hard". An assessment was undertaken in respect to her mental health, medication given and a review appointment made for 1 month. When she returned on 5th December she reported feeling "much better", putting this down to the fact that she had been made redundant and "had more time to herself".

There are no recorded contacts with the police from 10/04/2011 until 31/03 2013, so it is possible that these visits may be unrelated to abuse or control. However, anecdotal evidence from friends

and family confirm that their relationship was “stormy” and “volatile” and that Howard was extremely jealous and controlling of Belle throughout their relationship.

On 03/10/2014 B attended the GP again with depression and reports “current relationship problems” although she said she loved her job and cats. Again, assessment of her mental health was made and medication commenced.
This could have been an opportunity to explore more about the “relationship problems” and what they actually were, domestic abuse enquiry is not routinely embedded into GP assessment it would be up to the GP to spot worrying signs and probe further. From speaking with the practice, it was confirmed that the GP would enquire if they felt there might be a risky situation. At this time, it was not evident to the GP that this was a dangerous abusive relationship. Belle, returned to the surgery, with her mother M in attendance, on 07/11/2014 and again disclosed a “difficult relationship with husband”. Her medication was increased, and a review scheduled for three weeks later.

The disclosure of the “relationship problems” and “difficult relationship with husband”, both of which have been recorded by the GP, provide a foundation for probing questions which might have disclosed control if not violence. GPs need to be aware that coercion and control are a far more accurate predictor of death than physical violence, and to know the appropriate questions to put to the patient. Ask and Act training should help with this, but a marker, put on by the surgery after intelligence from other agencies onto Belle’s file would have given the GP grounds to explore these disclosures carefully. Currently a pilot concerning markers on both perpetrators’ and victims’ files is on-going at a national level and work surrounding this and improved sharing of intelligence between agencies is of great relevance to the issues in this case but precludes the formation of a recommendation at this time.

On 1/12/2014 Belle attended for review of her depressive episodes and reported “still problems at home partner has alcohol problems”. She also reports at this visit that he is verbally abusive and has been physically abusive in the past but not now”. The GP suggested trying online CBT (Cognitive Behavioural Therapy) as this had helped Belle in the past and they planned a review appointment in two months or before if Belle felt worse. This might have been an opportunity to do a more formal risk assessment with Belle, e.g. a Domestic Abuse Stalking Harassment Risk Assessment (DASH), or to have the discussion around the need for a safety plan. However, this is not currently an expectation of Primary Care nor have many GPs undertaken DASH training.

The statutory Ask and Act Training which the Health Board is implementing will address this issue.

Again, Ask and Act training should be of assistance here, but the marker referred to above would be a firm indicator that questions needed to be asked by the GP. The time frame for rolling out Ask and Act training needs to be short, and refresher training available to ensure that this becomes embedded.

On 10/02/2015 Belle attended her GP for the review as planned. It can be determined from the records that Belle was asked about her thoughts and feelings as it records “no suicidal ideation” and “home situation the same, no physical abuse”. It is clear that the practice was aware of the connection between depression and the possibility of domestic abuse and made enquiries when B attended as to her wellbeing and safety. Domestic abuse in the form of coercion or controlling behaviour was perhaps not fully explored but could have been considered by health professionals.

Again, the Ask and Act training should influence future thinking and practice. It appears that B was not viewed as being vulnerable but independent and able to manage the situation at home. She did not appear to be frightened of H.

This view is consistent with that of most family members and friends, but there is evidence from their accounts that Belle was certainly frightened during and after Howard's attacks. *(Source – Interviews with AM & H and with G.)* It is quite possible that Belle was concealing her true feelings and also that there was a tension between her wish to escape the relationship and her genuine sympathy and affection for Howard.

Enquiries made with the GP by the panel chair led to the GP commenting that although she did try to discuss the physical violence with Belle, her patient clearly did not want to disclose or discuss anything further. Prior to the Serious Crime Act 2015 (in particular Section 76), the awareness of the accelerated risk of death posed by controlling and coercive behaviour was much lower and health professionals would not routinely ask questions such as which partner made decisions regarding the couple's finances, how their transport was arranged etc. This will be comprehensively addressed during Ask and Act training.

Howard

During this time, Howard was also seeing the GP for depression and issues to do with his general health which was poor due to his arthritis. The response of the practice was to continually encourage Howard to attend for his mental health and rheumatology appointments actively referring and contacting other professionals to try and ensure engagement.

It is not clear however, within GP practice how emerging problems and possible domestic abuse within a relationship would be identified unless the couples present together or critical incidents occurred. It appears that both B and H were being managed as individuals. It is possible that the GP would not have known that these two individuals were in a relationship.

In the current provision of NHS services, individuals are free to register with a general practitioner of their choice within their locality. This means that members of the same family may be registered with different GPs. Information concerning other individuals in relationships with patients cannot be known, unless the patient chooses to disclose this or in circumstances where individuals are known to be at risk and this is shared with agencies, including GPs. This would be via the MARAC process; in those circumstances, a read code could be used to flag that a patient may be 'at risk' to promote vigilance at GP attendances. The risk could be risk of harm or, in the case of a perpetrator, of being a risk to partner(s).

It is clear from the NPS (National Probation Service) chronology that Howard discussed his health with his offender manager, but it seems unlikely that they had information regarding his suicide attempts or the extent of both his mental health problems and his history of non- attendance for both physical and mental health appointments. Communication between agencies could be considered – it may have been useful information for the GP to be aware of Howard's community order, in the context of his depression. Currently, unless an offender is in the MAPPP (Multi Agency Public Protection Panel) system, or there is a Mental Health Requirement set by the court, there is no process for NPS officers to retrieve information from the offender's GP or other health professionals without consent; they are dependent on information given to them by the offenders

themselves. Markers on files placed by GPs could possibly be an avenue to such information, but they would need signed consent from the offender before contacting a GP for this or any other purpose. Had his criminal history, in particular the conviction from 2000, been known to NPS, Howard would almost certainly have been assessed as higher risk. The sharing of information between agencies in this case could have led to different risk assessments and therefore different referrals, however this would not necessarily have resulted in a different outcome.

As earlier reflected, further enquiries with patients presenting with depression and reporting relationship issues by using a structured risk assessment may elicit more information and thus identify if there is significant risk which warrants further action /referral. Implementation of Ask and Act will better equip GPs to identify and respond to and to direct possible victims.

It is clearly extremely important that Ask and Act training is rolled out to general practitioners and also to Accident and Emergency staff out as promptly as possible, and the importance of questions designed to uncover coercive and controlling behaviour cannot be underestimated.

The GP practice consistently tried to engage Howard to address both his physical and mental health issues. Primary mental health services arranged appointments, sent follow up letters, attempted telephone contact and continued to accept re referrals from the GPs. It is clear the GP tried to address the fact that Howard was non-compliant with referrals to assist with his mental and physical health. Howard had mental capacity and was free to choose whether or not to take up the offer of services. There was no indication that the presenting mental health concerns should have triggered additional actions by the GP.

The possible knowledge combination of a domestic violence marker from the police and the knowledge that Howard was on probation for a domestic violence related assault potentially could have led to some form of action, possibly referring back to the other agencies involved. It is accepted that the use of such markers would be difficult and controversial but it could save lives and should be at least discussed. It is unlikely that perpetrators of controlling and violent behaviour will disclose this but, once known about, it could be explored and assistance offered – if effective work with perpetrators is to start, the perpetrators have to be identified before they reach the ultimate end of their relationship through the death of their partner and / or themselves. As referred to above, the use of such markers is currently being explored at a national level.

ABUHB Serious Untoward Incident Process - learning points

GP kept making referrals for Howard for primary mental health services but these were largely ineffective as Howard often cancelled appointments.

A Wales Applied Risk Research Network Risk assessment (WARRN) was not carried out at Howard's initial appointment with mental health services. Consideration to complete this assessment at the first appointment would usually be if there were any presenting immediate risks otherwise the assessment may be best completed over a couple of sessions (a persistent theme in this case was Howard's lack of engagement which hindered this assessment being carried out).

Again, if Howard's conviction for assault and domestic violence had been flagged on his medical notes, this would clearly have signified a higher level of risk, particularly if the details of his very serious assault on his second wife had been available.

In his conclusion, the Deputy Medical Director Primary Care reported that he did not identify any significant issues in the management of Howard from a primary care perspective. However, he suggested that GPs should consider actively flagging patients with a definite history of domestic abuse as they are probably more likely to present as a risk when they feel ambivalent about their future and that GPs should consider to specifically enquire about their feelings toward others in this type of situation.

Currently domestic abuse incidents are not routinely communicated to GPs within ABUHB. During 2016 ABUHB have been looking at how this could be addressed and will start by looking at how MARAC information may be shared. ABUHB intend to pilot this at a GP practice in each local authority area in the autumn.

As outlined above, work on this area is ongoing at a national level.

Actions agreed by ABUHB

1 Domestic Abuse to be included within the planned Continuous Professional Development (CPD) sessions for GPs on Safeguarding, this ***will now be strengthened by the statutory roll out of Ask and Act***

2 The WARRN training package will be reviewed to include the importance of completing the WARRN as soon as possible during the assessment process

3 An alert to be sent to all teams reminding them of the importance of completing the WARRN at initial assessment

All the actions have been completed. The training for GPs on domestic abuse is part of their current rolling CPD programme.

3.2 GWENT POLICE

The analysis below is taken from the Individual Management Review produced by Gwent Police, and has been modified for this report, although the text is that of the IMR. The combined chronology attached to this report gives detailed information for all these incidents as well as indicating the policy and procedures in force at the times of the incidents.

Comments from the report author are in plain text

Date		
13/05/2008	*Call received from member of the public of domestic in progress. Officers attended and spoke to Belle. Not forthcoming with any information, and*	*Reviewing this incident, it was dealt with in line with policy and procedures at the time. This was the first notification of domestic abuse between the two parties and a*

	refused to disclose reason for argument and said "Howard has a lot on his mind and needs help ". Belle conveyed to her mum's address for the night. DV1 not completed at the time as Belle had been drinking. Howard also refused to provide any further information. DV1 completed and submitted 2 days later. *Follow up by officer on 15/05 when Belle stated she wanted no assistance with her domestic arrangements*	*Standard Grading would be appropriate in the circumstances.*
16/02/2009	*Report from Belle's mother that Howard had texted Belle and it sounded as though he was going to commit suicide. Mother stated that he had previously slit his wrists and throat.*	*No further action was taken here. There was no indication of self-harm or intent to self-harm. There was no requirement in this event to make contact with any Mental Health via referral.*
29/04/2009	*Report from member of the public male and female arguing, shouting and screaming at each other, lots of banging noise, a recurring problem. 969 attended and spoke to both parties, who stated they had a minor verbal argument only. Neither disclosed any offences, both parties refused to complete a DV1 though one was submitted.*	*In this case the risk was assessed as Standard. In addition to undertaking relevant VSI* (address checks) *and AP checks in this case a latter was sent to Belle advising her of support being offered by the DAIU and referencing other support services available to help. This response is beyond the minimum requirements in this case.*
14/11/2010	*999 call received from member of public stating a neighbour is screaming for her life and a male is beating her up. Update from officer that Belle stated her partner had held her down with his arms and shouted at her, pulled her hair and tried to strangle her. Howard arrested and DASHRA submitted – initially graded High and then downgraded to Medium.*	*Officers initially attending this incident graded the risk as High. This was reviewed by a specialist Domestic Abuse officer and downgraded to Medium after consultation with the attending officers and Belle herself. Belle refused support from the IDVA and Women's Aid at that time. This matter was discussed within DAIU and was prior to the DACC being introduced in Monmouthshire. A letter offering support was sent to both parties following the refusal of charge for Howard and records kept of these facts.*
26/02/2011	*999 Call redirected from Gloucester Police stating domestic opposite with a male*	*A DASHRA is referenced within the command and control log as being completed. However, the original*

	trying to get in via a window and a female trying to shut the window. *Howard left prior to police arrival. No complaints forthcoming.* *Howard apparently trying to enter via window which had been opened by Belle. No entry was made to the premises and contact between Belle and Howard was via the open window.* *DASH form completed, but not verifiable.* *Safety planning advice given to Belle to lock doors and windows and use 999 should she have any further issues.* *It transpired that Belle had opened the window in order to speak with Howard.*	*document has not been located and it does not appear to have been discussed within the DAIU. Given the proximity of this and the previous incident, a HIGH-RISK grading would have been appropriate in the first instance, therefore ensuring review within DAIU. Since that time and with changes in policy and procedure a flag would now be added to STORM and to NICHE indicating the domestic nature of this call. ORIS (Command and Control) at that time would not have been searchable on the word DASH and therefore this does present a gap which has since been addressed in policy and procedure and therefore risks of the same situation are minimised.*
10/04/2011	*999 call from member of public reporting girlfriend has been attacked by ex -boyfriend. Officers attended and dealt with incident. Officer states not a domestic incident as it involves ex-girlfriend. Belle has stepped in between Howard and current boyfriend and has sustained a minor cut to finger. No complaints forthcoming. Officer stated advice given to Belle and the officer would attempt to speak to Howard regarding the incident the next day. Not known if this occurred.*	*As discussed earlier within the chronology the specifics of this incident would not have been considered as domestic in nature. The disagreement was between the two males present - current and ex-partner of Belle. Current procedures would take a wider definition of this incident.*
31/03/2013	*999 call from Belle stating she has had a verbal argument with Howard tonight and wants him out of the house. Belle left and stayed the night with her*	*This incident was some 23 months after the previous call. There is a note showing this was Graded as Standard and not discussed at DACC, given the change in assessment and criteria – repeat victims / perpetrators,*

	mother. Belle refused to complete the DASH form. Skeleton DASH submitted and DAIU informed of incident. DASH graded as Standard.	*high risk cases. A Domestic Abuse Officer may have made a decision if considered appropriate to grade a risk as High irrespective of whether the call meets the above. This incident may have benefited from that consideration and support may have been offered at that time. Belle refused to complete the DASH and was not supporting any allegations.*
13/05/2013	*999 CALL from H Public House, C, stating that husband and wife having a domestic in the pub. Male has hit female. Howard later arrested for assault and charged with common assault on Belle. OE marker placed on home address of Belle. DASH submitted and classified as Medium Risk. Bail Conditions placed on Howard not to contact Belle.*	*This incident was classified correctly as Medium risk and records kept within the Domestic Abuse Management System. At DACC partners discussed their knowledge of Belle and Howard and shared information / a lack of information held. Occurring just 6 weeks after the previous incident there was timely intervention by specialist resources and safeguarding put in place.*
06/03/2014	*999 call relating to male and female arguing. Female shouted to male "why did you hit me "and hung up.* *Assessed by attending officer as verbal argument.* *DASH refused. Graded as Standard.* *Safeguarding arrangements through staying at mother's address overnight.*	*This incident although initially graded as Standard with the DASHRA refused by Belle was discussed in the DACC. At this conference call reference is made to the fact that Howard is subject to Probation contact. As a result of that discussion the case was correctly upgraded to Medium risk. There is a note that the Probation Officer in Howard's case was to be informed of this incident, but there is no information regarding what happened within Probation and any contact or intervention with Howard in these reported circumstances. This would have presented an opportunity for an intervention – this will need referral to Probation for records to be checked.* Information from probation is included in the combined chronology, and in the NPS IMR.
19/06/2015	*Log 161*	*Reported incident of the deaths of both Belle and Howard.*

The IMR author has included careful analysis of the response to all the incidents and the combined chronology includes much detail of the policy and procedures in force at the time of each incident and the rationale for and level of the responses. There are identifiable opportunities for intervention which appear greater when the whole picture is viewed through the hindsight

provided by the chronology, but it seems clear that Belle did not wish – or was too frightened – to co-operate with the intervention offered by Gwent Police at the time of the incidents. It is not always clear whether these interventions and / or referrals were offered to Belle in the presence of Howard – clearly if a victim is offered help in the presence of the person who is perpetrating the violence, they would be a lot less likely to take up any offers of help. Further reflections upon this are included below.

Reviewing the Terms of Reference for this Domestic Homicide Review the additional comments can be made.

On each occasion the risk applied to the reported incidents were reported as Standard where no compliance was received from Belle. Officers did on one occasion make an initial HIGH risk grading and referred the case through to the appropriate specialist resources. This was downgraded on the basis of the information presented.

This appears to be appropriate in the context observed. MARAC arrangements within policy at that time would be applied to cases deemed to be Level 4 – VERY HIGH RISK. Therefore, it is clear that as described a MARAC would not have taken place.

In relation to the previous abusive behaviour towards the victim or any previous partner, it was evident during this IMR that Howard had lived in another force area with his ex-wife. It is this person against whom he had a conviction for assault. This conviction should have been known to Probation at the time of conviction at court for the assault on Belle in May 2013. It is not possible to comment here on whether this had been flagged and actioned by that agency.

It is easy, with hindsight, to form a critical view of the actions taken by Gwent Police following visits to Belle and Howard, after calls from members of the public alerted them to disturbances. It is very unfortunate that Howard's conviction for assault in 2000 was not known to Gwent Police, having been handled by another force. It is clear that Belle did know about this incident, though we cannot know whether the warning from Howard's second wife played a part in accelerating Belle's decision to leave. In this previous relationship, there was a similar pattern of neighbours calling the police to domestic incidents and this history also appears not to have transferred. Although knowledge of the incident may not have affected Belle's decision to remain in the relationship for as long as she did, it would have been available to agencies as information in tailoring the interventions made, and as background information for the Domestic Abuse Conference Calls it should certainly have influenced the grading of the incidents. Following the findings of the Bichard enquiry into the Soham murders in 2002 the Police National Database (PND) was designed and launched in 2011. This system saw the ability to join up disparate force intelligence databases and for forces to view intelligence relating to persons of interest within other areas, or who may have moved from one area of the country to another. Gwent Police guidance indicates that such a check should now be made.

The charge in this case, that of the assault on Howard's second wife A, was altered without the prior knowledge of the victim, who said that she would certainly have wished to appear in court if she had been told that the guilty plea made by Howard was in respect of a reduced charge of assault rather than the original charge of attempted murder – Howard had attacked his former wife with a meat cleaver in front of their children. The panel considered whether this change of charge without the victim's knowledge should form the basis of a recommendation but are

satisfied that practice in this regard has changed. Enquiries with the Witness Care Service in the Victims Hub in Gwent (Connect Gwent) produced the following information:

In these circumstances now, the Crown Prosecution Service would be responsible for any decision, would liaise with the Officer in Charge for victim views and would write to the victim to confirm this with them. All of this would enable the victim to have knowledge prior to an outcome in such a case.

Gwent Police have also helpfully provided the following updates to procedures since June 2015 and these are included here for clarity and context:

There are various pieces of work currently on-going within Gwent looking at changes that are anticipated to improve outcomes for victims of Domestic Abuse:

1. *Changes to the Domestic Abuse Conference Call (DACC)*

The Gwent Domestic Abuse Conference Call (DACC) was originally launched in Newport in November 2010 for the purpose of sharing police information on Domestic Abuse incidents with other agencies in order to provide a co-ordinated response to safeguard and support victims. This process was later rolled out across the five local authorities in Gwent.

Initially information on incidents of DA at all risk levels was shared and discussed; however, due to the volume of information and the length of time this was taking a set of criteria were brought in to limit the number of cases being discussed. These are high risk, those involving a repeat victim or serial perpetrator, those where there have been two or more reported incidents in a rolling 12-month period and those where other vulnerabilities have been identified. Details of other cases are shared where the victim has given consent.

A review in 2015 identified that in order to further develop the DACC and to allow more agencies to engage in the process a move to a computer based system will be required as agencies covering more than one Local Authority area, or where their workload does not allow them to commit to a live call at a specific time out of their day cannot join the present process. A pilot of a computer based system was run in Caerphilly with no notable difference to DA outcomes. Monmouthshire moved away from the live call in 2016 as their low number of cases and the low number of agencies involved in the call resulted in the live call being unsustainable.

Gwent Police are currently looking to make improvements to the current software that would allow sharing of information between agencies and look to specifically target Mental Health services, Drug and Alcohol Support Services and Education to become more engaged with the DACC process. In addition, a Multi-Agency Safeguarding Hub is due to be piloted in Newport. Moving to this process will also allow greater sharing of information as the current criteria can then be removed and information can be shared on cases at all risk levels. It is anticipated that this will result in some cases having their risk levels raised as a result of information held by partner agencies.

In order to assist with this change a "Request for Change" was submitted to the National NICHE user group for changes to the current "consent" question on the Public Protection Notice. This will change the wording from the current general "do you consent to your information being shared with other agencies" to wording informing the victim that their information will be shared for

safeguarding purposes and a question asking them whether they consent to being contacted by agencies who wish to offer them support. This has been agreed and is awaiting implementation. The DACC currently only share information on incidents that have been reported to the police and have consent to share with other agencies for support. The future plan for the computer based system is for other agencies such as the National Probation Service or third sector agencies to be able to put forward cases for information sharing and discussion that do not meet the current MARAC threshold of high risk; thereby offering an opportunity for a multi-agency intervention before crisis point. This will also allow a process for cases highlighted as a result of the Ask and Act legislation to be brought into a multi-agency forum.

Regionally some areas for improvement have been highlighted with both the DACC and MARAC processes; these are currently being reviewed by SafeLives, as numbers have dropped regionally. From this piece of work an Improvement Plan will be developed for implementation by the regional VAWDASV Partnership Board.

2. WISDOM (Wales Integrated Serious and Dangerous Offender Management) programme
Gwent Police and the National Probation Service will be piloting this in the Caerphilly area in 2017. This is a process being led by IOM (Integrated Offender Management) Cymru and NOMS (National Offender Management Service) throughout Wales and looks to focus on those offenders who are considered to be complex and to pose a high risk of causing serious harm.

In Gwent, the initial cohort will be made up of violent offenders, particularly high risk DV offenders, predominantly identified out of the MARAC process.

3. NICHE automated information sharing with Probation
The NICHE computer system allows offenders to be flagged for automatic notifications to be sent to a point of contact should they be involved in any incident. In Gwent, Registered Sex Offenders and offenders on Life Licence in the community are currently flagged.

This is being taken one step further to allow automatic notifications to be sent to the National Probation Service for all offenders in their cohort. This process is currently being piloted in the South Wales Police area and will be rolled out to Gwent in 2017.

This report has dealt only with the period of time covering Belle and Howard's relationship. Since the assault in 2000, police procedures have changed and such information should now be held on record for both police and probation purposes, but it is sobering to note the suggestion from A, Howard's second wife, that during any visit to a domestic incident, officers should always ensure that they speak to the victim alone, out of the sight and hearing of the perpetrator of the offending behaviour. This should be as true when the behaviour is coercive and controlling as when it presents as violent assault and is reflected in one of the Panel's recommendations.

3.3 NATIONAL PROBATION SERVICE

The analysis below is taken from the Individual Management Review produced by the National Probation Service, and has been modified for this report, although the text is that of the IMR. The combined chronology attached to this report gives detailed information for all these incidents.

Comments from the report author are in plain text.

Having explored the Chronology of the case, the following organisational learning points have been identified:

More proactive information sharing by agencies throughout the duration of a perpetrator's sentence, where there is no statutory requirement for victim contact. This can range from agencies providing information on what the requirements of any sentence is and agencies sharing any contact and safety planning undertaken for the victim at the time of the reported incident.*

From a National Probation Service (NPS) singular viewpoint, exploration re: setting up specific points of contact when a perpetrator does not meet Multi Agency Public Protection Arrangements (MAPPA) criteria or when the victim is not assessed as high risk of domestic abuse and therefore not in MARAC. This would also prove effective for Community Orders without a requirement of the sentence attached for the perpetrator to complete the accredited Integrated Domestic Abuse Programme (IDAP). Current Policy and Procedures only allow for the appointment of a Women's Safety Worker, to work with the victims of DV, for Community Sentences with an IDAP requirement.

This would enable more effective information sharing and risk management where checks and information shared, are completed routinely at significant stages, to increase the voice of the victim. This could be as basic as providing the Domestic Abuse Unit (DAU), with the OM's details and the details of sentence, which would enable a more fluid information exchange if concerns presented.

**Gwent NPS Local Delivery Unit are currently taking part in a Reportable Incidents pilot - sharing of information of any Police contact between Police and Probation Offender Managers. There are two NPS Team Manager SPOCs (Single Points of Contact) co-ordinating and disseminating this information to the OM's Line Manager. Also, outlined in our previous submissions, Gwent is in the process of reforming a NPS Local Delivery Unit Safeguarding group, with training being a substantive agenda item.*

It is clear from the above that improved data and intelligence sharing is supported by the NPS; the emphasis in these learning points is very clearly on the need for improving communication between agencies. It is interesting to note that NPS do not mention communication with health professionals and this seems to be an area which is perceived as very difficult by all agencies, including health themselves. As issues of low self-esteem and mental health difficulties play a very frequent part in domestic abuse and in deaths arising from abusive behaviour, these links must be made and used. There should ideally be encouragement that whilst a perpetrator is on probation that he attend his GP surgery and co-operates with any mental health interventions available. As observed above, NPS would need written permission from an individual before making contact with their GP or other health service providers. Clarification of this point has been sought from the NPS who gave more detail:

At pre-sentence stage, if service user presents with mental health issues/concerns, a referral would be made to forensic mental health CPN for assessment. Further to this, a request may be made of the Court to consider adjourning for a Psychiatric or Psychological assessment.

When considering a proposal to put before the Court to assist when sentencing, the report author/Probation Officer, takes consideration of issues highlighted by these assessments and viability of managing the risk of serious harm, as part of their risk assessment and risk management plan.

The service user needs to give consent for a Mental Health Treatment requirement to be attached to a Community Order and a named Doctor has to give their consent to deliver the treatment required.

Although reference is made throughout the NPS records of the case to Howard's engagement with health services, there was clearly no way they could be aware of the number of missed appointments as all their information was being given to them by Howard himself. He reported on several occasions that he had a forthcoming appointment, but not that he had failed to attend.

It is interesting to note the points made in the analysis about contact, or lack of contact, with the victim – because it is the life of the victim that is in danger. But by concentrating on the victim we lose the focus on the perpetrator as the cause of the problem. The behaviour is serial – perpetrators almost always abuse more than one woman and leave a trail of damage behind them. Greater concentration on the perpetrator as the cause of the problem must surely be more likely to improve the lives of all concerned rather than current approaches which focus on the victim as the problem. It is not likely that Howard would have told his offender manager that he had informed his wife that she was not permitted to be in the house during the visits, but this is another reason why contact with a perpetrator's partner or ex-partner might be very helpful, even if it is just to inform them about the visit and their potential role during the visit. If current policy and procedures do not allow this, then they should perhaps be changed.

The following extract, from a recommendation in "Domestic Abuse, Gender and Homicide" (Jane Monckton Smith and Amanda Williams with Frank Mullane), describes a very different approach: "Abusers should be profiled by first responders and not treated as though they were ordinary men having an argument with their wife. A history from the victim, and observation of the behaviour of the alleged abuser, can often allow a first responder to recognise risk. "

This approach encapsulates the focus on the perpetrator and should be borne in mind at every stage of the perpetrator's journey, and with the history from the victim being taken in a safe place, well away from the alleged abuser, and with the observation of the abuser's behaviour extended to cover all past known history from health and police sources used to inform the programme put in place by offender managers.

3.4 MONMOUTHSHIRE COUNTY COUNCIL SOCIAL SERVICES DEPARTMENT

No contact with Monmouthshire County Council Social Services Department has been found for Belle. Howard only contacts are concerning the issuing and de-registering of his Blue Badge. The Head of Children's Services has submitted the following information:

Chronology Table

Date	*Source of information*	*Family members*	*Event description, action and outcome*	*Relevance to terms of reference*
12/12/2001	*Social Services archive*	*Howard*	*Blue Badge issued – then renewed every three years*	*None*
27/10/2004	*Social Services archive*	*Howard*	*Bus Pass issued*	*None*
09/05/14	*Social Services archive*	*Howard*	*Badge de-registered*	*None*

This is the only record on Monmouthshire social services data-base. Search on Belle and other family members produced a nil return. Because of these results it was agreed that it was not necessary for Monmouthshire County Council Social Services Department to produce a chronology or an Individual Management Review.

3.5 CYFANNOL WOMEN'S AID AND OTHER AGENCIES

It is clear from the chronology and Individual Management Review from Gwent Police that Belle was given information and signposted to domestic abuse services in her local area on several occasions. The panel requested that the representative from Cyfannol Women's Aid should undertake a search to discover whether such contact had been made. None of Belle's family members or friends believed that she had sought advice from an agency or made any contact of this nature. The results of this search are shown below. Because of the results, it was agreed that it was not necessary for Cyfannol Women's Aid to produce a chronology or an Individual Management Review.

Statement by panel member Helen Swain, CEO, Cyfannol Women's Aid

Following the meeting 15th April 2016, I was tasked to make contact with Domestic Abuse agencies in Gwent and the Bristol Area to confirm whether or not they had any contact with or about Belle or Howard since 1st January 2006 (please see attached letter). At the meeting 27th May 2016, I was asked to extend this search to cover the Bath area.

Request was sent to 9 agencies in total and to date the responses are as follows:

Agency	*Area*	*Reply received*	*Was there any contact?*
Cyfannol Women's Aid	*Torfaen & Monmouthshire*	*Yes*	*None recorded*
Newport Women's Aid	*Newport*	*Yes*	*None recorded*
Llamau	*Gwent*	*Yes*	*None recorded*
Monmouthshire Gateway	*Monmouthshire*	*Yes*	*None recorded*
Live Fear Free Helpline	*All of Wales*	*Yes*	*None recorded*
Refuge (English National helpline)	*All of England*	*Yes*	*Awaiting response Chased again 19/7*
Survive DV	*Bristol*	*Yes*	*Awaiting response Chased again 19/7*
Next Link Housing	*Bristol*	*Yes*	*None recorded*
Missing Link	*Bristol*	*Yes*	*None recorded*
South Side (IDVA service)	*Bath*	*Yes*	*None recorded*
Voices	*Bath*	*Yes*	*None recorded*
Julian House	*Bath (Manage the MARAC process)*	*Yes*	*Awaiting response*

4 CONCLUSIONS, LEARNING LESSONS

5.1 Conclusions

Throughout this section reference is made to, and quotations are used from, the 2014 book "Domestic Abuse, Gender and Homicide" (Jane Monckton Smith and Amanda Williams with Frank Mullane, Palgrave Macmillan, 2014, ISBN 978-1-137-30472-2). This book has been invaluable in considering some of the issues raised in Belle's story and particularly around her family's and friends' comments about her maintaining the relationship with Howard and not leaving despite the difficulties within the relationship. In this section, quotes from the book are in italics.

"*Domestic abuse is discursively considered a private matter in which the victim could, in fact, sort out her own problems if she would just leave, and not one for the attention or resources of law enforcement*."

In this case, as in so many others, the spoken and unspoken question rings through – *"Why didn't she just leave?"* Clearly, this question is not a simple one and the reasons are many, subtle and varied according to the victim's circumstances. But the question surrounding Belle's remaining with Howard despite strong advice from family and friends must be addressed.

The focus on this and many other cases centres around the concentration on the victim when the problem is surely the perpetrator rather than the victim – Howard had left a trail of evidence behind him of petty crime, domestic violence, mental health issues and related suicide attempts. It seems possible, if not probable, that a greater level of communication between agencies might have been able to pick up and work to resolve some of these issues and to identify the risk that Howard might pose to women with whom he formed relationships.

"Coercive control and verbal threats are more positively correlated with homicide than violence alone, and should be taken very seriously."

There is a lot of evidence of verbal and written threats and related coercion in the text messages from Howard, the behaviour reported by friends and family members and the facts we have about the couple's lives. Belle depended on Howard for transport, all the bills were paid from Howard's bank account despite the fact the Belle was the breadwinner, Belle was frightened to smoke in front of Howard, Howard decided that G was staying in the house too often despite Belle's enjoyment of her visits. These and many more examples show a pattern of coercion and control that was recognised by those close to Belle and Howard but not picked up and identified by the professionals with whom they engaged. This is an easy conclusion to make in hindsight, but it does indicate the need for even more close probing by health, police and other professionals in order to recognise the indicators of a pattern of coercive control, as well as appropriate training in recognising this behaviour and its possible consequences. It is particularly difficult for professionals if the coercion and control is not highlighted by the person on the receiving end of the behaviour.

"Controlling men are identified as presenting the highest risk for killing their intimate partner or former intimate partner, irrespective of whether they are also habitually violent. In fact, Stark, (2013) reports that coercive control is a higher risk than violence alone by a factor of 9:1."

With the advent of the new offence of controlling or coercive behaviour in an intimate or family relationship (S76, Serious Crime Act 2015), Gwent Police provided training to all operational frontline staff in this area. This training aided officers in the identification and understanding of such behaviour, tactics used by perpetrators and actions for officers to consider – including the ability to hold a safe enquiry with the victim. In addition, a video training package was developed and shared with staff and further training has extended to include stalking and harassment offences.

"Domestic arguing is commonplace, and many men and women assault each other without there being ongoing coercive control and abuse. This is the area in which we find most bi-lateral violence, which is sometimes confused with domestic abuse. It is when the violence is used as a means of control, that it is domestic abuse."

We have a lot of anecdotal evidence from family members and friends that Belle and Howard's relationship was physical and violent on both sides. Family and friends' comments included "she gave as good as she got" and "she had to scram him to free herself". A text from Belle to Howard reads "I'm sorry I spat at you". There is a report of one incident where Howard was arrested but charges dropped because his injuries were worse than Belle's. But it was almost always Belle who left the house and stayed with her mother, who hid from Howard and who fled to friends in great distress. However, it was not unreasonable for this bi-lateral violence to cause some confusion for the police officers in determining the right approach and the level of intervention necessary – particularly as Belle made it clear that for her part, no intervention was required. The relationship was generally seen as stormy and troubled. But it is very difficult for a strong, capable woman to admit, even to herself, that she is frightened of her husband. She may be very confused, especially if she still has affection for him and has worked hard to make the relationship work. The one person who was certain that Belle was extremely frightened of Howard was MB, her new partner, who disclosed that Belle had shared her fears with him, and who had urged her to seek the safety of her mother's home. Despite this, he too believed that Belle felt that Howard could not overpower in a fight and that she could "handle him".

The support from Belle's family and the close relationship and contact maintained with her mother throughout her relationship with Howard was a significant feature. Maintaining close relationships where there is domestic abuse is difficult to balance due to the tactical isolation fundamental to such abuse and the powerlessness that is frequently experienced by family members. That Belle was able to maintain close links with her family was testament to their efforts. Belle always had the option of a home and / or refuge with her parents, and used this on many occasions.

The Welsh Government Right to be Safe Strategy (10, 000 Safer Lives Project 2012) placed specific duties on public bodies to develop work place policies for staff members who were experiencing domestic abuse. The introduction of work place policies and associated guidance for employers recognises that many victims of domestic abuse (75%) are targeted at work and yet at the same time it can be work that provides a safe haven from abuse and where victims can safely access support. There are examples of good practice being adopted within the private business sector and in Belle's case, her work community were offering significant support and protection without any formal policy, guidance or training; in interviews, they shared that they would have welcomed

guidance on how best to support Belle. This review raises the importance of community and workplace based support for victims and this includes that of friends, family and employers.

"*Many abusers are dysfunctional on many levels and there may be appropriate health, mental health or substance abuse and anger management interventions. ……What we do know is that certain men who need to control their partners, or feel a sense of diminishing control in their lives, can become very dangerous."*

There was a pattern of controlling his partners in Howard's life and the GP notes as well as comments from family members, particularly Howard's, show evidence of his lack of self-esteem, low mood and frustration. His awareness of his reliance on Belle for financial, physical and emotional support had been growing and the texts between the couple show an increasing desperation on Howard's part at the thought of Belle's leaving the marriage. Belle's and Howard's deaths occurred at the point in which Belle was planning to leave Howard's control by taking action and leaving – her packed bags in the kitchen of their home show that this was the day she intended to go, though we cannot know whether she planned to go to her mother's home or to that of her new partner, MB. MB himself does not know where Belle was planning to go that night. She had made no arrangements with him or with her mother to come and collect her.

Howard had already made several suicide attempts, with one of the most serious being after the assault on his second wife.

"Many of the homicides we come across were risk assessed at medium or standard levels, some were not seen as serious enough to warrant a risk assessment at all. Yet in every case coercion and control were present."

"*…the most vulnerable and seriously abused victims are the ones who are often given the least time and attention across services*."

It is difficult to reach firm conclusions regarding the appropriate level of help, intervention and risk assessment on the part of the agencies involved. Belle was offered support and intervention but declined this on several occasions – yet we know that she must have been extremely unhappy and that she was certainly afraid of Howard during some of their violent episodes. It is possible that the intervention and support that was on offer was not enough for to balance with Belle's fear of being hounded, or of being seriously hurt by Howard if she attempted to leave him.

There have been many changes in practice and procedure in all agencies since the start of Belle's relationship with Howard. It is difficult, if not impossible, to determine whether the application of these changes at an earlier time could have changed the course of events. It does seem unlikely, but there are still many valuable lessons to be learned which may inform future practice.

5.2 Addressing the terms of reference

The panel believes that its purpose, as stated in section 1 "Purpose of the Panel" of the terms of reference has been fulfilled.

In section 2, "The Scope of the Panel Review", we have changed the date of the start of the period from 1st April 2009 to 1st January 2006 following information received from family members.

Although reference has been made at 2.4 to reviewing national best practice, although this has been considered in the production of this report, it has not been possible within the timescales to conduct such a review. Other than this, the panel believe it has met the terms in Section 2.
The panel has considered and addressed all the items in Section 3 of the terms of reference. It has not been possible to speak to all the family and friends that we should like to have engaged in the process, because not every individual was prepared to engage with us. It is probable that the fact that this was both a homicide and a suicide made this very difficult for family members and friends of Howard's in particular, although this has clearly been difficult for all those who did feel able to take part in the review. The panel is extremely grateful to all those who did feel able to speak to us and provide the information which enabled the report to be produced. The draft report has been given to close family members of Belle for comment and correction of factual errors before being sent to the Home Office.

5.3 Multi-agency working, communication between agencies and recording

Every local authority in Gwent now has a daily "Domestic Abuse Conference Call" (DACC). These were initiated by Gwent Police in order to "create an opportunity for early intervention to provide a better service to all victims of domestic abuse." Gwent Police have also "set up a secure web site that can be accessed by statutory partners to share information safely, freely and quickly. We place all reports of domestic abuse incidents on the site and we refresh the information every 24 hours." This is an initiative which has had excellent results, with early analysis showing a 28% reduction in repeat victims.

There was one such conference call in respect of Belle and Howard, following an incident on 6th March 2014, when Belle apparently phoned 999 herself following an argument in which Howard had hit her. This was discussed at a DACC the following day and, because it was clear during the call that Howard was currently serving a Community Order, the incident was correctly upgraded from standard to medium. This did not trigger a Multi-Agency Risk Assessment Conference, which would only have taken place following a rating of high risk. But the calls do demonstrate a commitment to multiagency working and communication between agencies which is bringing results and which is unique in Wales at present.

It would be useful to extend this to a form of permanent recording which would identify persistent perpetrators of abusive behaviour as well as potential victims of such behaviour. The flagging system referred to above and in Recommendation 7, where markers are put onto the health records of persons with a known history of abusive behaviour could be informed and checked against information arising out of the DACC. Multi-agency training to improve and monitor and extend the use of such information and the means of sharing and using it might be usefully considered.

Ask and Act Training, as mentioned above, is currently being rolled out to a range of professionals including many not covered in this report e.g. housing, fire services etc. This provides another opportunity for sharing experiences and making links between professionals which should only improve current practice.

It is important that Community Mental Health Teams are included in this information sharing as issues of non-engagement or attendance by perpetrators posing a risk could then be highlighted and acted upon. We understand that research is currently underway in Wales steered by the

national VAWDASV Steering Group, and hosted by Public Health Wales, which is looking at best ways to share information to assist and inform GP's with their patient's assessment. The use of markers may be being considered as part of this work and any opportunity to feed into this would be timely.

5.4 Predictability and preventability

Belle was a strong, healthy young woman. It is clear from our collected evidence that she did not suffer the physical violence from Howard without fighting back. The fact that she tried to fight back and manage the situation in this way demonstrates this strength and shows that she had not entirely lost her self-esteem and had some motivation to change her situation. It must have been hard for her to balance this with her sympathy for Howard with his mental and physical difficulties; and it is important to note that sympathy for a perpetrator's difficulties may form a significant part of coercive control over the victim. For those around her, her strength of both body and character may have masked the real situation. Certainly, she presented to professionals as not requiring support or intervention. The focus of much of the intervention was upon Belle as the victim rather than on Howard as a risk. It is possible that greater concentration upon Howard might have led to more details of his history being known to the professionals involved, though it is unlikely that this would have altered Belle's response to intervention.

Howard completed a "Respectful Relationships" programme with NPS as part of his Community Order, but although three home visits were made, Belle was never seen either during or following the period of the Order. This was because Howard had told Belle that she was not allowed to be present during the Offender Manager's visits. It is not clear how Belle would have engaged on more than a superficial level with such a visit. It is also unclear whether the extent of Howard's mental health issues and non-attendance was explored at length during the period of the Order, but again, it is unlikely that such an intervention would have altered the course of events. It is significant to note that following the incident on 6th March 2014, referred to above, there had been no interaction with police until the day of the tragedy well over a year later.

Belle's decision to leave appears to be linked to the starting of a new relationship, rather than to increasing violence on Howard's part. Friends report a growing in confidence, strength and happiness in Belle during this period which may have given her the impetus to make the decision. Belle's solicitor had advised her to leave as soon as possible and Belle's mother had strongly seconded this advice. Belle clearly was planning to leave on the day that she died as her bags were packed and in the kitchen. Neither she nor those around her could have predicted what followed. The escalated danger at the point of leaving should be made very clear and explicit in domestic abuse literature and by those advising women in abusive relationships.

5 RECOMMENDATIONS

(See also Recommendations Action Plan at Appendix Two)

NB All of the recommendations below, whether collective or individual have been fully discussed and are supported by the panel.

6.1 Individual Management Review Recommendations

N.B. The individual recommendations have been suggested by the agencies involved in the review but have been wholly discussed and are supported by the DHR panel. The DHR panel recommendations have been drafted by the panel which includes representatives from all the participating agencies.

Aneurin Bevan University Health Board Recommendations

Recommendation ABUHB 1

In line with the National Training Framework (NTF), ABUHB ensure Ask and Act training is implemented across own organisation

Recommendation ABUHB 2

ABUHB ensure Ask and Act training focused initially on targeting Primary Care Services, specifically GPs.

From Wales Untoward Serious Incident Process:

Recommendation ABUHB 3

Domestic Abuse included within the planned Continuous Professional Development (CPD) sessions for GPs on Safeguarding.

This will now be strengthened by the statutory roll out of Ask and Act training.

Recommendation ABUHB 4

The WARRN (Wales Applied Risk Research Network) training package is reviewed to include the importance of completing the WARRN as soon as possible during the assessment process for all people accessing a Community Mental Health Team (CMHT).

Recommendation ABUHB 5

An alert is sent to Community Mental Health Teams (CMHTs) teams reminding them of the importance of completing an agreed risk assessment at initial assessment for all people accessing a CMHT, and a documented risk assessment is completed for all people accessing Primary Care Mental Health Support Services (PCMHSS).

This is in line with PCMHSS operational processes.

Gwent Police Recommendations

No individual recommendations were made by Gwent Police.

National Probation Service Recommendations

No individual recommendations were made by National Probation Service.

6.2 Domestic Homicide Review Panel Recommendations

Recommendation 6

All Community Safety Partnerships, police and other agencies have clear, lean protocols to enable Domestic Homicide Reviews to commence as quickly as possible after death.

It is possible for this to happen whilst not impeding the police investigation. This will ensure that a panel chair can be appointed and have the advantage of familiarity with the case from an early stage and the opportunity of being present at the inquest. It will also ensure that family members may be signposted to and able to access independent advocacy and thus be supported throughout the inquest and beyond.

Recommendation 7

A briefing note to be compiled to raise awareness of coercive and controlling behaviour and to be signposted to Gwent GPs.

Recommendation 8

All practising solicitors in Gwent dealing with marital and family issues to be signposted to information to highlight the dangers are trained to understand the dangers that may be faced by a woman leaving an abusive relationship.

This should assist in the recognition that coercive and controlling behaviour is a more effective predictor of death than violence, and to aid in the provision of practical advice and coping strategies to clients facing these situations.

Recommendation 9 (a)

Initial interviewing of suspected victims of domestic abuse, whether violence or coercive and controlling behaviour always takes place out of sight and hearing of the suspected perpetrator.

Recommendation 9 (b)

Intervention visits e.g. by Gwent Police Domestic Abuse Officers or by National Probation Service officers take place in a neutral location, well away from the suspected and/or convicted

perpetrator. Such visits are always made after Community Orders finish and following incidents where police have attended.

Recommendation 10

All hospitals, clinics, health centres and GP surgeries in Gwent be provided with public information material offering signposting and information regarding domestic abuse including coercive and controlling behaviour.

This is largely already the case, but it is important that stocks are maintained in all locations and that the material is also in places where patients may pick it up without being seen e.g. in WC facilities etc.

Recommendation 11

When family members, friends or other personally interested parties appear at the scene of a homicide, a Duty Supervisor is always appointed to support them, act as an information conduit and explain crime scene procedure. They also ensure that other close relatives are promptly informed either by themselves or by other officers.

6 GLOSSARY & DEFINITIONS

AAFDA	Advocacy After Fatal Domestic Abuse
ABUHB	Aneurin Bevan University Health Board
CMHT	Community Mental Health Team
CPD	Continuing professional Development
CSP	Community Safety Partnership
DA	Domestic Abuse
DACC	Domestic Abuse Conference Call
DASH	Domestic Abuse, Stalking & Harassment and Honour Based Violence
DAU	Domestic abuse unit
DHR	Domestic Homicide Review
GP	General Practitioner
GP	Gwent Police
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
MAPPA	Multi Agency Protection Planning Agreement
MAPPP	Multi Agency Public Protection Panel
MARAC	Multi Agency Risk Assessment Conference
MCC	Monmouthshire County Council
MPSB	Monmouthshire Public Service Board
NPS	National Probation Service
PCMHSS	Primary Care Mental Health Support Service
SPOC	Single Point of Contact
WARRN	Wales Applied Risk Research Network

APPENDICES

Appendix One – Combined Chronology

Appendix Two – Action Plan - Recommendations

Appendix Three – Contents - Evidence Box given to CE on 20/07/16 (Incident No. K35 - 2015)

The Appendices are held as separate documents which have restricted access.